

Physician-Focused Payment Model Technical Advisory Committee

Preliminary Review Team Findings on

Hospital at Home Plus (HaH-Plus) Provider-Focused Payment Model

Submitted by Icahn School of Medicine at Mount Sinai

Harold Miller (Lead Reviewer)
Rhonda Medows, MD
Len Nichols, PhD

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Presentation Overview

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

Preliminary Review Team Composition and Role

- The PTAC Chair/Vice Chair assigns three PTAC members, including at least one physician, to each complete proposal to serve as the PRT. One PRT member is assigned to serve as the Lead Reviewer.
- The PRT identifies additional information needed from the submitter and determines to what extent any additional resources and/or analyses are needed for the review. ASPE staff and contractors support the PRT in obtaining these additional materials.
- After reviewing the proposal, additional materials gathered, and public comments received, the PRT prepares a report of its findings to the full PTAC. The report is posted to the PTAC website three weeks prior to public deliberation by the full Committee.
- The PRT report is not binding on PTAC; PTAC may reach different conclusions from that contained in the PRT report.

Proposal Overview

The proposal describes the model as “designed to engage physicians and other professionals in ordering, providing, and managing hospital-level services at home for beneficiaries with selected acute illnesses and acuity levels who would otherwise be hospitalized.” The proposed PFPM aims to reduce costs and improve quality by reducing complications associated with hospitalization and avoiding readmissions.

Intervention

- ❖ HaH-Plus offers eligible patients the option of receiving hospital-level care within their own home. Eligibility depends on multiple factors:
 - A diagnosis that would fall into one of 44 MS-DRGs
 - Clinical and other characteristics that would justify inpatient admission
 - Clinical and home characteristics indicating patient can be safely cared for at home under HaH-Plus
- ❖ Services to patients under HaH-Plus are divided into two parts:
 - An acute phase similar to an inpatient stay
 - Includes daily visits by physicians/nurse practitioners and registered nurses; visits from social work, physical and occupational therapy as needed; labs, diagnostic tests, and pharmacy
 - 30 days of transition services similar to post-acute care
 - Includes scheduled post-discharge visits, urgent visits by community paramedics as needed, and care coordination with the patient’s regular care providers

Proposal Overview (continued)

Payment to Support HaH-Plus Services

- ❖ The APM Entity managing the HaH-Plus services would be paid in two parts:
 - A bundled payment set equal to 95% of the sum of:
 - DRG payment that would have been paid to a hospital for an inpatient admission, and
 - Average professional fees that would have been paid had the patient been admitted
 - A performance-based payment (quality-adjusted shared savings/shared losses) based on:
 - Total spending during the acute care phase and 30 days afterward relative to a target price
 - Performance on quality measures
- ❖ The target price for determining savings would be based on:
 - Average spending during the episode (acute care phase + 30 days post-discharge) for hospitalized patients in the same geographic region with matching DRGs
- ❖ Details on the performance-based payment:
 - Spending below target price: CMS receives first 3% of savings, remainder is paid to APM Entity
 - Spending above target price: APM Entity pays CMS the difference (i.e., the loss)
 - APM Entity payments for savings/losses are capped at 10% of the target price

Summary of the PRT Review

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

Key Issues Identified by the PRT

Strengths:

- Fills a gap in the current Medicare payment model portfolio; currently, Medicare has no payment mechanism to support hospital-level care in the home.
- Aims to increase quality and reduce costs by reducing complications associated with hospitalization, which are more common among elderly patients.
- Bundled payment for both acute and post-acute care prevents cost-shifting to the post-acute phase and offers providers flexibility to reduce costs and improve quality during the critical and often costly post-acute period.
- Attractive model for an all-payer option. Including other payers may mitigate concerns around patient volume in the model while ensuring integration of alternative payments across payers.

Weaknesses:

- The financial viability of services depends on sufficient patient volume, which could encourage enrolling patients who either would not be admitted to an inpatient unit or would be better served in an inpatient unit.
- Payments may not accurately reflect true costs and savings during the acute and post-acute care phases compared to what would have been spent if the patients had been hospitalized.
- Link between quality and payment is limited; only the performance-based payment is tied to quality.
- Quality metrics do not comprehensively capture adverse events (even if data are only used for monitoring).
- Mechanisms for ensuring patient safety are limited: formal monitoring to ensure appropriate escalation, timely provider visits, and recording and reviewing adverse events.

Criterion 1. Scope of Proposed PFPM (High Priority)

Criterion Description

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

PRT Conclusion

Meets criterion

Unanimous or Majority Conclusion

Unanimous

Strengths:

- Current Medicare FFS payment does not cover home-based acute services.
- No other CMS APMs provide a home-based alternative for patients requiring inpatient-level care.

Weaknesses:

- A minimum volume of patients is needed to make the program financially viable, which could limit it to large communities.
- Most small practices would need to be part of a larger organization to implement HaH-Plus because of the need to organize and manage backup support and to have sufficient financial capital to support the significant financial risks under the proposed payment methodology.

Summary:

- The proposed services and eligible patients are significantly different from what is currently supported under standard Medicare payments and other Alternative Payment Models.

Criterion 2. Quality and Cost (High Priority)

Criterion Description

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

PRT Conclusion

Meets criterion

Unanimous or Majority Conclusion

Unanimous

Strengths:

- Multiple studies have demonstrated the HaH care model improves quality and reduces costs relative to inpatient hospitalization. HaH-Plus is specifically designed to do both.
- Post-acute care costs are included in the benchmark, which discourages cost-shifting.
- Care during the acute and post-acute phases is provided by the same team of providers.

Weaknesses:

- Potential for safety risks to patients if they are not carefully selected for participation; review process for adverse events provides limited assurances regarding quality of care.
- Need for minimum volume of patients could encourage enrolling patients into HaH-Plus who would not have been admitted to an inpatient unit at all.
- The average cost to the hospital for patients who are admitted may increase if the patients diverted to home care would have involved less intensive inpatient services.
- Payment methodology may overestimate savings during post-acute phase.
- Total savings to Medicare will be limited because only a small proportion of patients could participate.

Summary:

- The HaH care model has been demonstrated to improve quality and reduce costs, and the payment model for HaH-Plus is designed to support that. However, modifications are needed to ensure patient selection is based on clinical, not financial, considerations, and the DRG-like payment could better reflect the actual cost and quality of home care.

Criterion 3. Payment Methodology (High Priority)

Criterion Description

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

PRT Conclusion

Meets criterion

Unanimous or Majority Conclusion

Unanimous

Strengths:

- Payment methodology is described in detail and examples have been provided.
- Bundled payment includes acute and post-acute spending to prevent cost-shifting.
- Bundled payment is directly tied to DRG amounts at a discount and ensures Medicare spends less for acute care than if the patient been admitted to the hospital.
- Bundled payment uses components similar to CMMI BPCI, including the standard CMS DRG grouper, exclusions, post-acute care definitions, and shared savings methodology.

Weaknesses:

- Payment for the acute phase is not adjusted based on quality.
- Magnitude of the discount to the DRG applied to the HaH-Plus payment is not based on the differential needs and costs of patients admitted to HaH-Plus vs. the inpatient unit.
- Benchmarking methodology does not account for the likelihood that HaH-Plus patients are less likely to require SNF care than patients admitted to the hospital.
- The amount of risk the APM Entity bears remains constant over time.

Summary:

- Proposed PFPM is designed to achieve the goals of the PFPM criteria. However, some modifications to the DRG-like payment, benchmarking, and risk-bearing are needed.
- The “Observation at Home” and “Palliative Care at Home” components are not sufficiently well described to determine whether they meet the criterion.

Criterion 4. Value over Volume

Criterion Description

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

PRT Conclusion

Meets criterion

Unanimous or Majority Conclusion

Unanimous

Strengths:

- High-quality care will be necessary to encourage sufficient patient participation in this voluntary model.
- Shared savings payments and losses are tied to quality performance.
- Program proposes physician compensation be tied to quality performance and readmission rates, rather than to service utilization or savings.

Weaknesses:

- A minimum patient volume is needed for financial viability; this could lead to enrolling patients better treated in an inpatient setting or who would not be admitted as inpatients.
- No direct financial penalty for poor performance on quality measures; poor performance only reduces the amount of shared savings or increases the payment on losses.
- APM Entity experiences financial penalty if patient escalated to inpatient unit. This could lead to keeping patients at home when they should be escalated.

Summary:

- Proposed PFPM incentivizes providers to deliver high value care. However, physicians could be encouraged to admit patients inappropriately as the model depends on volume.
- Making the DRG-like payment contingent on quality, monitoring for appropriate admissions and escalations, and adding an all-payer option may mitigate concerns around achieving a minimum volume.

Criterion 5. Flexibility

Criterion Description

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

PRT Conclusion

Meets criterion

Unanimous or Majority Conclusion

Unanimous

Strengths:

- APM Entity has complete flexibility to determine number and types of services patients need and the best individuals or organizations to deliver those services.
- APM Entity has flexibility to deliver more services to some patients than others, as long as overall costs for all patients served does not exceed revenue.

Weaknesses:

- Challenges in gaining adequate participation to cover the financial costs of the program could make the program less willing or able to deliver all services that patients need.
- APM Entity is accountable for post-acute care spending and would have flexibility to deliver different services than are available today, but it would not be able to control all aspects of post-acute care services (e.g., what skilled nursing facility (SNF) a patient chooses or how effectively the SNF provides care).

Summary:

- Bundled payment for acute and post-acute care offers flexibility to redesign the delivery of care to achieve reduced spending and maintain or improve quality.

Criterion 6. Ability to be Evaluated

Criterion Description

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

PRT Conclusion

Meets criterion

Unanimous or Majority Conclusion

Unanimous

Strengths:

- Proposal specifies goals for quality of care and costs that can be evaluated.
- Results of similar HaH evaluations could be combined with the evaluation of this PFPM to allow more robust conclusions about the impact of the care model.
- The Mount Sinai Health Care Innovation Award (HCIA), which forms the basis for the proposed PFPM, is currently being evaluated, and a method for drawing a valid comparison group is expected to be developed as part of that evaluation.

Weaknesses:

- Because of the diversity of patients participating, it may be difficult to accurately compare costs and quality other than for the most common types of patients.
- Limited number of potential participants may make it difficult to precisely measure effects, and it may be challenging to implement a randomized test of the model.

Summary:

- Proposed PFPM describes evaluable goals for quality of care and cost. The Mount Sinai HCIA, which forms the basis for this proposed PFPM, is currently being evaluated, and lessons learned from that experience can inform the evaluation of this proposed PFPM.

Criterion 7. Integration and Care Coordination

Criterion Description

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

PRT Conclusion

Meets criterion

Unanimous or Majority Conclusion

Unanimous

Strengths:

- As the program is responsible for the costs of escalations to inpatient care and for all post-acute care, it must develop relationships with hospitals and post-acute care providers.
- The same team provides care during the acute and post-acute phases, which ensures continuity of care during the critical post-discharge period.
- PCPs are involved upon admission to the HaH-Plus program (via direct referral or as a consult). PCPs receive a discharge summary, and HaH-Plus staff schedule PCP follow-ups.
- During post-acute phase, HaH-Plus providers begin transitioning care to the patient's PCP, providing critical information about the patient's home situation to inform the care plan.

Weaknesses:

- Program creates new situations in which coordination, communication, and transition would be needed – initial transfer from the ED to the HaH-Plus program (at home), a transfer to the hospital from home (if escalation to inpatient care is required), and a possible transfer back to HaH-Plus care (at home) following an escalation.

Summary:

- HaH-Plus has several mechanisms to ensure the patient's usual providers are aware of the patient's participation in HaH-Plus and are involved in care planning as appropriate. By providing care in the home, HaH-Plus providers can provide insights into the patient's home situation, which may be particularly useful for care planning.

Criterion 8. Patient Choice

Criterion Description

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

PRT Conclusion

Meets criterion

Unanimous or Majority Conclusion

Unanimous

Strengths:

- HaH-Plus provides a new home care option for eligible patients, which evaluations have shown is preferred by many patients and their families.
- Admission to the program would be voluntary on the part of the patient.
- Payment model would provide flexibility to the care team to deliver non-traditional services to patients.

Weaknesses:

- Because of the inherent limitations on the intensity of services that can be provided in the home, some patients who would like to participate in HaH-Plus may not be eligible.
- The discretion involved in determining patient appropriateness could result in providers encouraging participation of patients who would be better served in an inpatient setting in order to meet participation goals.

Summary:

- Eligible patients may decide to participate in HaH-Plus or to receive traditional inpatient admission. Serving patients in their home affords patients and their families more control over the environment in which care is delivered.

Criterion 9. Patient Safety

Criterion Description

Aim to maintain or improve standards of patient safety.

PRT Conclusion

Does not meet criterion

Unanimous or Majority Conclusion

Unanimous

Strengths:

- HaH-Plus aims to reduce adverse events associated with hospitalization.
- Participation in the program is intended to be limited to patients with diagnoses and other characteristics that can be cared for safely in the home.
- Patients can be escalated to an inpatient unit at any time.
- Proposal specifies minimum number of daily visits by providers during the acute phase.
- The same team provides care during the acute and post-acute phases.

Weaknesses:

- Provider visits are not externally monitored to ensure their timely completion.
- Providers may have incentives to encourage participation by patients better served in an inpatient setting in order to meet participation goals.
- There is a financial disincentive to escalate care to the inpatient unit.
- There is not a clear mechanism for patients or their families to report adverse events nor is an independent entity designated to review adverse events and the response to them.

Summary:

- HaH-Plus would likely reduce complications associated with hospitalization. However, additional safeguards to assure patient safety are needed, such as monitor and review of provider visits and escalation and adverse event rates. Tying payment for the acute phase to quality may provide further incentives to assure patient safety.

Criterion 10. Health Information Technology

Criterion Description

Encourage use of health information technology to inform care.

PRT Conclusion

Meets criterion

Unanimous or Majority Conclusion

Unanimous

Strengths:

- The use of multiple types of personnel and potentially multiple organizations to deliver care would serve as an incentive to record and share information electronically.
- The relatively small scale of the program means that essential elements of tracking and exchange of patient information could be successfully carried out using simple tools.

Weaknesses:

- Current EHR systems do not support inpatient-level services in an ambulatory environment.
- Lack of effective interoperability of current EHR systems will make it difficult to share information if separate organizations are providing services to patients.
- While the proposed PFPM encourages health data/information sharing across multiple care providers, the small scale of this model may not be sufficient to prompt investment in data integration systems and interoperability, and the costs of EHR modifications required for optimal functioning of HaH-Plus may limit its attractiveness to potential APM Entities.

Summary:

- While current EHR capabilities pose challenges to HaH-Plus program implementation, the proposed PFPM encourages use of HIT. Programs such as HaH-Plus could encourage EHR vendors to develop better cross-setting and interoperability capabilities. Given their relatively small scale, individual HaH-Plus programs likely could be implemented even in the absence of optimal EHR functionality.

Physician-Focused Payment Model Technical Advisory Committee

Preliminary Review Team Findings on:

**Advanced Care Model (ACM)
Service Delivery and Advanced Alternative Payment Model**

Submitted by the Coalition to Transform Advanced Care (C-TAC)

Bruce Steinwald, MBA (Lead Reviewer)
Paul Casale, MD, MPH
Elizabeth Mitchell

September 7, 2017

Presentation Overview

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Model Overview

- Targets care in last 12 months of life. Patient enrollees must meet 2 of 4 criteria:
 - **Acute Care Utilization:** 2 hospitalizations in last 12 months **OR** one ER visit and one hospitalization in the last 6 months **OR** 2 ER visits in the last months;
 - **Functional Decline:** New, irreversible dependence in at least one ADL in last 3 months;
 - **Nutritional Decline:** Involuntary lean body weight loss > 5% in last 3 months; or
 - **Performance Scales:** Palliative Performance Scale Score < 60, Karnofsky Performance Scale Score < 60 **OR** Eastern Cooperative Oncology Group (ECOG) Score > 3.
- PLUS**
- Negative response to “Would you be surprised if this patient died in the next 12 months?” (“The Surprise Question”).
- Model does not require beneficiaries be told prior to enrollment that the program is for people in last 12 months of their life. This information to be discussed at an appropriate time, as determined by the patient’s clinicians.
- Payments made to “ACM entities” who cover palliative & curative/treatment care. ACM entities:
 - May be ACOs, hospitals, medical groups, home health agencies, hospices, others.
 - Include interdisciplinary teams delivering palliative care and care management; and
 - Include network of treatment/curative care physicians choosing to participate in the model.

Payment Overview (Provider Payments and Incentives)

➤ **Two-pronged payment model:**

- \$400.00 wage-adjusted PMPM
- Shared risk based on total cost of care in last 12 months of life

➤ **PMPM:**

- Replaces FFS payment to palliative care providers
- Made for up to 12 months; ends earlier if death, enrollment in hospice, condition improves, moves out of area, or discharged

➤ **Shared Risk:**

- Limited to “shared savings” in first year of an ACM’s participation
- Two-sided risk after first year: 4% total risk and minimum loss rate; 75-85 % shared savings and loss rate; 30% total savings limit; 10% total loss limit; and
- Entities not achieving shared savings have 6-month correction phase after which required to drop out if cannot perform in two-sided risk.

➤ **If patients live longer than 12 months, the 12 month period for which the entity received the PMPM ≠ the 12 month period for which Total Cost of Care is calculated.**

Care Delivery Overview

- ACM interdisciplinary teams provide “comprehensive care management,” advanced care planning, and 24/7 access to a clinician.
- “Comprehensive care management” includes care coordination and care management of patient’s total (curative and palliative) healthcare across all services and providers including: primary, specialty, hospital, post-acute and social services
- Interdisciplinary teams have (at a minimum) a provider with palliative or hospice expertise, RN, and SW delivering care through face-to-face and telephonic encounters
- Treatment/curative care through patient’s primary and specialty providers who may/may not participate in the model
- ACMs may choose to continue to provide this care after 12 month PMPMs end
- Payment to be tied to performance on quality metrics

Summary of the PRT Review

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

Criterion 1. Scope of Proposed PFPM (High Priority). The proposal aims to broaden or expand CMS' APM portfolio by either: (1) addressing an issue in payment policy in a new way, or (2) including APM Entities whose opportunities to participate in APMs have been limited.

PRT Conclusion: Proposal Meets the Criterion with Priority Consideration

- CMS' Medicare Care Choices Models is a similar model offering both palliative and curative care, but it is limited to hospice providers only and to individuals with a 6-month life expectancy.
- Target population – Medicare beneficiaries with advanced, progressive illness not eligible for hospice – is one with substantial needs not adequately addressed by current payment systems.
- PRT acknowledges the arbitrariness of the 12-month life expectancy criterion, but concluded that the model would provide appropriate services to a population in need of coordinated care.

Criterion 2. Quality and Cost (High Priority). The proposal is anticipated to (1) improve health care quality at no additional cost, (2) maintain health care quality while decreasing cost, or (3) both improve health care quality and decrease cost.

PRT Conclusion: Proposal Does Not Meet the Criterion

- Approach to coordinated care has potential to reduce hospitalizations and ER visits, and improve patient experience of care. However:
- Concerns:
 - Majority of proposed quality measures are utilization measures
 - Sustainability of improving quality and lowering costs for participants surviving beyond 12 months when PMPM no longer provided
 - Interdisciplinary team to include EITHER a provider with hospice or palliative care certification OR provider who has practiced more than half time in hospice or palliative care for at least three years. Concern that experience without certification might be insufficient to assure quality of care.
 - Shortage of clinicians with palliative care certification may limit model's reach.

Criterion 3. Payment Methodology (High Priority). Pay APM Entities with a payment methodology designed to achieve the goals of the PFPM Criteria. Addresses in detail through this methodology how Medicare, and other payers if applicable, pay APM Entities, how the payment methodology differs from current payment methodologies, and why the PFPM cannot be tested under current payment methodologies.

PRT Conclusion: Proposal Does Not Meets the Criterion

- Payment elements (FFS for curative care, 12 mo. PMPM for care coordination & palliative care, and shared savings) should encourage patient & provider participation and care coordination
- However:
 1. Model may not be suitable for all people with advanced illness; cancer patients generally more predictable than patients with other illnesses.
 2. Risk of stinting on care / concern for safety of patients surviving > one year. Although PMPM ceases after 12 months, patients living longer remain in the model for calculating total cost of care in last 12 months and shared savings.
 3. Difficulties in calculating shared savings baseline amounts and accurate risk-adjustment.
 4. Overlap and potential competition with hospices and the Medicare Care Choices Model.

Criterion 4. Value over Volume. The proposal is anticipated to provide incentives to practitioners to deliver high-quality health care.

PRT Conclusion: Proposal Meets the Criterion

Potential benefits:

- Incentives to substitute less costly palliative care for more costly curative services when appropriate
- Compromise between palliative care under hospice benefit and siloed specialty care

Concerns:

- Few patient-oriented quality measures
- Compound effect of the two different types of financial incentives (i.e., loss of PMPM after 12 months and shared risk based on total cost of care in last 12 months of life.)
- Incentive to discharge to hospice v. continuing to provide curative services

Criterion 5. Flexibility. Provide the flexibility needed for practitioners to deliver high-quality health care

PRT Conclusion: Proposal Meets the Criterion

Potential benefits:

- Availability of curative and palliative services in a coordinated care environment provides flexibility to patients and providers.

Concerns:

- Which provider types are appropriate for participation in the model? e.g., proposal states any willing provider; however resources required to implement and accept risk suggest only larger organizations such as health systems and large home health agencies could participate.
- Concern that hospices might have a financial conflict of interest between keeping patients in the model or moving the patient to the hospice care for which there is a higher reimbursement (per diem vs. PMPM)

Criterion 6. Ability to be Evaluated. Have evaluable goals for quality of care, cost, and any other goals of the PFPM.

PRT Conclusion: Proposal Meets the Criterion

Proposal has evaluable goals but challenges in evaluating whether goals met:

- Proposal recommends episode-based actuarial modeling to develop a matched control group evaluation strategy, but leaves specifics of the evaluation to CMS;
- Quality measurement concepts identified for evaluation, but no specific measures or measure specifications identified;
- Most concepts to be measured would address service utilization, as opposed to patient-oriented outcome measures; e.g., no measures of functional status, depression management, measures of inappropriate underutilization, premature worsening of health or death;
- Evaluating model's effects on cost of care requires measurement of actual costs incurred and measurement of what would have been incurred in the absence of the model – the same estimates required for calculating shared savings. Actuaries express concern about accuracy of these calculations.

Criterion 7. Integration and Care Coordination

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

PRT Conclusion: Proposal Meets the Criterion with Priority Consideration:

- Principal focus of the model is on care coordination for a population with evident need for such coordination.
- Apart from reservations noted elsewhere, the model's integration of curative and palliative services is a feature that should improve the patient experience of care and conserve resources without denying needed curative services when appropriate.

Criterion 8. Patient Choice. Encourage greater attention to the health of the population served while also supporting the unique needs and preferences of individual patients.

PRT Conclusion: Proposal Meets the Criterion

- Model designed to encourage shared decision-making between patients and families and the providers who are tasked with coordinating care.
- PRT generally agreed that model would promote patient choice in a fragmented delivery system.
- PRT discussed at length the need to ensure that eligible patients, prior to enrollment, should be fully informed:
 1. That they are being recruited into a program for people thought to be in the last 12 months of life,
 2. That providers will temporarily receive extra payments for coordinating their care and providing palliative services for up to 12 months,
 3. That providers will share in any cost savings to the Medicare program that providers can make in the beneficiary's care in the last 12 months of life;
 4. About the overall design and goals of the program.

Criterion 9. Patient Safety. How well does the proposal aim to maintain or improve standards of patient safety?

PRT Conclusion: The Proposal Meets the Criterion

- PRT generally agreed that home-based care coordination elements of the model should promote patient safety.
- However, PRT has concern for:
 - 1) patients to be fully informed of the nature of the program prior to their enrollment in it, so that the patient or their representative can fully participate in shared decision-making; and
 - 2) safety of patients who survive more than 12 months in view of the model's cessation of the PMPM after 12 months and use of financial incentives to control costs in the last 12 months of life.
- Proposed model also seeks waivers of conditions of participation requirements for hospice and home health for parties that seek to provide these services.

Criterion 10. Health Information Technology. Encourage use of health information technology to inform care.

PRT Conclusion: The Proposal Meets the Criterion

- Model:
 - Would require participating entities to utilize an HER; and
 - Proposes that CMS expand its claims data collection to enhance participating providers' ability to assess eligibility and care process activities.

However:

- Like other PFPM proposals received by PTAC, there little attention given on how the exchange of information among providers would be optimized in a way to enhance the model's care coordination and integration goals.

Key Issues Identified by the PRT (1 of 3)

- Most positive conclusions derive from the needs of the target population – beneficiaries with advanced progressive illness not eligible for hospice care.
- PRT generally finds payment methodology incentives – including shared savings and risk – congruent with the model’s coordinated-care objectives.
- However, PRT has serious concerns:
 1. Broadness of the patient populations targeted by the model.
 - Model relies on predictable course of decline and eventual death of participants, but patients with differing underlying illnesses might exhibit varying predictability.
 - Literature on end-of-life predictions indicates that cancer tends to be more predictable than other diseases. PRT concerned that patients with illnesses that exhibit substantial variability in life expectancy might be inappropriate participants, even if they meet the selection criteria.

Key Issues Identified by the PRT (2 of 3)

2. Model open to almost any type of provider organization, but PRT unconvinced that all organization types would be able to provide the resources and assume the risk to be successful. PRT especially concerned about potential conflict of interest and overlap with the Medicare Care Choices Model if hospices were to implement the model.
3. Because the model would significantly alter care patterns for a vulnerable population, PRT believes there need to be greater assurances concerning patient engagement and shared decision-making than evident in the proposal – including decisions about palliative versus curative care, as well as information provided to the patient and family prior to electing to participate.
4. Patients need to be fully informed about the model design; e.g., that additional, palliative services will be provided to them and that providers would be compensated an extra payment for providing these services with the expectation there would be savings from providing fewer curative services. However, PRT uncertain about how prescriptive to be about other elements of the design, such as the expectation that the patient has 12 months or less to live.

Key Issues Identified by the PRT (3 of 3)

5. Concerns about the nature of the metrics to be used to evaluate quality of care. Would like to see more patient experience of care measures than were included in the proposal. Especially concerned that there should be safeguards to ensure that beneficiaries who participate for more than 12 months are not disadvantaged in any way.
6. Determining the effect of the model, including calculating the savings that will be included in the shared savings program and the losses that might be incurred by some provider organizations, will be challenging.
7. A related challenge is that the introduction of the C-TAC model, and its patient recruitment, might affect the evaluation of other models, including ACOs, operating in the same locale. While such challenges are not unique to the C-TAC model, the PRT believes that they need to be addressed.

Questions ?

Physician-Focused Payment Model Technical Advisory Committee

Preliminary Review Team Findings on:

Oncology Bundled Payment Program Using CNA-Guided Care

Submitted by Hackensack Meridian Health and Cota, Inc.

Tim Ferris, MD, MPH (Lead Reviewer)
Robert Berenson, MD
Bruce Steinwald, MBA

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Presentation Overview

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

Preliminary Review Team (PRT) Composition and Role

- PTAC Chair/Vice Chair assigns two to three PTAC members who have no conflicts of interest (including at least one physician) to serve as the PRT for each complete proposal. One PRT member is tapped to serve as Lead Reviewer.
- PRT identifies additional information needed from the submitter and determines to what extent any additional resources and/or analyses are needed for the review. ASPE staff and contractors support the PRT in obtaining these additional materials.
- After reviewing the proposal, additional information provided by the submitter, information from other materials gathered, and public comments received, the PRT rates the proposal on each of the Secretary's criteria and prepares a report of its findings to the full PTAC. The report is posted to the PTAC website at least two weeks prior to public deliberation by the full Committee.
- The PRT report is not binding on the PTAC; PTAC may reach different conclusions from that contained in the PRT report.

Model Overview

- Proposal is explicitly written as a pilot for Hackensack Meridian Health (HMH)
- Bundled payments for care of patients with newly diagnosed breast, colon, rectal, and lung cancer.
- 27 bundles; each bundle is an aggregation of “Cota Nodal Addresses” (CNAs) – Cota’s proprietary patient classification system of demographic, biologic, treatment factors
 - Model as written requires this proprietary software
- Each patient assigned a CNA; only patients with a CNA would be enrolled in the model.
- Each CNA has multiple treatment “lanes” – pre-determined sets of treatment protocols developed by the submitter based on their three-year retrospective analysis of patient characteristics, treatments, outcomes, and costs of care. Content (protocols) within lanes based on national guidelines.
- physician & patient choose the patient’s treatment lane from among the options within a CNA.

Payment Overview (Provider Payments and Incentives)

- Bundle covers one year starting on day of pathologic diagnosis of cancer
- Prospective bundled payments include cost of oncology care and “unrelated services.”
 - Ambiguity on this issue
- HMH proposes to work with CMS using historical claims data on HMH patients to estimate the Medicare 12-month cost (either total or oncology only) for each CNA represented in the patient population.
- The costs of each CNA will be aggregated up to the bundle level using a weighted average approach. These would be used to compute a prospective 12-month price for each of the 27 bundles that cover all the CNAs in the 4 cancer types. HMH would be paid an amount that would be the sum of the bundled price X the number of patients in each bundle.
- Case mix-adjusted payments – if a different mix of patients (as identified through CNAs) presents in the performance year compared to the base year, then the payments (defined by the CNA) will adjust to reflect the different mix.

Payment Overview (cont.)

- HMH will receive the prospective payments and use them to compensate providers and pay for care coordination and other uncovered services.
- HMH will be at risk for costs of delivering care if costs exceed the prospective bundled payment.
- At the end of one year, the bundle payment will no longer apply to an enrolled patient. All medical services will revert to FFS reimbursement.
- Proposal requests a stop-loss arrangement and proposes a stop-loss threshold at twice bundle payment per patient. “If the expenses for a patient reaches the designated stop loss threshold, such patients will then exit the bundle and be considered outliers.”
- Once a patient is enrolled in a bundle, all claims billed to CMS from any HMH-related provider will be forwarded to HMH. HMH will then pay those claims, and pay physicians based on the standard FFS Medicare rate.
- Part of the compensation to physicians would be incentive-based – based upon services provided, achievement of clinical quality and patient satisfaction outcomes, and total cost of care.

PRT Assumptions

- Given unresolved question regarding the acceptability of a recommendation for a single site proposal, the PRT proceeded with review assuming a single site proposal would be acceptable.
- Our evaluation against criteria was for a single site pilot (as proposed) and not for a deployable national model.
- Given unresolved question regarding the acceptability of a payment model that relied on proprietary software, the PRT proceeded with their review assuming proprietary software would be acceptable.

Summary of the PRT Review

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

Criterion 1. Scope of Proposed PFPM (High Priority). The proposal aims to broaden or expand CMS' APM portfolio by either: (1) addressing an issue in payment policy in a new way, or (2) including APM Entities whose opportunities to participate in APMs have been limited.

PRT Conclusion: Proposal Meets the Criterion

- Cancer costs have highest growth rate for any clinical area for several years and predicted to be among the highest cost growth areas for the near future.
- Although proposal addresses a clinical area (and a group of specialist physicians) who already have an alternative payment option with CMS' Oncology Care Model (OCM), several aspects of this model are novel and potential improvements over the OCM.
- If the model requires the use of the proposed proprietary software, this could limit its uptake.
- As written, this model is not generalizable, although there are some very attractive aspects of this proposal that should be incorporated into an oncology payment model.
- Overall, assuming concerns could be overcome, the proposed model would be a valuable addition to CMS' portfolio, even though CMS' portfolio already includes the OCM.

Criterion 2. Quality and Cost (High Priority). The proposal is anticipated to (1) improve health care quality at no additional cost, (2) maintain health care quality while decreasing cost, or (3) both improve health care quality and decrease cost.

PRT Conclusion: Proposal Meets the Criterion

Strengths

- Treatment pathways and monitoring of variance are innovative, evidence-based, and likely to reduce unwarranted variation and improve care for patients with cancer.
- Precision of diagnosis and treatment (through the use of CNAs and treatment lanes) reduces chance of inappropriate assignment of patients to bundles:
 1. Patients less likely to be enrolled in a bundle without a documented, auditable need (based on pathology report and captured in the CNA).
 2. Patients unlikely to end up in the wrong bundle given the specificity of the assignment and reliance on prescribed criteria and auditable clinical data.

Both of these reduce potential for gaming this payment system.

Concerns

- how patient preferences impact lane assignment
- verification of the pathology and stage, possibly through a clinical audit process
- Assessing proposal's impact on cost is challenging, depends largely on the bundles pricing. Using costs from a single site to set prices limits pricing to the care patterns at that site. Nonetheless, the prospective nature of the payment method should result in more predictable costs for CMS and should reduce variation in costs for CMS.
- Cancer care changing rapidly: what assurances are there that software will be updated appropriately?

Criterion 3. Payment Methodology (High Priority). Pay APM Entities with a payment methodology designed to achieve the goals of the PFPM Criteria. Addresses in detail through this methodology how Medicare, and other payers if applicable, pay APM Entities, how the payment methodology differs from current payment methodologies, and why the PFPM cannot be tested under current payment methodologies.

PRT Conclusion: Proposal Meets the Criterion

Potential benefits: Four aspects of model particularly strong and improvements over the existing OCM: 1) Cancer stage included in the grouping; 2) One-year time frame; 3) Case mix adjustment; and 4) Prospective payment.

Concerns:

- Will low frequency of some CNAs affect accuracy of prospective prices?
- Will historical data accurately represent unit costs in the prospective model?
- How will the model handle “leakage” of both patients and doctors?
- How will savings be calculated and will they be valid estimates?
- If it’s an “oncology costs only” model (proposal ambiguous on this point), how will oncology costs be isolated?
- Pricing the non-cancer services - costs associated with co-morbid conditions may not reflect the costs in a general population; e.g., PRT analysis found the prevalence of cardiovascular conditions much higher for patients with 3 of the 4 included cancers than in the general population. Thus, proper pricing for non-cancer services would need to adjust for the prevalence of co-morbidities found in each of these cancer populations; and the small number of cancer patients of any particular provider could make provider-level variances very significant.
- The mechanism for initiating the bundle was not well specified in the proposal. The two possibilities, using a pathology claim or a separate communication, need to be examined and tested.
- The model proposes to exclude outliers. Consider winsorization (reducing outlier costs down to some predetermined threshold) a more appropriate approach for dealing with outliers.

Criterion 4. Value over Volume. The proposal is anticipated to provide incentives to practitioners to deliver high-quality health care.

PRT Conclusion: Proposal Meets the Criterion

Potential benefits:

- Through prospective bundled payments, model provides incentives to practitioners to deliver high quality care.
- Because enrollment is tied to a pathology report, the enrollment criteria make it unlikely that this model could be abused by incentivizing more bundles as can occur with discretionary procedures.
- Protection against skimping on care within bundles addressed by the model's adherence to high quality, evidence-based treatment protocols, with oversight to assure that clinicians are not "free-lancing."
(Although this commitment by HMH raises issues of the model's generalizability.)

Concerns:

- Some risk of patients not being enrolled (assigned to a CNA) appropriately, and this could be used to create advantageous selection if providers know in advance that a patient will be unusually expensive.
- Submitters rely on the precision of their software and the incentives to reduce costs, however, the proposal does not describe in any detail the mechanism by which costs will be reduced.

Overall: PRT found the risks well balanced.

Criterion 5. Flexibility. Provide the flexibility needed for practitioners to deliver high-quality health care

PRT Conclusion: Proposal Meets the Criterion and deserves priority consideration

Flexibility relevant to three different aspects of this proposal: 1) the use of specific software, 2) the use of this type of software (in general), and 3) the impact of the financial model on practitioner behavior.

Concerns:

- If Cota software is required for this model, then the proposed model provides minimal flexibility to practitioners (although this constraint likely to benefit patients by reducing unwarranted variation).
- Lack of transparency of the proprietary software also could overly constrain practitioner behavior and, importantly, affect patients' ability to express their preferences for treatment options.

However:

- The multiple lanes available within each CNA and the explicit linking to NCCN and ASCO guidelines suggest practitioners will have sufficient flexibility to provide optimal care to their patients.
- If any system of cancer care paths can be used with this payment model, and the decision support software ties each and every treatment or service to publicly available evidence, and each recommended action is best standard of care, then the PRT considers this proposal as providing practitioners with adequate flexibility.

Criterion 6. Ability to be Evaluated. Have evaluable goals for quality of care, cost, and any other goals of the PFPM.

PRT Conclusion: Proposal Meets the Criterion

- PRT presumes the evaluation will compare historical to actual costs, possibly using a difference in differences approach.
- Plan to measure patient experience and quality metrics appears appropriate.
- Concerns about the challenges created in the overlap between this proposed model and the Medicare Shared Savings Program.
- The single site, use of proprietary software, and relatively small numbers all limit the ability of this proposal to be evaluated. Or, if one considers the evaluation of a pilot to be more about proof-of-concept than generalizability, then this proposal could be evaluated against that more limited standard.

Criterion 7. Integration and Care Coordination

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

PRT Conclusion: Proposal Meets the Criterion

- PRT analysis confirms high rates of co-morbidities (especially cardiovascular conditions) in the target population, so care integration and coordination will be important.
- Payment model encourages care integration and care coordination in a general sense, but there is limited description of the specific nature of the care coordination efforts or of the incentives internal to the organization that would encourage these goals.
- To the extent that care integration is an inherent characteristic of a clinically integrated network, and all providers involved were using the same EHR (both components of the described pilot test of this model), the PRT did not have significant concerns.

Criterion 8. Patient Choice. Encourage greater attention to the health of the population served while also supporting the unique needs and preferences of individual patients.

PRT Conclusion: Does Not Meet the Criterion

- Concern that the proposal did not address how patient preferences are to be handled with regard to assignment (or re-assignment) to CNAs, nor is there any description of formal or even informal shared decision-making processes.
- None of the examples of why clinicians might select one or another treatment lane mentioned patient preferences as a reason.
- Given the importance of context-specific choices in cancer care, the PRT found this omission troubling, though the submitters made encouraging statements on this topic during the PRT's interview with them.

Criterion 9. Patient Safety. How well does the proposal aim to maintain or improve standards of patient safety?

PRT Conclusion: The Proposal Meets the Criterion

- The use of HIT to define and monitor the delivery of cancer care should enhance patient safety.
- PRT would like to see attention to the verification of the pathologic diagnosis given research indicating that a significant number of patients are over-diagnosed with cancer and then subsequently subjected to the risks of potentially toxic medications.

Criterion 10. Health Information Technology. Encourage use of health information technology to inform care.

PRT Conclusion: Proposal Meets the Criterion and Deserves Priority Consideration

- The use of HIT to incorporate clinical data into highly specified clinical categories that both define appropriate treatments and monitor variance is a laudable aspect of this proposal.
- proposal demonstrates how HIT can be used as a vehicle for improving the payment system by incorporating detailed clinical data into the assignment of patients to specific clinically coherent categories. This grouping supports a payment model that (in concept) appears aligned with clinical care and is less prone to either gaming or errors in performance measurement.

Key Issues Identified by the PRT

The PRT was impressed by the precision offered by the HMH-Cota model, particularly as compared to CMS' Oncology Care Model already in the field. However, several major issues needed to be addressed:

- 1. Single site proposal:** If a single site is acceptable, PTAC should consider whether and how a HMH-Cota pilot study could yield information that would determine if expansion of the model is appropriate.
- 2. The proprietary nature of the Cota software.** Dissemination of the model would require either licensing the Cota software or allowing the use of a substitute that accomplishes the same process steps as the Cota software. Because the payment bundles themselves depend on the specific classification system used in the software, if different software systems were used by different sites then the payment model would require sufficient flexibility to be adapted to different software systems. This seems unrealistic.
- 3. Total cost of care or oncology-costs-only model.** The proposer appears to be open to either approach, but PRT was undecided on which approach would be better and if the practical issues in making distinctions could be overcome.