PTAC Public Meeting

December 10, 2018

Physician-Focused Payment Model Technical Advisory Committee

Preliminary Review Team Findings on

Making Accountable Sustainable Oncology Networks

Submitted by Innovative Oncology Business Solutions, Inc. (IOBS)

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Presentation Overview

- Preliminary Review Team (PRT) Composition and Role
- Proposal Overview
- Summary of the PRT Review
- Key Issues Identified by the PRT
- PRT Evaluation Using the Secretary’s Criteria

Preliminary Review Team Composition and Role

- The PTAC Chair/Vice Chair assigns two to three PTAC members, including at least one physician, to each complete proposal to serve as the PRT. One PRT member is tapped to serve as the Lead Reviewer.
- The PRT identifies additional information needed from the submitter and determines to what extent any additional resources and/or analyses are needed for the review. ASPE staff and contractors support the PRT in obtaining these additional materials.
- The PRT determines, at its discretion, whether to provide initial feedback on a proposal.
- After reviewing the proposal, additional materials gathered, and public comments received, the PRT prepares a report of its findings to the full PTAC. The report is posted to the PTAC website at least three weeks prior to public deliberation by the full Committee.
- The PRT report is not binding on PTAC; PTAC may reach different conclusions from those contained in the PRT report.

Proposal Overview

Background – The proposal is based on the Community Oncology Medical Home (COME HOME) model.

Goals – MASON seeks to improve care for patients at increased risk of hospitalization by providing these patients with a physician who cares for them in both the clinic and hospital settings.

APM Entity – An oncology practice would serve as the APM entity.

Core Elements of the Program:

1. Upon first consultation with an oncologist, and based on relevant clinical factors and patient preferences, patients will be assigned to a treatment plan and be categorized into an Oncology Payment Category (OPC).
2. The OPC has a designated target price that reflects all cancer care-related expenses. All drugs, including parenteral and oral chemotherapy, are excluded from the OPC target amount.
3. OPC assignment prompts creation of a “virtual account,” visible to both providers and patients, that tracks cancer care expenditures against the target amount, including care received by external providers. Services are paid in a fee-for-service (FFS) manner, with retrospective reconciliation.
4. If patients are managed in a way that reduces their expenditures below the target amount, the participating practice shares in these savings if quality benchmarks are sufficiently met.
5. Quality is measured via pathway compliance and patient and family surveys. A 4% quality withhold from all Evaluation and Management (E&M) payments is used to form a quality pool.

Proposal Overview – *Continued*

Payment – Payment is determined by patient classification into OPCs, which groups patients based on disease state, comorbidities, and treatment plan.

- **A target price based on the expected costs of caring for patients in a given OPC is assigned.**
- **OPCs have not yet been developed but are modeled after CMS's Ambulatory Payment Classification for care delivered in the outpatient hospital setting. They will be generated using a machine learning algorithm and cognitive computing infrastructure.**

OPC Target Price includes

- One-time $750 payment for new patient consultation
- E&M visits
- Infusion center facility fees
- Variable radiation and infusion inputs
- Hospital charges and facility fees
- Other physician care related to cancer treatment, imaging, and laboratory services

Quality

- A 4% withhold from all E&M payments is used to form a quality pool.
- Quality is measured via technical quality (treatment pathway adherence) and customer service quality (patient and family surveys).
- For both criteria, an 80% threshold is established as defining satisfactory performance.

Summary of the PRT Review

Criteria Specified by the Secretary (at 42 CFR §414.1465)	PRT Conclusion	Unanimous or Majority Conclusion
1. Scope (High Priority)	Meets Criterion and Deserves Priority Consideration	Unanimous
2. Quality and Cost (High Priority)	Does Not Meet	Unanimous
3. Payment Methodology (High Priority)	Does Not Meet	Unanimous
4. Value over Volume	Meets	Unanimous
5. Flexibility	Meets	Unanimous
6. Ability to be Evaluated	Meets	Unanimous
7. Integration and Care Coordination	Meets	Unanimous
8. Patient Choice	Meets	Unanimous
9. Patient Safety	Meets	Unanimous
10. Health Information Technology	Meets	Unanimous

Key Issues Identified by the PRT

- The OPCs are not currently operational, and developing them is a time-intensive process that will require frequent and similarly time-intensive updating to reflect ever-evolving developments in both pharmaceutical and therapeutic advances in cancer care.
- While the OPCs represent a granularity in care that is much needed in this clinical area, there were also concerns about generalizability of the OPCs; if they are developed based on the utilization patterns of a select group of practices that does not reflect the practices of the broader population, the benchmarks and classifications may not be representative for broad scaling.
- The PRT was also concerned about how compliance with the pathways is assessed and whether deviations that are voluntary are distinguished from unexpected events that trigger clinically necessary protocol changes.
- The PRT also had operational concerns about the approach to adjudicating whether a service is related to the cancer episode, and therefore, included in the OPC target price. While the PRT appreciated the submitter's new, creative suggestion to cluster codes to help make this determination, rather than use an appeals process, such an approach is undeveloped and untested.

Key Issues Identified by the PRT– *Continued*

- While clinicians have the opportunity to enter a justification for going off-pathway, it was not clear how these justifications would be factored into the quality scoring process to avoid penalizing practices for appropriate deviations. If unaddressed, this could create misalignment between the provider's best clinical judgment and the model's financial incentives.
- The model's effort to delineate cancer and non-cancer care may disincentivize care coordination beyond the core team of cancer care providers.
- The PRT would have liked to see a more robust and detailed plan for shared decision-making, especially given the importance of patient preferences at many decision points in a cancer care trajectory, such as chemotherapy initiation near the end of life.
- The process for and implications of patients exiting the model were not fully described and could introduce unintended incentives to disenroll patients who are relatively more expensive within a given OPC.

Criterion 1. Scope (High Priority)

Criterion Description

Aim to either directly address an issue in payment policy that broadens and expands the CMS APM portfolio or include APM Entities whose opportunities to participate in APMs have been limited.

PRT Conclusion

Meets criterion and deserves priority consideration

Unanimous or Majority Conclusion

Unanimous

- While the CMS Alternative Payment Models (APM) portfolio already includes a model addressing the proposal's clinical area (cancer) and provider entities (oncologists) via the Oncology Care Model (OCM), we believe the proposed model potentially represents a significant improvement on the OCM.
  - The proposed model acknowledges the very granular and individualized nature of treatment plans for different types of cancer, and the payment model reflects this precision by using evidence-based pathways as the basis for establishing payment amounts.
  - The proposed model is not based on a predefined time frame, but rather the episode length reflects the specific disease and the care plan selected.
  - Participating providers are directly incentivized to provide care coordination and other services beyond those directly related to chemotherapy, acknowledging that in some cases chemotherapy is not the most appropriate course of action.
  - The payment model attempts to hold oncologists accountable only for cancer-related expenditures, rather than total cost of care (TCOC).

Criterion 2. Quality and Cost (High Priority)

Criterion Description
Are anticipated to improve health care quality at no additional cost, maintain health care quality while decreasing cost, or both improve health care quality and decrease cost.

PRT Conclusion
Does Not Meet Criterion

Unanimous or Majority Conclusion
Unanimous

- Using evidence-based treatment pathways and measuring and rewarding clinical quality based on adherence to these pathways is a clear strength of the proposal and would be expected to improve the quality of care.
- However, the OPCs, which are critical for classifying patients into treatment pathways and assigning target prices, are not currently operational. Developing them is a time-intensive process that will require frequent and similarly time-intensive updating to reflect ever-evolving developments in both pharmaceutical and therapeutic advances in cancer care.
- There were also concerns about the generalizability of the OPCs; if they are developed based on the utilization patterns of a select group of practices that does not reflect the practices of the broader population, the benchmarks and classifications may not be representative for broad scaling.
- Compliance with the pathways is also potentially problematic. Specifically, there are concerns as to how deviations that are voluntary are distinguished from unexpected events that trigger clinically necessary protocol changes. It is even possible that such an occurrence could switch a patient to a new OPC, potentially further muddling how compliance is gauged.

Criterion 3. Payment Methodology (High Priority)

Criterion Description

Pay APM Entities with a payment methodology designed to achieve the goals of the PFPM criteria. Addresses in detail through this methodology how Medicare and other payers, if applicable, pay APM Entities, how the payment methodology differs from current payment methodologies, and why the PFPM cannot be tested under current payment methodologies.

PRT Conclusion

Does Not Meet Criterion

Unanimous or Majority Conclusion

Unanimous

- A clear strength of this proposal is the payment model's attention to care coordination and other medical home activities, which broadens the scope of the model beyond OCM's focus on chemotherapy.
- Basing payment on cancer-related care rather than TCOC holds participating providers accountable only for the utilization that is under their direct influence.
- The PRT is supportive of the inclusion of an administrative fee related to drug purchasing and administration, and endorses the submitter's revision of this fee to a flat rate rather than a percentage of the drug price.
- Developing the OPCs, which support the payment model, is a time-intensive and unstable process, in that it will need to be updated to reflect new drugs and therapeutic changes.
- Using Hierarchical Condition Categories (HCCs) as the driver of predictions for cancer-related expenditures has not been established as accurate for cancer-related spending specifically.
- The process of adjudicating whether a service is related to cancer care, while revised in a new, creative way by the submitter, is undeveloped and untested.

Criterion 4. Value over Volume

Criterion Description
Provide incentives to practitioners to deliver high-quality health care.

PRT Conclusion
Meets Criterion

Unanimous or Majority Conclusion
Unanimous

- The review of accounts and the process of identifying providers delivering low-value care, as captured by pathway deviations and other metrics, is compelling and likely to improve the value of cancer care.
- The payment model challenges addressed in the previous criterion, such as the practical issues associated with isolating cancer care expenditures from expenditures for other conditions, complicate the model's effort to improve value.
- How deviations from OPC pathways are handled is likely to affect the value proposition of the model, since unexpected events may in some cases trigger a change in pathway that may appear to be noncompliance, depending on how comprehensively the OPCs are defined.

Criterion 5. Flexibility

Criterion Description
Provide the flexibility needed for practitioners to deliver high-quality health care.

PRT Conclusion
Meets Criterion

Unanimous or Majority Conclusion
Unanimous

- The combination of the evidence-based pathways and a process for accommodating deviations from those pathways balanced the need for incentivizing high-quality care while also allowing for physician autonomy in tailoring that care.
- The model would benefit from a more nuanced process for accommodating deviations in the quality measurement process; while clinicians have the opportunity to enter a justification for going off-pathway, it was not clear how these justifications would be factored into the quality scoring process to avoid penalizing practices for appropriate deviations. If unaddressed, this could create misalignment between the provider's best clinical judgment and the model's financial incentives.

Criterion 6. Ability to be Evaluated

Criterion Description
Have evaluable goals for quality of care, cost, and any other goals of the PFPM.

PRT Conclusion
Meets Criterion

Unanimous or Majority Conclusion
Unanimous

- The submitter has articulated metrics for capturing quality of care, cost, and patient satisfaction for the proposed model.
- The as-yet-undeveloped nature of the OPCs, and the lingering concerns about specific elements of the payment formula is a concern.
- There are concerns about using the OCM patient cohort as the comparator and would prefer to also see non-OCM cohorts used in the control group.

Criterion 7. Integration and Care Coordination

Criterion Description
Encourage greater integration and care coordination among practitioners and across settings where multiple practitioners or settings are relevant to delivering care to the population treated under the PFPM.

PRT Conclusion
Meets Criterion

Unanimous or Majority Conclusion
Unanimous

- A strength of the proposal is its emphasis on cancer care to include more than just the time a patient is undergoing chemotherapy, as reflected in aspects such as how an episode is defined and the direct incentives around care coordination that are not linked with a specific treatment approach.
- This model is inclusive of independent practice physicians, rather than being designed with integrated health systems in mind.
- One concern is that the model's effort to delineate cancer and non-cancer care may disincentivize care coordination beyond the core team of cancer care providers, a potential problem in a Medicare population in which cancer occurs in individuals who often have multiple, chronic conditions.
- The emphasis on spending, and granular detail on spending that is available to participating entities, may inhibit integration and coordination. Specifically, the possible exclusion of high-spending clinicians may not necessarily generate the highest-quality team.

Criterion 8. Patient Choice

Criterion Description
Encourage greater attention to the health of the population served while also supporting the unique needs and preferences of individual patients.

PRT Conclusion
Meets Criterion

Unanimous or Majority Conclusion
Unanimous

- It is explicitly stated that patient preferences for providers and hospitals will be solicited and accommodated when feasible.
- The proposal briefly describes a patient “app” that will facilitate timelier and more direct patient-initiated communication with the clinical team.
- The model would benefit from a more robust and detailed plan for shared decision-making, especially given the importance of patient preferences at many decision points in a cancer care trajectory, such as chemotherapy initiation near the end of life.
- An additional concern is the potentially cumbersome process of switching OPCs due to a change in care plan or disease status. This may inhibit patient choice if it delays a patient’s desired changes in their care plan.
- The process for and implications of patients exiting the model were not fully described and could introduce unintended incentives to disenroll patients who are relatively more expensive within a given OPC. This issue may be compounded in the absence of streamlined distinctions between cancer and non-cancer care.

Criterion 9. Patient Safety

Criterion Description
Aim to maintain or improve standards of patient safety.

PRT Conclusion
Meets Criterion

Unanimous or Majority Conclusion
Unanimous

- The evidence-based care pathways are likely to yield improvements in patient safety to the extent that they steer providers to care regimens that reflect the latest evidence and guidelines on safety of care.
- The data capture supporting these pathways and their quality compliance metric is also intended to facilitate monitoring that, in theory, can support patient safety goals.
- The transparency and detail of the virtual accounts, which will include data on providers both in and out of the APM entity practice, offers additional visibility that in theory could improve patient safety to the extent that it is used to evaluate collaborating providers.

Criterion 10. Health Information Technology

Criterion Description
Encourage use of health information technology to inform care.

PRT Conclusion
Meets Criterion

Unanimous or Majority Conclusion
Unanimous

- This proposal employs health information technology in a variety of ways to both support the model's infrastructure and facilitate its ongoing operation.
- The machine learning and cognitive computing platform are vital to the development and updating of the OPCs, and participating practices in the pilot version of this proposal will all be advanced users of EHRs.
- The virtual accounts are another technological backbone of the proposed model, though on this point more detail would be helpful as to the interoperability of systems across participating providers.

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