Physician-Focused Payment Model Technical Advisory Committee
Public Meeting Minutes

September 15, 2020
10:00 a.m. – 4:10 p.m. EDT
Virtual Meeting

Attendance*

Physician-Focused Payment Model Technical Advisory Committee (PTAC) Members
Jeffrey Bailet, MD, PTAC Chair (President and Chief Executive Officer, Altais)
Grace Terrell, MD, MMM, PTAC Vice Chair (President and Chief Executive Officer, Eventus WholeHealth)
Paul N. Casale, MD, MPH (Executive Director, NewYork Quality Care ACO)
Lauran Hardin, MSN, FAAN (Senior Advisor for Partnership and Technical Assistance at the National Center for Complex Health and Social Needs, Camden Coalition of Healthcare Providers)
Angelo Sinopoli, MD (Chief Clinical Officer, Prisma Health)
Bruce Steinwald, MBA (President, Bruce Steinwald Consulting)
Jennifer Wiler, MD, MBA (Chief Quality Officer Denver Metro, UCHealth, and Professor of Emergency Medicine, University of Colorado School of Medicine)

PTAC Members in Partial Attendance
Jay S. Feldstein, DO (President and Chief Executive Officer, Philadelphia College of Osteopathic Medicine)
Joshua M. Liao, MD, MSc (Medical Director of Payment Strategy, UW Medicine, and Director of the Value and Systems Science Lab and Associate Professor of Medicine, University of Washington School of Medicine)
Kavita Patel, MD, MSHS (Vice President, Payer and Provider Integration, Johns Hopkins Health System)

Office of the Assistant Secretary for Planning and Evaluation (ASPE) Staff
Stella (Stace) Mandl, PTAC Staff Officer
Audrey McDowell, Designated Federal Officer
Sally Stearns, PhD

ASPE Contractor Team, NORC at the University of Chicago (NORC)
Karen Swietek, PhD

Via Webex Webinar unless otherwise noted

List of Proposals, Submitters, Public Commenters, and Handouts

1. **The "Medical Neighborhood" Advanced Alternative Payment Model (AAPM) (Revised Version) submitted by the American College of Physicians (ACP) and the National Committee for Quality Assurance (NCQA)**

   Submitter Representatives
   Shari Erickson, MPH (American College of Physicians [ACP])
   Brian Outland, PhD (ACP)
   Amir Qaseem, MD, PhD, MHA, FACP (ACP)
   Suzanne Joy, MPP (ACP)

Samantha Tierney, MPH (ACP)
Michael Barr, MD, MBA, MACP (National Committee for Quality Assurance [NCQA])
Joe Castiglione (NCQA)
Paul Cotton (NCQA)

Public Commenters
Sandy Marks, MBA (Senior Assistant Director, Federal Affairs, American Medical Association)
Leslie Kociemba, MPH (Care Delivery Program Manager, American Academy of Neurology)

Handouts

- Agenda
- Committee Member Disclosures
- Preliminary Review Team (PRT) Presentation
- PRT Report
- Additional Information from Submitter
- Additional Information or Analyses/Data Tables
- Public Comments
- Proposal

2. **Patient-Centered Oncology Payment Model (PCOP) submitted by the American Society of Clinical Oncology (ASCO)**

Submitter Representatives
Jeffery C. Ward, MD
Brian Bourbeau, MBA
Blasé Polite, MD, MPP
Stephen Grubbs, MD

Public Commenters
Harold Miller (President and CEO, Center for Healthcare Quality and Payment Reform)
Sandy Marks, MBA (Senior Assistant Director, Federal Affairs, American Medical Association)

Handouts

- Agenda
- Committee Member Disclosures
- Preliminary Review Team (PRT) Presentation
- PRT Report
- Submitter's Response to PRT Report
- Additional Information from Submitter
- Additional Information or Analyses/Data Tables
- Public Comments
- Proposal

[NOTE: A transcript of all statements made by PTAC members, submitter representatives, and public commenters at this meeting is available on the ASPE PTAC website located at: http://aspe.hhs.gov/meetings-physician-focused-payment-model-technical-advisory-committee].
The PTAC website also includes copies of the presentation slides and a video recording of the September 15, 2020 PTAC public meeting.

Welcome and Chairman's Update

Jeffrey Bailet, PTAC Chair, welcomed members of the public to the second PTAC public meeting that is being held virtually because of the coronavirus pandemic. He noted that PTAC sent two reports to the Secretary of Health and Human Services (HHS) that included comments and recommendations on the *Eye Care Emergency Department Avoidance (EyEDA)* and the *Patient-Centered Asthma Care Payment (PCACP)* proposals, both of which PTAC voted on during its last public meeting on June 22, 2020.

Chair Bailet noted that this is PTAC's eleventh public meeting that includes voting on proposed Physician-Focused Payment Models (PFPMs), and emphasized that PTAC remains committed to having a submitter-driven process, with proposals being accepted on a rolling basis. He also indicated that PTAC intends to post the responses that are received to the request for public comment to collect information that will enhance the environmental scans that are conducted as part of the Committee's proposal review process.

Additionally, Chair Bailet indicated that given that many previous submitters have included telehealth in their proposed payment models, PTAC has organized the second day of its September public meeting to include a discussion of telehealth in the context of alternative payment models. PTAC anticipates that the scheduled panel discussions and public comments will help to enhance the depth and breadth of the Committee's knowledge on this topic.

Chair Bailet also welcomed three newly appointed members of PTAC: Dr. Jay S. Feldstein, the President and CEO of Philadelphia College of Osteopathic Medicine; Ms. Lauran Hardin, a Senior Advisor for Partnership and Technical Assistance at the National Center for Complex Health and Social Needs, and a nurse by training; and Dr. Joshua Liao, the Medical Director of Payment Strategy and Associate Professor of Medicine at the University of Washington School of Medicine.

The Chair reminded the audience of the steps in the deliberation and voting process, introduced the full Committee, and introduced the PRT that reviewed *The "Medical Neighborhood" Advanced Alternative Payment Model (AAPM) (Revised Version)* proposal submitted by the American College of Physicians (ACP) and National Committee for Quality Assurance (NCQA).

The "Medical Neighborhood" Advanced Alternative Payment Model (AAPM) (Revised Version)

Committee Member Disclosures

Seven committee members disclosed no conflicts.

Vice Chair Grace Terrell stated that she is a fellow of the American College of Physicians, pays dues annually, and participates in their continuous medical education opportunities. She was the first NCQA level three patient centered medical home in North Carolina in 2007. In 2015, she spoke at the NCQA Quality Talks conference (for no remuneration other than travel and lodging).

Vice Chair Terrell also read Joshua Liao's disclosure statement because he had a scheduling conflict, which stated that "I currently serve on several national ACP committees, including those related to medical quality, coding and payment policy. While I did not participate specifically in the creation or submission of this PFPM and there are no financial conflicts of interest, a reasonable individual would view my committee involvement with ACP, and corresponding discussions about alternative payment

models, as an inability to remain impartial. I recuse myself from the review, deliberation, and voting of this proposal."

Kavita Patel stated that she is a dues paying member of the American College of Physicians but outside of PTAC has not reviewed this proposal. She has also done work with NCQA over the years, but not on this proposal.

PRT Report to the Full PTAC

The PRT for *The "Medical Neighborhood" Advanced Alternative Payment Model (AAPM) (Revised Version)* proposal consisted of Kavita Patel (PRT Lead), Angelo Sinopoli, and Jeffrey Bailet. Dr. Patel noted that this is a revised proposal and that the PRT that participated in the review of the previous submission's included Dr. Patel, Dr. Bailet, and Harold Miller. Dr. Patel presented an overview of the proposed PFPM, which:

- Is a five-year multi-payer pilot based on the Center for Medicare & Medicaid Innovation's (CMMI's) Comprehensive Primary Care Plus (CPC+) model and the Primary Care First (PCF) model which is slated to begin in 2021. The proposed Medical Neighborhood Model (MNM) is designed to address the lack of specialist-focused APMs and the lack of coordination between primary care and specialist referrals. The submitter proposes that the MNM be piloted in a subset of CPC+ regions with specialties that have high-value electronic clinical quality measures (eCQMs) sufficient for implementation and monitoring.
- Aims to improve care for Medicare beneficiaries with multiple chronic conditions through better coordination of specialty and primary care. To be eligible, patients must be referred by a primary care practice (PCP) that participates in CPC+ or the forthcoming PCF model.
- Attributes patients to the model in three steps, as follows: 1) all referral requests from CPC+ or PCF participants are pre-screened to ensure a specialty visit is appropriate; 2) if the specialist is uncertain, an optional e-consultation is conducted to determine whether an in-person visit is appropriate; and 3) a patient for whom a visit is determined to be necessary has an office visit.
- Incorporates Patient-Centered Specialty Practices (PCSP) standards and guidelines developed and maintained by NCQA, including existing quality measures that focus on the domains of utilization, behavioral health, patient-reported outcomes, patient experience, and care coordination.
- Includes a payment model with three components: 1) a care coordination fee (CCF), where all participants receive a monthly CCF per beneficiary to support care delivery investments; 2) a performance-based payment adjustment (PBPA), where all participants receive performance-based payments based on spending relative to a benchmark; and 3) comprehensive specialty care payments (CSCPs). Participating specialty practices can choose from one of two tracks: Track 1 practices receive regular fee-for-service (FFS) payments, while Track 2 practices receive a reduced rate of FFS payments of 75 percent in exchange for prospective quarterly payments based on projected estimates of anticipated Medicare Physician Fee Schedule (MPFS) spending.
- All participating specialty practices receive a geographically-adjusted, non-visit based per beneficiary per month (PBPM) CCF on all attributed patients. The CCF payment is risk-adjusted at the population level for each practice to account for the intensity of care management services.

Key issues identified by the PRT included:

- While it is important to have the proposed MNM grounded in the CPC+ and PCF programs there are reasons why many providers do not currently have opportunities to participate in such programs.
- The proposed MNM needs further development on many aspects of both the care model and the payment model, to ensure successful implementation, even as a pilot or test model.
- Key aspects to be developed further include: the attribution methodology, payment, risk adjustment, and requirements relating to specialty measures.
- Despite some issues that need refinement, the MNM proposal itself provides a sufficient framework and mechanisms to justify further consideration.
- If refined and deemed successful through a pilot for the three specialties proposed by the submitter (cardiology, neurology and infectious diseases), the model could be considered for expansion to additional specialties.

The PRT unanimously agreed that the proposed model meets all ten of the Secretary's 10 criteria ("Scope," "Quality and Cost," "Payment Methodology," "Value over Volume," "Flexibility," "Ability to Be Evaluated," "Integration and Care Coordination," "Patient Choice," "Patient Safety," and "Health Information Technology").

[NOTE: The PRT's presentation slides and full report are available on the ASPE PTAC website located at: https://aspe.hhs.gov/meetings-physician-focused-payment-model-technical-advisory-committee.]

Clarifying Questions from PTAC to the PRT

The Vice Chair opened the floor for PTAC members' questions to the PRT. The discussion focused on the following topics:

- Discussion regarding how the revised proposal differs from its predecessor, including further refinements to attribution, payment methodology, clarification of measures, and the concept of a pilot with an initial phase rollout.
- Concerns that there is no initial downside risk in the proposed model. The PRT noted that given that the inclusion of downside risk during pilot testing may prevent practices from participating, downside risk may be added to the model as it is further refined.
- The likelihood that, given that the proposal was submitted as a pilot, many nuances will need to be worked out before the model can potentially be scaled.

Submitter's Statement

The Vice Chair invited the submitter representatives, Shari Erickson, Dr. Brian Outland, Dr. Amir Qaseem, Suzanne Joy, and Samantha Tierney from ACP; and Dr. Michael Barr, Joe Castiglione, and Paul Cotton from NCQA to make a statement to PTAC.

The submitter representatives from ACP and NCQA described their proposal as a collaboration that is designed to address the lack of opportunities for specialists to engage in value-based payment efforts with primary care providers. The proposal seeks to leverage the successes of the CPC+ model and the upcoming PCF model to improve primary and specialty care coordination, incentivize better outcomes and patient experiences, provide effective care, improve patient outcomes, and hold physicians accountable. The submitters stated that 80 percent of serious medical errors involve miscommunication during handoff between clinicians, and that referral issues can lead to harm in 83 percent of cases.

Submitter representatives noted that by including a pre-screening process for referrals, the proposed model saves time, reduces costs, and improves access for patients. They cited the observation that nearly half of referrals are routine follow-up appointments that can be done in a primary care setting with the same or better outcomes. The submitters emphasized the payment structure as key, with a PMPM fee to support practice transformation, an optional prospective payment, flexible risk options, and reduced administrative burden through the required submission of electronic health records (EHRs). Finally, the model's payment structure encourages the adoption of eCQM. The submitter representatives noted that PCSP is the only Medicare Access and CHIP Reauthorization Act of 2015 (MACRA)-approved specialty recognition program.

The representatives also explained that the program is flexible. Small practices might face barriers to entry into the PCSP program; however, the average size of an NCQA PCSP site is five clinicians, and changes can be made quickly in a practice of this size. The submitters noted that there are over 530 sites and over 3,100 clinicians recognized by NCQA, observing that this is a wholly scalable model that can apply to a broad range of specialties and can complement care coordination in other models like CPC+ and PCF. The model includes both general quality measures and specialty-specific measures, and submitter representatives believe that this will help to reduce cherry-picking. They also believe alignment across specialties will facilitate analysis and benchmarking. The submitters concluded by highlighting that the proposal promotes the use of telehealth through e-consults and virtual check-ins, which is important in the context of the recent public health emergency (PHE).

PTAC Questions for the Submitters and Discussion

PTAC and the submitters engaged in Q&A on the following topics:

- Whether requiring participation in the PCSP recognition program to be eligible for the proposed model would present financial or other barriers to participation.
- Specialist participation in other similar models (e.g., Bundled Payments for Care Improvement Advanced (BPCI Advanced) Model, CPC+) and how models with the same structures and incentives could prevent overlap in participation.
- MNM as an opportunity to build on the CPC+ and PCF models by actively engaging specialists, giving them accountability in the model, rewarding them for participating in care coordination agreements with primary care practices, and by providing specialists formal recognition as well as funding through the model. The MNM also includes a triage for every referral that comes to specialists.
- Participation in the model as open to both individual specialty practices and specialty practices as part of an integrative group, with a focus on information sharing across entities to create efficiencies within and outside of the model.
- How promoting discussion and collaboration between specialist and primary care providers, and pre-screening patients, may improve access to specialists for patients who need to see them the most.
- Flexibility of the proposed model and potential for integration and coordination across practices of varying size and the ability for small practices to scale their own risk.

Public Comments

Vice Chair Terrell thanked the submitter representatives and opened the floor for public comments. The following individuals made comments on *The "Medical Neighborhood" Advanced Alternative Payment Model (AAPM) (Revised Version)* proposal:

1. Sandy Marks (Assistant Director of Federal Affairs, American Medical Association)
2. Leslie Kociemba, MPH (Care Delivery Program Manager, American Academy of Neurology)

[NOTE: A transcript of commenters' remarks is available on the ASPE PTAC website located at: https://aspe.hhs.gov/meetings-physician-focused-payment-model-technical-advisory-committee.]

PTAC Voting on Secretary's Criteria

Eight PTAC members deliberated and voted on the extent to which *The "Medical Neighborhood" Advanced Alternative Payment Model (AAPM) (Revised Version)* proposal meets each of the Secretary's 10 criteria.

[NOTE: A simple majority vote will establish PTAC's determination for each of the Secretary's criteria. Members' individual criterion votes remain anonymous. However, the distribution of votes and the voting outcomes are presented in the table below. Individual member comments are available in the meeting transcript located on the ASPE PTAC website at: http://aspe.hhs.gov/meetings-physician-focused-payment-model-technical-advisory-committee.]

Eight PTAC members participated in deliberation and voting on the proposal (Dr. Feldstein was not present for voting). Five PTAC votes constituted a simple majority.

PTAC Member Votes on *The "Medical Neighborhood" Advanced Alternative Payment Model (AAPM) (Revised Version)*

Criteria Specified by the Secretary (42 CFR§414.146)	PTAC Vote Categories	PTAC Vote Distribution
1. Scope (High Priority)	* – Not Applicable	0
	1 – Does not meet criterion	0
	2 – Does not meet criterion	0
	3 – Meets the criterion	1
	4 – Meets the criterion	3
	5 – Meets the criterion and deserves priority consideration	3
	6 – Meets the criterion and deserves priority consideration	1
PTAC DECISION: Proposal Meets Criterion 1.		
2. Quality and Cost (High Priority)	* – Not Applicable	0
	1 – Does not meet criterion	0
	2 – Does not meet criterion	0
	3 – Meets the criterion	4
	4 – Meets the criterion	4

Criteria Specified by the Secretary (42 CFR§414.146)	PTAC Vote Categories	PTAC Vote Distribution
	5 – Meets the criterion and deserves priority consideration	0
	6 – Meets the criterion and deserves priority consideration	0
PTAC DECISION: Proposal Meets Criterion 2.		
3. Payment Methodology (High Priority)	* – Not Applicable	0
	1 – Does not meet criterion	0
	2 – Does not meet criterion	1
	3 – Meets the criterion	3
	4 – Meets the criterion	4
	5 – Meets the criterion and deserves priority consideration	0
	6 – Meets the criterion and deserves priority consideration	0
PTAC DECISION: Proposal Meets Criterion 3.		
4. Value over Volume	* – Not Applicable	0
	1 – Does not meet criterion	0
	2 – Does not meet criterion	0
	3 – Meets the criterion	3
	4 – Meets the criterion	4
	5 – Meets the criterion and deserves priority consideration	1
	6 – Meets the criterion and deserves priority consideration	0
PTAC DECISION: Proposal Meets Criterion 4.		
5. Flexibility	* – Not Applicable	0
	1 – Does not meet criterion	0
	2 – Does not meet criterion	0
	3 – Meets the criterion	2
	4 – Meets the criterion	6
	5 – Meets the criterion and deserves priority consideration	0
	6 – Meets the criterion and deserves priority consideration	0
PTAC DECISION: Proposal Meets Criterion 5.		

Criteria Specified by the Secretary (42 CFR§414.146)	**PTAC Vote Categories**	**PTAC Vote Distribution**
6. Ability to Be Evaluated	* – Not Applicable	0
	1 – Does not meet criterion	0
	2 – Does not meet criterion	0
	3 – Meets the criterion	5
	4 – Meets the criterion	2
	5 – Meets the criterion and deserves priority consideration	1
	6 – Meets the criterion and deserves priority consideration	0
PTAC DECISION: Proposal Meets Criterion 6.		
7. Integration and Care Coordination	* – Not Applicable	0
	1 – Does not meet criterion	0
	2 – Does not meet criterion	0
	3 – Meets the criterion	2
	4 – Meets the criterion	2
	5 – Meets the criterion and deserves priority consideration	3
	6 – Meets the criterion and deserves priority consideration	1
PTAC DECISION: Proposal Meets Criterion 7.		
8. Patient Choice	* – Not Applicable	0
	1 – Does not meet criterion	0
	2 – Does not meet criterion	0
	3 – Meets the criterion	2
	4 – Meets the criterion	5
	5 – Meets the criterion and deserves priority consideration	1
	6 – Meets the criterion and deserves priority consideration	0
PTAC DECISION: Proposal Meets Criterion 8.		
9. Patient Safety	* – Not Applicable	0
	1 – Does not meet criterion	0
	2 – Does not meet criterion	0
	3 – Meets the criterion	2
	4 – Meets the criterion	5

Criteria Specified by the Secretary (42 CFR§414.146)	PTAC Vote Categories	PTAC Vote Distribution
	5 – Meets the criterion and deserves priority consideration	1
	6 – Meets the criterion and deserves priority consideration	0
PTAC DECISION: Proposal Meets Criterion 9.		
10. Health Information Technology	* – Not Applicable	0
	1 – Does not meet criterion	0
	2 – Does not meet criterion	0
	3 – Meets the criterion	2
	4 – Meets the criterion	4
	5 – Meets the criterion and deserves priority consideration	2
	6 – Meets the criterion and deserves priority consideration	0
PTAC DECISION: Proposal Meets Criterion 10.		

PTAC Vote on Recommendation to the Secretary

[NOTE: A two-thirds majority is required to determine the final recommendation to the HHS Secretary. If a two-thirds majority votes to not recommend the proposal for implementation as a PFPM or to refer the proposal for other attention by HHS, that category is the Committee's final recommendation to the Secretary. If the two-thirds majority votes to recommend the proposal, the Committee proceeds to a secondary vote with four categories to determine the final, overall recommendation to the Secretary. PTAC members' votes on the recommendation to the Secretary are presented in the table below.]

Given that eight PTAC members participated in deliberation and voting on the proposal, a two-thirds majority of six votes was required for the final PTAC recommendation vote.

PTAC Recommendation Category	PTAC Vote Distribution
Not recommended for implementation as a PFPM	0
Recommended for implementation as a PFPM	8
Referred for other attention by HHS	0

Dr. Feldstein abstained

Based on the voting distribution, *The "Medical Neighborhood" Advanced Alternative Payment Model (AAPM) (Revised Version)* proposal was recommended for implementation as a PFPM, and PTAC continued to the secondary vote to determine the final recommendations to the Secretary.

PTAC Recommendation Category	PTAC Member Recommendation Vote
Proposal substantially meets the Secretary's criteria for PFPMs. PTAC recommends implementing the proposal as a payment model.	*No PTAC members voted for this recommendation category*
PTAC recommends further developing and implementing the proposal as a payment model as specified in PTAC comments.	Jeffrey Bailet
PTAC recommends testing the proposal as specified in PTAC comments to inform payment model development.	Paul N. Casale Lauran Hardin Kavita Patel Angelo Sinopoli Bruce Steinwald Grace Terrell Jennifer Wiler
PTAC recommends implementing the proposal as part of an existing or planned CMMI model.	*No PTAC members voted for this recommendation category*

Dr. Feldstein abstained

As a result of the vote, PTAC recommended testing *The "Medical Neighborhood" Advanced Alternative Payment Model (AAPM) (Revised Version)* proposal as specified in PTAC comments to inform payment model development.

Instructions on the Report to the Secretary

For PTAC's report to the Secretary regarding this proposal, Committee members made the following comments:

- Overall the proposed model addresses the important challenge of compensating specialists for engaging in care coordination with primary care providers, which can have significant implications for cost and quality. Existing models have not solved this problem to date.
- The proposed model has a number of strengths, including addressing the dearth of available APMs for specialists. The report should note that the model is expected to provide a framework for specialists to participate in APMs and has the potential to scale to additional specialties after the initial pilot. Additionally, the MNM model can be incorporated into current models.
- The Committee noted areas where the proposal can be further refined during the model pilot, related to: 1) payment methodology, including further development of the care coordination fee; 2) further refinements to the patient attribution methodology to address possible model overlap with CPC+ and PCF and potential duplicate shared savings payments; 3) the proprietary nature of the PCSP recognition process, where an alternative recognition process may be preferable; and 4) the value of an expanded financial analysis.
- The Committee noted the initial specialties included in the pilot may warrant further discussion, including consideration of how outcomes should be assessed for different specialties, such as

those that deal with acute care vs. specialties focused on care for chronic conditions. The report to the Secretary will note that the proposed pilot will allow for an opportunity to address these nuances in coordination with CMS.

The public meeting recessed at 12:11 p.m. EDT and reconvened at 1:45 p.m. EDT.

The American Society of Clinical Oncology (ASCO): Patient-Centered Oncology Payment Model (PCOP)

Committee Members Disclosures

Nine Committee members disclosed no conflicts.

Chair Bailet read Kavita Patel's disclosure statement, which indicated that "Because of my involvement in ASCO, I recuse myself from the review, deliberation, and voting of this proposal."

PRT Presentation to the Full PTAC

The PRT for the *American Society of Clinical Oncology (ASCO): Patient-Centered Oncology Payment Model (PCOP)* proposal consisted of Jennifer Wiler (PRT Lead), Paul Casale, and Charles DeShazer. Dr. Wiler noted that Dr. DeShazer resigned from the Committee and expressed appreciation for his work on the PRT. Dr. Wiler presented an overview of the proposed Physician-Focused Payment Model (PFPM), which:

- Was developed based on more than five years of input from stakeholders including oncologists, administrators, and payers.
- Seeks to transform cancer care delivery and reimbursement while promoting high-quality, well-coordinated, and high-value cancer care, by supporting new community-based Oncology Medical Homes (OMHs) that feature a team-based care led by a hematologist/oncologist.
- Identifies the APM Entity as practices that provide hematology/oncology services, specifically those prescribing and managing chemotherapy and immunotherapies for purposes of provider assignment, patient and episode attribution, and performance measurement. (Multi-specialty practices with hematology/oncology providers may also participate.)
- Includes three phases of cancer care: New Patient, Cancer Treatment, and Active Monitoring.
- Would create geographically-based PCOP Communities comprised of multiple providers, payers, and other stakeholders, to facilitate implementation, with Oncology Steering Committee (OSC) oversight. Participating practices would be required to comply with 22 PCOP care delivery requirements that are based on OMH standards, and requires compliance with the use of evidence-based clinical pathways.
- Includes a two-track payment model that includes monthly Care Management Payments (CMPs) and Performance Incentive Payments (PIPs), and the option to receive bundled Consolidated Payments for Oncology Care (CPOC). The performance methodology is based on meeting quality metrics, adhering to clinical pathways, and reducing cost-of-care.
- The OSCs select high-quality clinical pathways and a subset of six quality measures from ASCO's Quality Oncology Practice Initiative (QOPI®) most relevant to their patient population to implement. They are also responsible for establishing the value of CMP and PIP payments based on PCOP guidelines.

- Track 2 includes CPOC, in which practices may elect to bundle either 50% or 100% of the value of specified services and earn between 90% and 104% of the previous FFS amounts depending on their Aggregate Performance Score (APS).
- Offers care delivery requirements and level of financial risk that would differ for Track 1 and Track 2 participating practices. While Track 1 practices would be encouraged to advance into Track 2 within two years, the submitter has indicated participating payers will have discretion in this area.
- Specifies that each PCOP community must meet requirements related to sharing electronic health data from participating providers via certified electronic health record technologies (CEHRTs) and other data sharing requirements.

Key issues identified by the PRT included the following:

- Several aspects of the proposed model warrant consideration as other cancer models are developed—such as the need for more local, multi-payer efforts; greater private payer participation; and a more balanced payment methodology that may allow more oncology practices, particularly smaller ones, to participate.
- PCOP's cancer care model and related CMPs that address the entire care continuum (rather than just chemotherapy), while holding participating practices accountable for only quality and cost, are appealing.
- The proposed model does not appear to meaningfully expand the portfolio of APMs available for the hematologist/oncologist. Core aspects of the model are similar to the Oncology Care Model (OCM), which is also undergoing potential revisions, and several other oncology-related CMMI models that are in development (e.g., Oncology Care First).
- Certain requirements of the proposed model may limit the potential number of communities, payers, and practices that may be able to participate.
- The proposed model has the potential to improve quality and reduce cost, but there may not be sufficient reductions in the total cost of care (TCOC) to achieve cost neutrality or net savings. The PRT is concerned that recent evaluations of CMMI's OCM model indicate that care management payments are not resulting in statistically significant effects on Medicare expenditures or TCOC, or significant net cost savings to Medicare.
- The most recent OCM evaluation found no statistically significant declines in total episode payments. In fact, the combined Monthly Enhanced Oncology Services (MEOS) and Performance-Based Payment (PBP) payments for the first two Performance Periods (PPs) were greater than the small overall reduction in TEP, resulting in net losses to Medicare.
- The proposed model would give participating payers discretion related to applying the incentives that are designed to encourage practices to transition to Track 2, which has greater potential than Track 1 to reduce cost.
- It is unclear whether, and how, the participating hematology/oncology practices could further reduce current rates of inpatient admissions, emergency department (ED) visits and observation stays, and drug costs to offset the costs of the CMPs and PIPs.
- PCOP communities can each select their own clinical pathways and quality measures for assessing performance, and have flexibility to change the performance measure weighting for

non-Medicare payers. Without uniformity of measures and consistent weighting of performance metrics, evaluation of the model as a whole would be challenging.

The PRT unanimously agreed that the proposed model meets six of the Secretary's 10 criteria ("Value over Volume," "Flexibility," "Integration and Care Coordination," "Patient Choice," "Patient Safety," and "Health Information Technology"). The PRT unanimously agreed that the proposal does not meet four of the Secretary's 10 criteria ("Scope," "Quality and Cost," "Payment Methodology," and "Ability to Be Evaluated").

[NOTE: The PRT's presentation slides and full report are available on the ASPE PTAC website located at: https://aspe.hhs.gov/meetings-physician-focused-payment-model-technical-advisory-committee.]

Clarifying Questions from PTAC to the PRT

Chair Bailet acknowledged Dr. DeShazer's work on the Committee, and opened the floor for PTAC members' questions to the PRT. The discussion focused on the following topics:

- An inquiry regarding in what way the CMS Office of the Actuary helped to evaluate the proposal, and related analyses suggesting that the potential cost savings in the proposal were overstated.
- Clarifying how the proposed model would measure quality, including whether the quality methodology would include a distribution where there would be clear high and low performers.

Submitter's Statement

Chair Bailet invited the submitter representatives Dr. Jeffrey C. Ward, Brain Bourbeau, Dr. Stephen Grubbs, and Dr. Blasé Polite to make a statement to PTAC.

The submitters introduced the proposed model as have been published first in 2015 and then updated by a multidisciplinary team before being submitted to PTAC, informed by the evaluation to date of the CMMI OCM. The submitters described PCOP as a care transformation model, with care delivery requirements rooted in evidence and payment methodologies to measure and incentivize the successful deployment of a new oncology medical home model of care. The submitters explained two core principles that distinguish PCOP from OCM, namely that: 1) no provider should be financially penalized for providing the appropriate care to the appropriate patient at the appropriate time; and 2) providers should be held accountable only for aspects of care under their control.

The submitters highlighted the proposal's focus on appropriate utilization of drugs rather than price and the inclusion of validated quality metrics and the costs of cancer care most directly under an oncology practice's control. The submitters noted that the proposal's care delivery requirements feature adherence to clinical pathways, which have been shown to reduce the overall costs of drug treatments while mitigating the risk of stinting on care. The submitters contrasted the proposal's payment methodology with that of OCM, where monthly enhanced oncology services payments failed to reflect performance. They noted that, under PCOP, base care management payments would be similar to OCM but include monthly performance incentive payments to reward practices.

The submitters also noted that PCOP proposes CPOCs, which move from FFS payments to monthly, partially capitated payments that vary with performance and provide oncologists with the resources to implement innovative methods of care delivery. The submitters concluded by stating that PCOP's

balance of specificity and flexibility would enable multi-payer participation and help achieve a high-quality, cost-effective cancer program. The submitters encouraged discussion of three concerns that the PRT raised regarding the PCOP model, as follows: 1) that the OCM evaluation findings of no overall savings means that savings from utilization are not realistic, 2) that OCM's challenges in attracting and retaining practices and payers are relevant for PCOP, and 3) how PCOP's elimination of drug cost in a bundle and use of value-based pathways compliance make the proposed model unique.

PTAC Questions for the Submitters and Discussion

PTAC and the submitters engaged in Q&A on the following topics:

- The process and timeline for the development of the proposed HIE.
- Whether the proposed use of clinical pathways can keep pace with innovation in the oncology field and maintain measures that have fidelity to the latest evidence.
- How the proposed model differs from OCM in terms of payment methodology and scoring methodology for clinical pathway adherence and quality metrics.
- Prospects for the proposed model to include integration with specialists beyond medical oncology and to reward innovation beyond chemotherapy.
- The role and composition of the OSC in the proposed model.

Public Comments

Chair Bailet thanked the submitter representatives and opened the floor for public comments. The following individuals made comments on the *American Society of Clinical Oncology (ASCO): Patient-Centered Oncology Payment Model (PCOP)* proposal:

- Harold Miller (President and CEO, Center for Healthcare Quality and Payment Reform)
- Sandy Marks, MBA (Senior Assistant Director, Federal Affairs, American Medical Association)

[NOTE: A transcript of commenters' remarks is available on the ASPE PTAC website located at: https://aspe.hhs.gov/meetings-physician-focused-payment-model-technical-advisory-committee.]

PTAC Voting on Secretary's Criteria

Nine PTAC members deliberated and voted on the extent to which the *Patient-Centered Oncology Payment Model (PCOP)* proposal meets each of the Secretary's 10 criteria.

[NOTE: A simple majority vote will establish PTAC's determination for each of the Secretary's criteria. Members' individual criterion votes remain anonymous. However, the distribution of votes and the voting outcomes are presented in the table below. Individual member comments are available in the meeting transcript located on the ASPE PTAC website at: http://aspe.hhs.gov/meetings-physician-focused-payment-model-technical-advisory-committee.]

Given that nine PTAC members participated in deliberation and voting on the proposal, five PTAC votes constituted a simple majority.

PTAC Member Votes on ***Patient-Centered Oncology Payment Model (PCOP)***

Criteria Specified by the Secretary (42 CFR§414.146)	PTAC Vote Categories	PTAC Vote Distribution
1. Scope (High Priority)	* – Not Applicable	0
	1 – Does not meet criterion	0
	2 – Does not meet criterion	5
	3 – Meets the criterion	3
	4 – Meets the criterion	0
	5 – Meets the criterion and deserves priority consideration	1
	6 – Meets the criterion and deserves priority consideration	0
PTAC DECISION: Proposal Does Not Meet Criterion 1.		
2. Quality and Cost (High Priority)	* – Not Applicable	0
	1 – Does not meet criterion	0
	2 – Does not meet criterion	6
	3 – Meets the criterion	2
	4 – Meets the criterion	0
	5 – Meets the criterion and deserves priority consideration	1
	6 – Meets the criterion and deserves priority consideration	0
PTAC DECISION: Proposal Does Not Meet Criterion 2.		
3. Payment Methodology (High Priority)	* – Not Applicable	0
	1 – Does not meet criterion	0
	2 – Does not meet criterion	7
	3 – Meets the criterion	1
	4 – Meets the criterion	0
	5 – Meets the criterion and deserves priority consideration	1
	6 – Meets the criterion and deserves priority consideration	0
PTAC DECISION: Proposal Does Not Meet Criterion 3.		
4. Value over Volume	* – Not Applicable	0
	1 – Does not meet criterion	0
	2 – Does not meet criterion	0
	3 – Meets the criterion	5

Criteria Specified by the Secretary (42 CFR§414.146)	PTAC Vote Categories	PTAC Vote Distribution
	4 – Meets the criterion	3
	5 – Meets the criterion and deserves priority consideration	1
	6 – Meets the criterion and deserves priority consideration	0
PTAC DECISION: Proposal Meets Criterion 4.		
5. Flexibility	* – Not Applicable	0
	1 – Does not meet criterion	0
	2 – Does not meet criterion	0
	3 – Meets the criterion	3
	4 – Meets the criterion	6
	5 – Meets the criterion and deserves priority consideration	0
	6 – Meets the criterion and deserves priority consideration	0
PTAC DECISION: Proposal Meets Criterion 5.		
6. Ability to Be Evaluated	* – Not Applicable	0
	1 – Does not meet criterion	1
	2 – Does not meet criterion	6
	3 – Meets the criterion	1
	4 – Meets the criterion	1
	5 – Meets the criterion and deserves priority consideration	0
	6 – Meets the criterion and deserves priority consideration	0
PTAC DECISION: Proposal Does Not Meet Criterion 6.		
7. Integration and Care Coordination	* – Not Applicable	0
	1 – Does not meet criterion	0
	2 – Does not meet criterion	0
	3 – Meets the criterion	7
	4 – Meets the criterion	2
	5 – Meets the criterion and deserves priority consideration	0
	6 – Meets the criterion and deserves priority consideration	0

Criteria Specified by the Secretary (42 CFR§414.146)	PTAC Vote Categories	PTAC Vote Distribution
PTAC DECISION: Proposal Meets Criterion 7.		
8. Patient Choice	* – Not Applicable	0
	1 – Does not meet criterion	0
	2 – Does not meet criterion	0
	3 – Meets the criterion	3
	4 – Meets the criterion	6
	5 – Meets the criterion and deserves priority consideration	0
	6 – Meets the criterion and deserves priority consideration	0
PTAC DECISION: Proposal Meets Criterion 8.		
9. Patient Safety	* – Not Applicable	0
	1 – Does not meet criterion	0
	2 – Does not meet criterion	0
	3 – Meets the criterion	1
	4 – Meets the criterion	5
	5 – Meets the criterion and deserves priority consideration	3
	6 – Meets the criterion and deserves priority consideration	0
PTAC DECISION: Proposal Meets Criterion 9.		
10. Health Information Technology	* – Not Applicable	0
	1 – Does not meet criterion	0
	2 – Does not meet criterion	0
	3 – Meets the criterion	3
	4 – Meets the criterion	6
	5 – Meets the criterion and deserves priority consideration	0
	6 – Meets the criterion and deserves priority consideration	0
PTAC DECISION: Proposal Meets Criterion 10.		

PTAC Vote on Recommendation to the Secretary

[NOTE: A two-thirds majority is required to determine the final recommendation to the HHS Secretary. If a two-thirds majority votes to not recommend the proposal for implementation as a PFPM or to refer the proposal for other attention by HHS, that category is the Committee’s final

recommendation to the Secretary. If the two-thirds majority votes to recommend the proposal, the Committee proceeds to a secondary vote with four categories to determine the final, overall recommendation to the Secretary. PTAC members' votes on the recommendation to the Secretary are presented in the tables below.]

Given that nine PTAC members participated in deliberation and voting on the proposal, a two-thirds majority of six votes was required for the final PTAC recommendation vote.

PTAC Recommendation Category	PTAC Vote Distribution	PTAC Member Recommendation Vote
Not recommended for implementation as a PFPM	0	*No PTAC members voted for this recommendation category*
Recommended for implementation as a PFPM	0	*No PTAC members voted for this recommendation category*
Referred for other attention by HHS	9	Jeffrey Bailet Grace Terrell Paul N. Casale Jay S. Feldstein Lauran Hardin Joshua M. Liao Angelo Sinopoli Bruce Steinwald Jennifer Wiler

As a result of the vote, PTAC referred the *Patient-Centered Oncology Payment Model (PCOP)* proposal for other attention by HHS.

Instructions on the Report to the Secretary

For PTAC's report to the Secretary regarding this proposal, individual PTAC members made the following comments:

- The Committee votes to refer the proposed model for other consideration by HHS, and to make this referral with high priority. Despite the fact that the PCOP model did not meet the priority evaluation criteria, it provides valuable means to address important issues in oncology care, and can potentially be informative to CMS as it develops its portfolio of cancer care models. These recommendations are especially timely with the OCM ending in 2022 and Oncology Care First in development.
- The Committee concurs with the PRT's findings that the PCOP model does not meet the criteria of scope, quality and cost, payment methodology, or ability to be evaluated, but meets the criteria of value over volume, flexibility, care coordination, patient choice, safety, and HIT.
- The Committee agrees with the key concerns identified in the PRT report, regarding: 1) the lack of meaningful expansion of the portfolio of APMs available to hematologists and oncologists; 2) an unclear pathway to Track 2 that may lessen the potential to achieve cost neutrality or net savings; and 3) the challenge of evaluation without uniform measures and consistent weighting of performance metrics.

- The Committee is also concerned about the PCOP model's ability to improve quality due to the quality metric methodology's use of quartiles, which could result in a risk of having "topped-out" quality measures.
- PTAC recognizes that the PCOP model presents a valuable model for community engagement in care delivery, including employers in a multipayer model, and that the OSCs as a concept deserves consideration by CMS as it explores new multipayer models.
- The Committee especially appreciates the PCOP model's focus on adherence to evidence-based pathways, which are supported by the literature and could reduce disparities in care by reducing undertreatment. The committee recognized that one of the most crucial issues in oncology care that the current system does not address is how to make sure chemotherapy is neither stinted on nor the source of overpayment and overutilization. The PCOP model presents a thoughtful approach to achieving this balance.
- The Committee believes that the PCOP model's effort to hold oncology providers accountable for costs and utilization beyond drug payments, such as emergency department visits, is a valuable contribution.
- The data sharing infrastructure that would be built through PCOP, such as the OSCs, HIEs, and all-payer claims databases (APCDs), would require intensive effort and resources but could be leveraged to implement other APMs.

Closing Remarks
Vice Chair Terrell thanked the Committee members, submitters, and the public for their participation in PTAC's second virtual meeting. She encouraged attendance at the September 16 session, which will be a theme-based discussion on telehealth.

The public meeting adjourned at 4:10 p.m. EDT.

Approved and certified by:

//Audrey McDowell//	11/10/2020
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Audrey McDowell, Designated Federal Officer Physician-Focused Payment Model Technical Advisory Committee	Date

//Jeffrey Bailet//	11/6/2020
____	___________________________
Jeffrey Bailet, MD, Chair Physician-Focused Payment Model Technical Advisory Committee	Date