Physician-Focused Payment Model Technical Advisory Committee
Public Meeting Minutes

December 16, 2016
10:15 a.m. – Noon EST
Holiday Inn Capitol
550 C Street, SW
Washington, DC 20004

Attendance

Physician-Focused Payment Model Technical Advisory Committee (PTAC) Members In-Person
Jeffrey W. Bailet, MD (PTAC Chair; President, Aurora Health Care Medical Group)
Robert Berenson, MD (Institute Fellow, Urban Institute)
Tim Ferris, MD (Senior Vice President for Population Health Management, Partners HealthCare)
Rhonda M. Medows, MD (Executive Vice President of Population Health, Providence Health & Services)
Harold D. Miller (President and CEO, Center for Healthcare Quality and Payment Reform)
Elizabeth Mitchell (PTAC Vice Chair; President and CEO, Network for Regional Healthcare Improvement)
Len M. Nichols, PhD (Director, Center for Health Policy Research and Ethics, George Mason University)
Bruce Steinwald, MBA (Consultant)
Grace Terrell, MD (Founder and Strategist, Cornerstone Health Enablement Strategic Solutions)

PTAC Members Not Present
Paul Casale, MD, MPH (Executive Director, New York Quality Care)
Kavita Patel, MD (Nonresident Senior Fellow, Brookings Institution)

Speakers
Katherine Cox (Health Insurance Specialist, ORISE Research Fellow, Center for Medicare & Medicaid Innovation)
Ellen Lukens (Director, Division of Ambulatory Payment Models, Center for Medicare & Medicaid Innovation)
Ron Kline, MD (Medical Officer, Patient Care Models Group, Centers for Medicare & Medicaid Services)
L. Daniel Muldoon (Social Science Research Analyst/Health Insurance Specialist, Center for Medicare & Medicaid Innovation)

Public Commenters
Sheila Madhani (Senior Director, McDermott+ Consulting)
Robert Lookstein, MD (Vice Chair, Department of Radiology, Mount Sinai Health System; Professor of Radiology and Surgery, Division of Vascular and Interventional Radiology, Icahn School of Medicine at Mount Sinai)

PTAC Overview
The PTAC Chair called the meeting to order and welcomed attendees to the PTAC public meeting. The Chair provided some brief background about PTAC and discussed PTAC's statutory charge and emphasized the importance of a transparent process. The Chair provided an update of the PTAC's activities in the first year and discussed how PTAC will be using the Secretary of Health and Human Services' (the Secretary's) criteria for evaluating physician-focused payment models (PFPMs). The Chair announced that PTAC began accepting non-binding letters of intent (LOIs) in October 2016 and accepting proposals on December 1, 2016. Since then, PTAC has received 10 LOIs to submit proposals and two completed proposals. There is no deadline for proposals, although LOIs must be submitted 30 days prior to a full proposal.

The Chair emphasized that the Committee aims for transparency in all of its activities. It encourages stakeholder participation in meetings, and public comment on key documents.

Overview of PTAC Request for Proposal (RFP) and Proposal Evaluation Process
Bruce Steinwald outlined the 16-week process (from receipt of the proposal to a PTAC recommendation) that PTAC will be using to review and evaluate PFPM proposals. If recommended to the Secretary, the proposal is recommended for "limited-scale testing," implementation as proposed, or implementation as "high priority."

The initial review of the proposal will be conducted by a Preliminary Review Team (PRT) made up of three PTAC members, at least one of whom is required to be a physician. The Chair and Vice Chair will appoint a lead reviewer who will present the proposal and the PRT's recommendation to the full Committee. All proposals will receive full Committee review, although members with a conflict of interest (e.g., member was involved in proposal development) may be recused from deliberation and/or voting. The PRT can request research tasks, data analyses, or clinical expertise from ASPE's contractor to aid in their proposal review. PTAC received some questions from the public before the public meeting and the following information was provided by PTAC in response:

- Any tasks conducted by ASPE's contractor per PTAC's request will be paid for by PTAC.
- All complete proposals will receive a full Committee review, regardless of PRT recommendation, that will take place in a PTAC public meeting.
- All proposal submitters will be notified when their proposal will be reviewed, deliberated, and voted on and PTAC will make a concerted effort to reschedule if the submitters are unable to attend.
- Proposals that receive a score of zero in one of the high-priority criterion will not be recommended by PTAC.
- There is currently no appeals process, but proposal submitters are welcome to revise and resubmit their proposals.
- Once PTAC recommends a PFPM, it is up to the Secretary whether and how it will be implemented.

The floor was opened up to the public for questions and comments.

Public Comment Session
Robert Lookstein, Mount Sinai Health System, inquired about transparency related to proposal submissions and status updates of where PTAC may be with regard to its review process. PTAC stated the following: (1) all proposals will be posted on the PTAC website; (2) the public is invited and

encouraged to attend all PTAC public meetings in which all Committee deliberations and voting will take place; (3) the PRT review and discussion will not be transparent.

Sheila Madhani, McDermott+ Consulting, asked if the PTAC proposal review and recommendation process would evolve, as PTAC gains more experience. PTAC stated that it intends to utilize a continuous improvement approach as it analyzes proposals and may be revising the process as needed.

Oncology Care Model (OCM) Overview

PTAC invited the Centers for Medicare & Medicaid Services (CMS) and the Center for Medicare & Medicaid Innovation (CMMI or the Innovation Center) to provide an overview of the Oncology Care Model (OCM). CMS and CMMI speakers included: Ellen Lukens, Director, Division of Ambulatory Payment Models, CMMI; Katherine Cox, Health Insurance Specialist, ORISE Research Fellow, CMMI; Ron Kline, Medical Officer, Patient Care Models Group, CMS; and L. Daniel Muldoon, Social Science Research Analyst/Health Insurance Specialist, CMMI.

The presenters stated that OCM is a five-year episode-based, multi-payer payment model that focuses on six-month episodes of care triggered by chemotherapy and includes nearly all cancer types. The development of the OCM began in 2013 and was publicly announced in 2015. In June 2015, physician group practices and payers were invited to apply to participate in the model. The model went live on July 1, 2016, with almost 200 participating practices and 16 participating payers covering rural and suburban areas. Additionally, participants include smaller practices, including solo practitioners, and larger entities working with hospital based practices and multi-specialty practices. OCM practices are defined by the Tax Identification Number (TIN) used to bill for professional services and the specific practitioners are defined by their National Provider Identifier (NPI). The TIN/NPI combination is used for identification.

CMS presenters additionally discussed OCM episode definition, practice redesign requirements, quality measures, and payment structure:

OCM Episode Definition

CMS presenters discussed episode definition as follows:

- The episode initiates with chemotherapy due to its observability from claims.
- Episode duration is six months because data indicated that peak spending occurs between two and four months and that spending is stabilized between four and six months.
- Beneficiaries may have several episodes within the five-year model.
- CMS has devised a list of chemotherapy drugs that trigger OCM episodes (excluding topical formulations of drugs).
- The model is a “total cost of care” model.
- Episodes are retrospectively attributed to the practice that provides the most E&M visits with cancer diagnosis during the episode time period (i.e., plurality approach).
- All Medicare Part A and Part B services that a beneficiary receives during an episode are included. Certain Part D expenditures, the low-income subsidy, and the 80% of costs that are over the catastrophic threshold are also included.

Practice Redesign

Certain practice redesign activities are required of all practices participating in the model:

- Patients must have 24/7 access to a clinician who has access to the patient's medical records.
- Patient navigation services must be provided.
- Patient care plans must addresses the 13 elements of the Institute of Medicine's model care plan.
- Treatment must be consistent with nationally recognized guidelines for care.
- Providers must utilize certified EHR technology, and data for continuous quality improvement purposes.

OCM Quality Measures

OCM quality measures represent four of the National Quality Strategy (NQS) domains: 1) communication and care coordination, 2) person and caregiver-centered experience and outcomes, 3) clinical quality of care, and 4) patient safety. To the extent possible, OCM uses claims-based measures and measures that align with other CMS programs to reduce provider burden.

OCM considers three groups of measures:

1. Claims-based measures such as risk-adjusted proportion of patient with all-case hospital admissions within the six month episode and risk-adjusted emergency department visits and patients who are admitted to hospice for three days or more.
2. Practice-reported measures that are aligned to electronic Clinical Quality Measures (eCQMs), Physician Quality Reporting System (PQRS), or National Quality Forum (NQF) measures.
3. Patient-reported measures such as modified Consumer Assessment of Healthcare Providers and Systems (CAHPS) oncology questionnaire data aggregated at the composite score level

OCM Payment Structure

In OCM, fee-for-service payments continue to practicing providers. In addition, the OCM payment structure has an additional two-pronged approach. First, participating practices receive a Monthly Enhanced Oncology Services (MEOS) payment of $160 for patients who are likely to have OCM episodes attributable to the practice. The second component of the payment is the potential for semi-annual performance-based payments if expenditures are reduced below target prices and if the practices have an acceptable Aggregate Quality Score.

After all payment steps were discussed in detail, CMS discussed the practice-specific adjustment factor. CMS wrapped up the presentation with a few closing points regarding next steps and evaluation activities. CMS stated that they are evaluating the MEOS to identify where opportunity for improvement may exist and that an evaluation is occurring that is using a matched comparison group to try and understand the counterfactual and what spending would have been in the absence of OCM. Additionally, CMS indicated that OCM has a learning collaborative that will be shifting to a peer-to-peer learning model.

OCM Questions and Answer Session

PTAC followed up with the CMS presenters on several questions about OCM. CMS informed the public and the Committee on the a variety of topics including: the models' requirement that providers follow national guidelines and the 13-point Institute of Medicine (IOM) care plan; MEOS; beneficiary cost

sharing; the practice prediction tool provided by CMS; Part A, Part B, and Part D expenses; drugs and total cost of care; episode variation; historical periods for episodes; core set of quality measures; evaluation design; timing of the evaluation results; implications of changes in treatment best practices; risk adjustment; surgery and radiation therapy adjustments; and the potential for other modalities in episode triggers.

CMS also indicated that with OCM and other episode payment models, the ultimate long term goal would be to get to a prospective payment method. Additionally, OCM practices that accept the two-sided risk model will qualify as advanced APMs and could elect two-sided risk as of January 1, 2017.

Adjournment

Mary Ellen Stahlman, ASPE PTAC Staff Director, announced that the afternoon session presentation would be postponed due to the technical difficulties that would prevent individuals on the phone from presenting and hearing information.

The Public Meeting Session was adjourned at 12:00 p.m.

A transcript of this meeting can be found on the PTAC website.

Approved and certified by:

___/Ann Page/_____ _____8/14/2017_____

Ann Page, Designated Federal Officer
Physician-Focused Payment Model Technical
Advisory Committee

Date

__/Jeffrey Bailet/_____ _____7/19/2017_____

Jeffrey Bailet, Chair
Physician-Focused Payment Model Technical
Advisory Committee

Date