

Preliminary Review Team Findings on

**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)

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# Presentation Overview

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

# Preliminary Review Team Composition and Role

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

# Proposal Overview

**Background:** The Medical Neighborhood Model (MNM) proposal is a five-year, multi-payer pilot that builds on the Center for Medicare & Medicaid Innovation's (CMMI's) Comprehensive Primary Care Plus (CPC+) model and the Primary Care First (PCF) model slated to begin in 2021. The model incorporates Patient-Centered Specialty Practices (PCSP) standards and guidelines developed and maintained by NCQA.

- MNM is designed to address two key problems: 1) a dearth of specialty APMs; and 2) poor primary care practice and specialist referral coordination, which is a significant contributor to poor quality care, inefficient resource allocation, and unnecessary costs.
- The submitter proposes that the MNM be piloted in a subset of CPC+ regions (and PCF regions once initiated) with specialties that have enough high-value electronic clinical quality measures (eCQMs) that can be used to implement and monitor the MNM.
- The submitter proposes cardiology, infectious disease, and neurology as the three initial pilot specialties.

**Goals:** The MNM proposal aims to improve care for Medicare beneficiaries with multiple chronic conditions through better coordination between specialty and primary care practices (PCPs). Such coordination can often be compromised by functional and operational barriers.

**APM Entity:** Specialty practices that have achieved NCQA PCSP recognition.

## Proposal Overview – Continued

- **Eligibility:** Targeted beneficiaries are those with multiple chronic conditions that include the specific condition on which the model focuses. To be eligible, patients must be referred by a PCP that participates in CPC+ or the forthcoming PCF model.
- **Payment:** 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 spending.
- **Performance Measures:** The proposed model uses existing quality measures required of specialty practices that participate in NCQA's PCSP Recognition program. Measures focus on domains that include utilization, behavioral health, patient-reported outcomes, patient experience, and care coordination.

# Proposal Overview – Continued

## Core Elements of the Program:

- The MNM payment model has up to three components, depending on track:
  - Care Coordination Fee (CCF): All participants receive a monthly per beneficiary CCF to support care delivery investments, as well as a potential performance-based payment based on spending relative to a benchmark and adjusted for quality and utilization metrics. (Tracks 1 & 2)
  - Performance-Based Payment Adjustment (PBPA): All participants receive performance-based payments based on spending relative to a benchmark. (Tracks 1 & 2)
  - Comprehensive Specialty Care Payments (CSCPs): Participants who choose Track 2 receive quarterly prospective payments based on estimates of anticipated Medicare Physician Fee Schedule (MPFS) spending.
- All participating specialty practices receive a risk- and 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.

# Proposal Overview – Continued

**Attribution:** Patient attribution to the model occurs in three steps.

- First, all referral requests from CPC+ or PCF participants are pre-screened to ensure a specialty visit is appropriate.
- Second, if the specialist is uncertain whether a visit is necessary, an optional e-consultation is conducted to determine whether an in-person visit is appropriate.
- Third, a patient for whom a visit is determined to be necessary has an office visit with the specialist.

# Summary of the PRT Review

Criteria Specified by the Secretary (at 42 CFR §414.1465)	PRT Conclusion	Unanimous or Majority Conclusion
1. Scope (High Priority)	Meets Criterion	Unanimous
2. Quality and Cost (High Priority)	Meets Criterion	Unanimous
3. Payment Methodology (High Priority)	Meets Criterion	Unanimous
4. Value over Volume	Meets Criterion	Unanimous
5. Flexibility	Meets Criterion	Unanimous
6. Ability to Be Evaluated	Meets Criterion	Unanimous
7. Integration and Care Coordination	Meets Criterion	Unanimous
8. Patient Choice	Meets Criterion	Unanimous
9. Patient Safety	Meets Criterion	Unanimous
10. Health Information Technology	Meets Criterion	Unanimous

# Key Issues Identified by the PRT

- While some specialists may currently participate in APMs in conjunction with Accountable Care Organizations (ACOs) or health system initiatives, many providers do not currently have opportunities to participate in such programs.
- The PRT views the MNM as one possible approach to incentivizing better care coordination between primary care providers and specialists – both to potentially avert unnecessary specialty care as well as improve care within and between specialty practices.
- However, the PRT finds that the 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 Issues Identified by the PRT – Continued

- Key aspects to be developed further include:
  - a comprehensive set of required quality measures that may differ for various conditions or specialists;
  - adequate implementation support for specialty practices, including obtaining NCQA PCSP recognition (or development of an alternative approach);
  - a robust attribution methodology to ensure that payments are not duplicated across participating specialists and referring PCPs; and
  - careful evaluation to identify impacts on quality and costs.
- Despite the above limitations, the PRT believes that the MNM provides a sufficient framework and mechanisms to justify further consideration, with an acknowledgement that a specialist APM may not be able to achieve the threshold of large savings preferred for model development and implementation.
- If refined and deemed successful through a pilot for the three specialties proposed by the submitter, the model could be considered for expansion to additional specialties.

# Criterion 1. Scope (High Priority)

## Criterion Description

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

## PRT Conclusion

Meets Criterion

## Unanimous or Majority Conclusion

Unanimous

- The proposal aims to provide an opportunity for more specialists to participate in APMs, especially practices that do not have an opportunity to participate in ACOs or other Centers for Medicare & Medicaid Services (CMS) APM initiatives.
- The proposed model potentially leverages two existing CMMI APMs (CPC+ and PCF).
- However, it is unclear whether the volume of referrals to many specialty practices would be large enough to secure and maintain their participation.
- Specialty practices interested in joining the proposed MNM may not be able to readily join because they do not have NCQA PCSP recognition. PCSP recognition is proprietary and is not open source.

## Criterion 2. Quality and Cost (High Priority)

### Criterion Description

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

### PRT Conclusion

Meets Criterion

### Unanimous or Majority Conclusion

Unanimous

- The proposed model calls for the use of existing evidence-based quality measures that are captured electronically.
- While quality may be enhanced by the requirement for PCSP recognition, an alternative approach may be appropriate given the propriety nature of PCSP.
- Participating specialty practices must meet minimum quality standards to share in PBPAs.
- The submitter proposes that CMS provide regular performance feedback reports to participants, including meaningful comparison/benchmark data.
- However, the model's increased payments may be difficult to offset through downstream savings.
- The proposal states that pre-screening can be done by non-physician staff at the specialist's office; using non-physician staff rather than physicians for pre-screening may result in access, quality, or patient safety problems.
- Specialists may already be participating in care coordination activities under other models, including CPC+ or ACOs.

# Criterion 3. Payment Methodology (High Priority)

## Criterion Description

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

## PRT Conclusion

Meets Criterion

## Unanimous or Majority Conclusion

Unanimous

- The payment model addresses the challenge of compensating specialists for engaging in time-consuming care coordination with primary care providers by including a payment (CCF) to incentivize care coordination.
- However, without proper implementation of the proposed attribution methods, handoffs between providers and the quarterly nature of the payments under the MNM could result in duplicate shared savings payments.
- The model expects that participating specialists would use prospective CCFs and CSCPs to invest in care coordination staff, technology, or other related practice improvements. However, CPC+ already includes care management fees, and results of early evaluations have not shown cost savings.
- Downside risk is not incorporated into this proposal.
- Half of the PBPA benchmark would be based on regional spending. Although risk adjustment is included, such a benchmark could be difficult to define under a general formula to serve as a counterfactual spending target.

## Criterion 4. Value over Volume

### Criterion Description

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

### PRT Conclusion

Meets Criterion

### Unanimous or Majority Conclusion

Unanimous

- The proposed model requires pre-screening to reduce inappropriate specialist referrals and unnecessary or duplicate testing.
- The model intends to produce cost savings while maintaining quality through reduced or duplicative diagnostic testing or imaging, emergency department (ED) visits, and unplanned hospital admissions.
- However, the proposed model allows specialists to select quality measures from a bank of options, which may lead to cherry-picking of measures.
- The PRT believes that the model's success will be contingent on ensuring that the payment methodology, including attribution methods, adequately supports improved coordination between specialists and PCPs.
- Because the model will first be implemented as a smaller-scale pilot initiative, there will be an opportunity to refine the payment model prior to a larger-scale implementation.

# Criterion 5. Flexibility

## Criterion Description

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

## PRT Conclusion

Meets Criterion

## Unanimous or Majority Conclusion

Unanimous

- After the initial pilot, the proposed model can accommodate a range of specialist-patient referral relationships, including one-time consultations and ongoing collaboration with PCPs.
- The submitter suggests that the proposed model could be expanded over time to any specialty with sufficient high-value eCQMs and/or referrals from CPC+ or PCF practices.
- However, small practices may find obtaining PCSP recognition too costly and burdensome to participate in the proposed model.
- The volume of patients in smaller practices may be insufficient to warrant participation in small and rural practices.

# Criterion 6. Ability to Be Evaluated

## Criterion Description

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

## PRT Conclusion

Meets Criterion

## Unanimous or Majority Conclusion

Unanimous

- The submitter recommends that an independent third-party evaluator identify cohorts of patients who received a referral to an MNM specialist for follow-up care and compare them to a control group of patients who received care from non-MNM specialty practices.
- Proposed data sources would include Medicare claims, eQMs (reported), and Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey data (from surveys distributed to patients by referring practices).
- However, systematic differences between the treatment and control groups could still bias estimated effects of the proposed model.
- To guarantee a statistically valid sample size, the proposal requires that at least 100 patients must be attributed and trigger monthly CCFs over the course of a year. However, the proposal does not include calculations of statistical power, and it is not clear that this minimum sample size will be sufficient or attainable by all participating practices.

# Criterion 7. Integration and Care Coordination

## Criterion Description

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

## PRT Conclusion

Meets Criterion

## Unanimous or Majority Conclusion

Unanimous

- Improving integration and care coordination is an integral goal of the program, and the model design will encourage greater coordination of care between specialists and PCPs.
- However, while the proposal specifies the payments to be made to help make referrals more efficient, it does not provide or describe specific provisions or steps that specialty practices should undertake to improve care coordination or management.

# Criterion 8. Patient Choice

## Criterion Description

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

## PRT Conclusion

Meets Criterion

## Unanimous or Majority Conclusion

Unanimous

- The proposed model does not restrict patient choice of specialty care providers and would curtail unnecessary referrals and specialist visits.
- The submitter notes that the MNM's requirement that participating specialty practices be part of PCSP should result in greater access to specialty care, due to anticipated reduction of inappropriate referrals and priority given to urgent care.
- The process for attribution of patients may be a challenge. However, the submitter proposes that the model first be piloted in a limited number of practices, which would provide an opportunity to refine the attribution methods.

# Criterion 9. Patient Safety

## Criterion Description

Aim to maintain or improve standards of patient safety.

## PRT Conclusion

Meets Criterion

## Unanimous or Majority Conclusion

Unanimous

- The proposal suggests multiple approaches to maintain patient safety, including requirements under NCQA's PCSP model and monitoring specific to the proposed MNM model (i.e., CAHPS survey on patient experience, eCQMs, and administrative claims measures on quality and utilization).
- However, it is unclear what constitutes appropriateness of care for an e-consult and whether this definition would vary across specialties.

# Criterion 10. Health Information Technology

## Criterion Description

Encourage use of health information technology to inform care.

## PRT Conclusion

Meets Criterion

## Unanimous or Majority Conclusion

Unanimous

- The proposal calls for all data and measures to be captured electronically, either through administrative claims or eCQMs.
- The model requires practices to use certified electronic health record technology (CEHRT) and electronically report quality, cost, and outcomes data.
- The submitter proposes that participating practices should have multiple options for reporting and sharing data, with data entry into EHRs designed to reduce administrative burden on providers.
- The requirement for all clinicians and vendors to use uniform electronic data exchange standards may mitigate challenges of interoperability.
- However, some CEHRT may not perform functions that doctors need or that could actually improve coordination.
- The subsidies proposed to facilitate health information technology (HIT) upgrades and meet MNM-related requirements add to the cost of the model.

Preliminary Review Team Findings on  
**Patient-Centered Oncology Payment Model (PCOP)**

Submitted by the American Society of Clinical Oncology (ASCO)

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# Proposal Overview

- **Background:** The American Society of Clinical Oncology (ASCO) developed the “ASCO Patient-Centered Oncology Payment: A Community-based Oncology Medical Home Model” (PCOP) taking into account more than five years of input from stakeholders including oncologists, administrators, and payers.
- **Goals:** The PCOP proposal is designed to support community-based Oncology Medical Homes (OMHs), featuring team-based care led by a hematologist/oncologist. The objectives of the five-year, multi-payer model are to transform cancer care delivery and reimbursement while promoting high-quality, well-coordinated, and high-value cancer care.
- **Alternative Payment Model (APM) Entity:** Practices providing hematology/oncology services, specifically those prescribing and managing chemotherapy and immunotherapies. Multi-specialty practices with hematology/oncology providers may also participate. The practices would serve as the APM entity for purposes of provider assignment, patient and episode attribution, and performance measurement.

# Proposal Overview – Continued

## Core Elements of the Program:

- The proposal calls for the creation of “PCOP Communities,” comprised of multiple providers, payers, and other stakeholders, to facilitate implementation of the model in each geographic area.
- Participating practices would be required to comply with 22 PCOP care delivery requirements that are based on OMH standards, with an emphasis on the use of evidence-based treatment pathways.
- The payment model includes Care Management Payments (CMPs), Performance Incentive Payments (PIPs), and the ability 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 model includes three phases of cancer care: New Patient, Cancer Treatment, and Active Monitoring.
- The model’s care delivery requirements and level of financial risk 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.
- Each PCOP community will need to have an ability to meet requirements related to sharing electronic health data from participating providers via certified electronic health record technologies (CEHRTs), and other data sharing requirements.

# Proposal Overview: The Four Main PCOP Components

Geographically-based PCOP  
Communities with Oncology Steering  
Committee Oversight

Care Delivery Requirements  
Comprised of Seven Domains,  
Including Adherence to Clinical  
Pathways

PCOP

Two-Track Payment Methodology with  
Monthly Care Management and  
Performance Incentive Payments, and  
Bundled Payments for Selected Services  
(Track 2)

Performance Measurement Based  
on Quality of Care, Adherence to  
Clinical Pathways, and Cost-of-Care

# Proposal Overview: Role of the PCOP Communities

## The PCOP Community

- Comprised of multiple payers, employers, hematology/oncology practices, and other stakeholders in a geographic region that could represent a single metropolitan area, a single state, or multiple states.
- Led by an Oncology Steering Committee (OSC).

## Oncology Steering Committee (OSC)

- Selects 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.
- Identifies partners to facilitate successful implementation of the model (including funding and project management), potentially sets target pathway adherence rates, and distributes performance metrics.
- Is responsible for establishing the value of CMP and PIP payments based on PCOP guidelines.

# Proposal Overview: Care Delivery Requirements

- Participating practices would be required to comply with 22 PCOP care delivery requirements in seven categories, including adherence to safety standards.
- Track 2 practices would be subject to additional requirements, including patient and family advisory councils, triage and urgent care, patient navigation, risk stratification, and advanced care planning.

## PCOP Care Delivery Requirement Categories

**Patient Engagement** *(including patient education)*

**Availability and Access to Care** *(including 24/7 access to appropriate clinician)*

**Comprehensive Team-Based Care** *(directed by a medical oncologist)*

**Quality Improvement** *(including patient satisfaction)*

**Safety** *(follows QOPI<sup>®</sup> safety standards for the administration of chemotherapy)*

**Evidence-Based Medicine** *(including use of evidence-based treatment pathways, providing patients with clinical research study information)*

**Technology** *(required to use Certified Electronic Health Record Technology (CEHRT))*

# Proposal Overview: Performance Measurement

The Aggregate Performance Score (APS) used to determine Performance Incentive Payments (PIPs) would weight the following measures equally for Medicare; PCOP communities could adjust the weighting for other payers.

## Quality Metrics

- Based on an average of individual metric performance relative to benchmarks calculated by measure stewards, based on participating providers' reporting on a subset of six quality measures from ASCO's QOPI® that have been selected by the PCOP community's OSC.

## Adherence to Clinical Pathways

- Represents the number of patients who initiate a new or different course of treatment that is pathway-concordant divided by the total number of eligible patients with a new or different course of treatment during the quarter. Justification for off-pathway treatment must be documented. Patients in clinical trials will be deemed "on-pathway." Each provider's total pathway adherence will be weighted by cancer type.

## Cost-of-Care

- Based on a weighted average of individual metric performance relative to benchmarks established relative to national trends for unplanned acute care hospital admissions, unplanned emergency and observation care visits, and supportive and maintenance drug costs. Cost-of-care measures would be case-mix adjusted.

# Proposal Overview: Payment Model

## Key Features of PCOP's Two-Track Payment Model

### Care Management Payments (CMPs)

Monthly payments designed to support practice transformation and adjusted by phase of care:

- Cancer Treatment CMP
- New Patient CMP (amount is twice that of the Cancer Treatment CMP)
- Active Monitoring CMP (amount is one-third that of the Cancer Treatment CMP)

**Track 1:** CMPs are 2% of total cost of care (TCOC).\*

**Track 2:** CMPs are 3% of TCOC.

### Performance Incentive Payments (PIPs)

Monthly payments based on performance on quality metrics, adherence to clinical pathways, and cost-of-care metrics. Based on their Aggregate Performance Score (APS).

**Track 1:** PIPs are up to 2% of TCOC.

**Track 2:** PIPs are up to 3% of TCOC.

### Fee-for-service (FFS) vs. Consolidated Payments for Oncology Care (CPOC)

**Track 1:** Will continue to receive FFS reimbursements.

**Track 2:** Required to participate in 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).

\*Initially based on historical TCOC, and may be adjusted annually based on trends.

# Proposal Overview: Payment Model (cont.)

## Consolidated Payments for Oncology Care (Track 2):

- Participating Track 2 practices may elect to bundle either 50% or 100% of the value of the specified CPOC services.
  - The minimum set of covered services would include evaluation and management (E&M) and care management services by hematology/oncology providers, parenteral drug and biologic agent administration services, and drug and biologic reimbursement above the purchase cost of such agents.
  - The proposal indicates that PCOP communities would potentially have flexibility to include the following services: radiation planning, management, and treatment delivery; surgical services; and routine laboratory, imaging, and other diagnostic services. However, the CPOC payments that have been modeled in the proposal were limited to medical and hematology oncology services.
- 90% of bundled amounts will be guaranteed.
- 10% of the bundled amounts will be subject to the same performance adjustment used for the PIPs (times a 1.4 multiplier).
- CPOC follows the same phases of care as the CMPs and is adjusted using four proposed cancer cohorts.

# Summary of the PRT Review

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

# Key Issues Identified by the PRT

- 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.
- A cancer model, and related CMPs, that addresses the entire care continuum (rather than just chemotherapy) while holding participating practices accountable for only quality and cost is appealing.
- However, 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 Oncology Care Model (OCM), which is also undergoing potential revisions, and several other oncology-related Center for Medicare & Medicaid Innovation (CMMI) models 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.

## Key Issues Identified by the PRT (continued)

- While the PCOP model has the potential to improve quality and reduce cost, there may not be sufficient reductions in the TCOC to achieve cost neutrality or net savings.
- The proposed model would give participating payers discretion relating to applying the incentives that are designed to encourage practices to transition to Track 2, which has greater potential 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.

# Criterion 1. Scope (High Priority)

## Criterion Description

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

## PRT Conclusion

Does Not Meet Criterion

## Unanimous or Majority Conclusion

Unanimous

- The proposed model seeks to provide a comprehensive approach to delivering and paying for cancer care, an important clinical area for the Medicare program.
- The proposed model’s use of geographically-based, multi-payer stakeholder communities, led by OSCs, and community-specific flexibility in selection of clinical pathways and metrics could facilitate greater participation by private payers and small practices.
- The proposed model could provide an opportunity to test some alternative approaches relating to value-based oncology care, including a “life-cycle-based” cancer model and Track 2 CPOCs that hold hematology/oncology providers responsible for the quality and cost of services they have control over.
- However, the proposed model does not appear to meaningfully expand the portfolio of APMs available for hematologist/oncologists, and certain aspects of the proposed model may limit the potential number of communities, payers, and practices that may be able to participate.

## Criterion 2. Quality and Cost (High Priority)

### Criterion Description

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

### PRT Conclusion

Does Not Meet Criterion

### Unanimous or Majority Conclusion

Unanimous

- The proposed PCOP model emphasizes quality improvement through practice transformation and would allow some flexibility so that each PCOP community can address quality issues that are most salient to them.
- The OMH concept and the model's care delivery requirements, including adherence to safety standards and its high-quality clinical pathways, have been shown to improve quality and safety and have the potential to reduce costs.
- However, there may be variation in the model's impact on quality across the various PCOP communities due to discretion in selection of clinical pathways and performance metrics.
- The greater financial risk in Track 2 of the model could potentially result in some stinting on care or the use of costly drugs.
- There is a risk that any quality improvements that are achieved under the model may not correspond with sufficient reductions in TCOC to achieve net savings or cost neutrality.
- There is emerging evidence from the most recent CMMI OCM Evaluation that care management payments are not resulting in significant reductions in Medicare expenditures or TCOC, or in net cost savings to Medicare.

# Criterion 3. Payment Methodology (High Priority)

## Criterion Description

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

## PRT Conclusion

Does Not Meet Criterion

## Unanimous or Majority Conclusion

Unanimous

- The proposed model provides financial support for clinical practice transformation through CMPs, includes financial incentives related to quality and cost-of-care, and is designed to facilitate transitioning hematology /oncology practices from FFS to more accountability and value-based payment.
- Track 2 of the proposed model seeks to increase the potential for cost savings by introducing financial risk through CPOCs using a bundle that would be adjusted prospectively based on performance, which would allow participating practices to know their expected revenue for the next period.
- However, several of the proposed model’s payment methodology features that have the greatest potential to reduce costs are either optional, or could be delayed, such as the transition to Track 2.
- Drug costs, which are included in the Track 1 and Track 2 PIP and Track 2 CPOC payments, may be very difficult to predict, which may make the proposed model challenging to implement and manage.
- The PCOP CMP amounts for new patients and cancer treatment are two to three times higher than payments for current E&M services, are also higher than OCM’s MEOS payment, and would not be case-mix or risk-adjusted. <sup>17</sup>

# Criterion 4. Value over Volume

## Criterion Description

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

## PRT Conclusion

Meets Criterion

## Unanimous or Majority Conclusion

Unanimous

- The proposed model uses financial and non-financial incentives to encourage participating hematology/oncology practices and physicians to deliver higher-value care – such as PIP payments, the OMH care model, and the associated 22 PCOP care delivery requirements.
- The model’s proposed use of geographically-based, multi-payer stakeholder communities, and clinical pathways could strengthen efforts to reduce disparities in care/address unique needs of rural and urban communities.
- PCOP communities and practices advancing to Track 2 would have additional financial and non-financial incentives to deliver high-quality health care.
- However, although the proposed model states that “practices that elect Track 1 are expected to advance to Track 2 within two years,” the submitter has indicated that participating payers would have flexibility in determining whether to discontinue CMP and PIP payments, or extend the deadline.

# Criterion 5. Flexibility

## Criterion Description

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

## PRT Conclusion

Meets Criterion

## Unanimous or Majority Conclusion

Unanimous

- The proposed model calls for the creation of geographically-based PCOP communities, which would each be led by an OSC that would select clinical pathways and quality measures that are most relevant to their patient populations, and have flexibility regarding a variety of other decisions relating to the model.
- The model's inclusion of Track 1 and Track 2 is designed to allow participating payers to meet practices where they are while engaging them in value-based care.
- While the proposed model emphasizes the use of clinical pathways, the submitter has indicated that it would allow participating providers to justify off-pathway treatment.
- However, the required adherence to clinical pathways may be somewhat restrictive to some of the model's participants to the extent that off-pathways treatments are included in the calculation of measures for purposes of the model's payment components (e.g., PIP and CPOC).
- The submitter has indicated that the proposed model would allow participating providers to justify off-pathway treatment; however, this may invoke unintended consequences, such as dropping patients who express a preference for off-pathway care or develop problems that require changes in care by providers.

# Criterion 6. Ability to Be Evaluated

## Criterion Description

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

## PRT Conclusion

Does Not Meet Criterion

## Unanimous or Majority Conclusion

Unanimous

- The proposed model could potentially serve a large number of Medicare beneficiaries, and it would be feasible to obtain claims data on these beneficiaries and a comparison group.
- The proposed model would require participating practices to submit data to regional Health Information Exchanges (HIEs) and All Payer Claims Databases (APCDs), which would potentially provide a rich set of data.
- However, 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.
- An independent evaluator would not be likely to get data from a comparison group on adherence to clinical pathways.
- Additionally, the availability and sophistication of HIEs and APCDs vary by state, so not all participants will have sufficiently robust data to inform the evaluation.
- There may not be a sufficient number of participants to evaluate the proposed model's impact on TCOC.

# Criterion 7. Integration and Care Coordination

## Criterion Description

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

## PRT Conclusion

Meets Criterion

## Unanimous or Majority Conclusion

Unanimous

- The model encourages care coordination through its care delivery requirement for comprehensive team-based care.
- The proposed model would encourage the use of common, high-quality clinical pathways and quality metrics for all participating payers, which could also improve care coordination.
- The proposed model's monthly CMPs would help participating practices invest in care management resources.
- While the submitter has indicated that many of the proposed model's specific PCOP Care Delivery Requirements are in the public domain and can be used without restriction or cost, there are two or three areas where participating practices may need to use proprietary pathways and standards that result in a cost to the practice (e.g., symptom management pathways/guidelines and Quality Oncology Practice Initiative (QOPI®) safety standards for the administration of chemotherapy).
- While the model may promote integration and care coordination among hematology/oncology care providers, the model does not provide incentives for greater integration and coordination across all oncology sub-specialties.

# Criterion 8. Patient Choice

## Criterion Description

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

## PRT Conclusion

Meets Criterion

## Unanimous or Majority Conclusion

Unanimous

- The proposed model allows the PCOP communities' OSCs to select clinical pathways and quality metrics that can address the care needs of their specific patient populations.
- The proposed model's clinical pathway adherence benchmarks are set such that some individual providers and/or their patients can choose off-pathway care without undue risk of negatively impacting the practice's overall performance.
- The proposal includes fielding patient satisfaction surveys, developing family advisory councils, and other mechanisms to get patient input.
- However, there is concern in the oncology community that adherence to clinical pathways may inhibit the use of more expensive antineoplastic medications and could interfere with a patient-centered approach.
- The proposal does not explicitly include use of shared decision-making tools or patient reported outcomes.
- There may be a need to review the proposed model's clinical pathway benchmark levels and exemptions to ensure that provider flexibility is balanced with provider accountability for pathway adherence.

# Criterion 9. Patient Safety

## Criterion Description

Aim to maintain or improve standards of patient safety.

## PRT Conclusion

Meets Criterion

## Unanimous or Majority Conclusion

Unanimous

- The proposal requires compliance with QOPI<sup>®</sup> safety standards for chemotherapy administration under its care delivery requirements that span four specified domains related to: creating a safe environment; treatment planning, patient consent, and education; ordering, preparing, dispensing, and administering chemotherapy; and monitoring after chemotherapy is given.
- The proposed model also includes requirements related to comprehensive team-based care and safety.
- However, the bundling of the value of Medicare FFS payments for oncology-related professional services and drug costs under Track 2 would be subject to performance adjustments based on the aggregate performance score, which could raise concerns about the potential for stinting on necessary care.
- Because each PCOP community's OSC would have flexibility in selecting the quality metrics that would be measured for each performance period, ensuring patient safety within the proposed PCOP model assumes that the various OSCs would develop and select metrics that are safety-focused.<sup>23</sup>

# Criterion 10. Health Information Technology

## Criterion Description

Encourage use of health information technology to inform care.

## PRT Conclusion

Meets Criterion

## Unanimous or Majority Conclusion

Unanimous

- The proposed model's data management requirements relating to use of CEHRT, participation in regional HIEs, and submission of claims to APCDs may result in a streamlined approach to data sharing that reduces practice burden and results in more complete data at the community level.
- However, the lack of interoperability across health information technology (HIT) systems and state-level differences in HIE and APCD requirements could complicate data sharing within the proposed model.
- The data management activities that are necessary for managing performance data, governance, and transparency would practically limit participation in the proposed model to communities with robust HIEs and APCDs.
- Some information technology (IT), and related software and tools, are proprietary and would result in additional costs for participating communities and practices.
- The PCOP model does not propose the collection and use of clinical data that complement claims data for the purpose of developing stronger APMs.