Optimal Oncology Alternative Payment Models

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VIEWPOINTS

Shaping the future of alternative payment models in oncology

Executive Summary

The Centers for Medicare & Medicaid Innovation (CMMI) recently released the draft for Oncology Care First (OCF), a new oncology payment model projected to launch in January 2021 as the successor to CMMI's Oncology Care Model (OCM).[1]

> *"Patients are at the core of [the OCF] model."*
>
> – Lara Strawbridge, Director, Ambulatory Payment Models, CMMI, OCF Listening Session, November 4, 2019

OCF affirms CMMI's commitment to shift away from the status quo fee-for-service (FFS) payment paradigm to one that incents value-oriented, patient-centered care and builds on OCM.[2] OCF, as it is currently conceived, meets CMMI's stated goal of having a single alternative payment model (APM) dedicated to managing cost and quality for Medicare cancer patients.[3]

CMMI's announcements of OCF and other primary- and specialty-care payment models have raised questions on what the end state for oncology APMs looks like. This question was top of mind for members of the oncology APMs advisory council, which gathered in November 2019 in Washington, DC, for its third meeting. The council, launched in late 2017, gives leading designers and implementers of oncology APMs the opportunity to learn from one another and catalyze new thinking and approaches to improve pilots in this space.[4] Participants addressed several perennial issues, including accountability and risk, the cost of drugs, meaningful outcomes measurement, and the utility of emerging tools such as electronic patient-reported outcomes (e-PROs). These challenges continue to underlie conversations in this space, as do the implications of the one-size-fits-all approach to oncology payment reform for Medicare that CMMI is spearheading through its OCF proposal.

During the meeting, participants considered the following topics:

- Challenges presented by the coexistence of oncology and primary-care APMs
- Acceptable risk and risk mitigation strategies for practices
- The cost of drugs in APMs
- The end state of oncology APMs

- New perspectives on oncology APMs: self-ensured employers and patients

Conversations on the above topics yielded several key takeaways:

- **The coexistence of specialty and primary APMs presents several challenges, particularly in the development of new oncology APMs.** More data is needed to demonstrate the value of dedicated oncology APMs in areas where accountable-care organizations (ACOs) are already in place. That said, many are concerned about the ability of ACOs to effectively manage quality and bend the cost curve in cancer care.
- **OCM practices have nuanced perspectives on two-sided risk and are taking diverse actions based on their appetite for risk.** Some larger OCM practices with more resources are becoming more comfortable with taking on risk in the program, while some smaller ones are not. Looking beyond OCM, practices of all sizes remain uncomfortable with being held accountable for the total cost of care and would prefer that future models carve out elements that are more difficult for clinicians to control.
- **Drug costs in total-cost-of-care APMs remain a persistent challenge with no easy answers.** Most problematically, currently proposed solutions for this issue, such as integrating value-based drug contracts between providers and manufacturers into APMs, continue to come up short. In the words of one provider, such contracts are problematic because of *"all the hypotheticals and lack of data."* More granular clinical details would help in the creation of more accurate targets that would presumably reflect appropriate treatment costs and adjustments, but the models cannot be overly complex or too finely stratified, otherwise, as one participant observed, *"We're returning back to fee for service."* Many providers prefer models that carve out drugs (especially novel therapies). Some are open to taking on risk for supportive-care drugs, and many support giving importance to adherence to clinical pathways when measuring provider accountability.
- **Slowly but surely, bundle-like models[5] are starting to emerge, signaling that the end state for oncology APMs may—for some payers—incorporate population-based approaches.** Participants noted they primarily see these bundles accelerating in radiation oncology and surgical oncology, but as evidenced by OCF, some bundling may soon start to materialize for certain services within medical oncology. Participants underscored that more debate is needed on whether supportive services like nutrition or mental healthcare could be included within bundles or similar capitated payments.
- **Self-insured employers are becoming a more prominent force in new experiments in managing cost and quality in cancer care, though questions remain about the sustainability and scalability of these approaches.** Participants see employer models as offering opportunities for innovation and for testing specific research questions, given that employers often have considerable resources and flexibility for innovation. Some are concerned that centers of excellence (CoEs) and second-opinion models of the sort being

offered by some of the nation's largest employers like Amazon and Walmart may diminish the relationship and value offered by local community oncologists.

- **How to engage patients appropriately in APMs remains a challenge. Particular issues include whether and how best to use e-PROs and how to incent better care coordination with the patient.** In light of the recent announcement of OCF proposing e-PROs as a potential additional transformation component, the group debated the value and utility of PROs for clinicians. They were conflicted on whether PROs could be meaningfully used to measure quality and inform prompt clinician decision making. Regardless, all agreed that care coordination continues to need improvement as patients are *"still getting lost in the system."* Patients' role in contributing to their own care management and individual patient variables such as social determinants of health need to be considerations in shaping APMs, many council members emphasized.

Introduction

"CMS [Centers for Medicare & Medicaid Services] is correcting misaligned financial incentives that have been in place for decades and creating new innovative payment models for providers … Today, only 10 percent of clinicians are participating in Advanced APMs and taking on significant levels of risk—no wonder frustration continues. The value-based transformation is not moving quickly enough."[6]

– Seema Verma, CMS Administrator, National Association of Accountable Care Organizations Spring 2019 Conference

"We want to advance models like these [APMs] in a collaborative manner. That has been a key priority for this administration since day one … But there is nothing virtuous about maintaining outdated systems within Medicare fee-for-service—effectively a mandatory system for so long—when we know we could be exploring better alternatives. We need results, American patients need change, and when we need mandatory models to deliver it, mandatory models are going to see a comeback."[7]

– Alex Azar II, Secretary, Health and Human Services

The pace of change in oncology payment reform has continued to accelerate. Many oncology practices participating in the ongoing OCM pilot are at an inflection point, facing the choice either to take on two-sided risk or to exit the model altogether.[8] Simultaneously, CMMI's recent release of the OCF model signals its urgency regarding transitioning to value-based outcomes. Currently there are more than 21 APMs in cancer, with various objectives and resource requirements,[9] leading many oncology leaders to call for more standardization across models and a better understanding of where these models are headed. One APM advisory council participant asked, *"Have we learned enough yet to anticipate how these models will work in the future?"*

Increasingly, oncologists and commercial payers developing their own oncology APMs are turning to CMMI for direction and leadership. They are looking at OCM developments and data, the recent mandatory oncology radiation bundle proposal (RADONC),[10] and OCF as harbingers of the potential end state of payment reform models in cancer. Innovators in this space are also increasingly mindful of new initiatives in primary and palliative care.

Participants are also looking at the experiments of new stakeholders in this space, such as self-insured employers, some of whom have launched their own pilots to address the rising costs of specialty care, including in oncology. These employers are using their early lessons to inform further efforts, and some are sharing their findings with the community.

All these developments make for a highly complex landscape for oncologists. One council participant described how some medical practices are *"pretty scared about the situation in US healthcare … We are going off a financial cliff."*

While pilots in oncology payment reform are no longer brand-new, many of the challenges discussed in previous council meetings and other forums remain evergreen. Payers and providers continue to ask whether APMs need two-sided financial risk to effectively make providers accountable for value-based care. If so, what is an acceptable level of risk? Should the cost of drugs be included? If two-sided risk for total cost of care is a given in future models, then what techniques can practices use to manage risk?

In its November 2019 meeting, the oncology APMs advisory council sought to address several fundamental questions on the topic of oncology payment reform: where are payment models in oncology headed? What more is needed to develop a final end-state model that is palatable to all stakeholders? What are the major challenges that remain? This *ViewPoints* synthesizes the views and recommendations that arose during the meeting and in conversations that preceded it, along with additional external analysis and perspectives from stakeholders involved in oncology APMs.

> *"In 2026, OMB [Federal Office of Budget and Management] says that we will be spending $5.5 trillion, which is all the money we have, on health care. And the Part A trust fund that pays hospitals, it's zero on January 1, 2026, according to OMB. I see in the meantime hospitals merging into bigger hospitals for higher market share. I see insurance companies merging into bigger insurance companies for higher market share. I see physician groups now merging into bigger groups for more market share … [In the meantime] I am seeing people in my practice having to decide whether they're going to buy food or their medicines or their doctor copay or their insurance premium … I think that we are really in trouble in health care in general and oncology is the canary in the coal mine."*
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> – Provider

Challenges presented by the coexistence of oncology and primary-care APMs

New APMs in both primary and specialty care are emerging at a rapid pace. One example is the Centers for Medicare & Medicaid Services' (CMS's) Primary Cares Initiatives, a group of voluntary payment models that CMS hopes will, among other things, encourage primary-care physicians (PCPs) to play a more prominent role in caring for patients with complex conditions.[11]

As these models proliferate, providers face challenges managing the resulting intricacy. In previous council discussions, participants questioned the potential overlap between proposed

advanced-care models and OCM.[12] Several participants also noted that providers and payers face difficulties developing new oncology APMs in areas with high ACO penetration. Participants discussed how, moving forward, these difficulties could be overcome and other factors to consider when attempting to initiate new APMs.

Building the business case for a specialty APM

Some participants emphasized that clear data should be used to demonstrate the need for a dedicated cancer model to payers in areas where ACOs are already in place. Speaking from a payer point of view, one participant noted that the impact of ACOs on cancer care is not yet widely understood and that without clear data, some payers continue to *"preferentially look to the ACO to assign reduction [of costs]."*

Other participants directly called into question ACOs' success in cost containment. A provider said, *"Looking at the most recent data on ACO savings, they saved $75 a patient. That's one office visit. That's not adequate to get us off the cost curve … If an ACO is the end game … will that be adequate for [controlling costs]?"* Indeed, some data on ACOs' lack of impact specific to cancer care is starting to emerge and may help inform conversations between payers and providers. Research from the Dana-Farber Cancer Institute suggests that spending on cancer for patients in an ACO is roughly the same as spending for non-ACO patients.[13] Some participants said that currently in ACOs, many cancer patients are automatically *"knocked out"* of the model as outliers, and cancer populations are oftentimes too small for ACOs to manage through a dedicated approach.

These factors signal that there is likely a need for dedicated models or carve-outs to better manage cancer patients' care and associated costs. For some payers, cancer-specific carve-outs or APMs may be impractical, but these payers may welcome explorations of other synergistic approaches. One provider shared that payers were approaching them to explore *"bring[ing] cancer back into the ACO and looking at bundled payments"* to effectively incent providers to coordinate care.

Clarifying attribution and accountability for care

Even if the data underlying a business case for a new oncology APM were sound, crafting a strategy for handling payments can be difficult. One provider described challenges with attribution with a local commercial payer that already had an ACO contract: *"All dollars and patients are already attributed to PCPs. If I reduce hospitalizations, the savings will need to be shared, and they are already paying the [PCP] … But we could reduce overall costs—and what they perceive as double paying could still save them money because overall savings would be increased."*

In light of this challenge, during the meeting participants discussed how to reasonably divide shared savings between oncologists and PCPs or existing ACOs. This would depend, in part, on how the model defined accountability during an episode of care. Several suggested that oncologists should be responsible for—or "*quarterback*"—a cancer patient's care during treatment. These participants declared that while an oncologist might not know as much about dealing with a diabetic comorbidity as a PCP, PCPs *"just don't have the clinical experience that we have with these patients … I think you must have the cancer patient and the bundle under the control of the oncologist or the cancer service line."*

> *"We can't ignore overlap [between primary and specialty] and start pulling people out in a world where we have direct contracting models. If ACOs can contract with a good oncologist, why do we even need these models? Doing back-end [attributions] claim by claim doesn't work. How to create incentives up front? How do we account for savings, and where do we award it?"*
>
> – Payer

Several participants, in contrast, said that there is value in coordinating with a PCP but were unclear how that could be incented given the inherent competition across practices. One said, *"There is probably value trying to incent coordinating care across teams … but this is complex. We don't have any clear solutions. How to incent a primary-care physician to work with a medical oncologist to work with a radiation oncologist? How do you do that with a financial structure that's tenable? If you're trying to integrate an ACO and oncology model, you can't retrospectively attribute claims to one or another."*

Some participants in the process of developing a new APM noted they were considering one potential solution: offering proportional amounts of shared savings or subcontracts between oncologists and PCPs. Such approaches could present oncologists with an *"opportunity as oncologists to figure out who we want to associate with,"* one said. Incenting clinicians would remain a challenge, however, because of competition between practices, as noted above. A participant from a comprehensive cancer center that invests heavily in effective patient management said, *"It's questionable whether or not we need to get a diluted amount of the savings [from sharing with an ACO] if in reality patients are managed entirely by the cancer center."*

Operational challenges

Many payers set up ACOs as multiyear contracts with PCPs and modify their IT, administrative, and operational infrastructure to support these contracts. In order to advance a new APM, payers with these contracts will need to consider the operational costs of carving out cancer patients. One participant recounted a local commercial payer's concerns: *"Many of the challenges were operational. This payer set up [their ACO], and it's been successful, and they invested in the infrastructure. They already had their providers in five-year contracts with budgets … If a proposal was to be considered, they'd need to amend all contracts."*

In addition, existing regulatory oversight, such as state-level review and approvals, can pose a challenge to new models, some participants said.

The relevant payer's profile and internal incentives

A payer's size and scale may also influence its appetite for investing in an oncology APM. One provider noted, *"Local payers will worry that assigning dollars in a separate contract to oncology providers may not give them enough return on investment versus the trouble. UnitedHealth or national carriers may have enough funds and scale that they could readily invest in onco-specific interventions. It depends on the local penetration of these carriers."*

That said, while larger payers may have more resources, they face more complex internal dynamics. One payer said, *"In large payers, different teams own different markets, and a new APM may compete internally with another team. How can one manage that competition?"*

Acceptable risk and risk mitigation strategies for practices

For many participants, discussions on risk have taken on renewed urgency with CMMI's release of the new OCF model, which advances two-sided risk for the total cost of care, and with the December deadline for practices to either drop out of the current OCM pilot program or accept two-sided risk. Several participants in the APMs advisory council agreed that the decision on two-sided risk is a benchmark for practices' appetite for risk more broadly. Against this backdrop, participants described how they are thinking about risk today, especially given the data and outcomes to date from OCM, and they discussed the potential tools available to help practices manage risk in the near-term future.

> *"As downside risk has an increased role in how these models are launched, how are we thinking about mitigating risk?"*
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> – Industry representative

The role of risk in incenting transformation

Providers debated what types and levels of risk they need to be exposed to in order to feel compelled to invest in practice transformation. Several emphasized that participating in OCM and taking on two-sided risk would generate considerable nonmonetary value, especially in the subsequent data and outcomes. These in turn could lead to the development of better *"organizational intelligence, [focus on] strategic planning for how value-based payments will evolve, and the development of systematic approaches to very complex decisions, i.e., whether to take [on] two-sided risk or not, take on stop-loss insurance or not, and how we analyze the impact of care delivery investments across not only Medicare but the commercial payer and Medicare Advantage patients as well."*

However, many noted that the levels of risk in two-sided risk models may not need to be high to achieve meaningful practice transformation benefits. One participant asked, *"Does exposure to overwhelmingly high, potentially practice-bankrupting levels of risk accelerate practice transformation?"* Many cautioned that it did not.

That said, some practices have an increasing appetite for certain types of risk, especially risk relating to appropriateness of clinical care and utilization, or what some have termed *"process risk."* In the words of one provider, *"I look at doing process risk as creating all these building blocks that I can then put together to say if I manage a breast cancer or lung patient optimally, when you roll it up, we should be in good shape."* For some, the uncertainty created by taking on risk for the total cost of care continues to be very concerning, as explored below.

"Doing the arithmetic" on two-sided risk in OCM

Practices are applying some of their thinking on the cost-benefit of taking on two-sided risk to the upcoming decision to do so for OCM. Some practices—those with more resources—were reasonably comfortable taking on risk in OCM when they factored in the benefits of the additional 5% that they would gain from being in an advanced APM. They pointed out that the option of exiting OCM was not appealing given the *"forgone risk premium that is represented by the MEOS [monthly enhanced oncology services] payments."* They said that factor *"present[ed] a pretty compelling reason to stay in the model,"* as did the loss of nonmonetary benefits of participating in OCM and the investments they had made over the past years to establish themselves as a leader in value-based care.

Smaller practices, in contrast, determined that the potential upside of staying in OCM and taking on two-sided risk was not worth the potential downside. They noted that the law of small numbers undermines their ability to survive a loss. In the words of a provider, *"If there's going to be a loss, how many years of gain do I need to make it up? Can I survive two years of loss in a row in my practice, which has very slim margins because I take care of poor people? Is there enough upside gain potential in terms of what can I do in two-sided risk? … So, we did all those kind of calculations … And because the law of small numbers has not been repealed, that means that my variation is going to be higher from year to year … The arithmetic for me said two-sided risk does not give me enough additional benefit to be willing to say I'm going to put my practice at risk … And that it would actually be counterproductive because of the risk [for] these people who depend on me either for jobs or for care."*

For commercial payers initiating APMs outside of OCM, approaches to and concerns about risk vary depending on their structure and philosophical approach to value-based care. That said, some are actively trying to learn from the OCM experience to *"avoid potential land mines"* in crafting a risk strategy for forthcoming models.

Managing downside risk through reinsurance and other tools

Several experts in this space are continuing to explore whether practices can employ reinsurance and other potential tools to mitigate providers' downside in two-sided risk APMs. One provider representative said, *"I now think reinsurance may be less far-fetched than I did a few months ago, given the OCM risk dilemma facing participants. Folks are asking whether to take two-sided risk and whether they need reinsurance to make it happen."*

> *"I think risk adjustment is a science that is just at its beginning. It has a such huge impact that, while we don't have systems in place to control [for risk] yet, we're going to have to [develop them] if we're going to be able to accurately price care."*
>
> – Provider

Some observed that reinsurers are starting to offer products to specialty APM participants, including those in OCM, to help practices mitigate downside risk. A subject matter expert noted, *"The landscape for oncology-based reinsurance is evolving very actively right now because of all these models that we're talking about."* The maturity of their offerings is still an open question, and few OCM practices have indicated that they are ready to use such a product, despite some discussion in the community.

As reinsurers learn more about cancer practices' risks, more competitive products that are priced more reasonably may come on the market. One participant concluded, *"The reality is there is now a market for reinsurance in this world."* This represents a major shift from even a year ago.

Some participants wondered whether there were tools other than reinsurance that could be used to help providers manage two-sided risk. They noted that new vendors are offering risk-modeling services that they claim are more accurate than such services have hitherto been. These services can help providers predict patient outcomes such as hospitalizations based on factors such as *"use of oxygen, depression, lack of a caregiver, etc."* Some providers believe that as expanded data gathering and inputs help these predictive models evolve, the models will become increasingly important and necessary, especially *"if we're going to … accurately price care."*

The cost of drugs in APMs

During the council meeting, participants discussed the "elephant in the room:" the cost of drugs and the accountability of the provider in managing those costs. It is not an issue that can be easily sidestepped. One participant observed, *"It's hard to talk about total cost of care without talking about drugs. It's also very difficult when it dwarfs everything else."* Most problematically, currently proposed solutions such as value-based drug contracts are failing to hold up to closer scrutiny, including from council participants.

Many reiterated that if two-sided risk and total-cost-of-care models are here to stay, more granular clinical details are needed to develop more accurate targets and adjustments. This in turn ignited further discussion on social determinants of health and the appropriate level of granularity and stratification required for these models. Contemplating a scenario in which providers are not held accountable for the cost of drugs in new models, participants stressed that adherence to value-based clinical pathways would be a desirable metric on which to reward good performance, assuming stakeholders could agree on how to define a good value-based pathway.

> *"Drug costs are really driving the majority of the expense in cancer. In diabetes, there's a lot more we can do around drug costs—generics, competition, etc. … In oncology, we've got one choice. As new products come in, they are equally expensive."*
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> – Provider
>
> *"[The] drug issue is important. But if [payers think] squeezing practices [is] going to change cost of drugs, they're crazy."*
>
> – Subject matter expert

The potential use of value-based drug contracts

Several shared data showing that the rising cost of new treatments, especially in the last few years, has negated the gains practices have achieved in reducing other high-cost healthcare interventions, such as unnecessary emergency-room visits. One provider said, *"I am very concerned about the impact of drugs in the total-cost-of-care model. Our data bears this out. Drugs were sitting at about 35% of the total cost of care in the baseline periods in 2012 and 2013. For [OCM] performance period 4 in 2018, they're approaching 60%."*

Participants debated one novel proposal to help solve providers' frustrations in this regard: integrating manufacturer-provider value-based drug contracts (VBCs) into payer-provider APMs. This was originally proposed by the Community Oncology Alliance (COA) in their June 2019 OCM 2.0 proposal to the Department of Health and Human Services' Physician-Focused Payment Model Technical Advisory Committee (PTAC).[14] OCM 2.0 made the following specific recommendations:

- CMMI should incentivize more experiments in VBCs.
- CMMI should waive several regulatory barriers that are obstacles to broad uptake of these contracts.
- Assuming waivers materialize, pharma companies should work with providers to guarantee prespecified clinical outcomes (e.g., specified tumor reduction or money back to the provider and/or the patient).
- Pharma/bio manufacturers should contract directly with provider care sites.

Participants discussed their views on the value of COA's proposal and its objectives, with one observing, *"Forty to fifty percent of the price of the drug is paid for before it gets to the patient.*

So, the middleman is a large expense. If [providers] can have direct contracting, hopefully [they] can work around the middleman and lower the cost with the patient and provider involved … This would help align the definition of value, so everybody understands it the same way from the drug standpoint."

Those in the council with experience evaluating these contracts, however, pointed out that implementing APMs is complex and suggested that adding another layer of contracting with drug manufacturers may be impractical. They cited several difficulties:

- **Agreeing on outcomes.** Many participants were skeptical that manufacturers and providers could agree on the desired clinical outcomes of a drug and on how to measure patient response against those outcomes. One provider representative said that the *"biggest challenge we see [with using more value-based contracts] is measuring response. Are manufacturers going to guarantee tumor reduction? Are they going to guarantee a cure?"*

> *"Why are we being approached by manufacturers directly? Is it to gain more access within our center for utilizing those drugs versus a true discussion of value proposition that's measurable and important?"*
>
> – Provider

- **Population limitations.** Some providers with experience in VBCs commented that the stringent inclusion and exclusion criteria for eligibility makes identifying patients difficult and causes patient pools to shrink. One provider said, *"With one of the largest populations that could be identified [for a proposed VBC], we were able to come up with 30–40 patients per year that might be applicable for that. And if we were going to try to measure some expected or anticipated outcome and then be paid shared savings, that was getting down to three or four patients' difference by the end of the year. It's even smaller numbers than we imagined."*

- **Burdensome contract administration and complexity of purchasing relationships.** Participants also emphasized that monitoring patient outcomes and administering contracts would be onerous. One said bluntly, *"Who the hell has time to report all that?"* Defining contractual features and understanding the implications of any changes would add challenges to managing existing multiple-payer relationships and patient benefit plans, a task that is already complex. One provider highlighted the challenge: *"Is [such a contract] going to be a prospective payment, a retrospective payment, or a quarterly payment based on numbers of patients? And then we throw into the loop [the fact that] we have different relationships with each payer and with every patient who has an out-of-pocket difference. And we also have different payer relationships with governmental payers versus commercial payers."* Another focused on the impact a VBC might have on other purchasing relationships: *"Whether that is with their primary wholesaler or if there is a group purchasing organization, that oftentimes can make it a challenge to do some of the things*

that people may want to do directly with a manufacturer—again, not impossible but it's just another one of those things to keep in mind."

- **Perverse incentives.** Many participants were concerned that linking VBCs to traditional APMs would also create perverse incentives for providers. One provider said, *"It seems like a backwards way to deal with the issue. Each practice negotiating a different value-based contract with each manufacturer would reward the best negotiators—it would be more about price and less about quality of care."*

> *"Value-based drug contracting will not work. It will not lower the price of drugs. And we are nibbling around the edge … Until somebody has a mechanism to be able to negotiate launch price of drugs down, none of this stuff is going to have a big effect on drug costs."*
>
> – Provider

- **Uneven distribution of risk.** Some participants cautioned that because outcomes-based agreements are frequently proposed for very short time periods, manufacturers are taking on very little risk in these arrangements. One payer offered the following caveat: *"If pharma is coming out with outcome-based agreements, they should come out with a real risk … With 30-day response rates, you don't expect anybody to fail in 30 days. So what risk are you really taking for charging so much? … I would caution providers before you enter into agreements like this to make sure to come out with meaningful agreements. Otherwise, there is not a big pot of money because, at the end of the day, you are going to be collecting additional data, doing extra work, and then not getting anything for it."*
- **Lack of proven benefit for patients.** Finally, some participants were concerned about the ability of VBCs to return any tangible benefits to patients. One noted, *"Even if we could get through all the regulatory issues, past the concept of small volumes, and [could] feel [that] the ethics of payments that come back to us for shared savings were ethical (and are not viewed as kickbacks), we still thought that the patients were the ones that should have gotten the benefits of the response rate. We just found it literally impossible to try to come up with a value-based payment model."*

Overall, the business case for VBCs was not convincing to most council participants, even assuming the above challenges were addressed. In the words of one participant, VBCs would not be *"the savior"* that solved the problem of drug costs in APMs.

That said, a few, having looked at the risks, signaled they would be willing to experiment and continue to have dialogue with manufacturers on VBC proposals, although not in the context of payer-provider APMs. One provider, whose institution is on the verge of entering into such a contract, said, *"The reason we're doing it is to learn, quite frankly."* Another participant thought VBCs could have value if they are carefully structured as a tripartite agreement across payers, providers, and manufacturers: *"To do this effectively, you have to have a payer partner involved in it, because ultimately, at the end of the day, if we are providing an infusion or we*

are providing a medication to a patient, we bought that drug, but we're generally being reimbursed for that. And so if, a quarter later, six months later, two years later, we get some kind of replacement drug or a payment back to us, [we need an agreement that clarifies] how do we then share that with the payer and/or the patient if they had a copay?"

Following the CMS OCF announcement, COA indicated it would remove its OCM 2.0 proposal from PTAC submission.[15] In light of this move and the council's conclusions, there is unlikely to be much momentum for further explorations of integrating VBCs into broader payer-provider APM frameworks, at least not in the near term.

Alternative approaches to managing drug costs

With participants' conclusion that VBCs are not the way to manage drug costs in APMs, attention turned to other methods. Ideas differ depending on whether drugs are included in a given model or carved out.

Carve-out scenarios

Several models under development propose options for dealing with drugs through a carve-out approach. In such an approach, providers are not held accountable for the cost of drugs.

> *"We also need to keep in mind whose cost of care we are lowering. Is it for the end consumer? Is it whoever is paying the bills? That gets lost in the mix … I don't think we are solving for total cost of care for oncology anytime soon. I think we really need to step back and say how can we really drive change."*
>
> – Payer

> *"I swear I've played this chess match out, and I always end up at value-based pathways as your answer."*
>
> – Provider

Some noted that the American Society of Clinical Oncology (ASCO) will be doing a refresh of their APM proposal—the Patient-Centered Oncology Payment (PCOP)—and, similar to the Making Accountable Sustainable Oncology Networks (MASON) proposal submitted to PTAC in 2018,[16] practices will *"be paid an acquisition cost of drugs … The cost of oncolytic drugs would be taken out of the risk of the total cost of care."*[17] In the PCOP model, however, supportive drugs would be treated differently. Where there are options to pick less expensive, equivalent drugs, supportive drugs would remain *in* the model and clinicians would be at risk for their cost and effective utilization.[18]For clinicians envisioning the arrival of more models that use carve-outs, the role of value-based pathways is especially prominent. One reflected, *"What does a drug-in versus a drug-out [APM model]—[or], carve-in [versus] carve-out—world look like? On the carve-out side, you then face the question of how to manage utilization of very expensive drugs so that they are given appropriately, and [you] return to the concept of value-based pathways which, fundamentally, requires an agreement around what constitutes value."* Indeed, some believe that pathways could be an indirect way to deal with drug pricing because *"if you decide what goes on pathway and what's not on pathway based on a value proposition, that impacts how pharma*

decides they need to price a drug depending on their results from clinical trials." The challenge, noted some participants, is the lack of incentive for any of the stakeholder groups involved to move forward with a bold vision of value: *"It is a very bad position for any one of us to be the first out, trying to define value and trying to incorporate it."* Some noted that government could potentially *"force us to come to an agreement on value"* and suggested that if that happened, it would be possible to advance value-based pathways as the foundation for oncology payment reform more systematically.

Participants discussed the details of how pathways could be practically applied in APMs to drive "happy medium" scenarios in which providers are put at risk for a range of elements but not the cost of certain types of oncolytics. One noted that in applying pathways in APMs, *"you could set up value-based pathways as a high-stakes quality metric that would put a certain amount of either the management fee money or the shared savings at risk, based on drug utilization."* Another described *"things like performance-based metrics, adhering to clinical pathways, appropriate utilization of these high cost drugs rather than completely taking them out of the model"* as *"sort of a middle ground."* Others pointed out that it might be possible to carve supportive drugs into the risk or accountability model for participants, echoing the approach outlined in the new PCOP model. As one noted, *"Not all drugs are the same."*

Carve-in scenarios

For models that hold participants accountable for targets that include the cost of drugs, participants agreed that these targets need to be finely balanced. Care categories need to be broad enough so that physicians are incentivized to find ways to use drugs in a more cost-effective manner, but they cannot have too much granularity.

Participants offered several considerations in this regard. First, the complexity of tracking detailed subtypes, especially given innovation and scientific advances, will increase exponentially. One participant asked, *"Where do you draw the line on subtypes?"* Second, models that are too granular could remove technical risk entirely, making them practically indistinguishable from fee for service. One participant explained, *"There needs to be a balance in not moving to essentially new fee for service, where we have created such discrete bundles that it doesn't really matter what the physician does."* On the other hand, many are optimistic about the role that more detailed clinical data could play in better predicting targets and treatment costs. Some participants referenced the Association of American Medical Colleges' proposal to use drug prescriptions derived from claims as a proxy for efficiently identifying cancer subtypes. All welcomed future conversation on this topic as the new OCF model refines its approach.

Finally, while there was significant pessimism regarding the possibility of addressing oncolytic drug costs directly, many remained optimistic about the benefits of tackling the other 40% of the total cost of care. One emphasized, *"Thirty-five to forty percent is still real money. The percentages are a percentage of a growing pie, so it's still real dollars. And I think these value-*

based models really are forcing us to think how to better take care of patients in a more efficient way."

The end state of oncology APMs

In the newly unveiled OCF model, CMMI indicates that some services will be paid on a prospective monthly basis through its new monthly population payment (MPP) stream.[19] This suggests that slowly but surely, bundle-like approaches are emerging, not only for radiation oncology and surgical oncology, but also for certain services within medical oncology. During the November meeting, council participants discussed a variety of experiments and initiatives that are currently structured as bundles, partial bundles, or bundle-like (i.e., capitated) budgets that providers need to manage. Participants contemplated these models' longer-term direction and evolution. Early experiments in bundles reveal several challenges, and participants underscored that bundles will require safeguards and robust quality measurement. As one noted, *"We're trying to disincentivize overutilization but not incentivize underutilization."*

> *"What is the endgame? And is this the best way to get there?"*
>
> – Provider
>
> *"What is the future standard of care in cancer going to cost?"*
>
> – Provider

Edging toward bundled payments and population-based models

The potential emergence of bundles was front and center at the CMMI OCF listening session, with CMMI's leadership referencing the well-known Health Care Payment Learning & Action Network's framework that outlines a longer-term trajectory toward population-based models.[20] These are models that award payments to providers for managing high-quality, coordinated care across a large pool of patients.[21] As the healthcare community moves forward on that trajectory, a participant reiterated that *"bundles are somewhere in the middle."*

Reflections on the new CMMI oncology models

CMS's recent release of RADONC and OCF highlights two distinct approaches to building more risk into APMs. RADONC is mandatory and is a prospectively defined bundled payment, while OCF will cover certain services delivered within a specific time frame through its prospective new MPP mechanism. *(For brief overviews of RADONC and OCF, please see the Appendix).* While some commercial players (e.g., UnitedHealth) have experimented with bundled payments, bundles have remained relatively limited on a national level in oncology.[22] RADONC, as initially presented, would offer a much broader playing field to test the value and effectiveness of such payment models in oncology, and specifically in radiation oncology.

As for the OCF proposal, participants had diverse reactions. One provider said, *"I'm hoping that the endgame will eventually not be total cost of care as that's too big a bite … I'm hoping that the endgame will be a bundle, and it will be a granular bundle [with a] price corridor. Pay me that price corridor, let me manage to that, and if I can beat it, great, and if I can't beat it, then I'm willing to take risk on that."* Others supported the concept that the OCF MPP could potentially better incent add-on services and provide flexibility to oncologists in care treatment—for example, it might allow the practice to *"bring in the social worker, the nutritionist, etc. … to avoid hospitalizations down the road."* Furthermore, depending on the MPP's final structure, it could pull the *"plus-6%"* fee physicians receive for drug reimbursement out from the *"back end of the pharmacy"* so that the oncologist could apply it more readily at the front end of treatment to more meaningful services.

> *"I think bundles are practically impossible for medical oncology … You can gather data year over year, but the drugs are such a moving target."*
>
> – Provider
>
> *"We still believe strongly in the total-cost-of-care model because regardless of drugs, there are things that we can do, as a provider … We can control ancillary costs, imaging, readmissions, hospitalizations … Utilization is probably where we can win on appropriate costs over time. So that that's one of our lessons learned."*
>
> – Provider

Broad perspectives on bundles

Outside of their opinions on the specific new CMMI models, participants had diverse views on the pros and cons of bundles more broadly. From the provider perspective, those who have explored bundles in a variety of oncology subspecialties shared both challenges and lessons learned with council participants:

- **Definition and applicability of the bundle.** Designing a well-crafted bundle that takes into account potential risk to providers is complex. *"One of the key challenges is defining who is in the bundle. The analytics can be overwhelming. Bundles also get into real risk, so you need to get it right up front,"* one provider said. The law of small numbers is also challenging, and many felt that bundles are only applicable to certain subspecialties in the field. Several participants agreed that radiation oncology, for example, is one of the few subspecialties in oncology that might readily lend itself to a bundle—unlike, by contrast, medical oncology.
- **Administrative burden of managing multiple contracts across payers.** Some providers with experience evaluating bundles emphasized the resources that bundle implementation requires: *"The administrative burden in doing the bundles was overwhelming, because even if we're not reporting it, we're still monitoring and managing those patients and trying to identify them prospectively."* Some providers, however, shared that being able to prospectively identify the patients for contracts has helped them manage costs. Differences in quality measurement across payers also add to the administration burden of bundles:

"We have the problem that every payer wants a different measure, and there is no standardization of those measures. We also run into the problem of just the sheer volume of quality measures that we have to work on," one reported. Some stated that more standardization in quality measures and APM payment methodology would reduce these burdens and enable more providers to participate.

- **Innovation.** Many cited the pace of innovation in cancer treatment as a persistent challenge to developing oncology bundles, especially in medical oncology. *"If CMS bundles a payment, it may not apply next year. How do you keep tabs on that when there's three drugs that just flooded the market because they address a driver mutation?"* one participant asked.

Some participants continue to have a more positive outlook on the feasibility of bundles in medical oncology over the long term.[23] Some have observed that while personalized medicine and comorbidities make chemotherapy-based bundled-payment models complex, the number of variables is not infinite. Cognitive computing tools, data analytics, and other predictive tools could make setting target prices for episodes of oncology care more accurate. Over time, some suggested, these tools could facilitate the establishment of bundles for a wide variety of cancers. One said, *"As we continue using data science to narrow and narrow and narrow oncology payment categories, [pricing] will [eventually] become accurate enough that the amount of shared savings will very quickly become minimal, in which case, you then have a bundle."*

Learning from Maryland's all-payer model

In visualizing potential futures for oncology, participants looked to lessons learned from Maryland's unique all-payer payment model.[24] The model's original objectives were to provide fixed, predictable revenues to hospitals that would allow them the flexibility to invest in value-based care improvements. Under the recent extension, all payers in Maryland set annual global budgets for hospitals. Maryland agreed to limit all-payer per capita hospital growth, including inpatient and outpatient care, to 3.58%. In return, Maryland's hospitals committed to making significant quality improvements, including reductions in the rates of 30-day hospital readmissions and hospital-acquired conditions.

> *"The challenges with cancer are the patients are really sick, and whether you're managing them on the inpatient side or the outpatient side, it is costly to do it."*
>
> – Provider

All-payer model hospitals can grow specific programs, such as oncology services, relative to others, so long as growth stays within the overall cap. In addition to the cap, providers must adhere to specific quality metrics and targets. A provider commented, *"The program actually works very well in terms of managing the quality piece. Our visits are low; we've done a tremendous amount of shifting from the inpatient to the outpatient setting … And given [that*

our] Medicare payment is slightly higher than the national payment for Medicare, but the commercial payment is lower, the average balances out for providers overall."

In January 2019, Maryland became fully at risk for the total cost of care for Medicare beneficiaries. Maryland's new total-cost-of-care (TCOC) model, which was announced in partnership with CMMI, is the first statewide model that focuses on total cost of care.[25] TCOC builds on the work of the all-payer model, extending the approach on a voluntary basis to nonhospital healthcare providers, including primary care providers.[26] The goal is to create incentives to improve the coordination of patient care and to tackle health problems such as diabetes, heart disease, and substance-use disorder: "In doing so, Maryland's entire healthcare system will work to ensure that patients receive the right care, at the right time, in the right setting."[27] Many will be watching to see whether TCOC can deliver cost-effective, higher-value care.

New perspectives on oncology APMs: self-insured employers and patients

As payers and providers continue to change the fee-for-service paradigm, other players with an interest in defining value-based healthcare are becoming more prominent. In the United States, 61% of all covered employees are in a plan that is partially or completely self-funded by their employers.[28] Many self-insured employers are banding together in coalitions, joint-purchasing groups, and other alliances to advocate for high-quality care for their employees and to help contain costs. In discussions at the council meeting, many participants saw employer models as offering opportunities for innovation and a means of testing specific research questions, but there are concerns about their sustainability and scalability.

Patients are also becoming more active advocates on healthcare cost, quality, and value. While all participants agreed that payment reform must continue to place patients at the forefront, engaging patients appropriately on the topic of APMs remains a challenge. E-PROs in particular are top of mind for several participants because OCF may be adding e-PROs as a transformation measure. Participants debated the value and utility of e-PROs in measuring and enabling better care, and more broadly addressed how to actively engage patients in their own care management and coordination.

Self-insured employers' approaches to managing cost and quality

Council participants were eager to better understand self-insured employers' views on healthcare and how to draw self-insured employers into the conversation on payment reform in cancer. While employer views differ depending on workforce composition, age, and demographics, there are several key issues that all employers are facing today:

- **High-cost individuals.** Some participants and external experts reported that self-insured employers are concerned about the rapid increase in numbers of high-cost individual claimants. These may be patients requiring therapies like CAR-T or long-term cancer treatment. Employers are especially concerned about cancers that are rare, unpredictable, and hard to identify in early stages. Consultants and other service providers are increasing their business offerings to support employers in dealing with complex individual claims.
- **Skyrocketing stop-loss claims.** In the past, many self-insured employers have mitigated the risk of both high-cost claimants and aggregate costs by purchasing stop-loss insurance. Some, however, reported that stop-loss costs are becoming prohibitive, implying that more risks—and associated costs—will ultimately be absorbed by employers. One explained, *"We have stop-loss—anything over $500K gets kicked over to our reinsurer—but those reinsurance premiums go up 40%–50% annually. For us, it's that $500K-plus claimant level where the increase really is. And it's the oncology care that can get into the six-figure level."*
- **Market consolidation.** Some participants reported that employers are frustrated with misaligned incentives around utilization of high-cost sites of care. These frustrations have been compounded by consolidation and the dissolution of many independent community practices, as has been well documented by COA.[29]
- **Questions of quality.** Quality healthcare is a powerful retention tool and has been shown to reduce longer-term absenteeism and the need for follow-on healthcare procedures.[30] When it comes to cancer, many employers want to better understand how they can avoid misdiagnosis and ineffective treatment for their employees. One participant reflected on one employer program: *"Patients really did want to know and feel confident and feel comfortable that they had the right diagnosis and stage, and we have the sense that some providers are better than others."*

Both directly and through coalitions, self-insured employers are starting to experiment with new APMs and initiatives to respond to the above challenges. Broadly, some employers are engaging in direct contracting[31] and CoEs, including in cancer.[32] Direct contracting arrangements are still rare, however, and council participants reported challenges in trying to forge these contracts with employers, given the existing contracts employers already have in place.

Also common in cancer are models that incent accurate diagnoses. Walmart's healthcare programs include a cancer evaluation program that helps confirm diagnosis and treatment.[33] Participants emphasized that self-insured employers are distinct from other payers, with differing motivations and areas of interest in launching these models.

> *"The last thing we'd want is for a practice to go out of business, but the reality is if we design the model right, [so it is] rewarding the right things and aligned the right way, then a practice that's providing good care should succeed."*
>
> – Payer

For employers, *"the endgame is a little bit different. It's not just clinical costs, it's recruitment and retention, it's disability, it's productivity—how quickly do people come back to work, did they work through treatment, etc. These are big cost drivers."*

City of Hope: An emerging oncology CoE of choice for America's largest employers

In January 2019, on behalf of a large employer, the Pacific Business Group on Health (PBGH) expanded its work to establish CoEs for employers in other specialties to include cancer care. PBGH chose City of Hope, a cancer treatment and research center, as its first cancer-oriented CoE. The program partners with local community providers with the intent to keep the *"vast majority of care with the patient's home oncologist,"* while also providing "access to specialized center of excellence-based care."[34]

In April 2019, PBGH added Amazon to the program and is looking to expand to serve other employers, including those that have large distributed workforces across the United States, and it is considering partnerships with additional CoE institutions.

In this new model, employer participants support employees' travel for care at City of Hope to help reduce misdiagnoses and provide workers with access to the highest-quality care.[35] Participants acknowledged that CoE models require close coordination between the CoE institutions, various participating employers, and third-party administrators, as all these participants can have differing approaches to treatment authorizations. One participant involved in the project said, *"This will probably be something we have to work through with every employer and their payor differently."*

Within this context, participants commented on the challenges and benefits of this new wave of CoE models, including the Amazon CoE advanced with City of Hope and PBGH. One participant emphasized that employers' hope is that the models will provide physicians with more flexibility, including through an additional payment for an evaluation bundle that encompasses a set of agreed-upon prospective components. To address the perceived potential for perverse incentives to increase the volume of treatment, the PBGH CoE model separates the treatment plan decision maker (the CoE) from the plan's implementer (the local community oncologist), which *"pull[s] apart some of those misaligned incentives around reimbursement."*

Some participants noted the value of the CoE approach in ensuring accuracy of diagnosis. In the Walmart pilot, for example, the CoE institution found that 30% of participating employees initially diagnosed with cancer in fact *"didn't have cancer."* Some questioned whether this structure might lower patients' perception of the value provided by local community oncologists. One said, *"How often do I [as a community provider] get fired because there's no confidence now in what I'm doing with that patient because they got sent elsewhere? How often are people changing their medical oncologist?"* Several participants, however, saw opportunities for enhanced collaboration between community oncologists and CoEs, provided the programs had strong buy-in from the community oncologists. Many were keen to see what insights future data from these programs might provide.

Finally, participants noted that these programs are likely to benefit wealthier employers and their employees disproportionately, but they pointed out that the programs are still valuable to a larger economic demographic because they offer templates and systems that smaller employers with fewer resources might be able to model.

Challenges of engaging patients in APMs

All acknowledged the need for payment models that better incent patient-centered outcomes, and they agreed that standards for measuring outcomes beyond traditional clinical and process-quality measures are also needed. As noted earlier, OCF has proposed one approach: incorporating e-PROs as an additional care transformation element, building on previous elements required under OCM.

With this new proposal in mind, the council discussed the potential scalability and value of PROs for clinicians. More broadly, all agreed that patients can be a strong force in their own care coordination, and that more needs to be done to improve care coordination as APMs advance across the country and as patients continue to get *"lost in the system."*

Pros and cons to the use of e-PROs

PBGH contributed insights to the discussion on PROs based on a recently launched initiative in Michigan with multiple hospitals from the Alliance of Dedicated Cancer Centers. The PBGH-led consortium aims to validate PROs as quality measures, specifically measures relating to quality of life and pain management. They are exploring existing PRO tools such as the rapid version of the Functional Assessment of Cancer Therapy-General, the European Organisation for Research and Treatment of Cancer's PRO tools, the PRO tool of the Common Terminology Criteria for Adverse Events, and others, but are focusing in particular on Patient-Reported Outcomes Measurement Information System (PROMIS) instruments.[36] The end goal is to demonstrate the feasibility and sustainability of PROs as quality measures, including understanding the burden of data collection, the feasibility of moving forward in a standardized way, and the reproducibility of the measures.

Participants discussed the value of PROs and how ready practices are to adopt them. Many suggested that for PROs to be useful, clinicians must be able to use them easily to initiate timely and appropriate care interventions—and participants are skeptical about the possibility of this currently. Some participants stressed that PROs must cease being merely an *"academic health-services research exercise"* and must become a clearly implemented process within clinical practice. Some emphasized the distinction between PROs' collection of patient data for clinical use and for measuring quality. One said, *"An ideal model would actually include both of those, and your quality metric would reflect how your patient reports the care you're giving, but also the way in which we can manage their symptoms and use their symptom report to improve their care."*

Additionally, while some acknowledged the potential of PROs to enhance clinical practice, they indicated that additional incentives from CMMI/CMS would be needed to help curb the high investment cost associated with implementing them. One said, *"I do not have extra money, and everybody and their dog says, 'Oh, but this is just 10% of the MEOS payment.' [But] we've spent about 250% of the MEOS payment already on all of the other stuff that we have to do."* Several also observed that vendors of these solutions need to better integrate their systems into clinical workflows, opining that electronic health-record vendors are oftentimes not amenable to making these software products accessible as part of their systems.

The role of patients in APMs

Participants agreed that APMs need to incent *"coordination of patient care, quality metrics to ensure care is not skipped, and a high-functioning primary-care system to ensure early diagnosis and appropriate treatment."* One participant reminded the group how challenging it is to turn that vision into a reality—even for providers and payers as knowledgeable as those that comprise the council: *"You're like Lake Wobegon, where all your children are exceptional. You all have great systems; you all take great care of your patients and everything is perfect … But I will share that in the real world it doesn't work that way … It's Balkanization, and the patients getting lost in the middle of all."*

Participants brainstormed some ways to help alleviate the burden on patients. Several suggested multidisciplinary approaches such as having primary-care teams integrated into cancer centers, and they stressed the importance of involving the patients themselves. One said, *"We talk about multidisciplinary care and forget that the patient is part of the care team. If the patient doesn't buy into where to go when they have certain symptoms [and shows] up at wrong place, then it will fall apart regardless. That seems like low-hanging fruit—conversations on financial toxicity, care management, and navigation*."

Participants also discussed the role of other patient variables, such as social determinants of health and behavioral health conditions and the impact of these factors on cancer outcomes. Research, including increased data collection within APM programs, continues to highlight the relevance of these variables. One participant said, *"We were shocked when we saw that food insecurity is equivalent to adjuvant chemotherapy in terms of outcomes for early-stage breast cancer. You know, that's really a major unexpected finding, and so now a group of National Cancer Care Alliance practices are starting to implement screening for food insecurity, e.g., on our intake forms, so that we can come up with food banks and other ways to try to manage some of these social determinants."* Some payers concurred, with one noting, *"People that have a behavioral-health condition diagnosis have a much higher cost of care for their cancer and for the [first calendar] year when they get diagnosed with cancer. Plus, there are so many downstream impacts in terms of outcomes, [like] more hospitalization, more ER visits."* This conversation in turn raised questions for many participants regarding which of these additional

services should be included in an APM for cancer: *"Is it a societal problem or is it a healthcare problem, or who should be addressing this?"*

Conclusions and the way forward

The release of the OCF and RADONC frameworks has reaffirmed CMS's commitment to payment reform in cancer and provides a directional signal as to the shape and scope of the longer-term endgame for public payers in oncology. While these and other APMs are still in early stages, they are yielding valuable lessons and insights that council participants are starting to use to inform their visions for the future of oncology care and payment. In this spirit, one participant reflected on the evolution of council discussions: *"While we have the same themes again, the conversation is different now because we've got now three- to four-plus years in APMs out there, and there's things we're all learning."* Accountability, balancing risk and uncertainty, drug costs, incentives for coordinating oncology practice with other practices and services—including across oncology specialties, primary, palliative, and social services—and infrastructure investments all remain challenging issues. Yet where there is concern, there is also great enthusiasm. Payers and providers are working together more collaboratively to achieve a balanced approach to APMs in this specialty, while new stakeholders, such as self-insured employers, are starting to wield more influence.

> *"How do we make sure that we are setting up a model where quality is going to improve, where the patient is at the center of the decisions that the oncologist is making, where the pricing is appropriate, and where the risk is appropriate?"*
>
> – Payer

Based on their discussions, council participants and guests offered their suggestions for next steps the council can take that could benefit the broader community of payers, providers, and other stakeholders experimenting in oncology payment reform:

- Conducting a deeper dive into IT/data infrastructure enablers for APMs; specifically, engaging with external stakeholders such as EMR vendors and/or e-PRO vendors to better understand how data can improve the clinical workflow and decision making
- Exploring better approaches to risk adjustment and stratification of patients, including more effective use of data analytics and predictive models for patient outcomes and costs, and looking beyond hierarchical condition categories
- Sharing the lessons and successes of current oncology APMs in a more systematic, transparent way, potentially through the following measures:
    - Creating a framework or set of principles that all models in this space should uphold

  - Examining oncology APMs' interactions with primary-care models to determine when and why oncology patients should be carved out or reattributed to oncologists for a period of care
  - Looking at how ACOs' treatment of their populations compares with Medicare Advantage's (MA's) treatment, as currently the MA population is carved out of OCM
- Conducting a deep dive on drug pricing to understand what levers are practically available to stakeholders to address drug costs

Participants agreed that shared learning and communication are more necessary than ever for the oncology community. One said, *"The practices that are actually in these APMs and trying to make them work and learning from them right now are a very small percentage of the oncology practices in the United States. My concern is, as we figure things out, if suddenly we flick that switch and everybody goes [into an APM], there is going to be chaos and real problems with providing care across the United States."*

About this document

ViewPoints *reflects the use of a modified version of the Chatham House Rule whereby comments are not attributed to individuals, corporations, or institutions. Italicized quotations reflect comments made by participants before and during the meeting.*

Tapestry Networks is a privately held professional-services firm. Its mission is to advance society's ability to govern and lead across the borders of sector, geography, and constituency. To do this, Tapestry forms multistakeholder collaborations that embrace the public and private sector, as well as civil society. The participants in these initiatives are leaders drawn from key stakeholder organizations who realize the status quo is neither desirable nor sustainable and are seeking a goal that transcends their own interests and benefits everyone. Tapestry has used this approach to address critical and complex challenges in corporate governance, financial services, and healthcare.

Appendix: RADONC and OCF

RADONC is a proposed episode-based payment model that would provide prospective, predictable payment amounts for 90 days of radiation therapy services.[37] In contrast to an OCM- or OCF-like model, RADONC is not looking at total cost of care but is instead focused on a defined, distinct set of radiation therapy services (e.g., dose planning, CT simulations, and treatment aids). As proposed, its 90-day episodes would start with an initial planning visit and include all radiation therapy services for 17 different cancer types. RADONC has the following goals:

- To address the issue of site neutrality by removing current differences in payment associated with whether a facility is a hospital or a freestanding center
- To offer a modality-agnostic approach: centers will be paid the same, for example, whether they offer brachytherapy, a conventional external beam, or proton beam therapy
- To address the issue of mis valued codes in the physician fee schedule
- To promote alignment of quality and value rather than volume (e.g., to remove perverse incentives to select a treatment plan that includes a high volume of services, even if they are not medically necessary)
- To recognize practice differences through blending a participant-specific payment (based on what the participant had billed historically) with a national amount

OCF, by contrast, has two primary elements:[38]

- A prospective MPP for the practice or hospital's Medicare FFS population who have cancer or a related diagnosis. The payment will include evaluation and management services, as well as additional enhanced services that may include imaging, labs, and drug-administration services. The drug-administration component could potentially include costs relating to the average sales price plus 6% (or plus 4.3%, due to current sequestration cuts), as was raised in the open listening session.
- Accountability for total cost of care, including drugs, incurred over a six-month episode. An episode would be triggered when a patient receives a Part B or chemotherapy drug. The practice would have the opportunity for a performance-based payment or owe repayment to CMS, based on quality performance and costs relative to targets. This APM will likely only allow two-sided risk for most practices.

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Endnotes

[1] "Oncology Care First Model: Informal Request for Information," Centers for Medicare & Medicaid Services, November 1, 2019.

[2] "Oncology Care Model," Centers for Medicare & Medicaid Services, November 13, 2019.

[3] APMs in this effort are defined broadly and include efforts outside of standard fee-for-service models, e.g., accountable-care organizations, pathways, medical homes, bundled-payment models, and other commercial payer- and provider-designed efforts, as well as the Oncology Care Model.

[4] Oncology APMs Advisory Council, *Launching an Advisory Council To Accelerate Rapid Learning Across Oncology Alternative Payment Models,* ViewPoints (Waltham, MA: Tapestry Networks, 2018), 5-6.

[5] Bundled payments offer fixed payments for a defined episode of care for a defined period. Greg Reh, Mitch Morris, Sonal Shah, and Bushra Naaz, *The Evolution of Oncology Payment Models: What Can we Learn from Early Experiments?* (Deloitte, 2016), 5.

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