Optimal Oncology Alternative Payment Models

July 2020

VIEWPOINTS

Advancing next-generation oncology alternative payment models in the COVID-19 era

Executive summary

COVID-19 prompted oncologists across the United States to rapidly deliver new interventions and policies to protect their patients and workforce. As the acute crisis abates in some states, stakeholders are contemplating the longer-term implications of COVID-19 on oncology. Such implications include the crisis's impact on the ongoing shift to a value-based care paradigm and alternative payment models (APMs).[1]

COVID-19 arrived when value-based oncology was already at an inflection point: the advent of a successor model to the country's largest oncology payment reform experiment, the Oncology Care Model (OCM). This past fall, the Center for Medicare and Medicaid Innovation (CMMI) released a request for information describing the potential successor, the Oncology Care First (OCF) model, and CMMI's vision to base aspects of the OCF model's payment methodology on cancer type, a more granular approach than is used in OCM. Although the fate of the new model is uncertain following CMMI's extension of OCM in response to COVID-19, the evolution of more granular payment models remains top of mind for participants in the oncology APMs advisory council, as do the underlying data foundations needed to achieve more granularity and accuracy.

Council participants met virtually in June 2020 to address the above issues and, specifically, the following:

- The influence of risk stratification and predictive modeling on oncology APMs
- How more granular clinical data can inform the design and payment methodology of APMs
- Data repositories to support next-generation APM development
- The effects of the COVID-19 crisis on APMs

Before the meeting, the council also discussed how patient-reported outcomes (PROs) could be meaningfully integrated into APMs given their potential inclusion in the OCF model. While most participants recognize PROs' importance, they agreed more research remains to be done on integrating PROs into clinical practice and, without new data to discuss in that regard, they prioritized the topics above for discussion in June.

Key takeaways from the June meeting are as follows:

- **Better risk stratification and predictive modeling are needed for oncology as a specialty.** Tools ranging from artificial intelligence (AI)-enabled platforms to manual, ad hoc efforts have the potential to improve care and drive value-based decision-making. Many emphasized that predictive modeling is most valuable when models provide actionable insights that can be seamlessly integrated into clinical workflow. Participants are concerned that electronic health record (EHR) integration and resourcing challenges may hinder the uptake and sustainability of these tools.
- **Optimal levels of clinical granularity and risk in oncology APMs continue to be debated.** While participants view more granular approaches positively in principle, many noted that the data needed to achieve more accurate cost estimates for specific cancer types has limitations. Greater granularity and accuracy also do not necessarily reduce variation or cost, prompting participants to ask for better measures on how the community can assess what constitutes a *"good model."* Finally, as a result of ongoing struggles with data credibility, small numbers, and reduced risk appetite during COVID-19, several commercial payers are making a definitive shift away from risk-based models, instead focusing on clinical pathways with enhanced care management incentives.
- **Timely access to adjoined clinical and claims data—*"the holy grail for APMs"*—continues to be elusive.** However, participants described how existing imperfect data sources such as all-payer claims databases can be used to model costs. Some also detailed efforts to improve oncology data standardization as a foundation for better regional health information exchanges, which in principle could facilitate more timely, automated, clinically granular data access.
- **COVID-19 has further demonstrated the success of—and need for—value-based care.** Participants noted that the types of interventions that APMs are designed to incent (e.g., enhanced patient navigation) are precisely the activities that are needed for practices to successfully manage through the COVID-19 era.

Although COVID-19 has prompted significant uncertainty about the trajectory of the US healthcare system, participants hoped that a continuous-learning environment for oncology payment reform experiments would endure. With the OCF model paused, now may be an opportune time to undertake robust research and analysis in some of the areas noted above to generate critical insights for next-generation oncology APMs. These may include better understanding of how predictive modeling can play more of a role in value-based care and assessing core drivers of care and cost variability, among other topics.

Introduction

Going forward, value-based care can help ensure healthcare resiliency. By accepting value-based or capitated payments, providers are better able to weather fluctuations in utilization, and they can focus on keeping patients healthy rather than trying to increase the volume of services to ensure reimbursement. Value-based payments also provide stable, predictable revenue—protecting providers from the financial impact of a pandemic.[2]

—Seema Verma, administrator,
Centers for Medicare and Medicaid Services

COVID-19 needs to be looked at as a laboratory for value-based payment.

—Subject matter expert

In November 2019, CMMI published a request for information describing the OCF model, the agency's potential successor to the OCM. Stakeholders were especially struck by the potential new model's incorporation of cancer type as a variable in its payment methodology and its advancement of two-sided risk. Many have long contended that only by leveraging detailed clinical information—not only cancer type but also stage, biomarker status, and the like—will APMs be able to develop more accurate financial targets and demonstrate success over the long run.

The shift to a more granular approach in the OCF model echoes the increasing attention the oncology community is giving to greater granularity and precision through data-driven analytics and advanced risk stratification broadly.[3] However, although data-driven insights are on the rise, significant data gaps and siloes in oncology remain, impeding the underlying data foundations needed for next-generation oncology care and payment reform experiments. Furthermore, some wonder how granularity can be reconciled with the high volumes and principle of aggregation required for actuarially sound APMs.

This already complex inflection point in value-based oncology was further complicated when COVID-19 emerged. As practices rapidly prioritized patient and staff safety, some oncology payment reform efforts were put on hold; most notably, CMMI paused its efforts to launch the OCF model in the short term.[4]

Throughout the spring of 2020, the oncology APMs advisory council addressed the above challenges through a series of phone discussions, culminating in a full council meeting in June. Across their conversations, participants considered the following specific topics:

- How are risk stratification and predictive modeling influencing oncology APMs?

- How can more granular clinical data inform the design and payment methodology of APMs?
- What data foundations are needed to support and scale next-generation APMs?
- How can PRO data be meaningfully integrated into APMs?
- What is the impact of COVID-19 on oncology payment reform?

This *ViewPoints* synthesizes the views that arose during the meeting and in the conversations that preceded it, along with additional external analysis and perspectives from stakeholders involved in oncology APMs when relevant.

How are risk stratification and predictive modeling influencing oncology APMs?

Data-driven analytical tools such as risk stratification and predictive modeling, many of which are fueled by algorithms and AI, can help identify patients at high risk of complex or costly services or even short-term mortality.[5] In the context of APMs, if such patients are identified in a timely fashion, clinicians can act to mitigate risks or offer targeted interventions, increasing the likelihood of "managing cost and being financially efficient" while maintaining quality care.[6] While council participants recognize the benefits of these tools, several remain skeptical about their scalability and integration into clinical workflow.

Actionable interventions are critical

While many participants agree these tools have merit, some stressed that predictions of likely hospitalizations, readmissions, and so forth are not inherently valuable. Instead, they emphasized that such analytics are valuable only when they are accurate (albeit not perfect), are paired with interventions, and promote a sustainable change in clinical practice. Risk stratification and predictive modeling should prompt interventions *"that ideally every cancer patient would get, but practices don't always have enough time or resources to do [these interventions] for everyone."* Such interventions may include, for example, initiating advanced illness conversations for those with short-term mortality risk or making referrals to available social services when helpful for facilitating or improving a patient's course of care.

> *"Imperfect but good is certainly something that we recognize, as necessary. There is no perfect algorithm."*
>
> —Subject matter expert

Most importantly, algorithm-informed decision-making must be sustainable in daily practice. One expert described validating an algorithm for mortality risk that helped identify patients who may benefit from advanced-illness conversations and ensured that such prompts were effectively integrated into practice via weekly email alerts. Data from this initiative revealed that *"even among patients who weren't flagged by the algorithm, we saw an increase in*

[advanced-illness conversation] documentation, which suggests that there may be a spillover effect of predictive algorithms in promoting value-based care."

> *"If it isn't actionable, if it isn't practical, then physicians and clinicians of all variations will discard the insights quickly."*
>
> —Subject matter expert

Without validation in the clinic, algorithms may only act as a self-fulfilling prophecy—identifying but not mitigating future problems, like identifying an unmanageable number of active patients as high risk, as one clinician noted. Furthermore, analytics should not only provide clinicians with alerts about patient risk profiles but also inform them of the underlying drivers generating the alert, one expert stressed.

Concerns and caveats

Despite efforts to validate these tools' ability to prompt meaningful, timely interventions, some participants remain skeptical. Specifically, IT platform limitations and resource constraints compound these participants' concerns about effective integration into the clinical workflow.

Practices have limited financial resources to procure and implement advanced solutions. For those practices able to invest in a vendor-based solution or an in-house algorithm, seamless integration with the EHR remains a persistent challenge. One participant noted, *"How do you get the Epics of the world to open their orchard to let any practice plug and play and put these algorithms in place so that they seamlessly integrate into workflow?"* Other participants, however, cautioned that EHRs may not be the bottleneck that many assume them to be: *"We do not necessarily need these algorithm outputs to be housed in the EHR. In fact, physicians have decided to see these prompts outside of the EHR so they wouldn't just click through a prediction."*

Others questioned the validity of the tools themselves. Participants were concerned about how social determinants of health and biases, as has been demonstrated in recent research,[7] are being accounted for in the AI-fueled algorithms that many of these analytical tools employ. They agreed that robust attention should be paid to potential bias as algorithms increasingly influence clinical decision-making across the country.

Risk stratification and predictive modeling in the COVID-19 era

In addition to the concerns noted above, some participants discussed how COVID-19 has further exposed the value and limitations of risk stratification and predictive models. The limitations addressed include participants' concerns about the reliability of the models themselves. In conversations prior to the meeting, some noted that even the best algorithms and models cannot account for unlikely situations like COVID-19. Others, however, believe the opposite may prove out: *"Today's experiences will help us to understand how to change future models to factor in unknowns and still identify cost drivers. COVID may make models better."*

Participants also reflected on risk stratification and predictive model implementation during COVID-19. This crisis has compelled many clinicians to conduct ad hoc risk stratification for decisions such as deferring treatment for low-risk patients or changing the site of care for chemotherapy. One clinician discussed her practice's experience in this regard, which did not employ an automated or AI-driven algorithm. She was pleasantly surprised with the results: *"Despite our great nursing navigation system and our nurses knowing our high-need patients, this process identified many additional patients with unmet needs."* At the same time, the clinician noted that while successful in the short term, such ad hoc efforts consume time and resources, are not seamlessly integrated into workflows, and are likely unsustainable without automation or other changes. *"The issue is that this process is really only something we can do once. It is too much to be implemented all the time,"* she said.

> *"COVID-19 has heightened the need for improved risk stratification for managing patients outside the clinic. [This need has been] accelerated by APMs but has been greatly accelerated by COVID."*
>
> —Clinician

How can more granular clinical data inform the design and payment methodology of APMs?

CMMI's announcement of the OCF model provided an opportunity for the community to reflect on the next phase in oncology payment reform, an opportunity which is now prolonged with the extension of the OCM. The OCF model embraces more clinical granularity in its trend factor and novel therapies adjustment—something most council participants see as a positive development, though many note that additional detail remains to be seen.[8] Furthermore, such an approach has drawbacks; it may not be scalable for other payers and models and may not resolve fundamental questions about how the community can optimally judge whether, in the words of one participant, *"a model is good or not."* Additionally, these caveats are further complicated by payers' and practices' reduced risk appetite in the COVID-19 era.

The trade-offs of granularity

Participants largely agreed that more clinically granular models are likely to predict more accurate financial targets. One expert, for example, described how a modeling exercise she conducted using staging data yielded better correlation between actual and predicted payments when compared with the OCM. However, there are several caveats that may inhibit scaling more granular modeling across cancers and practices:

- **Granularity may only be feasible for certain types of cancers.** Participants underscored that accurate cost forecasting for specific types of cancers—especially cancers with low volumes—is challenging. In rare cancers, one expert explained, there is reduced credibility[9] from an actuarial perspective about the sample size used to predict pricing. Models may turn to historical data or blended data to enhance credibility, but that can result in using *"inappropriate and incomparable data and completely mess up the variation."* One proposed solution is to focus only on the four most common cancers in the United States because, as has been echoed in other research,[10] their volume may be enough to sustain APMs. However, others argued that certain rare cancers, such as testicular and endocrine, are ripe for inclusion in APMs because of the *"variation in practice, minimal innovation in treatment patterns, and serious consequences of deviation from protocols."* Such diverse viewpoints prompt questions about what type of variability APMs should aim to reduce, as is further discussed below.

> *"We need to get more granular. We need a process to target an optimal price for specific cancers and comorbidities."*
>
> —Clinician

- **More granular data may not be scalable.** Even if a model were to achieve more granular targets for specific types of cancers, these may be not be sufficient to develop regional or statewide models. Data from practices used to predict financial targets may be inaccurate for other practices, again underscoring challenges with credibility. One payer recounted his experience in this regard: *"A model we designed for our large health systems may not and actually likely is not viable largely due to the credibility issues that were brought up for our independent practices."*

Considerations on risk

Greater accuracy and granularity also may not reduce risk for practices. One participant underscored that *"there is always a trade-off between granularity and actuarial risk"* for practices because of reductions in sample sizes. Prompted by these observations, participants discussed the need to better define the types of variability that models aim to reduce and how risk is accordingly structured.

As has been discussed in prior meetings, many supported the concept of practices undertaking technical risk, which holds practices accountable for value-based clinical decision-making and interventions, but not actuarial risk,[11] which is insurers' role.[12] However, some participants underscored nuances that complicate this distinction, especially when considering the implications of more granularity:

- **Drugs in or out: does it matter?** Some advocated to remove chemotherapy drugs from the cost of care for which a practice is held accountable. Theoretically, this approach would incent clinicians to better manage costly interventions over which they presumably have

greater control, such as emergency department visits. Some pointed to data indicating that chemotherapy is the largest contributor to the interregional variation in total spending in OCM-defined episodes.[13] A payer participant, however, referenced prepublished data suggesting that excluding drugs from models does not necessarily reduce variability around practice performance for nondrug costs such as hospitalization.

- **What kind of variability is most important?** The challenge, one clinician participant underscored, lies in pinpointing inappropriate variation. He urged participants to recognize that some models may be clinically and technically accurate but fail to reduce variability and costs, in part because a costly standard of care may dominate. Therefore, better understanding the drivers of variability would be a valuable starting point for more research to design better APMs, as another expert explained: *"Is variability being driven by variation in care, where you could say improving the care would result in reduced variability, or is it random variability? Is it just variability related to cost of care? [The important factor is] where variability is driven by quality of care, and the ability to disentangle that is one of the biggest challenges that needs to be addressed."*

> *"You may have very little variability [in a model where high-cost, standard-of-care drugs dominate], but does that make it a good model and ultimately get at technical risk?"*
>
> —Clinician

Implications for commercial payers

Interwoven throughout these conversations are the many challenges commercial payers face in creating oncology APMs. Using more granular data to generate more accurate costs narrows an already limited patient pool, as has been addressed at earlier meetings. Today, the trade-off between granularity and smaller sample sizes[14] is playing out amid the COVID-19 crisis, resulting in many commercial payers making a definitive retreat from more complex, risk-based models. The following box highlights some payers' recent positions.

> *"The challenge is to adapt our aspirations for what we want in value-based care models to what is both viable and there is an appetite for in the provider world."*
>
> —Payer

The outlook for commercial payers in oncology APMs

Many stakeholders have long been skeptical that commercial payers can develop risk-based, clinically granular models that are akin to the OCM for their relatively smaller populations. Participants in the council highlighted several trends that suggest commercial payers' efforts to emulate two-sided risk models like the OCM are on hold:

- For some payers, COVID-19 underscored that *"while they are set up for actuarial risk, providers are not;"* furthermore, most clinicians' appetite for risk has dissipated in the face of COVID-19, prompting payers to retreat from higher-stakes APMs to be able to reach and enlist more practices.
- Outside of COVID-19, some have observed that *"the biggest challenge and hardest work have been figuring out how to balance the provider-controlled risk versus the actuarial risk."*
- As a result of the above factors, many are making a definitive play toward pathways-based approaches with care management-related incentives in their models.
- As telehealth and home care have proliferated, some payers are refreshing how they approach various sites of care—for example, one payer noted that while community-based oncology practices are the preferred site of care in the payer's model, the program is also assessing alternative sites of care for administering specific subgroups of immuno-oncology agents with low risk of adverse effects.
- Some are looking to alternative third-party, *"off-the-shelf"* solutions to improve quality and value in oncology care. Participants discussed a new program by CVS Health that takes results from a patient's broad-panel genetic testing to enhance decision-making by tailoring therapy to the cancer's genetic profile and following National Comprehensive Cancer Network guidelines.

Ultimately, participants agreed that to advance APMs, more large-scale models need to exist to engage diverse practices and institutions. One emphasized that *"one big national model, no matter how brilliant, cannot work for everyone,"* signaling that there should be room for more payers to enter this space, albeit with adaptations for specific regions and populations. As has been discussed in past meetings, models would ideally espouse some degree of alignment on design elements and transparency on outcomes so the community can minimize burdens on practices and more rapidly learn how to optimize models over time, respectively.[15]

What data foundations are needed to support and scale next-generation APMs?

As participants have pointed out in earlier council meetings, *"the holy grail for any of these APMs is the appropriate and proper joining of high-quality clinical data and claims data."* However, timely access to adjoined clinical and claims data continues to be elusive for many stakeholders designing new oncology APMs. If more models are to be tested, how can the community create better data foundations to support stakeholders' vision of a robust environment for oncology payment reform experiments?

Although there is no immediate cure-all for the clinical-claims divide, participants continue to explore ways to utilize existing data repositories to generate lessons for their peers that may be relevant to APM design and development. They offered the following examples:

- **All-payer claims databases (APCDs) for cost modeling.** These state-specific databases, with their combination of large sample sizes, geographic representation, and longitudinal care information across payers, can be advantageous for modeling potential APMs in a state or region. The American Society of Clinical Oncology (ASCO) used Maine's APCD to assess the cost savings of their Patient-Centered Oncology Payment APM, including deriving historical costs of care, calculating incentive payments, and determining the model's potential impact.[16] There are only 17 states with existing APCDs with mandatory reporting; however, many other states are looking into or actively implementing APCDs. One participant lamented that despite leveraging a long-standing database, *"there was still data we had to screen out, as some payers were not completing the fields that were required*." Another subject matter expert noted that while their state had a robust APCD, claims data could not be linked to clinical registries and thus it was more convenient to collect data from payers directly to create a merged data set. However, efforts to expand and standardize APCDs are ongoing, as described by some participants, and may better enable future analyses similar to those done by ASCO.
- **Tumor registry data to develop adjoined clinical-claims data sets.** Cancer registries, which include cancer-related data on individual patients reported by hospitals, could provide relevant clinical data to inform more granular APMs. Institutions like the Hutchinson Institute for Cancer Outcomes Research (HICOR) are integrating registry data with claims to build robust databases to better understand cost and quality. However, tumor registries also present limitations for APM development. Data materializes too slowly—some participants noted that data is *"at least two years out of date by the time we get it, if not more."* Furthermore, even an adjoined clinical-claims database may have less value for APMs than some expect. A participant reported that a large payer and practice failed to use her institution's adjoined data for a value-based contract because small numbers still made the contract unfeasible. Nonetheless, replicating a data set like HICOR's could serve as a

powerful building block to better understand cost and quality variation in a given region, which, as noted above, may be an important factor in more granular model design.

- **Enhanced oncology data standardization as a foundation for better health information exchanges.** One expert outlined a vision for improved data standardization to advance more robust regional health information exchanges than exist today.[17] In principle, health information exchanges can provide automated access to various types of healthcare data, including high-quality clinical data that may be useful for oncology APM development.[18] Some participants pointed to ASCO's Minimal Common Oncology Data Elements (mCODE) initiative as one step in realizing this vision. mCODE aims to implement a *"common standard and language for oncology"* in EHRs, making it easier to collect data on patients with cancer and share it across stakeholders.[19] While some participants were optimistic that standardizing clinical data collection efforts through mCODE may solve some data quality and interoperability issues, and thus make relevant data more available for those looking to build APMs, others offered caveats. Specifically, a participant noted that *"clinicians only code cancer stage into the EHR about 50% of the time, at best"* and therefore mCODE's efforts may not be as automated as some may hope.

How can PRO data be meaningfully integrated into APMs?

The potential OCF model's inclusion of electronic PROs as a practice transformation requirement sparked widespread discussion about practices' readiness to implement them. In conversations in late 2019 and early 2020, participants agreed that PROs were important, pointing to the multiple studies that demonstrate that capturing PROs and using them to inform subsequent interventions ultimately raises patient quality of life.[20] Still, they underscored that *"PROs are difficult to collect and tie to payment"* and questioned whether PROs are ready for widespread implementation as a performance-related measure in a payment model.

> *"Most of us are just on the cusp of thinking about PROs, and we keep running up against logistics that keep us from implementing them."*
>
> —Payer

Many are especially concerned about the workflow integration and scalability of PROs. As one participant stated, *"You can't just shove all this information at the physicians. You need a triage-and-management system in place to make this an effective rather than dangerous process."* Participants also emphasized that successes in select academic medical centers do not ensure wide scalability and may not translate to practices with fewer resources and different priorities. Furthermore, existing pilots to scale PRO implementation and validate their use as quality measures are either nascent or still ongoing, without results to report.

> *"At many forums, such as the National Cancer Policy Forum, PROs are right there front and center. Patients want them. They're top of mind."*
>
> —Patient advocate

As a result of these factors, participants did not address PROs as a high-priority agenda topic at the June meeting. Some participants hope that these measures mature quickly, especially given patients' considerable interest in seeing them used more frequently.

What is the impact of COVID-19 on oncology payment reform?

The arrival of COVID-19 has altered the current healthcare landscape and called into question if and how APMs should continue to evolve.[21] Participants' experiences with COVID-19 and its impact on payment models varied based on their regional circumstances. However, many participants noted that the crisis has affirmed the need for continuing APM development rather than scaling back, and they reflected on both short- and long-term implications in the meeting.

How will COVID-19 change oncology APMs in the short to midterm?

As previously mentioned, clinicians and several payers have noted a reduced appetite for risk given the current crisis. At the outset of the crisis, many clinicians urgently called for CMMI to delay mandatory two-sided risk in the OCM and the transition to the OCF model. Participants were also especially concerned about a surge later in 2020 in patients who delayed screening and might present with advanced-stage cancers requiring more complex interventions that could soon result in high cost for practices. However, with CMMI's announcement offering practices the opportunity to forego two-sided risk and other flexibilities in early June, the immediate impact of COVID-19 on APMs was somewhat ameliorated.

Instead, ongoing short-term concerns that participants cited during the meeting include management of telemedicine services, continuing workflow changes, and protecting and retaining clinical staff. One clinician whose area has not yet been hit hard by COVID-19 noted that they have focused on changing workflows to protect patients by shifting to telemedicine when possible. Participants in areas with large numbers of COVID-19 infections are planning how to maintain services with fewer resources, noting *"with hiring freezes and our inability to fill open slots, we are trying to figure out how we can take care of our cancer patients while our nurses are being deployed to our respiratory diagnostic centers and inpatient ICU beds. [We're thinking through] what to do if oncologists are pulled to cover inpatient services."*

What lessons can we apply from COVID-19 to long-term oncology care innovation and payment reform?

Participants observed several lessons from the current crisis that may influence broader oncology care transformation, including with respect to payment models and reimbursement. As one subject matter expert put it, COVID-19 may be *"the crucible for figuring out evidence-based medicine and value-based care."* Participants generally agreed that the types of care

coordination activities APMs are designed to incent—such as enhanced patient navigation and team-based care—are precisely those needed to manage and fare well during the crisis.

One hope from oncologists is that in the wake of COVID-19, payers will reimburse and incent telemedicine and home care visits more effectively than in the past. One clinician said, *"I appreciate telemedicine allowing us to do phone visits and be paid for them because it has allowed us to reach some of our neediest patients."* Payers and clinicians underscored the importance of *"keeping providers whole"* from a payment perspective—that is, not undercutting independent practices by inappropriately shifting services, such as infusions, to home-based settings without robust analysis and consideration for the implications.

Indeed, many are concerned that independent practices facing significant financial stress may close or be acquired following COVID-19, accelerating a trend that began prior to the crisis.[22] Clinicians pointed to anecdotal evidence that some oncologists may choose to retire rather than bear the financial risk and/or exposure risk related to the virus. Collectively, this would result in fewer available sites of care for patients, especially in more rural communities. One participant noted, *"I think we really are going to have to reevaluate how we are going to place healthcare resources across this country because, otherwise, we are going to be in a world of hurt going forward."*

Conclusion

For some participants, *"the COVID-19 crisis has unmasked flaws in our care delivery system."* There is an urgent impetus now—financially and clinically—to figure out alternative ways of delivering care. While the full impact of COVID-19 on US healthcare remains to be seen, most council participants envision an ongoing and robust role for oncology payment reform. Experiments in this specialty will, now more than ever, need to be adaptable and informed by close collaboration between payers and clinicians while prioritizing patient needs and the sustainability of the delivery system across diverse communities in the United States.

Finally, as the timeline for and additional details about the OCF model remain uncertain, the time may be ripe for new critical insights to inform national oncology payment reform experiments. Focused research and analysis today could shed future light on the questions that emerged during the meeting—for example, how risk stratification and predictive modeling can better integrate into clinical workflows and appropriately inform value-based decision-making; how to achieve more accurate care-cost estimates and better understand cost- and care-variation drivers; how to define appropriate risk and develop benchmarks for evaluating models' benefits and success; and how to understand the potential evolution of site of care for treatment in the wake of the COVID-19 crisis.

About this document

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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.

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Endnotes

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[9] Actuaries define credibility as "the degree of accuracy in forecasting future events based on statistical reporting of past events," which is "used to provide a measure of the relative predictive value of the data being reviewed." ("Credibility," International Risk Management Institute, accessed July 2, 2020.)

[10] Nick Bluhm et al., *Redesigning the Oncology Care Model* (East Norwalk, CT: Remedy, December 2019).

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