

**PHYSICIAN-FOCUSED PAYMENT MODEL  
TECHNICAL ADVISORY COMMITTEE  
MEETING  
(Public Session)**

**December 16, 2016**

Holiday Inn Capitol  
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**ATTENDEES**

DR. JEFFREY BAILET - Aurora Healthcare  
DR. ROBERT BERENSON - Urban Institute  
DR. RHONDA MEDOWS - EVP, Providence Health Services  
MS. ELIZABETH MITCHELL - NRHI  
DR. LEN NICHOLS - George Mason University  
MR. BRUCE STEINWALD - Steinwald Consulting  
DR. GRACE TERRELL - Cornerstone Healthcare  
MR. HAROLD MILLER - CHQPR  
DR. TIM FERRIS - Mass General Physicians Organization;

**CMS PRESENTERS**

MS. KATHERINE COX  
MS. ELLEN LUKENS  
DR. RON KLINE  
MR. L. DANIEL MULDOON

**PUBLIC COMMENTERS**

MS. SHEILA MADHANI - McDermott Plus  
DR. ROBERT LOOKSTEIN - Society of Interventional  
Radiology

1 **WELCOME AND OVERVIEW**

2

3 **DR. BAILET:** Good morning and welcome to the  
4 Physician-Focused Payment Model Technical Advisory  
5 Committee public meeting. A little background on the  
6 committee. We've been in business for a year. All of us  
7 have been on the committee and highly interested in the  
8 process of getting ready. As of December 1<sup>st</sup>, we have and  
9 are accepting proposals.

10 That is what we have been doing as a committee,  
11 developing the process for evaluation. Our statutory goal  
12 on this committee is to make recommendations on alternative  
13 payment models to the Secretary, whether they should be  
14 tested and implemented. And that is our charge and we have  
15 set our processes in place, which we will walk through  
16 later this morning to actuate that.

17 Stakeholders, it's a transparent process. We  
18 have, and are, receiving proposals. We have officially  
19 received two proposals. We have now 10 letters of intent  
20 to submit proposals. These proposals come to the executive  
21 via Technical Advisory Committee and ultimately go through

1 our process whereby we render a recommendation to get all  
2 of that deliberation just in the public.

3 We are using the Secretary's criteria for  
4 evaluating the models. They're listed here. In our process  
5 you will see that we've put places of emphasis on specific  
6 criteria that we feel are highly important. And again,  
7 transparently we telegraph back to the stakeholders in  
8 advance so that as they craft their proposal, they have  
9 some directional sense of the committee's thinking about  
10 that.

11 There's a definition here of an alternative  
12 physician-focused payment model. I'm not sure it's  
13 beneficial to go through this, but if you stakeholders and  
14 folks on the phone have questions, we can address that  
15 because I'm trying to move us along here.

16 These are the characteristics that, from the  
17 committee's standpoint relative to physician-focus payment  
18 models, we feel will be favorably considered. And included  
19 in that is reduced spending without reducing the quality of  
20 care. Improving the quality of care without increasing  
21 spending. Or improving quality and reducing spending.  
22 Models that have those elements will be favorably

1 considered.

2           Unlikely for us to recommend proposals if the only  
3 change is essential to the -- that the eligible providers  
4 have the ability to -- essentially it's the fee  
5 modification in a vacuum. Those are probably unlikely for  
6 us to feel that those would warrant a recommendation.

7           And then just on a background, as I said, where we  
8 are, we've been accepting letters of intent starting in  
9 October. We have our systems and processes in place now to  
10 accept proposals as of December 1<sup>st</sup>. As I said, we have two  
11 that have been submitted and they are posted. We fully  
12 expect and anticipate that several more will be coming in  
13 based on the letters of intent.

14           We're very transparent as you guys know, and all  
15 of our comments are public. Our meeting minutes are  
16 published and we continue to invite you to visit our  
17 website. And as we go through our process we welcome -- as  
18 this meeting is the sole purpose -- we welcome the ability  
19 for stakeholders to provide feedback and input which helps  
20 sharpen the performance of our committee.

21           I'm going to stop there and open it up.

22 Elizabeth?

1           **MS. MITCHELL:** I would add one thing. Even though  
2 we have started receiving proposals there is no deadline.  
3 It is a rolling submission so at any point they can come  
4 in. Letters of intent just have to come in 30 days prior.  
5 There's no deadline on receiving them.

6           **DR. BAILET:** Perhaps we'll balance out the  
7 presentation with Bruce who's going to talk about the  
8 actual process that we've put in place.

9  
10           ***OVERVIEW OF PTAC RFP AND EVAL PROCESS/PUBLIC COMMENTS***

11  
12           **MR. STEINWALD:** I am briefly going to review the  
13 process that we have set down for reviewing and evaluating  
14 proposals. But first I would like to say that the person  
15 who's really been leading this effort is Dr. Kavita Patel.  
16 She is not present and I think she's probably not on the  
17 line especially since the line isn't working here. I'm  
18 pretty sure she's not.

19           She delivered a baby girl ten days ago and she, I  
20 guess, is on maternity leave. I have a picture on my cell  
21 phone if anybody, during the break, would like to see it.  
22 But she's adorable.

1           Many of you have seen the process because it's  
2 been posted on our website. And then some of you have  
3 submitted comments and questions that we have answers to,  
4 although we're going to try to get your additional comments  
5 and questions from the audience before we review those. We  
6 have a process, we're comfortable with it. We haven't  
7 tested it yet because we're just at the verge now of  
8 reviewing proposals.

9           We're hoping that our process will work very well  
10 but we need to gain some experience and that's what we want  
11 to do within the next few weeks. Here is a schematic of  
12 our process that enables us to come to a conclusion within  
13 a 16-week period. Starting with the letter of intent then  
14 we have 16 weeks to review a proposal and come out with a  
15 recommendation.

16           A recommendation could be that we don't recommend  
17 that the model be implemented by the Secretary. If we do  
18 recommend positively, there are several buckets that the  
19 proposal could fall into, including those that we deem are  
20 high priority for implementation and those that we deem are  
21 suitable for implementation but only on a small scale.

22           The initial reviews will be conducted by a



1 preliminary review team. Right now these review teams  
2 comprise of three members, one of whom has to be a  
3 physician. Anyone with a conflict of interest, having  
4 participated in some fashion in the development of the  
5 proposal, will not be a reviewer and potentially also will  
6 not be able to vote at the full committee level on whether  
7 the model should be adopted.

8           One member of the preliminary review team will be  
9 the lead reviewer who will present the proposal to the full  
10 committee when the full committee deliberates. And one of  
11 the questions that was raised -- and I can answer right now  
12 -- every proposal will be reviewed by the full committee,  
13 regardless of what the preliminary review team thinks of  
14 it. All will be reviewed.

15           We have staff support. We have very capable staff  
16 support; ASPE, the office of the Assistant Secretary for  
17 Planning and Evaluation at HHS. We also have a budget and  
18 contractors, so we can obtain expertise if we feel we need  
19 it to help evaluate the proposals.

20           That expertise can be of various kinds. It could  
21 be analytical expertise or it could be clinical expertise.  
22 And it's up to the committee to determine whether we need

1 to utilize those experts in the course of evaluating  
2 proposals.

3           Some have asked will the submitter of the proposal  
4 be able to attend the public meeting where it's discussed  
5 and the answer is absolutely yes.

6           I am not going to go through this whole thing.  
7 I'll let you inspect it at your leisure just for a moment.  
8 But it does, in greater detail, outline our process. It is  
9 a very public process, especially when we get to the point  
10 of the full committee evaluating the proposal. And then of  
11 course what we recommend will be made public and there will  
12 be opportunity for public comment.

13           Here's another schematic of the process. The  
14 point of this one is this is a rolling process. Anyone can  
15 submit a proposal at any time and it will start the process  
16 of reviewing it and eventually coming out with a  
17 recommendation. As Jeff mentioned, we have two proposals  
18 to review. We expect to get several more very soon.

19           Here are the questions that were raised. But we  
20 thought that rather than me answering these questions right  
21 now, we give the audience an opportunity to raise questions  
22 and make comments, both in response to what Jeff just

1 presented and in response to the outline of the evaluation  
2 process that I just presented.

3 I would like to turn it back to you Jeff for  
4 public comments.

5 **DR. BAILET:** Okay. Let's go ahead and open it up  
6 for questions based on the proposals and information that's  
7 been shared so far. Any comments? We have three people on  
8 the phone but I'd like to get to the folks here before I  
9 get to these folks. Is there anyone who would like to make  
10 a comment? Otherwise, I'll start with the folks on the  
11 phone.

12 Okay. We have Randy Pilgrim from Schumacher  
13 Clinical Partners. He's a participant and has a question.  
14 Randy?

15 **MS. ARGUETA:** We can't get him on the phone.

16 **DR. BAILET:** Pardon me?

17 **MS. ARGUETA:** We can't get him on the phone not  
18 having the audio.

19 **DR. BAILET:** It's a beautiful thing. Bruce?

20 **MR. STEINWALD:** Okay. All right we have two  
21 slides here of some questions that were raised that we  
22 believe answerable. I already mentioned the full committee

1 will review every proposal that's complete. There is an  
2 initial review by the staff to make sure that the submitter  
3 has satisfied all the requirements of the RFP.

4           Once the preliminary review team reviews a  
5 proposal, it will go to the full committee no matter what.

6 Can a proposal with a zero score in one of the high-  
7 priority criteria still receive a recommendation for  
8 implementation? Very unlikely. I think that's probably a  
9 simple no.

10           However, there can be some variations among all  
11 ten criteria in the extent to which the committee feels how  
12 well the criteria have been met. It's not the case that  
13 every criterion has to have a very high score. But the  
14 three that we've identified as high priority has to at  
15 least meet the criterion.

16           I mentioned earlier about the contractors and what  
17 their roles will be. Contractors exist to help us evaluate  
18 proposals. Someone said who will pay for their evaluation?  
19 And the answer is we will. We would not expect submitters  
20 to -- if the committee decides that some additional work is  
21 needed, we wouldn't expect the submitter to finance that or  
22 perform it, we would it do it on our own.

1           What is the process and instances when the  
2 preliminary review team is not reaching consensus? Their  
3 collective thoughts about the proposal will be taken to the  
4 full committee regardless of whether they are in consensus  
5 of what they feel about it or there are disagreements.  
6 That will all be brought to the full committee and the  
7 deliberation of the full committee will be made in the  
8 public session.

9           I already mentioned about the contractors. PTAC  
10 will absorb the cost. We have a nice budget. We have \$5  
11 million a year, is that right?

12           **DR. BAILET:** Right.

13           **MR. STEINWALD:** So we can afford to do some of our  
14 own analysis. Will PTAC have the discretionary authority  
15 to approve a plan for CMS review even if it doesn't meet  
16 all the ten criteria? Keep in mind that our statutory  
17 obligation is to make a recommendation to the secretary and  
18 it's up to the secretary to decide whether to accept that  
19 recommendation or not. There are no possibilities for  
20 substitute criteria because the criteria are subject to the  
21 law and regulations.

22           Will the submitter of the proposed model be

1 provided with specific information when the public meeting  
2 will be held? Yes. Of course. And if there is some  
3 problem of scheduling, we would try to be accommodative to  
4 the proposal submitter to make sure that the appropriate  
5 people could be present when their proposal is discussed  
6 and evaluated.

7 Will there be an opportunity to appeal? There is  
8 no appeal process. However, we are certainly leaving open  
9 the possibility that the submitter might want to revise  
10 their proposal and resubmit it. There is no constraint  
11 against that. However, there is no process for appealing  
12 PTAC's decision. Let's say we decided to not recommend,  
13 there wouldn't be a process for appeal, but there would be  
14 a process for reviewing and evaluating a new proposal that  
15 hopefully responded to some of the areas that we thought  
16 were deficient.

17 Once a proposed model has been approved, can it be  
18 implemented by any party? Would anyone with questions be  
19 told to contact the submitter? Once again, our process is  
20 to provide a recommendation to the Secretary of Health and  
21 Human Services. That recommendation will contain language  
22 that presents the rationale for PTAC's decision. But once

1 it leaves PTAC and goes to the secretary, we have no  
2 further role in determining whether it will be implemented  
3 and what organizations will be able to participate in  
4 implementation of the model.

5           Those are samples of the questions that we have  
6 gotten. We are trying to be very responsive to these  
7 questions. Some are easy to answer. Some have lead us to  
8 further discussion of our process. But for the time being,  
9 the process is as it was posted on our website. And that's  
10 the process that we will utilize to evaluate these early  
11 proposals that we are going to begin evaluating very soon.

12           **DR. BAILET:** Thank you Bruce. We're having  
13 trouble with the audio here. The transcript of this  
14 proceeding will be posted for those having difficulty  
15 hearing. Also I'd like to just open it up to members of  
16 the committee, so if there are comments that folks want to  
17 make at this point, the members of the committee. No?  
18 Harold?

19           **MR. MILLER:** Well, I would just say to the folks  
20 here we actually are interested if you have questions about  
21 -- if any of this is confusing, questions are welcomed.  
22 There is no such thing as a dumb question. If you have a

1 question we would welcome hearing them. I think we would  
2 welcome that, wouldn't we?

3 **DR. BAILET:** Yes. Of course we would. With open  
4 arms.

5 **MR. MILLER:** I know it's hard in a big room full  
6 of people to stand up and ask a question, but it would  
7 actually be helpful to us if things are not clear for you.

8 **DR. LOOKSTEIN:** My name is Robert Lookstein. I'm  
9 an interventional radiologist in New York City. My  
10 question is the committee offered their willingness to be  
11 as transparent as possible. Does that transparency  
12 translate to the actual proposals themselves?  
13 Specifically, are you at liberty to comment on the subject  
14 matter regarding the proposals that you have received and  
15 what the status is of the proposals that you've received?  
16 Were the proposals related to hypertension, diabetes or  
17 colon cancer or et cetera?

18 **MR. MILLER:** Sure.

19 **DR. LOOKSTEIN:** Does that level of transparency --  
20 does the public have the ability to see which proposals  
21 have been submitted? And in relatively real time, you know  
22 based on the logistics of the committee, to understand what



1 the status is of each of the proposals that the committee  
2 is reviewing?

3 **DR. BAILET:** So there's a couple parts to your  
4 question. The first part about the proposals, when we get  
5 them they are posted on our website. Specifically, you can  
6 go in and see them. You'll see what the committee sees.

7 The second point, relative to real time  
8 evaluation, we have a review team that evaluates the  
9 proposals and sort of make sure that they're complete,  
10 working with staff. And then they tee up for the entire  
11 committee, sort of directionally, their feelings about the  
12 proposal relative to our evaluation, so that when we get to  
13 the point of deliberation, there's been some spade work  
14 that's been done.

15 They may ask the stakeholders or the submitters  
16 for questions back and forth to sharpen the proposal before  
17 it ultimately comes to the committee. And the review team  
18 will make a recommendation, after that iterative process  
19 takes place, so that they provide the full committee with  
20 their recommendation.

21 But that process that I just described, that will  
22 not be transparent. But to the point where the committee

1 is deliberating on a specific proposal, that will be very  
2 transparent. Thank you for your question.

3 **DR. NICHOLS:** You might just add, I think we would  
4 let the public know when those proposals will be discussed  
5 in the next public meeting. So there would be opportunity  
6 to come and observe the discussion and to contribute to it.

7 **DR. LOOKSTEIN:** Thank you.

8 **DR. BAILET:** Yes?

9 **MS. SHEILA MADHANI:** Sheila Madhani, McDermott  
10 Plus. Do you see this as an evolving process? So you have  
11 this process that's been through a few iterations. You're  
12 going to be looking at a couple of proposals. There's sort  
13 of ten, you know, queues. You have letters of intent. So  
14 do you anticipate that as you go through this, after you do  
15 a couple, you're going to learn something and you'll be  
16 adjusting this and nothing is written in stone? If that is  
17 the plan, can you talk about how you will be evolving the  
18 process?

19 **DR. TERRELL:** So the answer to that is yes. We  
20 believe -- and I believe I stated this at a previous public  
21 meeting that we're starting with a statute. We spent a  
22 year creating a process and now we actually have some real

1 proposals in front of us.

2           As we go through the process of evaluating these  
3 and making recommendations to the secretary, we're sure  
4 that we will learn things. And we hope to learn things  
5 from all of you about your experience with the process,  
6 whether we are meeting the criteria that we set forth with  
7 respect to what we stated were the criteria for submission  
8 as well as high priority as well as transparency. And then  
9 from that we were hoping to learn from you so that we can  
10 continue to have a continuous improvement type approach to  
11 this as we go along.

12           **MS. SHEILA MADHANI:** Just a follow up. The  
13 process document that you have online right now, is that  
14 the criteria that you'll be using for the current models  
15 that you have?

16           **DR. TERRELL:** Yes.

17           **MS. SHEILA MADHANI:** Okay.

18           **MS. MITCHELL:** The Secretary's criteria.

19           **DR. TERRELL:** The criteria were the Secretary's  
20 criteria by the way.

21           **MS. SHEILA MADHANI:** I'm sorry, not the criteria  
22 but that process.

1           **DR. TERRELL:** The process, yes. That's what we're  
2 using right now.

3           **DR. BAILET:** Any other questions? So hearing  
4 none, we're going to go ahead and start. We believe we're  
5 prepared for the CMS portion of our meeting this morning so  
6 we're going to go ahead and -- Bob would you invite our  
7 speakers to come up.

8

9           ***OVERVIEW OF THE ONCOLOGY CARE MODEL - CMS***

10

11           **DR. BERENSON:** Thank you very much. If the CMS  
12 folks can come on up. We very much appreciate their  
13 willingness to come. We thought it would be very useful  
14 for the committee, in a public session, to have information  
15 about the Oncology Care Model.

16           We noted that in the letters of intent that we  
17 received, two of them -- I think it was two -- explicitly  
18 mentioned that the Oncology Care Model was what they were  
19 modeling their own proposal, or their letter of intent,  
20 after. It is a sort of prototypical bundled episode or  
21 episode approach that raises some generic issues that we  
22 anticipate will come up with many of the proposals that we

1 will see around episode-based payment.

2           Now you've got a nice long presentation. And what  
3 I think I want to do with your agreement is to try to put a  
4 limit of about 30 minutes, no more than 30 minutes, on the  
5 presentations. I mean you do have to get into some detail  
6 on this and yet we want an opportunity to explore some of  
7 these generic issues.

8           I'll give examples of the kinds of generic issues  
9 if perhaps in your presentation you could sort of address  
10 these. These are the kinds of things that we think will  
11 arise with almost any episode-based payment model.

12           One is the decision to trigger the episode with a  
13 treatment. With a procedure or a treatment you have to  
14 address the issue of appropriateness in some way perhaps.  
15 If you pick a condition rather than a treatment, then you  
16 would have to probably address the issue of accuracy of the  
17 diagnosis. So the decision that you made regarding  
18 triggering, as you'll explain, based on the claim for  
19 chemotherapy.

20           A second issue is the performance-based payment,  
21 which you'll explain, is a total cost of care analysis.  
22 The Innovation Center, in some of their models, have

1 adopted total cost of care. But in others like CPC Plus  
2 they moved away from total cost of care. We'd like to hear  
3 sort of some of the thinking around how that would work.  
4 Why you selected that?

5           The rationale for the length of the episode will  
6 come up. In this case six months. For some of the other  
7 BPCI models, shorter periods of time. How do you think  
8 about the length of the episode? And ultimately in any  
9 payment model that is incentivizing efficiency, how do you  
10 think about protecting against stinting on care?

11           Those are the kinds of issues that will come up  
12 generally. And so to the extent that you can address those  
13 in your presentation that would be great. But we want to  
14 leave 30 minutes -- we actually have a little extra time.  
15 Can we go until noon?

16           **DR. BAILET:** Right now we're scheduled to go until  
17 noon.

18           **DR. BERENSON:** All right if we can, that's great.  
19 But I'm still going to limit the presentations to 30  
20 minutes. I think the first thing to do would be to have  
21 you folks introduce yourselves. And then for the first 30  
22 minutes it's in your hands to do the presentation. Thank

1 you very much.

2           **MS. LUKENS:** Great. Thank you very much. I don't  
3 know if the audio is working now. I'm Ellen Lukens. I'm  
4 the Division Director of Ambulatory Payment Models at CMMI.  
5 To my left is Ron Kline. He's the medical officer on the  
6 model and also a medical oncologist. Dan Muldoon is our  
7 economist who is responsible for a lot of the modeling and  
8 probably will be answering a lot of your questions. And  
9 then Katy Cox here is the team lead and she is responsible  
10 for the day to day work on the model.

11           I also just want to introduce two folks in the  
12 audience. Chris Ritter is responsible -- she's our Group  
13 Director. She's responsible for all episodic payment  
14 models. And Laura Mortimer does our payer work as well as  
15 a lot of the QPP determinations.

16           We will definitely keep your comments in mind. We  
17 will also post this presentation to our public website. If  
18 you want to use it as a reference document that is  
19 absolutely fine as well. And we will definitely try to  
20 keep it down to the 30 minutes.

21           **DR. BAILET:** Can the audience in the room hear?

22           **AUDIENCE:** No.

1           **MS. LUKENS:** Is this working? We will try to  
2 speak loudly. I'll turn it over to Katy Cox who's going to  
3 start with an overview of the model.

4           **MS. COX:** So thanks Ellen and thanks to everyone  
5 here for the opportunity to present today. I'm going to  
6 start with a quick overview of the model. We started  
7 designing OCM back in 2013 and announced publically for the  
8 first time in February 2015.

9           In June of that year we did release applications.  
10 Physician group practices and also payers had the ability  
11 to apply for participation in the model. And then  
12 ultimately, on July 1<sup>st</sup> of this year, we did go live with  
13 almost 200 participating practices and also 16 payers  
14 participating in the model.

15           So OCM is a five-year episode-based payment model  
16 that really focuses on six-month episodes of care that are  
17 triggered by chemotherapy. The model really emphasizes  
18 practice transformation. And the three sort of overarching  
19 goals are to improve health outcome for patients with  
20 cancer, to improve quality of care and also to reduce  
21 spending.

22           As I mentioned OCM is a multi-payer model so we do



1 have several other payers that are participating with CMS.  
2 And essentially we have asked them to align their own  
3 individual payment models with that of CMS.

4           One of the key parts of practice transformation in  
5 the model are our three practice redesign activities that  
6 we require practices participating in the model to provide  
7 to beneficiaries. So the first is enhanced services and so  
8 that includes a few different items. The first is to  
9 provide 24/7 hour access to a clinician that also has  
10 access to your medical records.

11           The second is to provide core function of patient  
12 navigation. Also to provide a care plan that address the  
13 13 elements of the IOM care plan. And also to treat OCM  
14 beneficiaries with therapies that are consistent with  
15 nationally recognized guidelines.

16           In addition to enhanced services we also require  
17 practices to use certified EHR technology. And along with  
18 that we also ask practices to utilize data for continuous  
19 quality improvement. And part of that is we'll be  
20 providing the participants in our model with a quarterly  
21 feedback report which is intended to give them more real-  
22 time information about their performance in the model.

1           This slide just identifies the 13 elements of the  
2 IOM care plan which as I mentioned is part of the enhanced  
3 services, which is that first practice redesign activity.  
4 And I just wanted to emphasize here that the goal is really  
5 to engage the patient in the care planning. And we've also  
6 included an element of that financial discussion around  
7 cost of care.

8           As part of the model design we did identify the  
9 beneficiary population that would be eligible to  
10 participate. So Medicare beneficiaries have to meet all of  
11 these eligibility criteria for the full six months in order  
12 for the episode to be included in OCM.

13           The first part is that they have to be covered by  
14 Medicare Part A and Part B. Medicare also has to be the  
15 primary payer. And the beneficiary has to have received  
16 one of the included chemotherapy treatments for cancer as  
17 well as have received at least one E&M visit with a  
18 diagnosis of cancer during that six-month episode.

19           As I mentioned, we have nearly 200 practices that  
20 are currently participating in the model. In our model the  
21 practices are identified as a single TIN. These are  
22 physician group practices. We have a wide range of

1 participants in the model covering both rural and more  
2 suburban areas. We also have some smaller practices,  
3 including solo practitioners participating in the model as  
4 well as some larger entities that we are working with,  
5 including hospital based practices and also some larger  
6 multi-specialty practices.

7 I did want to mention that because of our payment  
8 methodology, we have excluded some entities that are paid  
9 differently. One example of this is the PPS-exempt cancer  
10 hospitals; they've been excluded from OCM.

11 As I mentioned, OCM is a multi-payer model. The  
12 goal of the multi-payer model is really to allow us to  
13 provide aligned incentive for the practices participating  
14 in our model including also aligned quality measure  
15 reporting. So that they're really able to take the  
16 principles of the model and apply it to total practice  
17 transformation.

18 We will be working really closely with the payers  
19 that are participating in our model. And we plan to meet  
20 with them on a regular basis and share sort of lessons  
21 learned around how the model is being implemented and also  
22 how we can better support the practices that are

1 participating in OCM.

2 With that I'll turn it over to Ellen.

3 **DR. BERENSON:** You're doing very well on time.

4 **MS. LUKENS:** I'm just going to talk briefly about  
5 episode definition. And in this section we can address  
6 some of the questions that Dr. Berenson "raves" about. Why  
7 certain decisions were made and what some of the design  
8 considerations were.

9 OCM does include nearly all cancer types. When  
10 Dan walks through the payment methodology he will talk a  
11 little bit about there are certain cancers that are  
12 excluded for the performance-based payment methodology.  
13 And I'll talk a little bit about why.

14 We did trigger or initiate the episode when the  
15 beneficiary starts chemotherapy. That was for a few  
16 reasons that Dr. Kline and Dan can elaborate on. But part  
17 of it was that it was very observable in claims. As you  
18 know, we were really limited to the claims data when we  
19 were formulating this model.

20 We have launched a data registry which will give  
21 us much more information about clinical markers and  
22 staging. But at this point in time we really are relying

1 on the claims data. It was observable in claims and the  
2 feeling was it was not gameable. Those were two key  
3 criteria we were thinking about in the trigger.

4 We have actually devised a list of the  
5 chemotherapy drugs that trigger OCM episodes, and we do  
6 include endocrine therapies, but we exclude topical  
7 formulations of drugs. We are also including, as we talked  
8 about, a total cost of care model. I think the feeling  
9 there -- Ron can elaborate -- is that medical oncologists,  
10 we really wanted them to be coordinating the patient's care  
11 and have a very holistic view of the patient's care over  
12 the episode.

13 We did also include certain Part D expenditures.  
14 We included the low-income subsidy and also the 80 percent  
15 of cost that are over the catastrophic threshold, so  
16 essentially the cost that Medicare fee-for-service bears.

17 We identified a six-month episode duration. Part  
18 of the reason for that was that the data showed that there  
19 was a peak in spending between months two and four that  
20 stabilized between four and six months. That was part of  
21 the justification for the six-month episode. Beneficiaries  
22 may initiate multiple episodes during the five-year model.

1           In terms of the drug list; so the trigger is a  
2 chemotherapy drug as well as cancer diagnosis. We did  
3 include the vast majority of chemotherapy agents. We did  
4 not include radiation sensitizing agents, supportive care  
5 medications or growth factors. And we did find that some  
6 chemotherapy drugs are frequently used for nonmalignant  
7 conditions. So we were concerned about triggering episodes  
8 inappropriately.

9           There were some cases where they were used  
10 frequently in combination with other drugs where we just  
11 include the other drug. An example would be prednisone.  
12 But we did not include a few drugs that are infrequently  
13 used in cancer, but frequently used for nonmalignant  
14 conditions. And an example would be hydroxyurea.  
15 Someone's about to ask a question.

16           **DR. BERENSON:** Let's hold questions if we can.  
17 Just accumulate your questions if you will.

18           **MS. LUKENS:** We are using what we're calling a  
19 plurality approach. Just to clarify, the episodes here are  
20 retrospectively attributed. The practices don't know --  
21 they know they're caring for the patient, they're not 100  
22 percent sure that it will be their episode. They're

1 attributed to the practice that provided the most E&M  
2 visits with cancer diagnosis during the episode time  
3 period.

4           As we said earlier, OCM practices are defined by  
5 the TIN used to bill for professional services. And the  
6 specific practitioners are defined by the NPI. So the TIN  
7 NPI combo is what we used for identifying OCM practitioners  
8 and that's -- if you think about the MACs paying the  
9 claims, the MEOS payments, they actually identify the OCM  
10 practitioners based on that match. It has to be the  
11 TIN/NPI match.

12           With that I'll turn it over to Dr. Kline who's  
13 going to talk about quality measures.

14           **DR. KLINE:** Good morning everyone. My name is Ron  
15 Kline. I'm a pediatric hematologist oncologist and work at  
16 CMMI on the Oncology Care Model.

17           We had various quality measures as part of the  
18 model to ensure that patients continue to receive quality  
19 care. And they cut across the four NQS strategy domains  
20 which are communication and care coordination, person and  
21 caregiver-centered experience and outcomes, clinical  
22 quality of care, and patient safety. And to the extent

1 possible we wanted to use either claims-based measures or  
2 measures that aligned with other CMS programs in order to  
3 reduce provider burden on the quality measures.

4 We have basically three groups of measures; we  
5 have claims-based measures, we have practice-reported  
6 measures. We have patient-reported experience.

7 The first group are the claims-based measures.  
8 And you can see those are the risk-adjusted proportion of  
9 patients with all-cause hospital admissions within the six-  
10 month episode. Risk-adjusted emergency department visits  
11 and patients who are admitted to hospice for three days or  
12 more.

13 Those -- if you appreciate -- are cross-cutting  
14 across all cancer types and really spoke to the issue. In  
15 some of the literature review, there was a feeling that  
16 patients sometimes are unnecessarily in the emergency  
17 department, they don't need to be, unnecessarily admitted  
18 when they don't need to be; and perhaps some of the end-of-  
19 life care could be better coordinated. And that's an  
20 unfortunate part of cancer care, but we wanted to make that  
21 as positive as we could also.

22 We also have patient-reported experience measure.



1 And it's essentially a modification of the CAHPS oncology  
2 questionnaire, which has been validated. There are some  
3 modifications to that, but that's what we used. And what  
4 happens with this survey is there's an aggregated composite  
5 level score that used as part of the quality measures.

6 We also have practice-reported measures. And, as  
7 I said before, they are generally aligned to eQOMs when  
8 available and feasible. And when they're not, we try to  
9 align them either with PQRS or NQF measures. And the idea  
10 here was that hopefully some of the EHRs, that are already  
11 in existence, would have these measures as part of the EHR  
12 or they align with other CMS programs. And again, trying  
13 to capture quality data, meaningful cancer-care data, while  
14 at the same time minimizing provider burden.

15 These are some of the practice-reported measures  
16 that you see. And I don't know how well you can see those,  
17 but I would point out that the first three of those OCM-4a,  
18 4b and 5 are really cross-cutting measures in terms of  
19 speaking to the whole oncology care experience.

20 One is, pain intensity is quantified. That's an  
21 NQF measure. The others, there's a plan of care for pain,  
22 another NQF measure. And that there was screening for

1 depression and having a follow-up plan as part of the  
2 cancer care.

3           The other measures that are practice reported are  
4 more specific to cancer types and really just sort of -- in  
5 my world -- sort of defines some minimum thresholds for  
6 what cancer patients should be receiving for different  
7 cancer types, for different types of treatment.

8           This is just a continuation of some of the quality  
9 measures. If you go back, I should mention OCM-7 through  
10 11 are aggregate measures. And by that I mean that the  
11 practice will have to report data for all the patients in  
12 the practice, not just Medicare fee-for-service  
13 beneficiaries.

14           Those are measures such as patients receiving  
15 adjuvant hormonal therapy for breast cancer. How rapidly a  
16 person with colon cancer, who is less than 80 years old,  
17 receives chemotherapy and other measures such as that.  
18 Those are aggregate measures that practices will be  
19 reporting.

20           The other part of the quality measurement is our  
21 data registry. And this has been a fairly large effort on  
22 the part of CMMI and CMS to put this out. And we're going

1 to collect biological and molecular characteristics of  
2 neoplasms that were relevant to cost and outcome. And the  
3 reason that we're doing this -- I think one of the  
4 criticisms of OCM has been that we have very, very broad  
5 cancer measures, so we have breast cancer, we have colon  
6 cancer, we have lung cancer. And those align with the way  
7 CMS collects data.

8           But to a clinician there's obviously a fairly  
9 significant cost differential between a woman with low-risk  
10 breast cancer on tamoxifen and a woman with triple negative  
11 breast cancer, you know -- not triple negative but a woman  
12 who has metastatic breast cancer who's getting her septic.  
13 But we can't do that right now using our claims data  
14 because we don't collect that information.

15           Part of what we're doing in OCM is to collect the  
16 relevant molecular markers, relevant anatomical staging  
17 markers, so that hopefully in a few years we can come out  
18 with new bundles that are clinically narrower and perhaps  
19 more clinically relevant.

20           Other aspects of what we're collecting are dates  
21 of progression and relapse, dates of death as part of the  
22 quality measures. And I think Dr. Berenson talked about a

1 concern about stinting on care and that is certainly a  
2 concern. I think, in a cancer-care model, the ultimate way  
3 to make sure that people are getting good care is, is their  
4 overall survival, is their progression-free survival  
5 equivalent to what you see in a fee-for-service world or  
6 commercial world? So we're going to try to collect that as  
7 well.

8 All of those measures together will align into an  
9 aggregate quality score, AQS. I think Dan will speak to  
10 this later. The performance-based payment will be a  
11 combination of the reduction in expenditures compared to a  
12 target price for a given cancer benchmark. And that we'd  
13 multiply by how you do on your aggregate quality score.

14 If you're reducing expenditures a lot but you're  
15 doing very, very poorly on your quality measures, you're  
16 not going to get a very high performance-based payment.  
17 Really it's a combination of trying to provide high-value  
18 efficient care, cutting out waste for cancer patients and  
19 at the same time providing good quality care. With that  
20 I'll turn it over to Dan Muldoon.

21 **MR. MULDOON:** Hi. I'm Dan Muldoon and I'm an  
22 economist that works in our group that deal with the

1 episode-based payment models and I've worked a lot so far  
2 on the development and implementation of OCM. We'll talk a  
3 little bit about the different aspects of the payment  
4 structure that we include in OCM.

5           First of all we have that fee-for-service payment  
6 do continue as usual to participating practices. But we  
7 have a two-prong payment approach that we incorporate for  
8 participating practices. The first being a monthly payment  
9 of \$160 that I think, as Ellen mentioned, practices can  
10 bill as they furnish enhanced oncology services to  
11 beneficiaries that they believe are likely to be OCM  
12 episodes that are attributable to the practice.

13           The second is a semiannual potential for a  
14 performance-based payment if expenditures are reduced below  
15 target prices and if the practice has an acceptable AQS.

16           The MEOS payment is a \$160 payment we make on a  
17 monthly basis. It's for the practices to furnish enhanced  
18 services to beneficiaries including that 24/7 clinician  
19 access, other patient navigation care services, as well as  
20 the other enhanced services Katy mentioned earlier.

21           Practices can bill this monthly payment for each  
22 of the six months that a beneficiary has an episode except

1 in the instance of beneficiary electing hospice or if the  
2 beneficiary dies. The payments do count against the total  
3 cost of care when we calculate our performance-based  
4 payment. And when we were designing the model I think we  
5 tried to target the amount of what we thought was  
6 appropriate for this payment by looking at sort of  
7 estimates of staff time associated with furnishing these  
8 different enhanced services as well as the salaries of the  
9 different types of staff that would be furnishing or  
10 working most directly on those services.

11           The other aspect of the payment for OCM is our  
12 performance-based payment. And so we have grouped OCM into  
13 a six-month performance periods and we assign episodes to  
14 those performance periods based on the date those episodes  
15 end. We allow practices then, for their performance-based  
16 payments, to have two different risk-arrangement options.  
17 The first being a one-sided risk and there CMS incorporates  
18 a 4 percent discount to the target amount that we compare  
19 total cost of care against. And in that one-sided risk  
20 arrangement then we take sort of a higher discount for the  
21 target amount. If a practice's expenditures exceed that  
22 target amount, they're not required to pay back Medicare

1 for the difference.

2           However, if a practice is in the one-sided risk  
3 arrangement, we do have a requirement that they either  
4 qualify for a performance-based payment or elect the two-  
5 sided risk option by the middle of 2019. Otherwise, they  
6 must leave the model.

7           We also, beginning in 2017 will have the option  
8 for a two-sided risk arrangement. So there Medicare takes  
9 a lower discount of only 2.75 percent on the target amount.  
10 But if a practice's expenditures do exceed that target  
11 amount, they're required to pay back Medicare by the amount  
12 by which the expenditures overrun.

13           And as I think Ron mentioned earlier, we have at  
14 most, I think 21 cancer types -- so the common cancer types  
15 you think of prostate, lung, colorectal, leukemia, breast  
16 cancer, et cetera -- are eligible for the performance-based  
17 payment.

18           When we were determining what cancers we were  
19 going to include as eligible for this performance-based  
20 payment, we sort of looked both nationally and at the OCM  
21 practices at the volume of different episodes to which we  
22 would assign different cancer types; and looked at both the

1 spending and variation in spending and the volume of  
2 episodes for different cancer types to try to identify  
3 where we thought that we would be able to set sort of  
4 stable target prices in our risk-adjustment model.

5           And we ended up in a place where with these 21  
6 different cancer types that we assigned to episodes -- I  
7 think we expect to cover around 95 percent of the OCM  
8 episodes that would be occurring nationally. Those other 5  
9 percent of cancer types, there we would still allow  
10 practices to bill the monthly payment of \$160. We would  
11 expect that as part of comprehensive practice  
12 transformation, those practices would be furnishing those  
13 enhanced services. But those monthly payments for the  
14 care-management fees would not count toward the total cost  
15 of care for determining the performance-based payment.

16           When we calculate the performance-based payment we  
17 have kind of seven overarching steps that we go through.  
18 The first is we just identify baseline episodes which we  
19 use episodes that started in 2012 to 2014 all throughout  
20 the country, not just those that are attributed to OCM  
21 practices. But we used those episodes to sort of serve as  
22 the basis for our historical risk-adjustment model. We



1 calculate from that the baseline expenditures as well as  
2 our risk-adjustment model.

3           Then when we move to the performance period we  
4 identify episodes that are ending in any given six-month  
5 period. For those episodes we attribute them to practices,  
6 calculate actual episode expenditures, compare those  
7 against the target amount for practice, potentially make an  
8 adjustment based on the performance multiplier and then  
9 that set of calculations would result in the performance-  
10 based payment.

11           We'll go through a little more detail on each of  
12 these steps in the next couple slides. The first is for  
13 our baseline period. And so there we're using, again,  
14 episodes that started in 2012 to 2014. Those are six-month  
15 episodes so they go into 2015 when we're identifying them.  
16 We looked first for those potential trigger events that  
17 Ellen went over and so that, again, is receipt of a  
18 chemotherapy claim with a corresponding cancer diagnosis.  
19 One little wrinkle there is that for the Part D claim for  
20 oral chemotherapy, there you don't actually have like a  
21 diagnosis code on the claim, so we look for an E&M,  
22 evaluation and management, visit within the preceding 59

1 days of the fill date to try to associate the drug with  
2 cancer.

3           We determine that episode eligibility sort of  
4 along the criteria, beneficiary must be enrolled in  
5 Medicare Parts A and B, must not have their eligibility  
6 tied to end-stage renal disease, et cetera. And then we  
7 assign cancer types and then attribute those episodes to  
8 practices based on the plurality method that Ellen  
9 described.

10           When we calculate episode expenditures, we are a  
11 total cost of care models so that means we include all  
12 Medicare Part A expenditures and all Medicare Part B  
13 expenditures. When we calculate those amounts, we  
14 incorporate what's called a CMS payment standardization  
15 methodology which removes geographic pricing differentials  
16 that are paid for different services in different parts of  
17 the country, as well as the effects of various Medicare  
18 payment-adjustment programs, so things like hospital  
19 readmissions or hospital value-based purchasing.

20           We use that payment standardization methodology  
21 sort of throughout all of our calculations, at least for  
22 Parts A and B. For Medicare Part D, we include the low-

1 income cost subsidy and 80 percent of the gross drug cost  
2 above the catastrophic threshold amount. And those really  
3 are the types of payments for Part D drugs that Medicare is  
4 really reinsuring. I think most of the other payments in  
5 Part D program are made on a capitated basis. Dollar  
6 reduction spending on drugs doesn't translate into a dollar  
7 of saving for Medicare.

8           And one thing also that we don't do in OCM, but  
9 some other models do, is that we exclude beneficiary cost  
10 sharing from the payment amounts we calculate for OCM.

11           **DR. NICHOLS:** You do?

12           **MR. MULDOON:** We do not include beneficiary cost  
13 share. Once we have all of the baseline episodes sort of  
14 defined and attributed to practices, then we work to  
15 calculate baseline prices with our risk-adjustment model.

16           And so there we have a predictive risk-adjustment  
17 model where we essentially run a big regression of every  
18 OCM type episode in the country, from that baseline period.  
19 And we risk adjust for things like beneficiary age and sex,  
20 the assigned cancer type, whether a beneficiary has  
21 received certain surgeries or they received radiation  
22 therapy, whether they're dually eligible for Medicare and

1 Medicaid, if they have Part D coverage, different types of  
2 comorbidities they might have as well as time since last  
3 chemotherapy.

4           And so that risk-adjustment model adjusts for lots  
5 of beneficiary characteristics that we sort of looked at  
6 and spent a lot of time perseverating and going back and  
7 forth on how that model was specified. But ultimately  
8 trying to associate those characteristics that are most  
9 predictive, or at least in the baseline period, were most  
10 predictive of the different types of expenditures that  
11 occurred during an episode.

12           Once we have that risk-adjustment model  
13 specified, sort of moving into, I guess, the performance  
14 period, but there we would calculate a practice's target  
15 price for the episodes assigned to it; as well as then the  
16 risk-adjusted target amount, which is just basically we  
17 would trend forward those baseline prices for episodes  
18 based on changes in spending in a cancer arena; and tailor  
19 that to the practice's spending or their case mix in the  
20 performance period as well as some other adjusts that I'll  
21 talk about on future slides.

22           In the performance period, again we identify

1 episodes almost identically to how we identify them in the  
2 baseline period. Except this would be based on episodes  
3 ending in a six-month period of time. We go through those  
4 same steps, both to identify episodes and to attribute them  
5 to practices. Again, for those episodes we calculate the  
6 spending. Again, along the same lines as we would in the  
7 baseline period, except the only change here is that we  
8 also incorporate those monthly payments for the enhanced  
9 services.

10           At this point we sort of have that target amount  
11 set. We have actual expenditures for all those episodes  
12 that we can move to make that comparison, except that we  
13 first calculate the performance multiplier which Ron went  
14 over. And so there I think we looked across -- I think  
15 it's 12 quality measures -- and basically assigned points  
16 based on a practice's performance there. And then add up  
17 those points and divide by the maximum available.

18           If a practice has a score in one of these ranges,  
19 it gets a corresponding performance multiplier with the  
20 maximum being 100 percent. And if a practice falls below  
21 30 percent, they are ineligible to receive a performance-  
22 based payment.

1           And then basically we just do a comparison of  
2 actual expenditures against the target amount and multiply  
3 that by the performance multiplier to come up with a  
4 performance-based payment. If the practice is in the two-  
5 sided risk arrangement, we neither increase nor decrease  
6 the amount they might owe back Medicare if spending exceeds  
7 that target amount.

8           And as this step, also not reflected in the slide,  
9 we also sort of all along the way we have not been  
10 accounting for things like sequestration. We've been  
11 assuming that all the payments had occurred as if  
12 sequestration had not been in place. We also incorporated  
13 a 2 percent reduction because of Medicare payments.

14           We also here, at this step, would incorporate a  
15 geographic adjustment that's based on the geographic  
16 practice cost index for a physician fee schedule  
17 professional services as well as hospital wage index for  
18 hospital services in an area. We don't have a geographic  
19 adjustment for any of the drug spending.

20           But this is sort of at the step at which we  
21 combine all of the actual spending compared against the  
22 target amount and then potentially reduce it for the

1 performance multiplier.

2           And then again just to sort of reiterate, we do  
3 have these requirements to receive a practice-base payment.  
4 The first being spending has to be below the target amount.  
5 The practice has to submit all of its required data to OCM.  
6 They must implement all of the practice redesign  
7 activities. And then they have they have to achieve an AQS  
8 above 30 percent.

9           One of the other adjustments that we incorporate  
10 here is for new therapies that come out during the  
11 performance periods of OCM. And so here we also  
12 incorporate a potential adjustment to a practice's target  
13 amount that could increase the benchmark price. And so  
14 this basically compares a practice's spending against  
15 spending at other practices in the country on new  
16 therapies.

17           Specifically, drugs that have received FDA  
18 approval after the end of 2014. And we look at the  
19 specific indication for those drugs. If a practice is  
20 spending more than other practices, it would be eligible to  
21 have its target prices increased a little bit to account  
22 for the fact that it's using novel therapies.

1           And so with that I think I'll turn it over to  
2 Ellen again to talk a little bit about monitoring and  
3 evaluation.

4           **MS. LUKEN:** Thank you Dan. We actually made Dan  
5 eliminate some slides and I'm just realizing that we didn't  
6 go through the practice-experience adjuster.

7           **MR. MULDOON:** Oh, we didn't. Yeah.

8           **MS. LUKEN:** So do you want to just talk quickly  
9 about that?

10          **DR. BERENSON:** You've got five minutes.

11          **MR. MILLER:** Let's take a vote on that.

12          **DR. BERENSON:** That's five minutes total. We're  
13 closing up. This has been great but we need to --

14          **MR. MULDOON:** Okay, I'll be quick. Also baked  
15 into the baseline prices, that I think we eliminated a  
16 slide on and we apologize for, is for practices we know  
17 what the actual cost that Medicare spent on the historical  
18 episodes in that 2012 to 2014 period, what Medicare paid.  
19 And then we also know what the risk-adjustment model there  
20 predicts for those practices. It doesn't come out to be  
21 exactly even all the time.

22           And so there what we can do is we have this thing



1 we call a practice-specific adjustment, or practice-  
2 experience adjustment factor, where we compare the actual  
3 expenditures for a practice's episodes in that historical  
4 period against what the risk-adjustment model predicts from  
5 that historical period. And so we can take that ratio  
6 there. And basically if the practice has actual spending  
7 above what the model would predict or conversely if it has  
8 actual spending below what the model would predict, we  
9 essentially increase or decrease the practice's baseline  
10 prices based on applying a 50 percent weight to that ratio  
11 of actual to predicted expenditures in that baseline  
12 period. And we use a 50 percent weight there.

13           Sort of again tested whether we should use a 100  
14 percent weight. Maybe have that weight go from, you know,  
15 a higher amount like 100 percent down to 25 percent  
16 throughout the course of the model. We ultimately settled  
17 on using 50 percent throughout all the model years just to  
18 give a practice some credit for their historical  
19 experience. But also to account for reversion to the mean  
20 and the fact that a practice who historically had higher  
21 spending than what would have been predicted or conversely  
22 lower spending than what would have been predicted, would

1 be likely to sort of trend more toward the average over the  
2 course of the model.

3 Now to Ellen to wrap up.

4 **MS. LUKEN:** So we just wanted to highlight quickly  
5 two things that will take a minute each. One is that we  
6 are monitoring, during the course of the OCM model, to  
7 measure potential stinting on care. I just also wanted to  
8 note that we also are in the monitoring process trying to  
9 evaluate the MEOS. I think it's imperfect science trying  
10 to do that, but we are doing time and motion studies to try  
11 to understand the amount of time to provide these services.

12 We are also conducting an evaluation. We have an  
13 evaluation team and they're using a match comparison group  
14 to try to understand the counterfactual, what spending  
15 would have been in the absence of OCM.

16 And the other thing we just wanted to highlight is  
17 that we do have a learning collaborative as part of OCM.  
18 It is sort of a private web portal for participants where  
19 they have all of the resource documents. We also run  
20 webinars to help educate participants about the model. And  
21 we're going to be shifting to more of a peer-to-peer  
22 learning model where they can share best practices in the

1 next year.

2 And with that I'll turn it back to Dr. Berenson.

3 **DR. BERENSON:** Great. You guys did great and  
4 these slides will be very helpful to us. What I'm going to  
5 do is ask the first question and then we'll just go around  
6 the table and go as long as we have time for with Qs and  
7 As.

8 I want to ask the first one. As the people on the  
9 committee know, one of my major things is around  
10 appropriateness of intervention. And I want to quote one  
11 sentence in the OCM sort of summary on the CMS website.  
12 "Practitioners and OCM are expected to rely on the most  
13 current medical evidence and shared decision-making with  
14 beneficiaries to inform their recommendation about whether  
15 a beneficiary should receive chemotherapy treatment."

16 And yet the model seems to be triggered by a  
17 receipt of a claim for chemotherapy. So where does the  
18 evidence-based decision making and shared decision making  
19 come into the decision around initiating chemotherapy, I  
20 guess, is my question?

21 **DR. KLINE:** I think that the 13-point care plan,  
22 IOM care plan, requires that a visit -- well, there are

1 sort of two components here. One of the practice redesign  
2 elements is that you follow national guidelines, so the  
3 NCCN guidelines in terms of treatment of patient. I think  
4 that's an ASCO guideline. Any nationally recognized  
5 guidelines -- well, not any, but many are incorporated into  
6 the treatment. That's one component of it.

7           The second component of it is if you look at the  
8 elements in the 13-point IOM care plan, there's a  
9 requirement for extensive discussion about the risks and  
10 benefits of chemotherapy. The intent of chemotherapy. The  
11 side effects of chemotherapy. I think that's part of  
12 stimulating a conversation between patients and physicians  
13 on chemotherapy and what the ultimate goal is and what we  
14 expect the outcome to be.

15           **DR. BERENSON:** But is there any sort of  
16 verification that that's happened?

17           **DR. KLINE:** Well, as Ellen pointed out, there will  
18 be site visits to make sure that these things are being  
19 done. And I can just tell you just from the discussion  
20 among the practices that incorporating the 13-point IOM  
21 care plan is really something they're focusing on and  
22 struggling with, but moving forward on.

1           **DR. BERENSON:** Okay, great. Let's just go down  
2 around. Len?

3           **DR. NICHOLS:** The \$160 MEOS seem to be roughly  
4 expected cost of delivering these enhanced services. Is  
5 there a MEOS for every type of cancer or is this across  
6 all?

7           **MR. MULDOON:** So there we set the MEOS, it's \$160  
8 regardless of the cancer type that is assigned to the  
9 episode. It's supposed to just support, at a practice  
10 level -- I think we anticipate that, across the different  
11 types of episodes, the different cancer types a practice is  
12 treating, that the \$160 per episode will be enough to sort  
13 of support furnishing those services to the beneficiaries  
14 in OCM.

15           **DR. NICHOLS:** So it's kind of an implicit  
16 assumption that the case mix across practices is roughly  
17 identical. Is that fact?

18           **MR. MULDOON:** I think it sort of is, does and  
19 maybe have that baked in. But again, I think we do see  
20 variation in the practices, but that didn't necessarily  
21 have -- we were looking to sort of set some uniformed  
22 design parameters.

1           **DR. NICHOLS:** I'm not criticizing, I'm just trying  
2 to figure out

3           **MR. MULDOON:** I think it is an assumption that's  
4 sort of baked into that, although we do see that different  
5 practices certainly do see a different range of case mixes  
6 in their patients. I think what first and foremost comes  
7 to mind is like a urology practice that would be treating  
8 predominantly bladder and prostate cancer relative to a  
9 medical oncology practice or a multispecialty practice.

10           **DR. NICHOLS:** So one might imagine some day in the  
11 future you'll have cancer specific MEOSs. Maybe you won't,  
12 but we might have. The other question would be, is the  
13 target aggregate or is the target per episode?

14           **MR. MULDOON:** We do come up with a prediction and  
15 a target price that we have for each episode. But then we  
16 do the reconciliation at the practice level. Essentially,  
17 we calculate that individual price per beneficiary's  
18 episode. And then when we move to do our reconciliation  
19 calculations, we aggregate those target prices up and some  
20 across the different episodes. And then some, all of the  
21 expenditures up across each of the episodes. So the  
22 practice wouldn't actually be receiving, you know, \$1000

1 for one beneficiary's episode and paying back, you know,  
2 \$500. We would aggregate all of the intakes.

3 **DR. NICHOLS:** Oh yeah, yeah. But my question is,  
4 is the target against which the practice is being judged,  
5 is it N times P or is it just P for every episode?

6 **MR. MULDOON:** No. Each episode with like a  
7 specific set of risk-adjustment characteristics. Like if  
8 you're a male with lung cancer who's age 75 and has 4  
9 comorbidities and lives in this part of the country, you  
10 would get a price. And then some other beneficiary with a  
11 different type of cancer would have a different price  
12 associated with their episode. And then we would sum each  
13 of those prices for each different episode up to the  
14 practice level. But the prices can vary between  
15 beneficiaries.

16 **DR. NICHOLS:** Okay. But sum across all the  
17 patients for that --

18 **MR. MULDOON:** That are attributed to that  
19 practice.

20 **DR. NICHOLS:** During a performance period?

21 **MR. MULDOON:** Yes.

22 **DR. NICHOLS:** And you compare it to the baseline

1 something. Is the baseline something a total span, P times  
2 Q or just P?

3 **MR. MULDOON:** So we came up with both a predicted  
4 price for each episode and then sum all of those predicted  
5 prices for episodes to come up with a practice-level  
6 target. And then against that practice-level target  
7 compare all of the actual spending. Because we allow all  
8 the actual spending under the fee for service system of  
9 Part D to continue to occur.

10 **DR. NICHOLS:** Okay. I'll quit badgering you. I'm  
11 headed to where Bob started, okay. If you have an N, a  
12 number of episodes baked into the target span --

13 **MR. MULDOON:** Right. No. No. No.

14 **DR. NICHOLS:** Then if you do -- do you not? Do  
15 you, or do you not?

16 **MR. MULDOON:** We do not.

17 **DR. NICHOLS:** Okay.

18 **MR. MULDOON:** It's a little confusing in the  
19 slides also, the way it's presented.

20 **DR. NICHOLS:** I was trying to solve Bob's problem.  
21 He had a N baked in, and then if they inflated episodes  
22 later, you could catch them.



1           **MR. MULDOON:** No. We don't have an N baked in.  
2 Each episode attributed in a performance period would get  
3 its own price, regardless of if the volume is higher in the  
4 performance period than it used to be or lower.

5           **DR. BERENSON:** Rhonda, do you have any questions?

6           **DR. MEDOWS:** I have one question about beneficiary  
7 cost sharing. You said it is not included in total cost of  
8 care? Is that because it's hard to get the data or because  
9 the focus is more on the government spend? Is there a  
10 reason or rationale?

11           **DR. TERRELL:** Can you repeat her question. She's  
12 got such a soft voice, to let the audience hear.

13           **MR. MULDOON:** Sure. The question is sort of  
14 explaining a little bit the rationale behind the decision  
15 to exclude beneficiary cost sharing in the model and focus  
16 on Medicare payments.

17           I think we decided here that we really did want to  
18 focus on Medicare payments. It's not because we'd have  
19 trouble accessing the beneficiary coinsurance or  
20 deductibles that beneficiaries pays. So that's information  
21 that we do have in the administrative claims data, but here  
22 decided that we're going to focus on Medicare payments.

1           **MS. LUKENS:** I just want to add one thing to the  
2 discussion about how would you know the beneficiary -- sort  
3 of what the predicted spending would be? We actually do  
4 give the practices a predict tool where they can put in all  
5 of the different variables associated with a patient and  
6 then it tells them because it is fairly complex. It helps  
7 them understand what that would be.

8           **DR. BERENSON:** Harold?

9           **MR. MILLER:** Two questions. One is you sort of  
10 portray this as being a total cost to care model. But if I  
11 understand it correctly, if a physician substitutes an  
12 expensive biologic oral drug, for a less expensive  
13 injectable drug, that would actually generate savings under  
14 the model for them because you're not counting Part D  
15 expenses and you are counting Part B expenses. Is that  
16 correct?

17           **MR. MULDOON:** So for Part A and B we include all  
18 the expenses. For Part D we include low-income cost  
19 subsidies as well as 80 percent of the drug cost above that  
20 catastrophic threshold. If a beneficiary, I guess, was  
21 receiving a more expensive biological drug I think we would  
22 anticipate that that would push them above that

1 catastrophic threshold.

2           **MR. MILLER:** So if they were using a somewhat less  
3 expensive biologic drug or they were simply using a Part D  
4 drug instead of a Part B drug, that would count as savings  
5 for them.

6           **MR. MULDOON:** It's possible.

7           **MR. MILLER:** And do I understand correctly, I was  
8 not aware of this, that you're excluding supportive drugs.  
9 That means Neulasta, Neupogen, and expensive antiemetics  
10 are not included in the total?

11           **DR. KLINE:** No. Let me clarify. They're counted  
12 as a total cost of care. They're not triggering agents for  
13 a chemotherapy episode.

14           **MR. MILLER:** Okay. Second question is I think  
15 we're going to be experiencing, with a lot of people who  
16 come in with proposed payment models, that they need to  
17 have some kind of a risk-adjustment mechanism. And the  
18 problem is that the data really to do that clinically  
19 doesn't exist.

20           And what you're doing, is you've launched a model  
21 with a claims-based risk adjustment system which I will say  
22 undoubtedly sucks. And you recognize that it's bad because

1 you're trying to set up the registry to be able to collect  
2 appropriate clinical data to do that. But you sort of  
3 launched everybody into the model initially with a claims-  
4 based risk adjuster which we know is not going to be any  
5 good.

6 I'm curious, one of the things that we've been  
7 talking about is whether for some of the models that come  
8 in where they really don't have the ability with claims  
9 data to do risk adjustment, that they should start in a  
10 more limited basis. That a small number of practices might  
11 start in this to be able to start actually setting up the  
12 clinical registry, collecting the data so that a better  
13 risk adjuster could be set up.

14 And I wonder whether you see any impediments or  
15 any problems in trying to do that as a two-phase model.  
16 One is to do it on a more limited scale to be able to get  
17 the clinical data and a more appropriate risk adjuster  
18 before you would expand to a broader population.

19 **DR. KLINE:** I'll delve into economics and then  
20 rapidly give it over to Dan. I think I agree with you in  
21 terms of there's a lot of variation with an episode. But  
22 the economics part of it would say that these are based on

1 historical expenditures for that practice, for that cancer  
2 type. There's been a lot of variations, but ultimately  
3 they do reflect reality, at least what was reality in the  
4 past.

5           And then I have no strong feelings about the two-  
6 phase model other than sort of the obvious statement that  
7 if you start out with a limited number of practices, your  
8 data collection will be slower early on, so that may be a  
9 slower process.

10           **MS. LUKENS:** So just one thing I also had to say,  
11 I think we certainly would not be opposed to collecting  
12 clinical data first. I think that one experience we have  
13 had -- and Katy's actually done a lot of work on the  
14 registry -- is that it is a fairly significant undertaking  
15 for the practices. It would probably need to be coupled  
16 with some sort of incentive for the practices to  
17 participate.

18           **MR. MILLER:** I wasn't suggesting that you collect  
19 the data first. I was saying actually put the model in  
20 place on a more limited scale to be able to collect the  
21 data with less risk associated with it so that you can  
22 actually develop a model. Because I think what we're going

1 to be seeing is a lot of people who would say, I'm not  
2 prepared to put a model in place and take risk for it  
3 unless there is an effective risk adjuster in place.

4 But we can't put in an effective risk adjuster in  
5 place if we aren't collecting the data that we need to be  
6 able to put an effective risk adjuster in place; so to move  
7 to a two-phase model where you start by trying something on  
8 a no-down-side model, and then move to something where you  
9 say now that we have a better risk adjuster, we can move to  
10 something where people can take accountability.

11 **MR. MULDOON:** I think that's also sort of how we  
12 have constructed OCM and, you know, initially had planned  
13 to have an extended period of time where it wasn't even an  
14 option for practices to opt for two-sided risk. But now  
15 practices who believe that they, you know, would be able to  
16 take on that type of two-sided risk do have the option.

17 **MR. MILLER:** Except that you said that if they  
18 don't reduce spending in the first two years, then they're  
19 dropped. That is a down size. Anyway, I don't want to  
20 hold us up anymore.

21 **MR. MULDOON:** Well, they can go to two-sided risk  
22 at that point if they would like to also.

1           **MR. MILLER:** That wasn't my point. But anyway.

2           **DR. BERENSON:** Tim?

3           **DR. FERRIS:** My question is about sustainability  
4 and I've heard -- and maybe this was part of the  
5 presentation, I'm sorry if I missed it -- but is the  
6 baseline rolling forward? I've heard from OCM participants  
7 that they get updates in the baseline. And I just wonder  
8 about the sustainability of a process in which they are  
9 improving and the updates are following along with them in  
10 the adjustments. So eventually don't you run into a  
11 problem?

12           **MR. MULDOON:** Actually, they are keeping that  
13 historical period set from the episodes for 2012 to 2014.  
14 And then when we do the trending forward for each of the  
15 performance periods, while we tailor the trend factor based  
16 on a practice's case mix, the actual like dollar amounts  
17 that are used to calculate the numerator and the  
18 denominator for that trend factor are actually based on  
19 non-participating practices. We tried to not bake in, sort  
20 of moving the goal post at each step along the way for  
21 practices that are in OCM.

22           **DR. FERRIS:** Thank you.

1           **DR. BERENSON:** Jeff?

2           **DR. BAILET:** I'm good.

3           **MS. MITCHELL:** My question is about the measure  
4 and payment standardization across pairs and sort of how  
5 aligned the measures actually are in terms of how they're  
6 calculated.

7           **UNIDENTIFIED FEMALE:** Excuse me, I'm sorry. Can  
8 you speak up for us? Thank you.

9           **MS. MITCHELL:** My question was about measure and  
10 payment standardization across pairs and sort of how  
11 standardized they actually are.

12           **MS. COX:** So we have asked payers to align what is  
13 essentially a core set of quality measures. I don't know  
14 them off the top of my head, but there are three claims-  
15 based measures. And we did that through a collaborative  
16 process with that and actually spent a lot of time getting  
17 their feedback and really focusing on getting a core set so  
18 we can all focus on collecting the same measures and then  
19 reducing the reporting in for the practices.

20           We have been pretty flexible with their payment  
21 approaches, but I think the key is that we're asking payers  
22 to also provide like a care-management fee or per



1 beneficiary, per month payment for enhanced services, very  
2 similar to the services that we're paying for. We've also  
3 asked them to include performance-based payment approach.

4 I think they have a little bit more flexibility to  
5 implement differently, but we've asked them to align on  
6 those core principles.

7 **DR. BERENSON:** Grace?

8 **DR. TERRELL:** My question for you is related to  
9 what you're calling this which is Oncology Care Model.  
10 There's a distinction between a payment model and a care  
11 model. And what I believe this really is is a payment  
12 model for which you're hoping to get care in ways that we  
13 haven't paid for before that is better for patients.

14 Well, every payment model out there, whether it's  
15 fee for service or anything else, has moral hazard in it.  
16 That's just the nature of payment. It's intrinsic moral  
17 hazard in any payment model. My question for you -- one of  
18 the things I'm most concerned about, not only for this but  
19 for what PTAC is doing or any sort of other alternative  
20 payment models -- is what do you do about that other than  
21 just program integrity that you spoke about specifically as  
22 it relates to innovation and evidence-based medicine?

1 I've been practicing medicine for a long time and  
2 I remember when coronary artery bypass grafting was the  
3 standard of care. And it moved to stents and now we have  
4 medications that often will prevent coronary artery  
5 disease. That was innovation and had we gotten stuck in a  
6 particular thing, we might not have actually gotten  
7 progress for what we should have been doing which occurred  
8 in the system that we had.

9 What are you all doing in your payment model in  
10 trying to provide an alternative for an approved-care model  
11 to make sure that there's the possibility for evidence-  
12 based medicine and innovation?

13 **DR. KLINE:** So a couple different points. I think  
14 it's a payment model, but I think it's also a care model  
15 because there are practice redesign elements, care  
16 navigation, access to your provider 24 hours a day, use of  
17 EHRs. Following national guidelines that really are care  
18 changes as well as payment changes.

19 I think in terms of following innovation,  
20 obviously oncology -- I think the whole oncology world is  
21 changing tremendously as we identify genes that cause  
22 cancer, molecular mutations that cause cancer, and then

1 develop medications that target those mutations. You know,  
2 Gleevec being the prototype from 15 years ago, I guess at  
3 this point it's changing.

4 I think the fact that we ask practices to follow  
5 nationally recognized guidelines, or document in the  
6 patient record why they're not following those guidelines,  
7 I think will ensure that physicians continue to follow the  
8 standard of care. Did I answer your question?

9 **MR. STEINWALD:** My question is about your non-  
10 randomized search and sign. Could you say a little bit  
11 more? How do you deal with the essential selection bias?  
12 When do you expect to get some results from that  
13 evaluation? And how do you intend to use it?

14 **MR. MULDOON:** So there, I think, as Ellen noted to  
15 me and what I was thinking too is I wish we had one of our  
16 evaluation colleagues here on the panel. But I know that  
17 it's sort of an ongoing effort I think. We have lots of  
18 collaboration with our evaluation colleagues. We provide  
19 them with as much detail as possible about the practices  
20 that are part of the model for them to use in the matching  
21 algorithms that they incorporate as part of their  
22 evaluation. And we have a healthy dialogue back and forth

1 there.

2 I don't know if I have that much more to say. We  
3 can ask our evaluation colleagues to provide, you know, a  
4 written answer on exactly more details there. I don't want  
5 to speak, sort of, out of turn there.

6 **MR. STEINWALD:** Maybe as a follow up; is there and  
7 evaluation grantee or contractor?

8 **MS. LUKENS:** Yes. We will definitely follow up  
9 with that question.

10 **DR. BERENSON:** Jeff?

11 **DR. BAILET:** I had a question relative to adjuvant  
12 therapy beyond the chemotherapeutic. The oncology practice  
13 has a lot of say in other treatments; surgery, radiation,  
14 referral, evaluation. Where is that body of work? How is  
15 that incorporated in the model? Because you can see where  
16 some practices may be very conservative and not offer the  
17 patient those kinds of referrals for other treatment. Is  
18 that factored in? How does that play through the model?

19 **DR. KLINE:** Thank you. If a patient is receiving  
20 surgery with an episode -- I guess that would be  
21 neoadjuvant therapy -- that would be after an episode of  
22 trigger with chemotherapy. Then we see surgery, there's a

1 surgical adjustment. We didn't want to financially  
2 penalize a practice if neoadjuvant therapy was better. If  
3 it was better for them to get chemotherapy first, shrink  
4 down the tumor, trigger an episode and then have the cost  
5 for surgery within an episode.

6           There is an adjustment for surgery. There is an  
7 adjustment for radiation therapy. There is an adjustment  
8 for bone marrow transplant. Wherever we felt that there  
9 was a fork in the road that had a subjective component to  
10 it, we wanted to make sure that we weren't penalizing the  
11 practices.

12           **DR. BAILET:** Part of my question is to your  
13 original question for appropriateness because that could  
14 influence decision making.

15           **DR. BERENSON:** When you say adjustment, is it like  
16 a carve out? You're not holding the practice accountable  
17 for the radiation therapy and spending? What's the form of  
18 the adjustment?

19           **MR. MULDOON:** We incorporated it into the risk-  
20 adjustment model. It would be an increase in episode  
21 target price. However, I think for surgery we went through  
22 -- for example we went through not trying to just include

1 any surgery, but with Ron and other medical oncologists we  
2 worked to identify surgery. As Ron mentioned, there was  
3 this sort of it would be clinically appropriate to perform  
4 -- you know, administer chemotherapy prior to doing the  
5 surgery and not just trying to incentivize -- you know,  
6 doing any surgery or just giving radiation during any  
7 episode. I don't know, Ron, if you have anything else to  
8 add.

9           **DR. KLINE:** Well, I mean it was just a hard thing.  
10 Basically, if there's a surgery that always is going to  
11 occur prior to chemotherapy; so brain tumor, brain tumor  
12 resection always occur prior to chemotherapy. There was no  
13 surgical adjustment in that situation.

14           Where there are examples of, you know, a  
15 lumpectomy, a mastectomy where you might do it either  
16 before chemotherapy or after, to shrink the tumor down,  
17 there was an adjustment. We tried to sort of balance that  
18 so as not to penalize the practices for doing the right  
19 thing, but also not allow them to game the system for doing  
20 the wrong thing.

21           **DR. BERENSON:** So I wanted to ask another question  
22 and then maybe we have time for just a couple more. I

1 wanted to go back to -- by habit I'm a splitter rather than  
2 a lumper. And you've got a lot of cancers included in the  
3 cancer model from acute leukemia, where I would expect that  
4 the spending would be largely attributable to the  
5 intervention, to the chemotherapy and all the complications  
6 that could happen to, as you mentioned, tamoxifen for  
7 breast or hormonal treatment for prostate, where I would  
8 think that the cancer costs are relatively small in  
9 relationship to total cost of care. I guess one is just a  
10 factual question. In the baseline spending across these  
11 cancers, would some have shown significant variations in  
12 spending like I would expect with prostate or breast;  
13 whereas others would show much less variation like leukemia  
14 or lymphoma?

15           And then where I'm really going on this is do we  
16 really -- I mean I used to manage prostate cancer as just a  
17 primary care internist, the hormonal treatment. Do we  
18 really think a total cost of care for those kinds of  
19 cancers is the appropriate metric as I think it probably is  
20 for some of the other cancers?

21           **MR. MULDOON:** I think there we did work to try to  
22 identify where there was potentially, like within breast

1 cancer sort of a very large difference between a woman  
2 who's receiving tamoxifen or other oral hormonal therapies  
3 rather than a woman who has metastatic disease. And so in  
4 the risk adjustment we actually do, where we were able to  
5 identify, have more granular within cancer distinctions.

6           Like for breast cancer, if a woman only receives  
7 the oral chemotherapy throughout an episode, that is sort  
8 of the cancer type risk-adjustment factor there. Sort of  
9 cancer by receiving only the oral chemotherapy and that  
10 would allow for the prediction of a much lower price for a  
11 woman who is on this long-acting hormonal therapy than a  
12 woman who receives more systemic chemotherapy, who  
13 potentially has metastatic disease going on.

14           **DR. BERENSON:** It's affecting the price. Okay.  
15 But the model is still the same. Go ahead, Ron, you wanted  
16 to respond.

17           **DR. KLINE:** I was going to quote my old professor  
18 who said the splitters always win. But I agree in terms of  
19 trying to move towards more clinically relevant episodes.  
20 And I think that's the point of the data registry. I  
21 think, you know, the total cost of care model, there are so  
22 many different cancer types and so many different



1 chemotherapy side effects. But I think trying to figure  
2 out at a national level what's chemotherapy related and  
3 what's not would be a very, very difficult task.

4           You know, the example I've always used when I've  
5 spoken to people is someone with cancer comes to the  
6 emergency department and they've broken their leg. Did  
7 they break their leg because they slipped on ice? Did they  
8 break their leg because they have a metastatic lesion in  
9 their leg that wasn't radiated appropriately? Did they  
10 break their leg because they had a neuropathy from the  
11 chemotherapy? Did they break their leg because they were  
12 dehydrated because they didn't get appropriate hydration  
13 after chemotherapy? And all we see at CMS is a broken leg.  
14 That's why we sort of went to a total cost-care model.

15           **DR. BERENSON:** So in other words, episode grouper  
16 for cancer is still a work in progress. You don't think  
17 you can clearly attribute what claims are associated with  
18 the chemotherapy and which ones probably aren't? Or you  
19 don't know?

20           **DR. KLINE:** I think there's a lot of difficulty.  
21 And I always tell people that making ICD 10 work with the  
22 diversity of cancer, work with the CMS claim system is

1 really a challenge. And that's what we're trying to do.

2 **DR. BERENSON:** We have five minutes so just five  
3 minutes' worth of quick Qs and As. And we'll stop it in  
4 five minutes.

5 **DR. BAILET:** That's all we have.

6 **DR. BERENSON:** Grace?

7 **DR. TERRELL:** One question then. This works very  
8 well for folks for which chemotherapy is the appropriate  
9 therapy. Do you have the ability now to incorporate other  
10 types of modalities as a treatment event in other  
11 specialties into an oncology care model? For example,  
12 radiation oncologist, surgeons or other types of therapy  
13 into a more comprehensive model that could be disease  
14 focused as opposed to modality focus in terms of the  
15 trigger and the approach.

16 **MS. LUKENS:** I think the Oncology Care Model as it  
17 is currently constructed is trigger by chemotherapy.  
18 That's not to say that we couldn't modify in some way to  
19 expand to include other modalities. But the research and  
20 the work that we've done to date in the risk adjustment  
21 model is all --

22 **DR. TERRELL:** But it can be done?

1           **MS. LUKENS:** I think it can be done, yeah.

2           **DR. BERENSON:** Any final questions from -- go  
3 ahead Elizabeth.

4           **MS. MITCHELL:** Can you comment at all on the  
5 ability or the chance of making these payments actually  
6 prospective.

7           **MR. MULDOON:** I think there's where the Medicare  
8 like claims processing system I think to date is -- I also  
9 have experience working on our bundled payments for care  
10 improvement initiatives where we have both a retrospective  
11 payer methodology as well as a flavor of that that has a  
12 prospective payment methodology. In that model the  
13 prospective payment methodology really just covers, you  
14 know, the payment for an inpatient stay which is already  
15 sort of made on a prospective basis as well as physician  
16 Part B claims provided during that inpatient stay.

17           And I'll say that we had a lot of both operational  
18 challenges at CMS in terms of getting all of those claims  
19 to pay correctly as well as at the hospitals. You know, it  
20 puts a lot of burden on hospitals or the entity that would  
21 be receiving that prospective payment to also have  
22 contracts in place to be able to pay the other entities

1 involved.

2 I think that with this episode payment model and  
3 other episode payment models, it's like a goal to get  
4 there. But it's not something that, I guess, we see as  
5 being really easy to do, you know, tomorrow or in the next  
6 six months.

7 **DR. BERENSON:** Last question and then we're going  
8 to stop. Can you clarify any plans to have the two-sided  
9 risk approach qualify as an advanced APM?

10 **MS. LUKENS:** Sure. We actually accelerated the  
11 option for practices to be able to elect two-sided risk as  
12 of January 1, 2017. We are allowing them the entire month  
13 basically of December. They don't have to let us know  
14 until the 28<sup>th</sup>. We can certainly let Mary Ellen and other  
15 folks know how many end up electing two-sided risks. But  
16 at this point, we don't know how many will accept this.  
17 The folks that do elect two-sided risk will qualify as an  
18 advanced APM.

19 **DR. BERENSON:** So meets the EHR requirement?

20 **MS. LUKENS:** That's correct.

21 **DR. BERENSON:** It qualifies, okay. Any last --

22 **MR. MILLER:** But they'll be using the current risk

1 adjustment structure if they're doing that, right?

2 **MS. LUKENS:** Yes.

3 **DR. BERENSON:** You did a great job. This has been  
4 very helpful to us and thank you for coming by.

5 **DR. BAILET:** A couple of things. We're going to  
6 conclude the session. We apologize for the technical  
7 difficulties that the hotel is experiencing relative to the  
8 power which is impacting their visual and audio systems.  
9 And to that end as we conclude the session we're going to  
10 have Mary Ellen announce how we're going to go forward  
11 given the acuity of the problem here. Mary Ellen?

12 **MS. MARY ELLEN:** Thank you CMS for a great  
13 presentation under not the best circumstances. As you've  
14 noticed there's a power problem in the back half of this  
15 room which apparently blew the audiovisual soundboard,  
16 Murphy's Law, so the people on the phone cannot hear.

17 In light of that, and the fact that two of the  
18 speakers for the afternoon session were going to be calling  
19 in because of the weather in the Midwest, we've decided to  
20 postpone that afternoon session. It's just the one session  
21 that we so wanted to have ourselves and we wanted the  
22 public to hear. And so many people were on the phone,

1 about 100 people were on the phone. We want to postpone  
2 that so that everybody can hear and everybody can benefit  
3 from those perspectives. We are so sad about it.

4           For those of you who were going to miss a holiday  
5 luncheon with your office this afternoon, you can now  
6 attend. I do want to apologize, I'm not making light of  
7 it. We're so disappointed with the service here at the  
8 hotel today, but these things happen as you well know. And  
9 again, I want to thank CMS for being so gracious about  
10 having to do a presentation under such difficult  
11 circumstances.

12           We'll post on our website when we can do that  
13 session and thanks very much.

14           **[PUBLIC MEETING ADJOURNED]**