Physician-Focused Payment Model Technical Advisory Committee LOI: Environmental Scan & Relevant Literature
Hackensack Meridian Health (HMH) and COTA Inc. **Letter Dated: 11/15/2016** **Letter Received: 11/15/2016**
Hackensack Meridian Health (HMH) is a large multi-hospital provider of cancer services that has experience with value based payment models with commercial payers. COTA is a big data precision analytic company with patented technology that enables providers to identify and prevent adverse behavioral care variance. The Physician-Focused Payment Model proposed by HMH and COTA will seek to optimize clinical outcomes while reducing total cost of care through a combination of precision diagnostics and therapeutics leveraging precision analytics. This model would feature an oncology bundled payment model in which care choices are driven by experiences of similar patients drawn from real world data, this process is currently known as Cota Nodal Address (CNA) Guided Care. The CNA Guided Care approach, which draws from retrospective data based on homogenously grouped oncology patients, is currently facilitating a move from fee for service to bundled reimbursement within the HNH network, and the proposed PFPM will capitalize on this experience. This proposed model would utilize a bundled pricing model for Medicare cancer patients at HMH. The bundled payment will encompass all payments for an oncology episode, including medical, radiation and surgical oncology associated fees with the episode. HMH will use the COTA's patented CNA system to analyze all attributes specific to a patient and their disease that affect clinical outcomes and cost of care. This system (developed by expert clinicians and based on peer-reviewed literature) organizes data about the cancer patients into homogenous groups to enable big data analytic approaches. There are about 7,000 Medicare beneficiaries with cancer served by the HMH network; those would be the expected participants of the model.
Key Search Terms
Oncology bundled payment models; disease specific episode payment; disease specific episodes; COTA nodal address cancer; episode payments electronic health records; data driven pricing healthcare; cancer patient categorization pricing; physician focused payment model; COTA Oncology Care Model; Oncology Care Model; Episodes of Care Oncology; oncology episode-based payment model

Research Task	Section	Contents
Environmental Scan	Section 1	Key documents, timely reports, grey literature, and other materials gathered from internet searches (3).
Relevant Literature	Section 2	Relevant literature materials (4).
Related Literature	Section 3	Related literature materials (3)

Section 1. Environmental Scan

Environmental Scan		
Key words: Oncology bundled payment models; disease specific episode payment; COTA nodal address cancer; episode payments electronic health records; data driven pricing healthcare; cancer patient categorization pricing; disease specific episodes; physician focused payment model		

Organization	Title	Date
COTA Inc.	Clinical outcome tracking and analysis(US 20150127385 A1)(Patent)	5/7/2015

Purpose/Abstract

Background: As the general population is living longer, medical costs associated with the aging population are increasing. The costs associated with diseases, such as cancer, are typically enormous. For example, cancer costs are projected to be the highest growth area in healthcare spending without a commensurate improvement in outcomes. Approximately $125 billion was spent in 2010 on cancer care in the United States alone, and estimates are that approximately 15-30% of the spending can be categorized as "waste". Conventional techniques to control costs, such as clinical pathways and disease management, are typically ineffective, but there are no quality alternatives that currently exist in the market today.

Summary: The described invention provides a system and method for clinical outcome tracking and analysis. The clinical outcome tracking and analysis comprises sorting, outcome tracking, quality of life metrics, toxicity to therapy and cost of care. The system and method includes receiving one or more parameters. Exemplary parameters for sorting include sex, age, ethnicity, comorbidities, tobacco use, source of insurance, medical record number, primary care physician, referring physician, hospital, approved service vendors, disease-specific clinical molecular phenotype, therapy intent, stage of therapy, biomarkers, and cost of care. A plurality of patient medical records are sorted, by a clinical outcome tracking and analysis module executed by a processor, to provide a set of patient medical records satisfying the one or more parameters. A nodal address, indicating one or more variables, is applied to the sorted set of patient medical records to determine a clinically relevant set of patient medical records as the sorted set of patient medical records satisfying the one or more variables. The clinically relevant set of patient medical records is analyzed. A communication is transmitted based on the analyzing to a user to effect treatment, to monitor performance, or to reduce at least one of treatment variability, waste or inefficiency while delivering on intended outcome.

Additional Notes/Comments

Environmental Scan

Key words: Oncology bundled payment models; disease specific episode payment; COTA nodal address cancer; episode payments electronic health records; data driven pricing healthcare; cancer patient categorization pricing; disease specific episodes; physician focused payment model

Organization	Title	Date
Cancer Outcomes Tracking and Analysis (COTA Inc.)	Innovations in Cancer Care: The Movement In Value-Based Care	2013

Purpose/Abstract

Background: Cancer Outcomes Tracking and Analysis (COTA) provides an innovative solution that addresses a critical challenge facing oncology providers & payers seeking to improve the quality of care, manage costs of care, and ensure patient safety. COTA aims to enable Oncologists to guide Care freed from insurance bureaucracy within a bundled payment model.

Summary: This document is a powerpoint presentation by doctors Glenn D. Pomerantz, Chief Medical Officer at Horizon Blue Cross Blue Shield of New Jersey; and Andrew Pecora who serves as President and CEO of Regional Cancer Care Associates. The presentation focuses on explaining the COTA system and how medical doctors can use the tool to provide better care to their patients. COTA is a system that supports Oncology management by analyzing specific data from every patient and developing comprehensive reports based on real world data of patients with similar characteristics. The reports contain clinical and financial analysis that allows providers the ability to perform full financial costing analysis. COTA analytics also allows providers to identify which candidates are appropriate for targeted therapy.

Additional Notes/Comments

Environmental Scan		
Key words: Oncology bundled payment models; disease specific episode payment; COTA nodal address cancer; episode payments electronic health records; data driven pricing healthcare; cancer patient categorization pricing; disease specific episodes; physician focused payment model		
Organization	**Title**	**Date**
Meridian Health/ Centers for Medicare and Medicaid Services	Press Release -- Hackensack Meridian Health Selected to Participate in New National Initiative to Prevent Heart Attacks and Strokes/ Million Hearts®: Cardiovascular Disease Risk Reduction Model	Access Date: 11/17/2016
Purpose/Abstract		
Background: Hackensack Meridian Health (HMH) has been selected by the Centers for Medicare and Medicaid Services to participate in the Million Hearts Cardiovascular Disease Risk Reduction Model along with other 516 organizations across the country. *Summary:* The Million Hearts Cardiovascular Disease Risk Reduction Model is a randomized controlled trial that seeks to bridge a gap in cardiovascular care by providing targeted incentives for healthcare practitioners to in engage in beneficiary CVD risk calculation and population level risk management.		
Additional Notes/Comments		
https://innovation.cms.gov/initiatives/Million-Hearts-CVDRRM/		

Section 2. Relevant Literature

Relevant Literature		
Key words: Oncology bundled payment models; disease specific episode payment; COTA nodal address cancer; episode payments electronic health records; data driven pricing healthcare; cancer patient categorization pricing; disease specific episodes; physician focused payment model; oncology episode-based payment model		
Journal	**Title**	**Date**
Journal of Oncology Practice	Changing Physician Incentives for Affordable, Quality Cancer Care: Results of an Episode Payment Model	9/1/2014
Purpose/Abstract		
Purpose: This study tested the combination of an episode payment coupled with actionable use and quality data as an incentive to improve quality and reduce costs. *Methods:* Medical oncologists were paid a single fee, in lieu of any drug margin, to treat their patients. Chemotherapy medications were reimbursed at the average sales price, a proxy for actual cost. *Results:* Five volunteer medical groups were compared with a large national payer registry of fee-for-service patients with cancer to examine the difference in cost before and after the initiation of the payment change. Between October 2009 and December 2012, the five groups treated 810 patients with breast, colon, and lung cancer using the episode payments. The registry-predicted fee-for-service cost of the episodes cohort was $98,121,388, but the actual cost was $64,760,116. The predicted cost of chemotherapy drugs was $7,519,504, but the actual cost was $20,979,417. There was no difference between the groups on multiple quality measures. *Conclusion:* Modifying the current fee-for-service payment system for cancer therapy with feedback data and financial incentives that reward outcomes and cost efficiency resulted in a significant total cost reduction. Eliminating existing financial chemotherapy drug incentives paradoxically increased the use of chemotherapy.		
Additional Notes/Comments		

Relevant Literature

Journal	Title	Date
Medical Care	Comparison of Approaches for Estimating Prevalence Costs of Care for Cancer Patients: What Is the Impact of Data Source?	7/1/2009

Purpose/Abstract

Background: National prevalence costs of medical care can be key inputs in health policy decisions. Cost estimates vary across data sources, patient populations, and methods, however. The objective of this study was to compare three approaches for estimating the prevalence costs of colorectal cancer (CRC) care using different data sources, but similar patient populations and methods.

Methods: The researchers identified prevalent CRC patients aged 65 and older from: 1) linked SEER registry-Medicare data, 2) Medicare claims only, and 3) the Medical Expenditure Panel Survey (MEPS). Controls were matched by sex, age-group, and geographic location. Mean per person total and net costs, measured as the difference between patients and controls, were compared for each approach during a similar observation period. The SEER-Medicare approach was the reference, and evaluated the impact of patient selection criteria with sensitivity analyses. Aggregate prevalence estimates were also compared.

Results: The study found considerable variability across the different approaches to estimating prevalence costs of CRC. Mean net annual per person estimates in the SEER-Medicare reference were $5,341 (95% CI: $5,243, $5,439), compared to $8,736 (95%: $8,203, $9,269) for the Medicare claims only and $11,614 (95% CI: $7,566, $15,663) for the MEPS. Aggregate national estimates of net prevalence costs of CRC in 2004 ranged from $4,524 million using the SEER-Medicare approach to $9,629 million using the MEPS approach. Estimates varied by data source based on the payors included and identification of prevalent CRC patients.

Conclusions: CRC prevalence cost estimates vary substantially depending on the data sources. The findings have implications for estimating prevalence costs for other cancers and other diseases without registry systems that can be used to identify newly diagnosed individuals as well as those diagnosed less recently.

Additional Notes/Comments

Relevant Literature

Journal	Title	Date
Medical Care	Comparison of Approaches for Estimating Incidence Costs of Care for Colorectal Cancer Patients	7/1/2009

Purpose/Abstract

Background: Estimates of the costs of medical care vary across patient populations, data sources, and methods. The objective of this study was to compare 3 approaches for estimating the incidence costs of colorectal cancer (CRC) care using similar patient populations, but different data sources and methods.

Methods: The 2 data sources used, linked SEER-Medicare and Medicare claims alone, to identify newly diagnosed CRC patients aged 65 and older and estimated their healthcare costs during the observation period, 1998 to 2002. Controls were matched by sex, age-group, and geographic location. Then the researchers compared mean net costs, measured as the difference in total cost between cases and controls, for: (1) a SEER-Medicare cohort, (2) a Medicare claims alone cohort, and (3) a modeled phase of care approach using linked SEER-Medicare data. The SEER-Medicare cohort approach was considered the reference.

Results: Considerable variability across approaches was found for estimating net costs of care in CRC patients. In the first year after diagnosis, mean net costs were $32,648 (95% CI: $31,826 and $33,470) in the SEER-Medicare cohort. The other approaches understated mean net costs in year 1 by about 16%. Mean net 5-year costs of care were $37,227 (95% CI: $35,711 and $38,744) in the SEER-Medicare cohort, and $30,310 (95% CI: $25,894 and $34,726) in the claims only approach, with the largest difference in the 65 to 69 age group. Mean net 5-year costs of care were more similar to the reference in the modeled phase of care approach ($37,701 [range: $36,972 and $38,446]). Differences from the SEER-Medicare cohort estimates reflect misclassification of prevalent cancer patients as newly diagnosed patients in the Medicare claims only approach, and differences in years of data and assumptions about comparison groups in the modeled phase of care approach.

Conclusions: CRC incidence cost estimates vary substantially depending on the strategy and data source for identifying newly diagnosed cancer patients and methods for estimating longitudinal costs. The findings may inform estimation of costs for other cancers as well as other diseases.

Additional Notes/Comments

Relevant Literature		
Key words: Oncology bundled payment models; disease specific episode payment; COTA nodal address cancer; episode payments electronic health records; data driven pricing healthcare; cancer patient categorization pricing; disease specific episodes; physician focused payment model; oncology episode-based payment model		
Journal	**Title**	**Date**
Medical Care	Estimating Health Care Costs Related to Cancer Treatment From SEER-Medicare Data	8/1/2002

Purpose/Abstract

Background: Cancer-specific medical care costs are used by health service researchers, medical decision analysts, and health care policymakers. The SEER-Medicare database is a unique data resource that makes it possible to derive incidence- and prevalence-based estimates of cancer-related medical care costs by site and stage of disease, by treatment approach, and for age and gender strata for individuals older than 65 years.

Objectives: This paper describes the cost-related data available in the SEER-Medicare database, and discusses techniques and methods that have been used to derive various cost estimates from these data. The limitations of SEER-Medicare data as a source of cost estimates are also discussed.

Results: Examples of cost estimates for colorectal and breast cancer derived from SEER-Medicare are presented, including estimates of incidence-based cost (average cost per patient) by the initial, terminal, and continuing care phases of cancer treatment. Estimates of cancer-related treatment costs, costs by type of treatment, and long-term costs are presented, as are prevalence-based costs (aggregate Medicare and national expenditures) by cancer type.

Additional Notes/Comments

Section 3. Related Literature

Related Literature		
Key words: Oncology bundled payment models; disease specific episode payment; COTA nodal address cancer; episode payments electronic health records; data driven pricing healthcare; cancer patient categorization pricing; disease specific episodes; physician focused payment model; oncology episode-based payment model		
Journal	**Title**	**Date**
Health Affairs	Policy Makers Will Need A Way to Update Bundled Payments That Reflects Highly Skewed Spending Growth Of Various Care Episodes	5/1/2013

Purpose/Abstract

Background: Bundled payment entails paying a single price for all services delivered as part of an episode of care for a specific condition. It is seen as a promising way to slow the growth of health care spending while maintaining or improving the quality of care. To implement bundled payment, policy makers must set base payment rates for episodes of care and update the rates over time to reflect changes in the costs of delivering care and the components of care. Adopting the fee-for-service paradigm of adjusting payments with uniform update rates would be fair and accurate if costs increased at a uniform rate across episodes.

Methods and Data: The researchers used data from the 2003 and 2007 MarketScan Commercial Claims and Encounters Database from Truven Health Analytics. For each of these years the selected participants were people under age sixty-five who had drug coverage, were in a commercial plan with valid plan type, and were continuously enrolled for the full year. Spending was classified into episodes using Truven Health Analytics' Medical Episode Grouper. For each episode, the researchers computed average spending per episode in 2003 and 2007 and the total count of episodes per capita, adjusted for age and sex. Finally, the distribution of spending growth was examined across disease categories, and the researchers calculated the contribution of each disease to overall spending growth and, importantly, the heterogeneity in spending growth per episode.

Results: The analysis of 2003 and 2007 US commercial claims showed spending growth to be highly skewed across episodes: 10 percent of episodes accounted for 82.5 percent of spending growth, and within-episode spending growth ranged from a decline of 75 percent to an increase of 323 percent.

Conclusions: Given that spending growth was much faster for some episodes than for others, a situation known as skewness, policy makers should not update episode payments using uniform update rates. Rather, they should explore ways to address variations in spending growth, such as updating episode payments one by one, at least at the outset.

Additional Notes/Comments

Related Literature

Journal	Title	Date
Health Affairs	The PROMETHEUS Bundled Payment Experiment: Slow Start Shows Problems In Implementing New Payment Models	11/1/2011

Purpose/Abstract

Background: Fee-for-service payment is blamed for many of the problems observed in the US health care system. One of the leading alternative payment models proposed in the Affordable Care Act of 2010 is bundled payment, which provides payment for all of the care a patient needs over the course of a defined clinical episode, instead of paying for each discrete services. The purpose of the study was to evaluate the initial "road test" of PROMETHEUS Payment, one of several bundled payment pilot projects.

Methods and Data: The evaluation was concurrent with the program's initial road test, which ran from 2008 to 2011. A case-study approach was chosen because of the small number of sites, the complexity and early phase of the intervention, and the primary interest in questions of implementation. The data collection occurred over the years 2009–11. The study involved conducting telephone interviews with key staff and a final site interview at the three pilots.

Results: The project has faced substantial implementation challenges, and none of the three pilot sites had executed contracts or made bundled payments as of May 2011. The pilots have taken longer to set up than expected, primarily because of the complexity of the payment model and the fact that it builds on the existing fee-for-service payment system and other complexities of health care.

Conclusions: Participants continue to see promise and value in the bundled payment model, but the pilot results suggest that the desired benefits of this and other payment reforms may take time and considerable effort to materialize.

Additional Notes/Comments

Related Literature

Journal	Title	Date
Medical Care	Administrative and Claims Records as Sources of Health Care Cost Data	7/1/2009

Purpose/Abstract

Background: Many economic studies of disease require cost data at the person level to identify diagnosed cases and to capture the type and timing of specific services. One source of cost data is claims and other administrative records associated with health insurance programs and health care providers.

Objective: To describe and compare strengths and limitations of various administrative and claims databases.

Data and Methods: Data sources included claims and enrollment records from Medicare, Medicaid, and private insurers; Veterans' Health Administration records; state hospital discharge datasets; Healthcare Cost and Utilization Project hospital databases; managed care plan data systems; and provider cost reports. Claims provide information on payments, whereas cost reports yield resource costs incurred to produce services. Administrative data may be significantly augmented by linkage to disease registries and surveys.

Results: Administrative data are often available for large, enrolled populations, have detailed information on individual service use, and can be aggregated by service type, episode, and patient. Service use and costs can often be tracked longitudinally. Because they are not collected for research purposes, administrative data can be difficult to access and use. Limitations include generalizability, complexity, coverage and benefit restrictions, and lack of coverage continuity. Linked datasets permit identification of incident cases of disease, and analyses of health care costs by stage at diagnosis, phase of care, comorbidity status, income, and insurance status.

Conclusions: Administrative data are an essential source of information for studies of the financial burden of disease. Cost estimates can vary substantially by specific measures (payments, charges, cost to charge ratios) and across data sources.

Additional Notes/Comments

Oncology Care Model and Oncology Bundled Payment Program Using CNA Guided Care™ Comparison Questions

	Comparison of Oncology Care Model and Hackensack Meridian Health Oncology Payment Program	
	Oncology Care Model (OCM)	**Hackensack Meridian Health (HMH) Oncology Payment Program**
1. **What triggers the beginning of an episode?**	Episodes initiate upon the date of service for an initial Part B chemotherapy drug or upon the fill date for an initial Part D chemotherapy drug claim with a corresponding cancer diagnosis on a Medicare claim. The cancer diagnosis on the drug claim must have occurred on the date or in the 59 days preceding the drug claim. The diagnosis must not have a place of service code indicating an inpatient hospital setting. Chemotherapy administered in a hospital would not qualify as a trigger for an OCM episode.	Episodes are triggered by a new diagnosis of breast, colon, rectal or lung cancer only. No other cancer diagnoses are eligible for the payment model at this time. Once diagnosed, the patient is identified for the Physician-Focused Payment Model (PFPM) using the Cota Nodal Address (CNA).
2. **What is the rationale for the one-year duration of the covered episode and what happens when the year is up but cancer care needs to continue?**	Episodes continue for 6 months. Beneficiaries who continue to receive chemotherapy after completing the 6-month episode will initiate a new episode. Any amount of time may pass between the end of one episode and the beginning of the next.	Episodes continue for 12 months from the initial cancer diagnosis. Per the HMH-Cota proposal, "It is most appropriate for the bundle payment unit to cover a year-long period from the initial diagnosis of cancer. HMH expects that the bulk of diagnosis, treatment, and progression will occur within the first 12 months. A shorter time span may not encompass all these components, whereas a longer time span than one year becomes more administratively complex for HMH to operationalize, and less clinically predictable".
3. **How many and what types of diagnostic categories are represented by each episodes?**	Patients with all types of cancers may be included in the OCM, although the performance-based payment is based only on care for high volume cancers.	The model includes patients with newly diagnosed breast, colon, rectal or lung cancer.
4. **What is the payment methodology?**	Participating practices receive Medicare FFS payments. Additionally, OCM incorporates two other payments: (1) Monthly Enhanced Oncology Services (MEOS)	CMS will pay HMH an agreed upon 12 month prospective bundled payment, beginning at the point of episode diagnosis through the first year of treatment.

Comparison of Oncology Care Model and Hackensack Meridian Health Oncology Payment Program		
	payment of $160 PBPM. This payment is provided to OCM practices to manage and coordinate patient care. OCM practices are eligible for this monthly payment for each month of the 6-month episode, unless the beneficiary discontinues chemotherapy or enters hospice. (2) Performance-based payment that serves as an incentive to lower the total cost of care and improve quality of care. This retrospective payment is calculated based on the practice's historical Medicare expenditures and achievement on selected quality measures. Performance-based payments are only made for high-volume cancers for which it is possible to calculate accurate benchmarks.	The bundled payment will encompass all payments for the oncology episode over a fixed time period, including medical, radiation, surgical oncology, pharmacy, diagnostic, technical and inpatient/outpatient fees associated with the episode. The comprehensive bundle payment amount includes costs for the oncology bundle and for unrelated services.
5. What is the benchmark used to determine if savings are achieved and how is it calculated?	Risk-adjusted benchmark expenditures for each OCM-FFS participating practice are calculated based on data from a historical baseline period. The benchmark includes all Medicare expenditures for eligible beneficiaries for a participating practice. The benchmark is then adjusted for risk and geographic variation and trended forward to the performance period. Benchmark prices are further adjusted for the use of novel therapies. A discount is then applied to determine a target price. (This discount is equal to 4% for practices with one-sided risk and 2.75% for practices with two-sided risk.) If actual expenditures are below the target price the practice may be eligible to receive a performance-based payment (which may be adjusted by the performance multiplier.) If a practice does not have enough eligible beneficiaries	The benchmarking approach was not detailed in the Hackensack-Cota proposal.

Comparison of Oncology Care Model and Hackensack Meridian Health Oncology Payment Program		
	for reliable benchmarking, national and regional data is used in conjunction with practice-level data to increase precision. Practices have the option of being pooled with other practices to further increase benchmarking precision.	
6. **What quality measures does the model use?**	The OCM incorporates the following quality measures: **Communication and Care Coordination Measures** OCM1 - Risk-adjusted proportion of patients with all-cause hospital admissions within the 6-month episode OCM2 - Risk-adjusted proportion of patients with all-cause emergency department visits or observation stays that did not result in a hospital admission within the 6-month episode OCM3 - Proportion of patients who died who were admitted to hospice for 3 days or more **Person- and Caregiver-Centered Experience** OCM4 - Pain assessment and management Composite OCM5 - Screening for Depression and Follow-Up Plan OCM6 - Patient-Reported Experience of Care **Clinical Quality of Care OCM Measure** OCM7 - Prostate Cancer: Adjuvant Hormonal Therapy for High or Very High Risk Prostate Cancer OCM8 - Adjuvant chemotherapy is recommended or administered within 4 months of diagnosis to patients under the age of 80 with AJCC III (lymph node positive) colon cancer OCM9 - Combination chemotherapy is recommended or administered within 4 months of diagnosis for women under 70 with AJCC T1cN0M0, or Stage IB - III hormone	Appendix A (page 26 of the proposal) outlines the quality measurements used in the HMH payment model. These consist of measures specific to breast, colorectal and lung cancer as well as measures that apply to all cancer types, including measures of pain, infection monitoring, medication reconciliation, patient experience, patient-reported outcomes, and care practices.

Comparison of Oncology Care Model and Hackensack Meridian Health Oncology Payment Program		
	receptor negative breast cancer OCM10 - Trastuzumab administered to patients with AJCC stage I (T1c) - III and human epidermal growth factor receptor 2 (HER2) positive breast cancer who receive adjuvant chemotherapy OCM11 - Breast Cancer: Hormonal Therapy for Stage I (T1b)-IIIC Estrogen Receptor/Progesterone Receptor (ER/PR) Positive Breast Cancer **Patient Safety** OCM12 - Documentation of Current Medications in the Medical Record	
7. What care delivery interventions are required components of the model?	Participants are expected to engage in practice transformation to improve the quality of care they deliver. This transformation is driven by OCM's 6 practice requirements: 1) Provide 24/7 patient access to an appropriate clinician who has real-time access to patient's medical records. 2) Use an ONC-certified EHR and attest to Stage 2 of meaningful use (MU) by the end of the third model performance year. 3) Utilize data for continuous quality improvement. 4) Provide core functions of patient navigation. 5) Document a care plan for every OCM patient that contains the 13 components in the Institute of Medicine Care Management Plan (e.g., treatment goals, care team, psychosocial support, and estimated patient out-of-pocket cost). 6) Treat patients with therapies consistent with nationally recognized clinical guidelines - Practices	HMH has created standardized diagnostic evaluations and therapeutic interventions using defined schedules and based on best practices. The treatment protocol or "lane" is a pre-determined plan of care designed to minimize adverse variance in care, and to reduce overutilization and underutilization of medical services. The selection of the treatment lane will differ based on the clinical decision of the physician and by choice of the patient. Each lane will provide for routine and comorbidity care management. The implementation will require education of all related specialties, detail of the metrics and protocols, and explanation of the monetization of the bundle. Non-physicians including ARNPs and RNs would undergo training and education as well.

Comparison of Oncology Care Model and Hackensack Meridian Health Oncology Payment Program		
	must report which clinical guidelines (NCCN or ASCO) they follow for OCM patients, or provide a rationale for not following the clinical guidelines.	
8. Are clinical treatment algorithms required? If so, what are they and how are they required to be used?	Practices must report which clinical guidelines (NCCN or ASCO) they follow for OCM patients, or provide a rationale for not following the clinical guidelines.	The HMH model include 27 treatment lanes, or algorithms of care plans that encompass the care for all stages and presentations of cancer types (breast, colon, rectal and lung). Physicians will be required to follow the selected lane and report patient progress and disease trajectory. Largely, this will be updated in EPIC. HMH is building a Bundle Assembly Tool (BAT) to electronically display options for physicians to select lanes ones they have assigned a CNA. Physicians who fail to comply with the clinical treatment algorithms may lose the ability to earn incentive payments and may ultimately be asked to withdraw from the demonstration.
9. What are the implications of a patient's changing from one treatment category to another for payment?	Reimbursement is on a fee-for-service basis and there is no change in payment when treatment is changed.	It is unclear how changes from one treatment lane to another will affect payment.
10. How does the model treat social and demographic risk factors?	Benchmark prices are risk adjusted by factors that include age, sex, and dual eligibility status.	Per the HMH-COTA proposal, the HMH bundle is neutral to socioeconomic factors. It will be open to all patients, regardless of background. There may be patient financial liability differences between treatments and HMH-Cota will have discussions with CMS as to how to neutralize these differences. HMH-Cota does not expect the model to adversely impact disparities among Medicare beneficiaries and it will be possible to perform an audit to determine the presences of biases in care due to socioeconomic factors.
11. Does the model address how a	A cancer recurrence triggers a new episode.	The proposal does not discuss recurring cancer.

Comparison of Oncology Care Model and Hackensack Meridian Health Oncology Payment Program		
recurrent cancer is handled?		
12. How are patient preferences sought and respected in choice of treatment plan?	OCM does not limit the choice of providers or dictate from whom patients can seek care. However, beneficiaries who do not wish to be part of OCM need to switch to providers in non-participating practices. Further, the model does not dictate which drugs or services practitioners must provide. Participating practices are expected to use shared decision making to work with beneficiaries to identify the most appropriate course of treatment.	The HMH-Cota proposal indicates that the decision of treatment or "lane" is determined by the physician and the patient.

Source: Information on the Oncology Care Model was compiled from publically-available resources available from https://innovation.cms.gov/initiatives/oncology-care/.

Information on the HMH-Cota proposal was obtained from the proposal submitted to the PTAC on March 24, 2017, and available from https://aspe.hhs.gov/system/files/pdf/255906/OncologyBundledPaymentProgramCNACare.pdf.