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), *Advanced Primary Care: A Foundational Alternative Payment Model (APC-APM) for Delivering Patient-Centered, Longitudinal, and Coordinated Care*, submitted by the American Academy of Family Physicians (AAFP). 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 AAFP's proposed model (submitted to PTAC on April 14, 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 19, 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.

PTAC believes there is an urgent need to preserve and strengthen primary care and recommends the *APC-APM* proposal to the Secretary for limited-scale testing, while emphasizing that limited-scale testing of the proposed

model is a high priority. The Committee finds that the *APC-APM* proposal, which builds on prior primary care initiatives, has promise and contains many desirable elements, such as creating broader opportunities for primary care participation and providing flexible monthly payments for evaluation and management and care management services. However, some aspects of the proposal, such as the multiple per beneficiary per month payment options, risk adjustment, patient attribution, and performance metrics, require further specificity or refinement, which PTAC believes can and should be resolved through limited-scale testing. The Committee believes that limited-scale testing of this model should be of sufficient size to facilitate rapid implementation on a broad scale.

The members of PTAC appreciate your support of our shared goal to improve 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 answer questions about this proposal 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

Advanced Primary Care: A Foundational Alternative Payment Model (APC-APM) for Delivering Patient-Centered, Longitudinal, and Coordinated Care

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, *Advanced Primary Care: A Foundational Alternative Payment Model (APC-APM) for Delivering Patient-Centered, Longitudinal, and Coordinated Care*, submitted by the American Academy of Family Physicians (AAFP). This report also includes (1) a summary of PTAC's review of this 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 AAFP, and additional information on the proposal submitted by AAFP subsequent to the initial proposal submission.

SUMMARY STATEMENT

PTAC believes there is an urgent need to preserve and strengthen primary care and recommends the *APC-APM* proposal to the Secretary for limited-scale testing, while emphasizing that limited-scale testing of the proposed model is a high priority. The Committee finds that the *APC-APM* proposal, which builds on prior primary care initiatives, has promise and contains many desirable elements, such as creating broader opportunities for primary care participation and providing flexible monthly payments for evaluation and management (E/M) and care management services. However, some aspects of the proposal, such as the multiple per beneficiary per month (PBPM) payment options, risk adjustment, patient attribution, and performance metrics, require further specificity or refinement, and PTAC believes these issues can and should be resolved through limited-scale testing. The Committee believes that limited-scale testing of this model should be of sufficient size to facilitate rapid implementation on a broad scale.

PTAC REVIEW OF THE PROPOSAL

The *APC-APM* proposal was submitted to PTAC on April 14, 2017. The proposal was first reviewed by a PTAC Preliminary Review Team (PRT) composed of three PTAC members, including two 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 19, 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. 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 *APC-APM* proposal*,* PTAC's comments and recommendation to the Secretary on this proposal, and the results of PTAC's evaluation of the proposal using the Secretary's criteria for PFPMs.

PROPOSAL SUMMARY

Physicians with a primary specialty designation of family medicine, general practice, geriatric medicine, pediatric medicine, or internal medicine would be eligible to participate in the *APC-APM*. The submitter indicates that the primary care practice would likely serve as the APM Entity.

Under the proposed model, primary care practices would receive payments in four parts: (1) a risk-adjusted payment PBPM for E/M services delivered by the primary care practice, (2) a risk-adjusted PBPM payment for care management services delivered by the practice, (3) prospectively-awarded incentive payments that may have to be repaid based on the practice's performance, and (4) continued payment under the Medicare Physician Fee Schedule for services other than E/M services and for E/M services that are not included in the monthly payments.

The APM Entity could select from two options regarding the PBPM payment for E/M services, one that includes only office-based E/M services and one that includes all E/M services regardless of site of service (e.g., including hospital-based E/M services). The incentive payments would be paid quarterly and reconciled against actual performance annually. The APM Entity would select six performance measures, including at least one outcome measure, from the Accountable Care Organizations, Patient-Centered Medical Homes, and Primary Care Measure Set developed by the Core Quality Measure Collaborative. Failure to meet agreed-upon benchmarks for performance would result in the APM Entity having to repay all or part of the incentive payments. The APM Entity would also be held accountable for two cost measures: (1) hospitalization utilization per 1,000 attributed beneficiaries, and (2) emergency department (ED) utilization per 1,000 attributed beneficiaries. The submitter proposes that the amounts a payer pays for the PBPM and incentive payments should be designed to ensure the total payments to primary care are equal to 12% of a payer's total health care spending on its members.

The primary method for determining which patients the practice would be accountable for would be the patients who had explicitly chosen to use the practice. However, if a patient used services from a practice but did not designate the practice as its primary care provider, the patient could still be assigned to the practice using a claims-based attribution methodology.

Those applying to become APM Entities would need to attest that they address or have a plan to address five key areas: (1) access and continuity, (2) planned care and population health, (3) care management, (4) patient and caregiver engagement, and (5) comprehensiveness and coordination. APM Entities would also be expected to adopt the Joint Principles of the Patient-Centered Medical Home. The proposed model also requires that at least 50% of the APM's participants will use Certified Electronic Health Record Technology (CEHRT), consistent with the requirements for an Advanced APM.

By making an APM available to more primary care practices, by increasing the total amount of payment for primary care, and by changing the incentives for primary care practices, the

submitter believes implementation of the proposal will improve clinical quality, improve patient outcomes, and reduce overall health care spending. Specifically, the submitter believes the increased percentage of total spending allocated to primary care would be more than offset by decreases in specialty and hospital services.

RECOMMENDATION AND COMMENTS TO THE SECRETARY

PTAC finds that the *APC-APM* proposal has promise and contains many desirable elements. While some aspects of the proposal need further specificity or refinement, the Committee concludes that these issues can and should be resolved through limited-scale testing. PTAC unanimously agreed that there is an urgent need to preserve and strengthen primary care and views limited-scale testing of the proposed model as a high priority.

PTAC believes the model has the potential to allow broader participation by primary care providers in an APM than what currently exists. The model would be more flexible than the Comprehensive Primary Care Plus (CPC+) model, providing enhanced resources and specifying fewer care delivery requirements, and it would enable primary care practices to deliver high-value patient services. The proposed model also would not require multi-payer involvement, which has limited the ability of primary care practices to participate in CPC+.

The Committee notes that while there have been challenges with primary care practice capitation payment systems in the past, the proposed model includes elements designed to address those, such as performance measurement and risk adjustment. While PTAC is supportive of the proposal overall, the Committee believes there are aspects of the proposed model that should be strengthened prior to wider implementation. PTAC believes most of these aspects would be best refined as part of limited-scale testing, since different approaches may be needed for different practice settings and different regions of the country.

The Committee is concerned that several elements of the proposal may be overly complex and burdensome, specifically the multi-step attribution methodology, use of two PBPMs, and inclusion of two levels of payments for E/M services. While the submitter sought to reduce provider burden by eliminating claims for E/M services and aligning the performance metrics with the Merit-based Incentive Payment System (MIPS), PTAC believes that encounter data and more robust performance metrics are necessary to ensure adequate accountability under the proposed monthly payments. These are necessary because of the incentives such payments create to stint on care or unnecessarily refer patients to specialists for issues that could be adequately addressed by the primary care practice. Furthermore, while PTAC supports spending more on primary care, the proposed model does not have any mechanism for

assuring that proportionate savings will take place.

Additionally, some important aspects of the model have not been specified, such as the actual payment amounts, how patients would share in costs, and how integration and coordination with specialists would be assured. While an initial risk-adjustment system based on the Hierarchical Condition Categories (HCC) system is defined, the submitter acknowledges its weaknesses and is interested in testing risk-adjustment approaches that include factors in addition to diagnosis codes, such as social determinants of health. Some PTAC members suggested using risk stratification systems to mitigate incentives for improper coding.

PTAC believes that while testing should be done on a limited scale, the scale should be of sufficient size to evaluate specific elements of the model (e.g., the attribution and risk adjustment systems) and to determine whether the model should be implemented more broadly. PTAC believes that it would be desirable to test different approaches to key elements of the model (e.g., different attribution methods including a model based solely on patient designation of the PCP, different risk adjustment/stratification methods, etc.). Testing should also examine the extent to which small and rural practices or other practices with small numbers of Medicare beneficiaries could feasibly participate and how the model works in different practice environments and communities (e.g., through testing region-specific models). Some members encourage the submitter to take the lead in proposing specific approaches to risk adjustment, proposing more robust measures for quality and cost, and ensuring coordination with specialists.

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 and Deserves Priority Consideration
2. Quality and Cost (High Priority)	Meets Criterion
3. Payment Methodology (High Priority)	Meets Criterion
4. Value over Volume	Meets Criterion
5. Flexibility	Meets Criterion
6. Ability to be Evaluated	Meets Criterion

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

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 and Deserves Priority Consideration

PTAC concludes that the proposed model meets this criterion and deserves priority consideration. Better payment models are needed to preserve and strengthen primary care, and the proposed model has the potential to address some of the major issues with both the current payment system and other primary care models. While CMS has launched models that focus on primary care, most primary care providers in the country have not had the opportunity to participate in any of these models. CPC+ is a multi-payer model limited to specific regions. Primary care practices that are not located in the regions where CMS has identified payer partners for CPC+ do not have an opportunity to participate in CPC+, and so the proposed *APC-APM* model would enable more primary care practices to participate in an APM. The submitter acknowledges and PTAC agrees that multi-payer involvement would be ideal, but PTAC believes that practices should be permitted to participate in an APM for Medicare beneficiaries even if no other payers are participating.

Although the Medicare Shared Savings Program also provides opportunities for primary care practices to participate in an alternative payment model as part of an Accountable Care Organization (ACO), there is no change in the underlying payment system for primary care practices in these ACOs, and any additional resources are dependent on the award of shared savings. In contrast, the proposed payment model would replace the majority of current fee-for-service payments to primary care practices with a flexible monthly payment and provide increased resources for care management services.

PTAC acknowledges that aspects of the model that are borrowed from CPC+, such as performance-based incentive payments, are currently being tested. PTAC also notes that the Next Generation ACO model includes an option for an all-inclusive population-based payment (AIPBP) that would completely replace payments to ACO participants for E/M services and other services. However, PTAC does not believe that the way the proposal's novel features would affect primary care practices is being tested under these other payment methodologies.

While any primary care practice could theoretically participate in the proposed model, it is not entirely clear whether small and rural practices or other practices with small numbers of Medicare beneficiaries could feasibly participate. The model's complexity, which may add unnecessary burden, and the lack of measure reliability when applied to small numbers of patients, could make it more difficult for smaller providers to implement.

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. Overall, increasing the resources directed at primary care and coupling greater flexibility in payment and care delivery with greater accountability could reasonably be anticipated to improve quality while reducing costs. However, PTAC believes that more robust performance measures for quality and spending are needed.

While PTAC supports spending more on primary care, the model does not guarantee that proportionate savings will take place. The submitter proposes that the overall model be evaluated using total cost of care but that primary care practices should not be held accountable for controlling total cost of care; PTAC agrees so long as more robust measures (e.g., those that might serve as proxies for total cost of care) are included.

The model requires fewer and different quality measures than are being used in the CPC+ model. Although the proposal seeks to align with MIPS reporting requirements, PTAC believes that this is insufficient for a model that would completely replace visit-based payments with monthly payments, since this type of payment creates incentives to stint on care and to inappropriately refer patients to specialists for conditions that could be adequately addressed by the primary care practice. Under the proposed model, a participating primary care practice could select quality measures that focus primarily or exclusively on one discrete health condition, such as diabetes. While this could ensure that the patients who qualify for the measures receive good care, it would not provide any assurance that other types of patients are receiving good care. Similarly, because rates of ED visits and hospitalizations are measured at the aggregate level, hospitalizations could increase for some groups of patients while decreasing for others. While the submitter noted that risk adjustment, fee-for-service payments for services other than E/M services, and the attribution methodology would counter incentives

to deny or delay care or inappropriately refer patients, PTAC believes that measures of patient experience and rates of referral to specialist are needed to ensure that patients are receiving adequate services from the primary care practice.

Another concern is that while the model is intended to be open to small and rural providers, the proposal does not address what would be done if a practice did not meet the minimum thresholds needed to have stable estimates of measure performance.

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: Meets Criterion

PTAC concludes that the proposed model meets this criterion. The Committee agrees that the payment methodology is designed to achieve the goals of the PFPM criteria. The submitter was also clear in articulating how the payment methodology builds on but differs from current payment methodologies (i.e., CPC+ and MIPS), and how the aspects that would be different from CPC+ would work, particularly monthly payments in place of E/M services and patient attribution rules. The payments would be risk-adjusted, and the submitter noted its desire to work with CMS to identify and test more comprehensive risk-adjustment approaches that include factors other than diagnosis codes, such as social determinants of health.

However, the Committee finds that there are several aspects of the payment methodology which need to be more clearly specified and some that should be revised to avoid potential problems:

- The actual payment amounts need to be specified.
- The proposed combination of patient election and claims-based attribution is overly complex and could lead to selection bias.
- PTAC is not convinced that two PBPMs are needed or that the two different levels of monthly payments for different subsets of E/M services are needed. PTAC believes that a single PBPM and a single track would be simpler to administer and would likely provide similar opportunities.
- Monthly payments in place of visit-based payments and a lack of robust performance metrics could lead to stinting on care or inappropriate referrals. While the submitter noted that risk adjustment, fee-for-service payments for services other than E/M services, and attribution methodology should counter incentives to deny or delay care or inappropriately refer patients, PTAC believes that measures of patient experience and

rates of referral to specialists are also needed. Furthermore, although the APM Entity would no longer need to submit claims for E/M services for payment, PTAC believes that it would still be important to collect data on encounters to protect against stinting and inappropriate referrals.

- The method of patient cost-sharing for services needs to be specified.
- If payments are risk adjusted using HCC scores, there would be undesirable incentives to add additional diagnosis codes in order to receive higher payments (upcode). At the same time, practices that have historically undercoded will need to ensure that they begin appropriately documenting patient conditions or risk underpayment. Some members suggested use of risk stratification (i.e., discrete categories of payment based on differences in patient needs) in order to mitigate incentives for upcoding.
- In the proposed model, if a practice underperforms, it would have to pay back some or all of the incentive payment. This puts the government in the position of performing collections on money already paid out and puts participants with weak balance sheets at significant financial risk. An alternative would be to pay all or part of the incentive payments after performance is achieved.

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 model changes provider incentives in a way that would be expected to enable and encourage the delivery of high-quality primary care. The risk-adjusted monthly payment in place of fees for office visits would give practices the ability to deliver high-value patient services for which physicians either cannot bill or have difficulty billing, while also discouraging unnecessary visits. The performance-based incentive payments would tie payments to quality and outcomes rather than to volume of services. The increase in primary care spending is also aimed at creating better value in the health care system.

However, the fact that payments are no longer directly tied to patient contacts creates the concern that patients' ability to access providers when needed may be harmed, as has happened in some areas where practice capitation models have been used. The submitter argues that the performance measures would discourage that, but PTAC does not believe the proposed measures are adequate for this purpose.

In addition, while using patients' designation of their primary care practice as the primary method of determining the patients for which the practice is accountable will reduce the likelihood of misattribution in comparison to current methods, it could also expose patients to

"cherry picking," if practices encourage enrollment of patients who are most likely to have favorable outcomes and have low use of practice resources. PTAC believes that additional mechanisms should be included to protect against this.

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. The monthly payments and overall increased primary care spending would give practices the flexibility to deliver a wide range of desirable services for which physicians either cannot bill or have difficulty billing, but that can support higher-quality care, such as responding to patients through telephone/email communication and providing patient education and self-management support using practice staff other than clinicians. PTAC also notes that because there would not be detailed requirements as to how services should be delivered, physicians would have the flexibility to invest in care teams and delivery approaches that meet the unique needs of their patient population.

Criterion 6. Ability to be Evaluated

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

Rating: Meets Criterion

PTAC concludes that the proposed model meets this criterion. The Committee believes that the proposed model is evaluable. However, PTAC notes that the model, with its multi-step attribution methodology, two PBPM payments, and varied options for E/M payments (the model creates two different tracks with small differences in terms of the services that are bundled together) and measure selection, is complex. The complexity and various ways in which APM Entities might implement the model would make evaluation challenging, although not impossible. Changes to performance measurement (e.g., adding and requiring more measures) and collapsing the payment options could make evaluation easier. Furthermore, the Committee notes that there has already been significant testing and evaluation in primary care around which an evaluation plan can be built.

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. Under the proposed model, practices would be expected to implement the five functions that guide CPC+ care delivery transformation and to adopt the Joint Principles of the Patient-Centered Medical Home, both of which include integration and care coordination. However, PTAC notes that there are no requirements or measures of care coordination for individual patients. The Committee also believes that details on how a participating primary care practice will coordinate with specialists, which might vary regionally, is lacking; PTAC believes the submitter should propose a mechanism for assuring such coordination occurs.

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 proposal meets this criterion. Under the model, patient choice is the primary method of determining the patients for whom the primary care practice will receive payment and be accountable. Further, the monthly payments as well as the increased resources directed at primary care would give the practice greater flexibility to respond to differences in patient needs than the current fee-for-service payment system. It is worth noting that when patient designation of primary care practices is the primary methodology for attribution, attention must be paid to avoiding unintended worsening of disparities and reducing access for patients with low literacy levels or low levels of self-activation. These are similar to concerns that exist about Medicare Advantage plan enrollment.

Criterion 9. Patient Safety

Aim to maintain or improve standards of patient safety.

Rating: Meets Criterion

PTAC concludes that the proposal meets this criterion. PTAC believes that the flexibility and enhanced resources provided by this payment model could enable primary care practices to

create more proactive mechanisms for early identification and rapid response to patient problems. These types of services are difficult to support using current fee-for-service payments that are based primarily on face-to-face encounters. In addition, because payments would be risk adjusted, practices that have more patients with multiple health problems would receive more resources to support these types of outreach and response services.

However, because the monthly payments would no longer be directly tied to specific services, a primary care practice would receive the same payment whether it provided these outreach and response services or not. This creates the potential risk that some practices could ignore patient problems or delay responding to them, thereby jeopardizing patient safety. Furthermore, under the proposed model, the APM Entity would no longer submit claims for E/M services, which could have acted as a check against stinting on care. As noted earlier, under the proposed model the APM Entity would select six measures, including at least one outcome measure, from the Accountable Care Organizations, Patient-Centered Medical Homes, and Primary Care Measure Set, which could mean the practice would only be measured for the quality of care delivered to a small subset of patients. While the measure set includes patient experience measures, the APM Entity would not be required to include them in their six measures. Because the practice would be evaluated based on its average performance for all of its patients, it would still be paid even if it did not respond in a timely or appropriate way when an individual patient experienced problems.

On balance, PTAC concludes that the potential positive impacts on patient safety from the flexibility and enhanced resources in the model outweigh the potential for negative impacts, particularly in comparison to the current fee-for-service payment system, where provider burnout can also lead to stinting on care or poor quality of care. However, PTAC believes it is necessary to strengthen the performance measurement component of the model to ensure adequate access to services for vulnerable patient populations. PTAC also believes that encounter data is necessary.

Criterion 10. Health Information Technology

Encourage use of health information technology to inform care.

Rating: Meets Criterion

PTAC concludes that the proposal meets this criterion. The proposed model requires that at least 50% of the APM's participants use CEHRT, consistent with the requirements for an Advanced APM.

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

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)[1]	-	-	-	1	3	6	1	Meets and Deserves Priority Consideration
2. Quality and Cost (High Priority)	-	-	-	6	4	1	-	Meets Criterion
3. Payment Methodology (High Priority)	-	-	-	6	4	1	-	Meets Criterion
4. Value over Volume	-	-	-	2	7	2	-	Meets Criterion
5. Flexibility	-	-	-	-	6	5	-	Meets Criterion
6. Ability to be Evaluated	-	-	2	8	1	-	-	Meets Criterion
7. Integration and Care Coordination	-	-	3	4	2	2	-	Meets Criterion
8. Patient Choice	-	-	-	2	7	2	-	Meets Criterion
9. Patient Safety	-	-	1	7	3	-	-	Meets Criterion
10. Health Information Technology	-	-	-	9	2	-	-	Meets Criterion

Not Applicable	Do Not Recommend	Recommend for Limited-scale Testing	Recommend for Implementation	Recommend for Implementation as a High Priority	Recommendation
-	-	6	1	4	Recommend for Limited-scale Testing

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