Physician-Focused Payment Model Technical Advisory Committee

February 28, 2018

Alex M. Azar II, Secretary
U.S. Department of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20201

Dear Secretary Azar:

On behalf of the Physician-Focused Payment Model Technical Advisory Committee (PTAC), I am pleased to submit PTAC's comments and recommendation to you on a Physician-Focused Payment Model (PFPM), *Multi-provider, bundled episode-of-care payment model for treatment of chronic hepatitis C virus (HCV) using care coordination by employed physicians in hospital outpatient clinics*, submitted by the New York City Department of Health and Mental Hygiene (NYC DOHMH). These comments and recommendation are required by the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) which directs PTAC to (1) review PFPM models submitted to PTAC by individuals and stakeholder entities, (2) prepare comments and recommendations regarding whether such models meet criteria established by the Secretary of Health and Human Services (HHS), and (3) submit these comments and recommendations to the Secretary.

With the assistance of HHS' Office of the Assistant Secretary for Planning and Evaluation (ASPE), PTAC's members carefully reviewed NYC DOHMH's proposed model (submitted to PTAC on May 18, 2017), additional information on the model provided by the submitter in response to questions from a PTAC Preliminary Review Team and PTAC as a whole, and public comments on the proposal. At a public meeting of PTAC held on December 18, 2017, the Committee deliberated on the extent to which this proposal meets the criteria established by the Secretary in regulations at 42 CFR § 414.1465 and whether it should be recommended.

Chronic hepatitis C virus (HCV) is a significant public health problem; many Medicare beneficiaries with HCV have substantial comorbidities, including

behavioral and mental health conditions, and are associated with high medical costs. PTAC believes that improvements in care for this patient population are needed, especially since curative treatment is now available. The proposal is based on a Health Care Innovation Award (HCIA) Round Two demonstration project, *Project INSPIRE*, in which the submitter is involved, and PTAC is impressed with the work that the applicant has been doing to improve care. However, members have concerns regarding the proposed payment methodology, particularly the mechanism for determining bonuses and penalties. Bonuses and penalties in the proposed model would be based on an estimate of annual medical costs from continued HCV infection avoided and number of life years gained with sustained virological response. The Committee finds that rewarding facilities for practicing high standards of care based on cost savings that are not attributable, in large part, to these high standards of care, but rather to pharmacotherapy, is problematic. The Committee also believes that the three elements of the proposal (i.e., care coordination, treatment initiation and adherence, and tele-mentoring) and the way in which the proposed payment methodology would support them need to be more clearly articulated. Therefore, PTAC does not recommend implementation of the proposed payment model to the Secretary.

PTAC has received several proposals from HCIA awardees. In some cases, final evaluation reports are not yet complete, so evidence of the services' efficacy may be lacking. However, PTAC believes that some of these models have improved care and is concerned that the services currently being supported by these models seem likely to disappear without a payment mechanism to sustain them. Members would like to have benefited from the results of the CMMI evaluation of the effectiveness of the services and of the feasibility of any payment models developed to sustain them under the HCIA grant prior to deliberation on the proposal. We urge greater information sharing on model efficacy to improve our process and inform our recommendations.

In addition, the proposal is one of several that PTAC has received from organizations seeking a way to support "care management" or "care coordination" services that have substantial similarities to the services described in the CPT codes for chronic care management on the Medicare Physician Fee Schedule. Care management is a key part of many effective APMs, but the applicants have indicated that the current CPT codes are inadequate to support the services they are trying to implement, either because of the requirements that must be met for billing the CPT codes, the inadequacy of the payment amounts for those codes, or other factors. It might be possible to accommodate needed changes within the Physician Fee Schedule.

The members of PTAC appreciate your support of our shared goal of improving the Medicare program for both beneficiaries and the physicians who care for them. The Committee looks

forward to your detailed response posted on the CMS website, and would be happy to assist you or your staff as you develop your response. If you need additional information, please have your staff contact me at Jeff.Bailet@blueshieldca.com.

Sincerely,

Jeffrey Bailet, MD
Chair

Attachments

Physician-Focused Payment Model Technical Advisory Committee

REPORT TO THE SECRETARY OF HEALTH AND HUMAN SERVICES

Comments and Recommendation on

Multi-provider, bundled episode-of-care payment model for treatment of chronic hepatitis C virus (HCV) using care coordination by employed physicians in hospital outpatient clinics

February 28, 2018

About This Report

The Physician-Focused Payment Model Technical Advisory Committee (PTAC) was established by the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) to (1) review physician-focused payment models (PFPMs) submitted by individuals and stakeholder entities, (2) prepare comments and recommendations regarding whether such models meet criteria established by the Secretary of Health and Human Services (HHS), and (3) submit these comments and recommendations to the Secretary. PTAC reviews submitted proposals using criteria established by the Secretary in regulations at 42 CFR § 414.1465.

This report contains PTAC's comments and recommendation on a PFPM proposal, *Multi-provider, bundled episode-of-care payment model for treatment of chronic hepatitis C virus (HCV) using care coordination by employed physicians in hospital outpatient clinics*, submitted by the New York City Department of Health and Mental Hygiene (NYC DOHMH). This report also includes (1) a summary of PTAC's review of the proposal (2) a summary of the proposed model, (3) PTAC's comments on the proposed model and its recommendation to the Secretary, and (4) PTAC's evaluation of the proposed PFPM against each of the Secretary's criteria for PFPMs. The appendices to this report include a record of the voting by PTAC on this proposal, the proposal submitted by NYC DOHMH, and additional information on the proposal submitted by NYC DOHMH subsequent to the initial proposal submission.

SUMMARY STATEMENT

HCV is a significant public health problem; many Medicare beneficiaries with HCV have substantial comorbidities, including behavioral and mental health conditions, and are associated with high medical costs. PTAC believes that improvements in care for this patient population are needed, especially since curative treatment is now available. However, members have concerns regarding the proposed payment methodology, particularly the mechanism for determining bonuses and repayments. The Committee also believes that the three elements of the proposal (i.e., care coordination, treatment initiation and adherence, and tele-mentoring) and the way in which the proposed payment methodology would support them need to be more clearly articulated. Therefore, PTAC does not recommend implementation of the proposed payment model to the Secretary.

PTAC REVIEW OF THE PROPOSAL

The NYC DOHMH's proposal was submitted to PTAC on May 18, 2017. The proposal was first reviewed by a PTAC Preliminary Review Team (PRT) comprised of three PTAC members who are physicians. These members requested additional data and information to assist in their review. The proposal was also posted for public comment. The PRT's findings were documented in the *Preliminary Review Team Report to the Physician-Focused Payment Model Technical Advisory Committee (PTAC)* dated November 15, 2017. At a public meeting held on December 18, 2017, PTAC deliberated on the extent to which the proposal meets the criteria established by the Secretary in regulations at 42 CFR § 414.1465 and whether it should be recommended to the Secretary for implementation.[1] The submitter and members of the public were given an opportunity to make statements to the Committee at the public meeting. Below are a summary of the proposal, PTAC's comments and recommendation to the Secretary on the proposal, and the results of PTAC's evaluation of the proposal using the Secretary's criteria for PFPMs.

PROPOSAL SUMMARY

The proposal is based on a Health Care Innovation Award (HCIA) Round Two demonstration project, *Project INSPIRE*, in which the submitter is involved. Unfortunately, the results of the evaluation of *Project INSPIRE* are not yet available. The proposal focuses on integrated care coordination of patients, particularly higher-need patients (i.e., dual-eligible patients, patients with behavioral health and substance abuse disorders, etc.) with HCV to ready them to initiate and adhere to pharmacotherapy. Ultimately, the proposed model aims to support successful

[1] PTAC member Kavita Patel, MD, MSHS, was not in attendance.

completion of drug treatment for HCV, which not only would be lifesaving for many patients but would also likely reduce avoidable health care utilization (e.g., emergency department visits) and costs associated with this patient population.

Under the proposed model, patients would undergo a comprehensive psychosocial evaluation to identify barriers to care and a medical evaluation to determine the complexity of liver disease. The care team would then assist patients in overcoming barriers through various means such as the following: referrals for psychosocial issues or other comorbid conditions; direct counseling services (except those separately billed for by the provider), including health promotion, alcohol counseling and treatment readiness assessment and counseling, or medication adherence measurement and counseling; helping patients navigate appointments; and assistance with prior authorization.

Expected model participants are employed physicians who treat HCV in hospital outpatient clinics. The model requires that all such physicians at a given facility participate. Primary care physicians would take on a greater role in managing patients with HCV, particularly those without advanced liver disease or other medical complexities. The proposal indicates that primary care physicians will be trained by hepatologists or other gastroenterologists through tele-mentoring. (While not clearly described in the proposal, the submitter indicated in its remarks to the full PTAC that tele-mentoring is a key component of the model.) Specialists, nurse practitioners, and physician assistants across the specialties of infectious disease, hepatology and other gastroenterology, and mental health would be included in the model's implementation to varying degrees based on patient need. Non-clinician staff, especially care coordinators, would also play a key role.

Under the proposed payment model, the APM Entity would receive a bundled episode payment for each patient enrolled in an episode. The episode is composed of three phases: (1) pretreatment assessment involving care coordination, (2) the treatment period, (3) the report of SVR12. The episode is not expected to exceed 10 months. Based on their demonstration project experience, the submitter suggests a $760 episode payment amount. (In its remarks to the full Committee, the submitter suggests a reduced payment of $670 for non-dual beneficiaries, who may require fewer services.) The submitter notes that CMS may want to geographically adjust this payment.

The APM Entity would be eligible for bonus payments and at risk of paying penalties based on its sustained virological response (SVR) rate, the proportion of enrolled patients who complete a full course of antiviral treatment and have undetectable HCV ribonucleic acid (RNA) 12 weeks after treatment cessation. The APM Entity's SVR rate would be adjusted for patient clinical and

demographic characteristics known or suspected to be associated with achieving SVR. The APM Entity's risk-adjusted rate would then be compared to a benchmark set by CMS (e.g., the average SVR for all participating facilities). An APM Entity with a risk-adjusted SVR rate at or above the benchmark would receive a bonus payment for each patient that achieved SVR. An APM Entity with a rate below the benchmark would be required to pay back a penalty for each patient who did not achieve SVR. These bonus payments (or penalties) for each patient who achieved (or did not achieve) SVR would be calculated by applying a CMS-determined shared savings rate or rates to the product of the following formula:

$$\begin{matrix} Expected\ annual\ cost\ (from \\ continued\ HCV\ infection)\ avoided \end{matrix} \times \ Life\ years\ gained\ with\ SVR$$

In the case of penalties, only the episode payment amount would be at risk. The estimates of expected annual costs avoided and life years gained would be based on the presence of cirrhosis and age; only medical costs for HCV-related disease would be included. The proposal indicates that this payment model design is intended to award the greatest bonuses to providers curing patients in a fibrotic or cirrhotic state, especially patients in younger age categories.

APM Entities can choose one of two options *a priori* to address instances in which the facility receives an episode payment for an enrolled patient, but the patient does not begin treatment: (1) the APM Entity returns a portion of the episode payment (approximately $400), and this patient is not included in the SVR rate calculation; or (2) the APM Entity keeps the full episode payment, but this patient is included in the SVR rate calculation.

RECOMMENDATION AND COMMENTS TO THE SECRETARY

PTAC is supportive of a model that would address the need for improved care for patients with HCV. However, the Committee has concerns regarding the proposed payment methodology. The Committee also believes that the three elements of the proposal (i.e., care coordination, treatment initiation and adherence, and tele-mentoring) and the way in which the proposed payment methodology would support them need to be more clearly articulated. Therefore, PTAC does not recommend the proposal to the Secretary.

HCV is a high-impact condition, affecting nearly a quarter of a million beneficiaries in 2016. Many of these beneficiaries have substantial comorbidities, and this patient population has high medical costs. HCV is also unique in that a cure is now available and has the potential to substantially improve the lives of beneficiaries with HCV. Therefore, PTAC is supportive of a model that would address this patient population and where the key outcome can be readily

measured. Further, PTAC recognizes the submitter's commitment to the delivery model and experience gained through participation in HCIA Round Two.

Based on the submitter's remarks to the full Committee, the model has three major components: (1) HCV treatment initiation and adherence, (2) care coordination, particularly for comorbid conditions, and (3) tele-mentoring of primary care physicians. PTAC recognizes that these activities may be appropriate to address this patient population. However, the significant role of tele-mentoring and how each of the components would fit together and be supported by the payment model is not clear in the proposal as written. For example, it is unclear whether tele-mentoring would involve mostly initial costs related to developing primary care competencies for caring for HCV patients or would require ongoing costs also related to tele-consultations for difficult clinical issues. Furthermore, since beneficiaries with HCV frequently have significant comorbidities, many would likely benefit from care coordination before and after their HCV-related treatment. Yet the proposal only addressed the need for care coordination for the period of hepatitis drug treatment and mostly targeted to achieving successful treatment.

PTAC also had concerns regarding the payment methodology. Uncertainty remains about whether some aspects of the model could be addressed under existing payments (e.g., chronic care management codes); however PTAC acknowledges that unlike fee-for-service payments, the proposed model creates accountability for a meaningful, reliable outcome measure. Bonuses and penalties in the proposed model would be based on an estimate of annual medical costs from continued HCV infection avoided and number of life years gained with SVR. The shared savings rate or rates have not yet been determined, but the Committee finds that rewarding facilities for practicing high standards of care based on cost savings that are not attributable, in large part, to these high standards of care, but rather to pharmacotherapy, is problematic. The approach is untested and unprecedented in Medicare; such a precedent would likely lead other parties, including drug manufacturers and other providers, to advance similar claims to a share of these savings. Furthermore, given the relative newness of curative treatment for HCV and the potential for further innovation, PTAC is concerned that the initial modeling may prove to be inaccurate.

Additionally, PTAC notes that the bundled payments lack adequate risk adjustment and that patient attribution is unclear. The submitter initially proposed a $760 episode payment amount. However, in its remarks to the full Committee, the submitter suggested a reduced payment of $670 for non-dual beneficiaries, who may require fewer services. However, the submitter did not indicate which patients with HCV are appropriate candidates for the model, would be offered the opportunity to enroll, and for which participants would receive payment and be

held accountable. It is also unclear who would decide. Lack of adequate risk adjustment in combination with the lack of clarity around patient attribution could lead to avoidance of patients who are more complex and require more services and would undermine accurate evaluation. The Committee also notes the payment methodology does not account for the high cost of pharmacotherapy, a key issue in payment policy regarding HCV.

While PTAC is not recommending the proposed model to the Secretary, PTAC believes that HCV is an important public health problem and that modifications to the Medicare Physician Fee Schedule, an alternative payment model, or both may be needed to support efforts to improve HCV care. There are many people in the country who have not received screening or do not have coverage for treatment or the types of services proposed in this model. PTAC also believes that exploring financial support for tele-mentoring is important, particularly where there are insufficient numbers of specialists to care for the patient population.

PTAC has received several proposals from HCIA awardees. In some cases, final evaluation reports are not yet complete, so evidence of the services' efficacy may be lacking. However, PTAC is concerned that the services currently being supported by these models seem likely to disappear without a payment mechanism to sustain them. Members would like to have benefited from the results of the CMMI evaluation of the effectiveness of the services and of the feasibility of any payment models developed to sustain them under the HCIA grant prior to deliberation on the proposal.

In addition, the proposal is one of several that PTAC has received from organizations seeking a way to support "care management" or "care coordination" services that have substantial similarities to the services described in the CPT codes for chronic care management on the Medicare Physician Fee Schedule. The applicants have indicated that the current CPT codes are inadequate to support the services they are trying to implement, either because of the requirements that must be met for billing the CPT codes, the inadequacy of the payment amounts for those codes, or other factors. It might be possible to accommodate needed changes within the Physician Fee Schedule.

EVALUATION OF PROPOSAL USING SECRETARY'S CRITERIA

PTAC Rating of Proposal by Secretarial Criteria

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

Criterion 1. Scope (High Priority Criterion)

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.

Rating: Meets Criterion

PTAC concludes that the proposed model meets this criterion. HCV is a high-impact condition, affecting nearly a quarter of a million beneficiaries in 2016. Many of these beneficiaries have substantial comorbidities, and this patient population has high medical costs. HCV is also unique from many other conditions in that a cure is now available. The Committee finds that a model that addresses HCV could create broad opportunities for physicians who treat HCV and have a major positive impact on the lives of this patient population.

There are issues in payment policy regarding HCV, particularly due to the high cost of pharmacotherapy. This model attempts to get at some of these issues. For example, care coordinators assist patients in accessing pharmaceutical company-sponsored patient assistance programs and avoiding breakdowns in the Medicaid and Medicare Part D prior authorization processes. The submitter notes that there is an insufficient number of gastroenterologists to address the number of patients with HCV. The model supports tele-mentoring of primary care

[1]Criteria designated as "high priority" are those PTAC believes are of greatest importance in the overall review of the payment model proposal.

physicians to enable them to take on a greater role in managing patients with HCV, thereby creating greater capacity in the health care system to treat patients with HCV.

Nevertheless, PTAC notes that the risk-sharing formula does not account for treatment costs, including considerable pharmacotherapy costs. Furthermore, uncertainty remains regarding whether some aspect of the model could be addressed through existing payment methods. In addition, the proposed model is designed for employed physicians in hospital outpatient clinics and seems rather specific to the large integrated health systems in New York City, so it may not be broadly generalizable.

Criterion 2. Quality and Cost (High Priority Criterion)

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

Rating: Meets Criterion

PTAC concludes that the proposed model meets this criterion. Under the proposed model, the SVR rate is used to measure a meaningful, reliable outcome measure reflecting quality. Coordinating care for patients with HCV and helping them overcome issues that may interfere with their readiness to initiate and adhere to pharmacotherapy seem likely to increase the proportion of patients who achieve SVR, improving the lives of these patients and reducing costs associated with complications. Disease transmission and subsequent costs would also be reduced. Because Medicare beneficiaries with HCV frequently have substantial comorbidities and are associated with high medical costs, focusing on this patient cohort also seems likely to reduce certain costs, such as those associated with avoidable emergency department visits for comorbid conditions having little or nothing to do with their HCV. The submitter provided initial internal findings from their HCIA project to support these conclusions (final evaluation results are not yet available). However, some aspects of the payment methodology create uncertainty about the model's overall impact on costs.

Criterion 3. Payment Methodology (High Priority Criterion)

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.

Rating: Does Not Meet Criterion

PTAC concludes that the proposed model does not meet this criterion. The proposal ties

payment to a meaningful outcome measure — the proportion of patients who complete treatment and achieve SVR. However, PTAC has a number of concerns. Uncertainty remains regarding whether some aspects of the model could be addressed through existing payments (e.g., chronic care management codes); however PTAC acknowledges that unlike fee-for-service payments, the proposed model creates accountability for a meaningful outcome. Bonuses and penalties in the proposed model would be based on an estimate of annual medical costs from continued HCV infection avoided and number of life years gained with SVR. The shared savings rate or rates have not yet been determined, but the Committee finds that rewarding facilities for practicing high standards of care with potentially very large bonuses based on cost savings that are not attributable, in large part, to these high standards of care is problematic. The approach is untested and unprecedented in Medicare; such a precedent could likely lead other parties, including drug manufacturers and other providers, to advance similar claims to a share of these savings. Furthermore, given the relative newness of curative treatment for HCV and the potential for further innovation, PTAC is concerned that the initial modeling may prove to be inaccurate. Members discussed that a more straight-forward bonus and penalty approach that does not include inherently imprecise estimate of savings might have served the purpose sought by the proposers.

Additionally, PTAC notes that the bundled payments lack adequate risk adjustment. The submitter initially proposed a $760 episode payment amount. However, in its remarks to the full Committee, the submitter suggested a reduced payment of $670 for non-dual beneficiaries, who may require fewer services. However, the submitter did not indicate which patients with HCV are appropriate candidates for the model, would be offered the opportunity to enroll, and for which participants would receive payment and be held accountable. It is also unclear who would decide. Lack of adequate risk adjustment in combination with the lack of clarity around patient attribution could lead to avoidance of patients who are more complex and require more services and would undermine accurate evaluation. The Committee also notes that the payment methodology does not account for the high cost of pharmacotherapy, a key issue in payment policy regarding HCV.

Criterion 4. Value over Volume

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

Rating: Meets Criterion

PTAC concludes that the proposed model meets this criterion. The proposal focuses on increasing the number of patients who are treated and cured, which would reduce utilization and costs associated with continued HCV infection. Curing patients with HCV also limits exposure and risk of downstream infections. Tying payment to a meaningful and reliable

outcome measure — the proportion of patients who complete treatment and achieve SVR — provides a powerful incentive to improve outcomes. In addition, Medicare beneficiaries with HCV frequently have substantial comorbidities and have high medical costs. Therefore, it seems likely that utilization and costs associated with avoidable emergency department visits for comorbid conditions could be reduced for this population. Finally, empowering primary care physicians to manage HCV also means fewer patient hand-offs/separately billable encounters.

Nevertheless, there is a lack of clarity around patient attribution and a lack of adequate risk adjustment, which could lead to the avoidance of patients who are more complex and high cost.

Criterion 5. Flexibility

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

Rating: Meets Criterion

PTAC concludes that the proposed model meets this criterion. Under the proposed model, the care team appears to have broad flexibility in meeting the unique needs of each patient. The model places emphasis on the outcome measure rather than inputs and processes. Furthermore the delivery model supports tele-mentoring of primary care physicians to enable them to take on a greater role in managing patients with HCV, thereby creating greater capacity in the health care system to treat patients with HCV and allowing gastroenterologists to focus on the most complex HCV patients or patients with other conditions.

Criterion 6. Ability to be Evaluated

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

Rating: Does Not Meet Criterion

PTAC concludes that the proposed model does not meet this criterion. The proposal incorporates a meaningful outcome measure. However, a lack of clarity around patient attribution and a lack of adequate risk adjustment could lead to patient selection imbalances and create other selection effects that would undermine accurate evaluation of the new incentive system. Furthermore, bonuses would be based on expected annual medical costs from continued HCV infection avoided and number of life years gained with SVR. In addition to PTAC's other concerns with this approach, given the relative newness of curative treatment for HCV and the potential for further innovation, the initial modeling may prove to be inaccurate.

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.

Rating: Meets Criterion

PTAC concludes that the proposed model meets this criterion. A key piece of the proposal is coordinating care for patients with HCV (particularly higher-need patients) and helping them overcome issues that may interfere with their readiness to initiate and adhere to pharmacotherapy. Care coordinators would assist patients in navigating the health care system. Furthermore, specialists would meet regularly with primary care physicians to provide tele-mentoring, support, and to accept referrals. Empowering primary care physicians to manage patients with HCV means fewer patient hand-offs. Primary care physicians are also more likely to have a more comprehensive picture of the patient's overall health. The submitter also notes that an advantage of implementing the model in hospital-based clinics is the ability for care coordinators to make referrals to other diagnostic and treatment services within the same facility. However, PTAC would like to have seen more detail on how and the extent to which information sharing would occur with outside providers relevant to the patient's care.

However, since beneficiaries with HCV frequently have psychosocial issues or other comorbid conditions, PTAC notes that many beneficiaries would likely benefit from care coordination before and after their HCV-related treatment. The proposal does not address the need for continuity of care coordination but rather only proposes care coordination related to treatment for HCV. Some members believe that to be a serious problem. However, the Committee overall finds that this criterion was met, relying on the submitter's positive early internal findings, and that intense coordination during certain periods (e.g., during HCV treatment) was 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.

Rating: Meets Criterion

PTAC concludes that the proposed model meets this criterion. Patients seem to have a choice of whether or not to enroll in the model. The proposed model would provide greater attention to the health of a patient population with high medical costs. The proposal considers patients' unique needs and preferences. For example, patients would receive referrals for conditions, such as substance abuse, that might interfere with their readiness to initiate and adhere to pharmacotherapy for HCV.

Criterion 9. Patient Safety

Aim to maintain or improve standards of patient safety.

Rating: Meets Criterion

PTAC concludes that the proposed model meets this criterion. Helping patients complete treatment and achieve SVR would reduce risks of complications from continued HCV infection. Furthermore, the model targets a patient population with high rates of mental and behavioral health issues. Coordinating care for these patients and helping them overcome issues that might interfere with their readiness to initiate and adhere to pharmacotherapy for HCV would improve patient safety. However, the proposal does not clearly define an attribution methodology. Therefore, it is somewhat unclear whether the model might incentivize exclusion of patients who might benefit from the intervention or include patients who are or could become poor candidates for treatment.

Criterion 10. Health Information Technology

Encourage use of health information technology to inform care.

Rating: Meets Criterion

PTAC concludes that the proposed model meets this criterion. Participants include employed physicians in hospital outpatient clinics. Therefore, the participants are likely to have EHR systems that are integrated across the facility. Furthermore, the submitter described how tele-mentoring is a key component of the model that could be done using inexpensive teleconferencing, webinar, and screen-sharing technology. However, PTAC would like to have seen more detail on how and the extent to which information sharing would occur with outside providers relevant to the patient's care.

APPENDIX 1. COMMITTEE MEMBERS AND TERMS

Jeffrey Bailet, MD, *Chair*

Elizabeth Mitchell, *Vice-Chair*

Term Expires October 2018

Jeffrey Bailet, MD
Blue Shield of California
San Francisco, CA

Elizabeth Mitchell
Network for Regional Healthcare Improvement
Portland, ME

Robert Berenson, MD
Urban Institute
Washington, DC

Kavita Patel, MD, MSHS
Brookings Institution
Washington, DC

Term Expires October 2019

Paul N. Casale, MD, MPH
NewYork Quality Care
NewYork-Presbyterian, Columbia University College of Physicians and Surgeons, Weill Cornell Medicine
New York, NY

Bruce Steinwald, MBA
Independent Consultant
Washington, DC

Tim Ferris, MD, MPH
Massachusetts General Physicians Organization
Boston, MA

Term Expires October 2020

Rhonda M. Medows, MD
Providence Health & Services
Seattle, WA

Len M. Nichols, PhD
Center for Health Policy Research and Ethics
George Mason University
Fairfax, VA

Harold D. Miller
Center for Healthcare Quality and Payment Reform
Pittsburgh, PA

Grace Terrell, MD, MMM
Envision Genomics
Huntsville, AL

APPENDIX 2. PFPM CRITERIA ESTABLISHED BY THE SECRETARY

PFPM CRITERIA ESTABLISHED BY THE SECRETARY
1. Scope. 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.
2. Quality and Cost. Are anticipated to improve health care quality at no additional cost, maintain health care quality while decreasing cost, or both improve health care quality and decrease cost.
3. Payment Methodology. 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.
4. Value over Volume. Provide incentives to practitioners to deliver high-quality health care.
5. Flexibility. Provide the flexibility needed for practitioners to deliver high-quality health care.
6. Ability to be Evaluated. Have evaluable goals for quality of care, cost, and any other goals of the PFPM.
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.
8. Patient Choice. Encourage greater attention to the health of the population served while also supporting the unique needs and preferences of individual patients.
9. Patient Safety. Aim to maintain or improve standards of patient safety.
10. Health Information Technology. Encourage use of health information technology to inform care.

APPENDIX 3. DISTRIBUTION OF MEMBER VOTES ON EXTENT TO WHICH PROPOSAL MEETS CRITERIA AND OVERALL RECOMMENDATION[1]

Criteria Specified by the Secretary (at 42 CFR §414.1465)	Not Applicable	Does Not Meet Criterion		Meets Criterion		Priority Consideration		Rating
	*	1	2	3	4	5	6	
1. Scope (High Priority)[2]	-	1	3	6	-	-	-	Meets Criterion
2. Quality and Cost (High Priority)	-	-	1	7	2	-	-	Meets Criterion
3. Payment Methodology (High Priority)	-	4	5	1	-	-	-	Does Not Meet Criterion
4. Value over Volume	-	-	-	6	3	1	-	Meets Criterion
5. Flexibility	-	-	1	3	6	-	-	Meets Criterion
6. Ability to be Evaluated	-	1	5	3	1	-	-	Does Not Meet Criterion
7. Integration and Care Coordination	-	1	1	7	-	-	1	Meets Criterion
8. Patient Choice	-	-	-	6	4	-	-	Meets Criterion
9. Patient Safety	-	-	1	6	3	-	-	Meets Criterion
10. Health Information Technology	-	-	-	9	1	-	-	Meets Criterion

Not Applicable	Do Not Recommend	Recommend for Limited-scale Testing	Recommend for Implementation	Recommend for Implementation as a High Priority	Recommendation
-	9	1	-	-	Do Not Recommend

[1]PTAC member Kavita Patel, MD, MSHS, was not in attendance.
[2]Criteria designated as "high priority" are those PTAC believes are of greatest importance in the overall review of the payment model proposal.