Physician-Focused Payment Model Technical Advisory Committee
Public Meeting Minutes

April 11, 2017
8:00 a.m. – 5:00 p.m. EDT
Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201

Attendance

Physician-Focused Payment Model Technical Advisory Committee (PTAC) Members In-Person:
Jeffrey W. Bailet, MD (PTAC Chair; Executive Vice President of Health Care Quality and Affordability, Blue Shield of California)
Robert Berenson, MD (Institute Fellow, Urban Institute)
Paul Casale, MD, MPH (Executive Director, New York Quality Care)
Harold D. Miller (President and CEO, Center for Healthcare Quality and Payment Reform)
Elizabeth Mitchell (PTAC Vice Chair; President and CEO, Network for Regional Healthcare Improvement)
Len M. Nichols, PhD (Director, Center for Health Policy Research and Ethics, George Mason University)
Kavita Patel, MD (Nonresident Senior Fellow, Brookings Institution)
Bruce Steinwald, MBA (Consultant, Bruce Steinwald Consulting)
Grace Terrell, MD, MMM (Founding Chief Executive Officer, Envision Genomics)

PTAC Member in Partial Attendance:
Tim Ferris, MD (Senior Vice President for Population Health Management, Partners HealthCare)

PTAC Member Not in Attendance:
Rhonda M. Medows, MD (Executive Vice President of Population Health, Providence Health & Services)

Presenter: Public Remarks to PTAC
Thomas E. Price, MD (U.S. Department of Health and Human Services [HHS] Secretary)

Presenter: The COPD and Asthma Monitoring Project (CAMP)
Daniel Ikeda, MD, FCCP (Physician, Pulmonary Medicine Associates)

Public Commenter on The COPD and Asthma Monitoring Project (CAMP):
James Gajewski, MD, MACP (American Society for Blood and Marrow Transplant; Professor of Medicine, Oregon Health Science University)

Presenters on The ACS-Brandeis Advanced APM:
Frank Opelka, MD, FACS (Executive Vice President of Health Care and Medical Education Redesign, Louisiana State University; Medical Director of Quality and Health Policy, American College of Surgeons)
Christopher Tompkins, PhD (Associate Professor and Director of the Institute on Healthcare Systems, The Heller School for Social Policy and Management, Brandeis University)

Public Commenters on The ACS [American College of Surgeons]-Brandeis Advanced APM:
W. Stephen Black-Schaffer, MD, FCAP (Associate Chief of Pathology, Massachusetts General Hospital;

College of American Pathologists)
Nick Bluhm (Director, Strategy & Government Policy, Remedy Partners, Inc.)
Dave Terry (CEO, Archway Health)
François de Brantes (Vice President and Director, Center for Payment Innovation, Altarum Institute)
James Gajewski, MD, MACP (American Society for Blood and Marrow Transplant; Professor of Medicine, Oregon Health Science University)
Joshua Lapps (Government Relations Manager, Society of Hospital Medicine)
Stephanie Stinchcomb, CPC, CCS-P (Director of Reimbursement and Regulation, American Urological Association)

NOTE: A transcript recording all statements made by PTAC members, the proposal presenters and public commenters at this meeting is available on the PTAC website located at: https://aspe.hhs.gov/meetings-physician-focused-payment-model-technical-advisory-committee . This website also includes copies of all presentation slides and a video recording of the meeting.

Public Remarks to PTAC

Welcome and Introduction to the Secretary

Jeffrey Bailet, PTAC Chair, called the meeting to order at 8:00 a.m. He then welcomed and introduced the Secretary of the U.S. Department of Health and Human Services (HHS), Dr. Thomas E. Price, to the meeting. The Chair emphasized that the Secretary remains an advocate for a patient-centered health care system that adheres to six key principles: 1) Affordability, 2) Accessibility, 3) Quality, 4) Choices, 5) Innovation, and 6) Responsiveness.

The Secretary's Remarks

The Secretary welcomed the public. He thanked the PTAC Chair, the PTAC Vice Chair, and the Committee for all of the work performed and completed to date. The Secretary also stated that he appreciated the opportunity to address and join the first PTAC meeting to deliberate and vote on physician-focused payment models (PFPMs). He then commended all of the submitters who had participated in the process.

The Secretary commented that he was in a unique position because he served in Congress from January 2005 through February 2017, which afforded him the opportunity to work on the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) legislation. He commented about the importance of having physicians involved either in defining or assisting in defining the payment models that would most appropriately facilitate patient care.

In identifying PFPMs, the Secretary commented on the importance of looking for more than just a single payment model, understanding that there may not be a "one-size-fits-all" solution, and that an opportunity must exist for physicians to have input into the models.

The Secretary stressed the importance of the six key principles, reiterated by the Chair, and urged the Committee to look "far and wide" across the models presented to ensure that innovation is taking place on the non-clinical side. In addition, as the transition is made to a model that attempts to identify and adhere to those principles of health care, it is necessary to ensure that a system works from both a financing and delivery standpoint. He also encouraged physicians and other providers to think about what payment model might work better for them and their patients, and to use the opportunity afforded by PTAC to put forth that payment model, especially models for rural and underserved areas.

In his concluding remarks, the Secretary stated that he is looking forward to the Committee's recommendations, their continued work, and ensuring that everything has been done to afford the Committee with an opportunity to recommend positive solutions to the current challenges faced in health care financing and delivery.

Opening Remarks from Committee Members

The Chair welcomed attendees to the PTAC meeting, noting that it was PTAC's first public meeting to include deliberations and voting on proposed PFPMs submitted by members of the public. The Chair highlighted PTAC's processes and procedures for receiving and reviewing PFPMs, adding that processes will continue to be shaped by stakeholder input and that the public is encouraged to provide their input as well. The Chair stated that all questions and comments for PTAC should be sent to the Office of the Assistant Secretary for Planning and Evaluation (ASPE) PTAC staff at the PTAC.gov mailbox (PTAC@hhs.gov).

The Chair informed the public that deliberation and voting would take place on two proposed PFPMs and informed the public that proceedings would occur in the following order:

1) The designated Preliminary Review Team (PRTs) will present their report to the full committee.
2) PTAC members will have an opportunity to ask PRT members questions concerning the reviewed proposal.
3) Submitters will be permitted to make a statement to PTAC, if desired.
4) The meeting will be opened up for public comments.
5) PTAC will deliberate and vote on the model.

The Chair and Vice Chair proceeded to emphasize that the PRT reports are not binding and do not represent the consensus or positions of PTAC. PTAC members emphasized that the Committee abides by the Federal Advisory Committee Act (FACA) rules and does not deliberate on any of the proposals, except in this public setting. Therefore, with the exception of the members of the PRT, there have been no discussions among the PTAC members about any of the proposals prior to this meeting. As such, PTAC may reach different conclusions and a different recommendation from the one contained in the PRT report. In addition, the report to the Secretary will be a new report encompassing PTAC's public deliberations and decisions.

The Committee proceeded with the deliberations and voting.

Pulmonary Medicine, Infectious Disease and Critical Care Consultants Medical Group, Inc. (PMA): The COPD and Asthma Monitoring Project (CAMP)

Committee Member Disclosures

Harold Miller, President and CEO, Center for Healthcare Quality and Payment Reform, stated that over the past year he has helped the American College of Allergy, Asthma, and Immunology on a payment model for asthma. However, he stated that he has no financial interest in that model, and sees no conflict between that work and the proposal submitted by PMA. He also stated that it is probably important for people to know that there is no limit on the number of proposals that PTAC can approve and that there is no competition among proposals.

All other PTAC members had no disclosures.

PRT Report to PTAC
Len Nichols (Lead Reviewer), Tim Ferris, and Grace Terrell served as the PRT for the CAMP proposal and proceeded to present their PRT report to PTAC.

Len Nichols briefly reviewed the PRT's role and provided a summary of the PRT's review and report to PTAC. He described the model as calling for CMS to: pay for peak flow meters, pay an inflation-adjusted per-beneficiary, per-month remote monitoring and management fee, waive copays for beneficiary access to services, and allow collaborating pharmaceutical and device companies to provide beneficiaries with discount pricing and coupons for drugs or equipment that may be prescribed to control their particular pulmonary conditions. The proposal aims to improve the health of patients and reduce avoidable ED visits and inpatient hospitalizations. Reductions in ED and inpatient utilization are expected to offset the costs of the interventions and thereby lower the total cost of care and patient mortality.

Len Nichols stated that the PRT concluded that the proposed model met eight out of 10 of the Secretary's criteria. The two criteria that the PRT concluded the CAMP proposal did not meet were "Payment Methodology" and "Integration and Care Coordination." He stated that the PRT was unanimous on all decisions, except for one; the PRT decided that the proposal met the Flexibility criterion by a majority (not unanimous) vote. The PRT agreed that the target population in this model would be high priority and of interest for CMS since numerous patients present with chronic obstructive pulmonary disease (COPD) and asthma. Although the PRT noted that they would like this model to be a successful payment methodology going forward, they also stated that there were elements of the proposed model that would require further development. PRT concerns about the model included: the lack of performance requirements to earn shared savings; failure to include certain costs (such as Part D drug costs); the proposed risk adjustment methodology; and insufficient detail about how clinical integration would be achieved. The PRT concluded that the PTAC should not recommend the model to the Secretary.

[The PRT presentation slides and full report is available at PTAC's website at: https://aspe.hhs.gov/proposal-submissions-physician-focused-payment-model-technical-advisory-committee.]

Clarifying Questions from PTAC
The Chair opened the floor for questions from PTAC members to the PRT, where the following issues were discussed:

- Accountability for patient care, and coordination and integration of care by multiple providers;
- Operations of the proposed model related to the payment mechanisms and the technology;
- The proposed payment methodology – separate from the care model – and lack of clarity in the payment approach;
- Flexibility of the model in terms of the use of care pathways or algorithms;
- The importance of ensuring robust quality and outcome measures;
- Limitations in the risk adjustment methodology;
- The extent to which the technology identified in the proposal would be necessary to participate in the model;

- The difficulty of integrating new information received from the submitter after the PRT had completed its review but before the start of this PTAC meeting; and
- How the submitter could have strengthened the proposal if technical assistance was available.

Submitter Statement
The Chair invited the submitter Daniel Ikeda, Physician, Pulmonary Medicine Associates, for his statement.

The submitter introduced himself and discussed how the proposed model emerged and elaborated on risk adjustment methodology, budget, and coordination of care. The submitter stated that during the development of the model the team grappled with the care model and reimbursement model concepts as well. Last, he discussed that although everyone wants a care model, the reimbursement structure associated with the care model helps to make it viable.

PTAC and Submitter Q&A and Discussion
PTAC proceeded with a number of questions and engaged in discussion with the submitter. The issues discussed included:

- How the variability in chronic disease severity would be accounted for in the model, and the potential for risk selection.
- The lack of evidence and testing with the model and the potential need for clinical research, particularly since there appears to be a lack of clinical studies encompassing both COPD and other chronic conditions.
- How patient and primary care provider engagement takes place, and the extent to which physicians interact with patients as opposed to other ancillary personnel.
- Due to the high-risk population targeted by the model, the appropriateness of a flat per beneficiary per month payment (PBPM) model and the potential for "cherry picking."
- The implications of developing a model for a population with COPD and asthma, as both conditions are historically underdiagnosed and misdiagnosed.
- Operationally, how care integration among other physicians and specialties may work, specifically regarding the distance that the patient(s) must travel to obtain health care services.
- Potential use of quality metrics.
- How the model would address co-morbidities.
- The model's readiness for implementation, including what the pilot of the model would look like and how the model would be scaled if the pilot implementation was successful.
- Barriers and solutions associated with the Health Information Technology (HIT) and how HIT and, specifically, medical records, could be an issue in attempting to scale the model.

Public Comments
The Chair thanked the submitter and opened up the floor for public comment.

James Gajewski, American Society for Blood and Marrow Transplant, Professor of Medicine, Oregon Health Science University provided comments to PTAC. He discussed acuity adjusters, problems with the accuracy of ICD coding, comorbidities and risk stratification, and the complexities of COPD and chronic diseases. In addition, he emphasized the likelihood of cherry picking among patients as previously voiced by PTAC. He also noted that because claims data are not as robust as they could be, if complex patients are treated correctly, it will be important to consider the way that patient complexity (including

emotional, social and environmental risk factors) is documented as well as how providers are paid for using this documentation.

The public comments concluded and the meeting was recessed at 10:16 a.m. for 10 minutes.

PTAC Criterion Voting

The Chair called on the committee to begin deliberation and voting on the extent to which the proposed model met each of the Secretary's criteria. Prior to voting on each criterion, PTAC members had the opportunity to comment on the extent to which the proposal meets each criterion. Individual member comments are located in the meeting transcript located at: https://aspe.hhs.gov/meetings-physician-focused-payment-model-technical-advisory-committee. PTAC member votes on criteria are anonymous; the distribution of PTAC member votes on the extent to which the model meets the Secretary's criteria and the full PTAC's decision are presented in the table below. The table shows the frequency of votes on the 1 to 6 voting scale. PTAC's "*Processes for Reviewing and Evaluating Proposed Physician-Focused Payment Models and Making Recommendations to the Secretary for the Department of Health and Human Services"* call for a simple majority vote for the criteria to determine the Committee's decision. Given that 10 PTAC members were present for the proposal deliberation and voting, six PTAC votes constituted a simple majority.

PTAC Member Votes on the Extent to Which the COPD and Asthma Monitoring Project (CAMP) Model Meets the Secretary's Criteria

Criteria Specified by the Secretary (42 CFR§414.146)	PTAC Vote Categories	PTAC Vote Distribution
1. Scope of Proposed PFPM (High Priority)	1 – Does not meet criterion	0 votes
	2 – Does not meet criterion	1 vote
	3 – Meets the criterion	0 votes
	4 – Meets the criterion	4 votes
	5 – Meets the criterion and deserves priority consideration	5 votes
	6 – Meets the criterion and deserves priority consideration	0 votes
DECISION OF PTAC: Proposal Meets Criterion 1.		
2. Quality and Cost (High Priority)	1 – Does not meet criterion	0 vote
	2 – Does not meet criterion	2 votes
	3 – Meets the criterion	5 votes
	4 – Meets the criterion	3 votes
	5 – Meets the criterion and deserves priority consideration	0 votes
	6 – Meets the criterion and deserves priority consideration	0 votes
DECISION OF PTAC: Proposal Meets Criterion 2.		
3. Payment Methodology (High Priority)	1 – Does not meet criterion	3 votes
	2 – Does not meet criterion	5 votes
	3 – Meets the criterion	2 votes
	4 – Meets the criterion	0 votes
	5 – Meets the criterion and deserves priority consideration	0 votes
	6 – Meets the criterion and deserves priority consideration	0 votes

Criteria Specified by the Secretary (42 CFR§414.146)	PTAC Vote Categories	PTAC Vote Distribution
DECISION OF PTAC: Proposal Does Not Meet Criterion 3.		
4. Value over Volume	1 – Does not meet criterion	0 votes
	2 – Does not meet criterion	0 votes
	3 – Meets the criterion	4 votes
	4 – Meets the criterion	6 votes
	5 – Meets the criterion and deserves priority consideration	0 votes
	6 – Meets the criterion and deserves priority consideration	0 votes
DECISION OF PTAC: Proposal Meets Criterion 4.		
5. Flexibility	1 – Does not meet criterion	0 votes
	2 – Does not meet criterion	1 votes
	3 – Meets the criterion	7 votes
	4 – Meets the criterion	2 votes
	5 – Meets the criterion and deserves priority consideration	0 votes
	6 – Meets the criterion and deserves priority consideration	0 votes
DECISION OF PTAC: Proposal Meets Criterion 5.		
6. Ability to be Evaluated	1 – Does not meet criterion	0 votes
	2 – Does not meet criterion	0 votes
	3 – Meets the criterion	4 votes
	4 – Meets the criterion	6 votes
	5 – Meets the criterion and deserves priority consideration	0 votes
	6 – Meets the criterion and deserves priority consideration	0 votes
DECISION OF PTAC: Proposal Meets Criterion 6.		
7. Integration and Care Coordination	1 – Does not meet criterion	4 votes
	2 – Does not meet criterion	4 votes
	3 – Meets the criterion	1 votes
	4 – Meets the criterion	0 votes
	5 – Meets the criterion and deserves priority consideration	1 votes
	6 – Meets the criterion and deserves priority consideration	0 votes
DECISION OF PTAC: Proposal Does Not Meet Criterion 7.		
8. Patient Choice	1 – Does not meet criterion	0 votes
	2 – Does not meet criterion	0 votes
	3 – Meets the criterion	4 votes
	4 – Meets the criterion	5 votes
	5 – Meets the criterion and deserves priority consideration	1 vote
	6 – Meets the criterion and deserves priority consideration	0 votes
DECISION OF PTAC: Proposal Meets Criterion 8.		

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

PTAC Recommendation Vote

After discussion of the vote categories available to PTAC members and the significance of them for this proposal, the Chair initiated voting on the PTAC's recommendation on this proposal to the Secretary. PTAC members' votes are presented in the Table, below. PTAC's "*Processes for Reviewing and Evaluating Proposed Physician-Focused Payment Models and Making Recommendations to the Secretary for the Department of Health and Human Services"* states that a 2/3 majority vote will determine PTAC's recommendation to the Secretary. Given that 10 PTAC members were present in the proposal deliberation and voting on CAMP, seven PTAC votes were required for the final PTAC recommendation vote.

PTAC Recommendation Category	PTAC Member Vote
Do not recommend proposed payment model to the Secretary	Jeffrey Bailet Robert Berenson Paul Casale Tim Ferris Harold D. Miller Elizabeth Mitchell Kavita Patel Len M. Nichols Grace Terrell Bruce Steinwald
Recommend proposed payment model to the Secretary for limited-scale testing of the proposed payment mode	*No PTAC members voted for this recommendation category*
Recommend proposed payment model to the Secretary for implementation	*No PTAC members voted for this recommendation category*
Recommend proposed payment model to the Secretary for implementation as a high priority	*No PTAC members voted for this recommendation category*

As a result of the vote, PTAC determined that it would not recommend this model to the Secretary. However, many PTAC members made comments in support of the need for the model and the creativity and innovation of the model. PTAC members stated that it would be an appropriate recipient of technical assistance to further its development, in particular in the development of better approaches to payment methodology including risk adjustment, information technology, and care integration.

The meeting recessed at 11:44 a.m. for lunch.

American College of Surgeons (ACS): The ACS-Brandeis Advanced APM

The meeting reconvened at 12:34 p.m. and the deliberations and voting on the ACS-Brandeis Advanced APM proposal began.

Committee Member Disclosures

Tim Ferris replied that he and Frank Opelka co-chaired the Consensus Standards Approval Committee for the National Quality Forum, and that he submitted a grant application to do a validation of the Episode Grouper for Medicare (EGM), the grouper system which is included in the ACS-Brandeis Advanced APM model, although that application was not funded. He has known Chris Tompkins for several years prior to these discussions and participated in meetings with CMS about this grouper on multiple occasions. Although not specifically involved in the development of the proposal, he stated that he would recuse himself from voting, but would contribute, with full disclosure, to the deliberations. The Committee accepted Tim Ferris' recusal.

Robert Berenson, Elizabeth Mitchell, Grace Terrell, and Harold Miller stated that they know Frank Opelka and have worked with him previously at different organizations and conferences and on different boards and committees. However, each respective Committee member determined that their previous and current relationships did not pose any conflicts with the development of the proposal.

Paul Casale, Jeffery Bailet, Bruce Steinwald, Kavita Patel, and Len Nichols indicated they had no conflicts.

PRT Report to PTAC

Grace Terrell (Lead Reviewer), Harold D. Miller, and Bruce Steinwald served as the PRT for the ACS-Brandeis Advanced APM proposal and proceeded to present their PRT report to PTAC.

Grace Terrell reviewed the role and process follow by the PRT and then summarized the ACS proposal. She described the ACS proposal as based upon episode-based payment models, where the episode groupers are defined by an updated version of an episode grouper previously developed for CMS by Brandeis University. The proposed model targeted more than 100 procedures and conditions that are designated as payment episodes. In this model, alternative payment model (APM) entities would enter into risk contracts with Medicare and be accountable for the costs and quality of episodes of care. Physicians would participate by contracting with an APM entity, but their payment would continue as usual in the Medicare Physician Fee schedule. The APM entity is at financial risk. Retrospective bonus payments or penalties are paid by CMS to the APM entity based on the difference between the observed and expected spending for the episode. The APM entity would engage in risk sharing with their affiliated providers.

As a result of its review, the PRT concluded that the ACS-Brandeis Advanced APM proposal met eight out of 10 of the Secretary's criteria. The two criteria that the proposal did not meet were "Quality and Cost"

and “Value over Volume.” Grace Terrell reviewed the PRT’s rationale for these unanimous conclusions. The PRT also concluded that the proposal should not be recommended to the Secretary by PTAC because it did not meet Secretarial criteria on quality and “Value over Volume.” The PRT also was concerned that the broad scope of the proposal and the limited detail on how it would affect individual conditions and procedures made it difficult to determine whether the ACS-Brandeis Advanced APM model would meet the criteria for PFPMs in all cases. The PRT concluded that PTAC should not Recommend Limited Scale Testing because the proposal did not identify a small number of specific clinical areas, episode types, and venues that would be appropriate for limited scale testing. However, members of the PRT indicated that the model could have considerable impact if these concerns were adequately addressed in a revised proposal.

In addition to the items in the PRT report, PRT members also commented on the submitter’s written response to the PRT report. The comments indicated that the model provides new incentives for the delivery team to evaluate each episode of care individually for variation in quality of cost and then drive innovation.

[The PRT presentation slides, full report, and transcript of this discussion are available at PTAC’s website at: https://aspe.hhs.gov/proposal-submissions-physician-focused-payment-model-technical-advisory-committee.]

Clarifying Questions from PTAC
The Chair opened the floor for questions from PTAC to the PRT. Issues discussed included:

- How the payment works (especially across the broad range of conditions and procedures targeted).
- The role and effectiveness of the grouper, and the need for detailed information on the clinical logic behind the grouper as no statistics are available to determine variance, size of variance, and the frequency in which individual cases occur.
- The model’s lack of clear quality metrics and lack of accountability for quality performance.
- The model’s lack of specificity in terms of the incentives at the individual practitioner level.
- The potential implications of the proposed model relative to quality metrics, care integration, and patient choice.
- Challenges seen in primary care physician (PCP) assignments in accountable care organizations (ACOs) and how this may inform the method in which clinicians are identified and assigned by algorithm (fiscal attribution).
- The proprietary nature of the EGM and the implications that may emerge related to funding and implementation.

Submitter Statement
The Chair invited Frank Opelka, Medical Director of Quality and Health Policy, American College of Surgeons and Christopher Tompkins, Associate Professor and Director of the Institute on Healthcare Systems, The Heller School for Social Policy and Management, Brandeis University, for their statement. Frank Opelka thanked PTAC and the PRT for the thoughtfulness and depth of the review. He addressed PRT concerns about quality and value over volume. Christopher Tompkins reviewed the history of some Medicare payment reform initiatives leading up to MACRA and then reviewed: the need for CMS to develop specifications for implementing the model including the entities participating in the model, who

is expected to participate in the model, information protocols to track expenditures in the model, and tracks within the model (i.e. procedural episode tracks, surgical tracks, specialist tracks, etc.).

PTAC and Submitter Q&A and Discussion
PTAC proceeded with a number of questions and engaged in discussion with the submitter on the issues listed below.

- The operations, development, application, and performance of the episode grouper, including:
    - Episode triggers and identification rules;
    - How the grouper distinguishes between warranted and unwarranted clinical services and payment;
    - How the grouper would handle complex Medicare patients with multiple conditions;
    - How the data analyses resulting from the grouper can provide insights into variations in care;
    - Validation of the grouper;
    - The proprietary nature of and maintenance of the grouper ;
    - Costs associated with the grouper software and updates.

- Elements of the model's design, including:
    - What triggers an episode;
    - The minimum starting set of procedural episodes;
    - Risk adjustment including the stratification feature and a risk factor table;
    - The potential for unanticipated, unintended consequences of the model given its complexity;
    - The allocation of risk and dollars within bundles and the fiscal attribution algorithms;
    - Incentives to promote physician engagement and resources that may be needed for model participation;
    - Measures of appropriateness related to procedure incidence, evidence-based guidelines, and quality metrics and safeguards;
    - The construction of operational risk and physician risk elements; and
    - The components of the model (e.g., feedback loops, measurement, and a learning environment) that have to come together for the model to be successful in improving care and saving costs.
- What the submitter believes would be the minimum or "starter set" of episodes needed for limited scale testing of the model.

Public Comments
The Chair thanked the submitter and opened the floor for public comment. The following parties made comments:

1. François de Brantes, Vice President and Director, Center for Payment Innovation, Altarum Institute;
2. Stephen Black-Schaffer, Associate Chief of Pathology, Massachusetts General Hospital, College of American Pathologists;
3. Nick Bluhm, Director, Strategy & Government Policy, Remedy Partners, Inc.;

4. Stephanie Stinchcomb, Director of Reimbursement and Regulation, American Urological Association; and
5. Joshua Lapps, Government Relations Manager, the Society of Hospital Medicine.

The Committee took a ten-minute recess. After the recess, the Committee heard from two additional commenters:

6. Dave Terry, CEO of Archway Health; and
7. James Gajewski, American Society for Blood and Marrow Transplant; Professor of Medicine, Oregon Health Science University.

A transcript of all seven commenters' remarks and commenters' responses to questions from PTAC are available on the PTAC website located at: **https://aspe.hhs.gov/meetings-physician-focused-payment-model-technical-advisory-committee** .

PTAC Deliberation

PTAC discussed the possibility of postponing the vote on the ACS-Brandeis Advanced APM in order to receive a demonstration of how the grouper works and additional information related to the model. The Committee discussed whether having more time would be feasible and helpful in continuing their deliberation of this model. Ultimately, the Committee agreed to move forward with voting.

PTAC Criterion Voting

The Chair explained the voting process to the public, and then the committee voted on the extent to which the model meets each of the Secretary's' criteria. The result of the PTAC votes on the extent to which the model meets each of the Secretary's criteria is presented below. The summary indicates the frequency of votes on the 1 to 6 voting scale. PTAC's "*Processes for Reviewing and Evaluating Proposed Physician-Focused Payment Models and Making Recommendations to the Secretary for the Department of Health and Human Services"* state that a simple majority vote determines the PTAC's vote on the extent to which the model meets each of the Secretary's criteria. Since nine Committee members voted, five votes constituted the majority. The PTAC criterion votes are anonymous.

PTAC Member Votes on the Extent to Which the ACS-Brandeis Advanced APM Model Meets the Secretary's Criteria

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

Criteria Specified by the Secretary (42 CFR§414.146)	PTAC Vote Categories	PTAC Vote Distribution
DECISION OF PTAC: Proposal Meets Criterion 5.		
6. Ability to be Evaluated	1 – Does not meet criterion	0 votes
	2 – Does not meet criterion	2 votes
	3 – Meets the criterion	6 votes
	4 – Meets the criterion	1 vote
	5 – Meets the criterion and deserves priority consideration	0 votes
	6 – Meets the criterion and deserves priority consideration	0 votes
DECISION OF PTAC: Proposal Meets Criterion 6.		
7. Integration and Care Coordination	1 – Does not meet criterion	0 votes
	2 – Does not meet criterion	1 vote
	3 – Meets the criterion	5 votes
	4 – Meets the criterion	1 vote
	5 – Meets the criterion and deserves priority consideration	1 vote
	6 – Meets the criterion and deserves priority consideration	1 vote
DECISION OF PTAC: Proposal Meets Criterion 7.		
8. Patient Choice	1 – Does not meet criterion	0 votes
	2 – Does not meet criterion	2 votes
	3 – Meets the criterion	5 votes
	4 – Meets the criterion	2 votes
	5 – Meets the criterion and deserves priority consideration	0 votes
	6 – Meets the criterion and deserves priority consideration	0 votes
DECISION OF PTAC: Proposal Meets Criterion 8.		
9. Patient Safety	1 – Does not meet criterion	0 votes
	2 – Does not meet criterion	1 vote
	3 – Meets the criterion	8 votes
	4 – Meets the criterion	0 votes
	5 – Meets the criterion and deserves priority consideration	0 votes
	6 – Meets the criterion and deserves priority consideration	0 votes
DECISION OF PTAC: Proposal Meets Criterion 9.		
10. Health Information Technology	1 – Does not meet criterion	0 votes
	2 – Does not meet criterion	0 votes
	3 – Meets the criterion	6 votes
	4 – Meets the criterion	2 votes
	5 – Meets the criterion and deserves priority consideration	0 votes
	6 – Meets the criterion and deserves priority consideration	1 vote
DECISION OF PTAC: Proposal Meets Criterion 10.		

PTAC Vote on Recommendation to the Secretary

The Chair then announced that the PTAC would move to vote on its overall recommendation to the Secretary. Committee members discussed the recommendation categories of "recommend" and "recommend for limited scale testing" and how to interpret them with respect to the ACS proposal. Members also discussed the need to be clear on what the PTAC's comments (in addition to the PTAC's recommendation) on this proposed model would be to the Secretary, as the comments would influence some members' votes on the recommendation. PTAC members discussed the following areas as subject matter for their comments to the Secretary: 1) implementing the model only when patient reported outcome measures (PROs) are developed and used with accountability for performance on them as opposed to only used in a "reporting-only" mode, 2) the need for greater accountability in the model; i.e., connecting payment to performance on quality metrics; and 3) that the model should move forward when a majority of the members of a clinical affinity group have agreed to participate in the model.

PTAC members then voted on a recommendation to the Secretary. PTAC's "*Processes for Reviewing and Evaluating Proposed Physician-Focused Payment Models and Making Recommendations to the Secretary for the Department of Health and Human Services"* state that the PTAC's recommendation to the Secretary will be determined by a 2/3 majority vote of voting PTAC members. Further, if two-thirds of the votes cast are for one or more of the three categories of recommending the model to the Secretary, the Committee shall determine which of the three recommendations shall be made to the Secretary by aggregating votes cast for the following categories in the following order. First: Implementation of the proposed payment model as a high priority. Second: Implementation of the proposed payment model. Third: Limited-scale testing of the proposed payment model. As soon as the aggregation of votes cast in the order above reaches a two-thirds majority of votes cast, the recommendation level at which the two-thirds majority is reached shall be the Committee's recommendation. Given that 9 PTAC members were voting on the ACS-Brandeis Advanced APM, a total of 6 PTAC votes was required for a 2/3 majority. The members' votes are presented below.

PTAC Recommendation Category	PTAC Member Recommendation Vote
Do not recommend proposed payment model to the Secretary	*No PTAC members voted for this recommendation category*
Recommend proposed payment model to the Secretary for limited-scale testing of the proposed payment model	Jeffrey Bailet Robert Berenson Paul Casale Len M. Nichols Kavita Patel
Recommend proposed payment model to the Secretary for implementation	Harold D. Miller Elizabeth Mitchell Bruce Steinwald Grace Terrell
Recommend proposed payment model to the Secretary for implementation as a high priority	*No PTAC members voted for this recommendation category*

Following the PTAC's processes, the PTAC's recommendation to the Secretary is: "Recommend proposed payment model to the Secretary for limited-scale testing of the proposed payment model."

Additional PTAC Comments on Report to the Secretary

Following the vote, The Chair asked the PTAC to identify any comments that it wanted to be made to the Secretary to accompany the PTAC's recommendations. PTAC members identified the following comments:

1. The testing should be for a limited number of both procedure and condition episodes.
2. Comments should call attention to the need for development of quality measures (in particular patient- reported outcomes (PROs)).
3. The episode grouper should be in the public domain; and a mechanism should be in place for continuous update of the grouper.

After this, the meeting adjourned at 5:50 p.m.

Approved and certified by:

__/Ann Page/_____ _____8/14/2017_____

Ann Page, Designated Federal Officer
Physician-Focused Payment Model Technical
Advisory Committee

Date

__/Jeffrey Bailet/_____ _____7/19/2017_____

Jeffrey Bailet, Chair
Physician-Focused Payment Model Technical
Advisory Committee

Date