



Physician-Focused Payment Model Technical Advisory Committee Meeting

**Hyatt Place Washington DC/National Mall
Washington, DC**

**Public Meeting
May 4, 2016**

Physician-Focused Payment Model Technical Advisory Committee (PTAC)

Jeffrey Bailet, MD, President, Aurora Health Care Medical Group; Chair, Aurora Physician Compensation Committee; Chair, PTAC

Elizabeth Mitchell, President and CEO, Network for Regional Healthcare Improvement; Vice Chair, PTAC

Robert Berenson, MD, Institute Fellow, Urban Institute

Paul Casale, MD, MPH, Chief of Cardiology, Lancaster General Health; Clinical Professor of Medicine, Temple University School of Medicine; Senior Scholar, Department of Health Policy, Sidney Kimmel Medical College, Thomas Jefferson University

Tim Ferris, MD, Medical Director, Mass General Physicians Organization; Senior Vice President for Population Health Management, Partners HealthCare; Associate Professor of Medicine and Pediatrics, Harvard Medical School

Rhonda M. Medows, MD, Executive Vice President of Population Health, Providence Health & Services

Harold D. Miller, President and CEO, Center for Healthcare Quality and Payment Reform

Len Nichols, PhD, Director, Center for Health Policy Research and Ethics; Professor of Health Policy, George Mason University

Kavita Patel, MD, Medical Director, Sibley Primary Care; Nonresident Senior Fellow, Brookings Institution (*absent*)

Bruce Steinwald, MBA, President, Bruce Steinwald Consulting

Grace Terrell, MD, President and CEO, Cornerstone Health Care

Speakers

Amy Bassano, MA, Director, Patient Care Models Group, Center for Medicare and Medicaid Innovation (CMMI), Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services (HHS)

Richard G. Frank, PhD, ASPE, HHS

Tim Gronniger, MPP, MHSA, Deputy Chief of Staff, CMS, HHS

Andy Slavitt, MBA, Acting Administrator, CMS, HHS

Scott R. Smith, PhD, Director, Health Care Quality and Outcome Division, Assistant Secretary for Planning and Evaluation (ASPE), HHS

Dr. Smith, the designated federal official (DFO) for PTAC, opened the meeting at 12:01 p.m.

Public Opening of Meeting and DFO Statement

Scott R. Smith, PhD, Director, Health Care Quality and Outcome Division, ASPE, HHS

Dr. Smith welcomed members of the public, including those on the telephone, to the second public meeting of PTAC. He then reviewed the agenda.

HHS Welcome

Richard G. Frank, PhD, ASPE, HHS

Dr. Frank explained that PTAC serves as the key conduit of proposals for new ways to pay for care to HHS and ultimately to CMS from the field. PTAC is one of several components involved in moving the country's payment system to incentives-based or value-based payments from fee-for-service payments. It is important for all of the moving parts to align with one another and transform the payment arrangements of CMS.

The Medicare Access and CHIP Reauthorization Act (MACRA) of 2015 describes the roles of PTAC and the public as advisors to PTAC. HHS and statute will provide criteria for PTAC's assessments of ideas about payments, and PTAC will operate within this framework. PTAC members must communicate with the field, provide technical assistance to help kernels of good ideas become strong proposals, and evaluate proposals to determine which models to recommend to the Secretary of HHS. HHS is also counting on PTAC members to serve as trusted advisors based on their stature in the field. At the same time, the committee's work must complement that of HHS, which will require constant communication and collaboration.

CMS Update

Andy Slavitt, MBA, Acting Administrator, CMS

Mr. Slavitt described some of the changes in the country's health-care system, including the Medicare program, that have been taking place in recent years. The opportunity exists now to accelerate these changes, partly through a focus on quality-based payments as part of the movement toward treatments in more comfortable and less resource-intensive settings. This transformation also involves enhanced attention to care coordination, prevention, and investments in technologies. In recent years, these investments have paid off through improved quality and reduced costs.

CMS recognizes that the Medicare program is too complex for those who practice medicine. Parts of the program are burdensome and affect physician motivation. The emphasis on quality is too often lost in all the noise.

MACRA has led to an unprecedented effort at CMS to listen and receive input from stakeholders, including patients and physicians. In May 2016 alone, CMS has scheduled 35 listening sessions for physicians. Based on what CMS is hearing, it has developed a set of principles: a patient-centered focus, better communications with physicians, and simplification.

Legislation alone cannot make health care more accessible, higher quality, or more affordable—this requires implementation. CMS has plenty to learn but is committed to learning and collaborating to advance the agency’s work.

CMS Quality Payment Program

Tim Gronniger, MPP, MHSA, Deputy Chief of Staff, CMS

The CMS Quality Payment Program is an umbrella term for the advanced alternative payment models (APMs) and Merit-Based Incentive Payment System (MIPS), which are the two branches of MACRA. The program repeals the Sustainable Growth Rate formula, streamlines multiple quality-reporting programs into MIPS, and provides incentive payments for participation in APMs.

PTAC was created by statute to evaluate physician-focused payment models (PFPMs) and recommend to the Secretary of HHS whether to test these models. CMS will not prescribe PTAC’s processes or recommendations, but it will develop criteria for PFPMs.

MIPS is a new program that replaces the Sustainable Growth Rate and provides annual updates to physician payments starting in 2019. Payments will be based on quality, resource use, clinical practice improvement, and meaningful use of electronic health records.

Advanced APMs must meet certain criteria defined by MACRA. Participation in advanced APMs can lead to 5% incentive payments and exclusion from MIPS reporting requirements. Based on the criteria, CMS anticipates that six current APMs will qualify to become advanced APMs in 2017.

The deadline for submitting comments on the MACRA Notice of Proposed Rulemaking is June 27, 2016 (see details, including instructions for submitting comments, at <http://go.cms.gov/QualityPaymentProgram>).

Discussion

Dr. Medows asked who will make the final decision about whether a model submitted for review to PTAC qualifies as an advanced APM. Mr. Gronniger replied that the Secretary of HHS will make this decision.

Mr. Miller commended Mr. Slavitt and Mr. Gronniger for coming to the meeting and expressing their commitment to work collaboratively with the Committee.

Courtney Yohe, Society of Thoracic Surgeons, called for advanced APMs that are open to specialty providers because the MIPS criteria will be particularly challenging for specialists. Mr. Slavitt agreed that more PFPMs are needed that are driven by medical specialties. He added that CMS can give credits to specialists participating in APMs that are not advanced APMs.

Chair and Vice Chair Statements

Jeffrey Bailet, MD, President, Aurora Health Care Medical Group; Chair, Aurora Physician Compensation Committee; Chair, PTAC

Elizabeth Mitchell, President and CEO, Network for Regional Healthcare Improvement; Vice Chair, PTAC

Dr. Bailet thanked the CMS representatives for joining the meeting and was delighted that so many interested stakeholders were attending the meeting in person and by telephone. Their participation demonstrates the great interest in payment models that reward value and quality care. PTAC is authorized under MACRA to provide comments and recommendations to the Secretary of HHS on PFPMs using criteria issued by Sylvia Mathews Burwell, Secretary of HHS. Secretary Burwell issued Notice of Proposed Rulemaking for MACRA on April 25, 2016, and will issue the final rule by November 1.

Since its first meeting in January 2016, PTAC has been hard at work preparing for the receipt of PFPMs for its consideration. The committee has developed bylaws and procedures to guide its work, and it aims to operate transparently. The committee is considering how to encourage stakeholders to submit PFPMs through outreach to providers and other stakeholders. PTAC is also building resources that will help stakeholders develop and submit PFPMs.

The proposed rule for MACRA and MIPS includes criteria for PFPMs, and PTAC encourages stakeholders to review and comment on the proposed criteria. The final rule will be the blueprint for the transition to value-based care delivery.

At this meeting, PTAC would present its draft proposal-review process, which was posted on the PTAC website for public comment on April 20, 2016. PTAC will accept comments on the draft process through May 13. PTAC would particularly like public feedback about the content of the proposals for PFPMs, the types of technical assistance that would be most useful to stakeholders, and the timeline for reviewing proposals.

Ms. Mitchell explained that PTAC was created to listen and learn from those in the field and facilitate submissions by physicians and other experienced stakeholders of proposals that will improve care for patients. She invited each PTAC member to explain what he or she would most like to hear from stakeholders and the challenges that PTAC might anticipate in advising the Secretary of HHS.

Dr. Terrell said that many physicians have a patient-centered perspective, but linking this approach to innovations and payments is challenging. All stakeholders, including specialists, need to understand how to link payment models to innovation. Mr. Steinwald hoped that PTAC's efforts will accomplish what the Sustainable Growth Rate was never able to do. Dr. Nichols is concerned about physician morale at a time when tremendous energy exists to improve the health-care system. The country needs more types of APMs, including models with a specialty focus. However, if a model does not lower costs and improve quality at the same time, it is unlikely to receive a favorable response from CMS.

Mr. Miller said that neither payers, nor physicians, nor patients are happy with the current health-care system. An opportunity is available to improve the system through collaborations among all stakeholders. Stakeholders need to develop strong proposals and submit them, and PTAC is eager to receive these proposals. He invited stakeholders to let PTAC know of models they are developing, even though the committee cannot evaluate proposals yet. Dr. Medows would like the committee to receive diverse types of proposals, including proposals that incorporate behavioral health, integrated care, and interoperability as well as those targeted to medical specialties. Dr. Ferris is part of a compensation plan that encourages physicians to communicate with their patients by email. All patients in the United States need more opportunities like this one. CMS, the HHS Secretary, and MACRA rules have put the country on a positive path to make these types of improvements.

Dr. Casale commented on the need for PTAC to help increase awareness of MACRA through education that reaches physicians where they work. MACRA extends beyond payment reform to redesigning care and enabling physicians to spend their time providing care and not on responding to regulatory requirements. Dr. Berenson said that collaboration between the public, PTAC, CMS, and ASPE will lead to strong APMs. Opportunities are also available to improve the functioning of the Medicare fee schedule. Even models that do not qualify as advanced APMs could lead to improvements.

Dr. Bailet said that PTAC does not view its role as saying no to proposals. A great deal of good innovation is happening, and PTAC wants to develop a process for stakeholders to submit proposals for PPFMs that allows the committee to critically evaluate them to ensure that they address the needs of a broad range of patients. If PTAC is unable to approve a model, it hopes to provide recommendations for enhancements or adaptations that could make the model successful in the future. PTAC does not want to be a gatekeeper or suppress information but, rather, to help stakeholders.

Proposed PTAC Criteria in the MACRA Notice of Proposed Rulemaking

Amy Bassano, MA, Director, Patient Care Models Group, CMMI, CMS, HHS
Tim Gronniger, MPP, MHSA, Deputy Chief of Staff, CMS, HHS

Ms. Bassano presented the definition of PPFMs in the MACRA notice of proposed rulemaking. She explained that any PPFM selected for testing by CMS that meets the criteria could be an advanced APM. PTAC will use the PPFM criteria to make comments and recommendations to the Secretary of HHS on PPFMs proposed by stakeholders.

The draft criteria are divided into three categories that are consistent with the administration's strategic goals for achieving better care, smarter spending, and healthier people: payment incentives, care delivery, and information availability. The criteria are broad so that they can fit many types of models. In addition to the proposed criteria, the Notice of Proposed Rulemaking includes supplemental information that is not required but is of interest to CMS. Ms. Bassano invited stakeholders to comment on the Notice of Proposed Rulemaking.

Discussion

Dr. Ferris asked how CMS will attribute cost savings to multiple models in the same geographical area. Ms. Bassano explained that CMMI is considering how to ensure that models in the same region work together and how to attribute savings to different models. CMS does not yet have an answer to this question but it is actively working on this issue. Ms. Mitchell pointed out that coexisting models might produce the best results when they are combined. Ms. Bassano said that CMS is considering ways to combine models or ensure that they work together in ways that minimize potential frictions.

Ms. Mitchell inquired about the timeframe for implementing approved PFPs. Ms. Bassano said that CMS is working to reduce the time required to implement models.

Dr. Medows asked about resources to help stakeholders develop PFPs. Mr. Gronniger explained that MACRA provides some direct technical assistance for MIPS implementation, and CMS is building new educational and technical resources for this purpose. Mr. Slavitt suggested that CMS communicate how to access these technical resources.

Dr. Nichols asked why the advanced APMs that Mr. Gronniger mentioned do not include bundled models. Ms. Bassano said that the existing bundled models do not meet the criteria for advanced APMs.

Kurt Mueller, Federal Office of Rural Health Policy at the Health Resources and Services Administration, emphasized the importance of involving rural physicians in health-care reform efforts. He asked whether CMS will require budget neutrality for the models it approves. Ms. Bassano said that although CMS is seeking cost-saving opportunities, it is not requiring budget neutrality, and it is seeking opportunities to engage rural providers in all models. Mr. Slavitt added that CMS is seeking feedback on the effects of MACRA and the regulations on small and rural practices.

Danine Grooms, American Speech-Language-Hearing Association, asked whether partially qualifying APM participants would receive credit under MIPS. Mr. Gronniger offered to look into this issue.

Sybil Green, American Society of Clinical Oncology (ASCO), requested clarification on the process for submitting proposals. Ms. Bassano replied that stakeholders will submit proposals to PTAC, and the Secretary will ultimately decide whether each model is worthy of being tested. After the model is tested, CMS will decide whether to establish it.

Sharon Cheng, Strategic Health Care, remarked that participating in advanced APMs will require a two-step process. Mr. Gronniger explained that MACRA and proposed rule offer new pathways for physicians into advanced APMs that meet the criteria in the statute. CMS will work with PTAC to help stakeholders understand how the process will work. Mr. Slavitt added that CMS and ASPE are trying to propose the simplest possible criteria while ensuring transparency in all of the steps once proposals are submitted. CMS and PTAC will work with stakeholders to make their models as successful as possible and to implement them as quickly as possible.

PTAC Draft Proposal-Review Process

Scott R. Smith, PhD, Director, Health Care Quality and Outcome Division, ASPE, HHS

PTAC used the information on its charge in MACRA as a starting point for its draft proposal-review process. The process has three phases:

1. Proposal submission and preparation
2. Preliminary review
3. Full committee review

Once Secretary Burwell finalizes the proposal criteria, PTAC will issue a request for proposals that will include instructions for preparation and submission along with a submission template. The committee will accept proposals on an ongoing basis. ASPE staff will check proposals for completeness, and complete proposals will undergo a preliminary review by a team of two or three PTAC members. PTAC will return proposals with technical deficiencies for revision and resubmission and can offer targeted technical assistance for revising proposals. Each PTAC member will review every complete proposal with no technical deficiencies and the findings of the preliminary review during a public meeting. Committee members will then comment on the proposals and issue recommendations.

Three caveats are that the final HHS criteria, which have not been issued, could alter the proposed review process; the committee cannot develop timeframes until it determines the volume of submissions; and the content of submissions might vary substantially.

Dr. Smith invited stakeholders to read the proposed criteria on the PTAC website (at <https://aspe.hhs.gov/sites/default/files/pdf/201241/PTACProposal.pdf>) and to send comments to PTAC@hhs.gov.

Discussion

Mara McDermott, CAPG, asked about the timeframe for the secretary's review of PTAC's recommendations. Dr. Smith said that no timeline for the Secretary's review has been specified.

Sandra Sherman Marks, American Medical Association, asked whether stakeholders will have access to technical assistance as they develop their proposals. Dr. Bailet explained that PTAC wants to provide technical assistance as models are developed or submitted, but it has not yet determined the process for this. Mr. Miller said that it would be helpful for stakeholders to identify the types of technical assistance they expect to need so that PTAC can focus its limited resources on the types of assistance that will be of greatest use to stakeholders.

A member of the public asked whether specialties can have medical homes. Dr. Bailet said that stakeholders may propose a specialty medical home. Such models currently exist under private payers.

Public Comment

Dr. Bailet asked members of the public to limit their remarks to 3 minutes. He invited those with more extensive comments to submit them to PTAC in writing.

Greg Jones, Aetna

Aetna has worked on a payment and clinical model for high-cost, high-need patients. Legislation has been introduced in the House of Representatives and the Senate to provide care to these patients at 98% of the cost of what it would otherwise be. Ms. Mitchell asked how the model would lend itself to multipayer or public/private arrangements. Mr. Jones replied that capitated payments would be provided by CMS to a Medicare Advantage plan or an affordable care organization, so the model would have only one payer.

Anne Hubbard, American Society for Radiation Oncology (ASTRO)

PTAC's proposal-review process seems straightforward, and the preliminary and final review components make sense. Ms. Hubbard suggested that PTAC invite public comment during the preliminary review stage and consider the following factors in its proposal-review process:

- Definition of services
- Targeted patient populations
- Flexibility of treatment options to preserve patient and physician choice
- Episode triggers and endpoints and what episodes include and exclude
- Ways to ensure quality of care
- Whether the model seeks to modify clinical practice with the goal of increasing adherence to best practices
- Application of care coordination and quality measures to ensure appropriateness of care
- Savings associated with the model's ability to change clinical practice

Technical assistance should help applicants understand how to identify and evaluate models through methods and applications. Technical assistance is also needed to help applicants model their own models and use Medicare data to understand how the models might be implemented and their impact on physicians. Ms. Hubbard described ASTRO's APMs for the palliative care of bone metastases and for the treatment of early-stage breast cancer.

Mr. Miller asked how PTAC should respond to proposals for multiple models from the same specialty. Ms. Hubbard replied that specialty societies must work together to advance APMs, and the models she described were developed with input from ASCO and palliative care societies. PTAC should facilitate discussions among different specialty societies.

Mara McDermott, CAPG

Some of the existing models have gaps, and more alternatives are needed for shared risk and capitated arrangements in traditional Medicare. Ms. McDermott asked whether PTAC has reviewed the models developed by CMMI and whether it will make recommendations to fill gaps in the existing framework. Dr. Bailet replied that PTAC is drafting a white paper on the existing models and it could identify gaps and share this information with stakeholders, which would help them develop robust and complete models.

Joanne Lynn Dorcas, Altarum Institute

MACRA appears to disadvantage physicians who care for frail elderly patients because they do well on quality improvement but very poorly on cost and quality measures. Risk adjustments do not take the characteristics of these patients into account, and quality measures do not make adjustments for survival time in these patients. Nursing homes, home care programs, and other settings that care for these patients do not have electronic health records. These sites will need technical assistance, including data, to develop APMs.

Ms. Mitchell asked whether any organizations are developing APMs for this population. Ms. Dorcas replied her group is developing models that depend on capitation, and developing APMs that address the needs of this population for longitudinal care, long-term services and supports, and community services is challenging. MACRA might provide an opportunity to build a care system that supports serious chronic illness.

Mr. Miller commented that it is difficult to ask a geriatrician to accept total risk in home support, palliative care, and the other services that their patients need. He suggested that those interested in APMs for physicians serving elderly populations consider payment models that are complementary with changes to hospice benefits. Instead of aiming to create a new palliative care program, for example, a stakeholder might create a palliative care program for physicians who will be accountable for their ability to manage palliative care.

James Scroggs, American Academy of Dermatology Association

As PTAC reviews models, it should consult a representative of the relevant medical specialty, and it should define the types of recommendations it might make for each proposal and clearly indicate how these different categories differ from one another. Other recommendations were for PTAC to clearly identify the weights it will assign to the criteria developed by the Secretary for PFPs and for HHS to develop an appeal process for proposed models with high scores from PTAC that the Secretary does not approve.

Sandra Sherman Marks, American Medical Association

Many specialty societies are developing APMs, and PTAC's plan to provide technical assistance and feedback will help stakeholders revise and resubmit their proposals. However, Ms. Marks suggested that the process be less formal and more interactive. Instead of issuing written questions to those who submit proposals and asking for written responses, PTAC should have conference calls with stakeholders to discuss their proposals. Another recommendation was to ask stakeholders to address the impact of their proposed model on quality and outcomes and not just cost. Physicians will need help addressing the financial risks of their proposed models. Ms. Marks encouraged PTAC to ask stakeholders to submit draft models now so that the committee can see what is possible and identify the challenges.

Tonya Saffer, National Kidney Foundation

Intervention at the earliest stages of kidney disease is vital to improve outcomes, lower health-care costs, and optimize patient experiences. As the disease progresses, the cost of care increases exponentially. The National Kidney Foundation is seizing this welcome opportunity to move health-care payment in the direction of paying for value, prevention, and better outcomes for

patients. The foundation will work cooperatively with patients with kidney disease and multidisciplinary health-care teams to develop a payment model that will promote earlier patient-centered kidney-disease care and produce substantial savings to the government. The foundation recommends that PTAC consider the role of patients and interdisciplinary health-care professionals in the development of the models and their roles in implementing the models. Another recommendation was for PTAC to consider how well proposed models will address current gaps in health-care delivery and the needs of individuals with chronic conditions.

Vinita Ollapally, American College of Surgeons

Ms. Ollapally was pleased to hear that PTAC views itself not as a gatekeeper but as an additional pathway to APMs or advanced APMs. She hoped that PTAC will develop a process to obtain the necessary expertise on the clinical and technical details of the proposals it reviews. For example, if a model includes colon resection, PTAC should solicit input from a colorectal surgeon. She also hoped that if a stakeholder submits a robust model, that stakeholder could have a conference call or in-person meeting with PTAC. Another recommendation was to give fair and timely consideration to all of the proposed models submitted for PTAC's review. Finally, the American College of Surgeons is developing an APM for surgery based on episodes of care.

Dr. Terrell asked about the criteria that PTAC should use to choose the right specialists to consult. Ms. Ollapally offered to respond to this question in her written comments. Mr. Miller asked how the college will determine which physicians and practices will implement the model that it proposes. Ms. Ollapally explained that the college's model will be applicable to both general and specialist surgeons, and it is developing the model with its members. Mr. Miller said that PTAC would like to understand whether a model is of interest only to a small group or to a broad range of members.

Sybil Green, ASCO

Ms. Green encouraged PTAC to recommend a variety of models, noting that probably only a few oncologists participate in APMs because there are not enough APMs for them to join. She agreed that the proposal-review process must be collaborative, iterative, and transparent. ASCO has experts who can assist with PTAC's reviews, and it has developed a PFPM in collaboration with ASTRO. Stakeholders might need data that will help them understand the effects of different models on practices.

Adjournment

Dr. Bailet thanked those who attended the meeting in person and by telephone for joining in the conversation. Dr. Smith adjourned the meeting at 2:51 p.m.

Summary of Recommendations

The recommendations offered by members of the public are summarized below:

- Create advanced APMs that specialty providers can join
- Involve rural physicians in health-care reform efforts
- Invite public comment during PTAC's preliminary proposal-review stage
- Include the following considerations in PTAC's proposal-review criteria:

- Definition of services
- Targeted patient populations
- Flexibility of treatment options to preserve patient and physician choice
- Episode triggers and endpoints and what episodes include and exclude
- Ways to ensure quality of care
- Whether the model seeks to modify clinical practice with the goal of increasing adherence to best practices
- Application of care coordination and quality measures to ensure appropriateness of care
- Savings associated with the model's ability to change clinical practice
- Impact of the proposed model on quality and outcomes
- Role of patients and interdisciplinary health-care professionals in the development of the models and in implementing the model
- Provide technical assistance to:
 - Help applicants understand how to identify and evaluate models through methods and applications
 - Help applicants model their own models and use Medicare data to understand how the models might be implemented and their impact on physicians
 - Support sites that provide care for frail elderly patients, including data, to develop APMs
 - Assist stakeholders in assessing the financial risks of their proposed models
- Review the CMMI models and make recommendations to fill gaps in the existing framework
- Consult relevant medical specialties during PTAC's proposal reviews
- Define the types of recommendations that PTAC will make on each proposal and clearly indicate how these differ from one another
- Clearly identify the weights that PTAC will assign to the criteria developed by the HHS Secretary
- Develop an appeals process for models with high scores from PTAC that the Secretary does not approve
- Meet in person or have conference calls with applicants instead of providing them with written comments and requiring written responses
- Ask for draft models now so that PTAC can see what is possible as well as the challenges
- Give fair and timely consideration to all of the proposed models submitted for PTAC's review