



THE SECRETARY OF HEALTH AND HUMAN SERVICES

WASHINGTON, D.C. 20201

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I am very pleased to respond to the comments and recommendations of the Physician-Focused Payment Model Technical Advisory Committee (PTAC) transmitted between October 2017 and May 2018.¹ Shifting our health care system to one that pays for value rather than volume is one of my top four priorities as Secretary of Health and Human Services (HHS). PTAC can help us make that shift by reviewing promising new ideas, providing expert analysis, commentary, and recommendations, and working collaboratively to realize the promise of new physician-focused payment models (PFPMs). I look forward to using the collective PTAC expertise as we design promising Centers for Medicare & Medicaid Services (CMS) Center for Medicare and Medicaid Innovation (Innovation Center) payment models.

HHS VISION FOR VALUE-BASED PAYMENT

HHS envisions our nation's health system as one that is responsive to the health care needs of Americans. To this end, HHS is pursuing initiatives that empower beneficiaries as consumers, give patients greater control over their health data, encourage price transparency, and increase choices and competition to drive quality and reduce costs. We also aim to remove government burdens that impede this transformation. We believe that the best ideas for improving outcomes often come from individuals and organizations on the front lines of the health care delivery system. PTAC provides a venue for health care providers, associations, coalitions and other innovators to share their promising innovations for consideration and possible adoption to a wider audience. With PTAC's expert analyses, commentary, and recommendations of the proposed new models, HHS can incorporate those ideas when designing payment models. This response provides an opportunity for me to acknowledge the substantial contributions of PTAC in helping HHS achieve delivery system transformation, reaffirm the Department's commitment to achieving that transformation, and communicate considerations the Department takes into account when reviewing proposed payment models.

PTAC'S CONTRIBUTIONS TO DELIVERY SYSTEM TRANSFORMATION

PTAC members have made an outstanding contribution, devoting much time and effort to reviewing proposals and making thoughtful, informed comments and recommendations on them. I particularly appreciate PTAC's comments and recommendations as they reflect the deep expertise PTAC members bring to the Committee's charge. I look forward to speaking with PTAC members and the public at an upcoming PTAC meeting about how we can drive delivery system transformation together. A commitment to health care payment innovation by PTAC and the broader stakeholder community is evident in the number and types of specialties represented in the proposals being submitted to PTAC. I am particularly interested in the two serious illness models proposed by the Coalition to Transform Advanced Care (C-TAC) and the American Academy of Hospice and Palliative Medicine (AAHPM). We agree with PTAC that a payment model that establishes incentives to provide optimal care for seriously ill beneficiaries should be tested by CMS, and Innovation Center staff have met with submitters and other stakeholders about both proposed models. While it is unlikely that all of the features of any proposed model would be tested as proposed, HHS is clearly benefitting from PTAC's comments and recommendations as we explore designing a future payment model for seriously ill beneficiaries.

¹ This response complies with the statutory requirement at §1868(c)(2)(D) of the Social Security Act to review and respond to PTAC's comments and recommendations on proposed physician-focused payment models (PFPMs).

CONSIDERATIONS FOR PROPOSED MODEL SUBMISSIONS

Prior to PTAC beginning its work, HHS and CMS set forth 10 criteria for PTAC to use in evaluating proposed PFPMs (as required by the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA)). See 42 C.F.R. § 414.1465. These criteria were derived from the factors that CMS uses in selecting models for testing (found in CMS' Alternative Payment Model Design Toolkit, which can be found at <https://www.cms.gov/Medicare/Quality-Payment-Program/Resource-Library/Alternative-Payment-Model-APM-Design-Toolkit.pdf>).

Consistent with these criteria and factors, I also ask that stakeholders take into account the following considerations as they develop new proposed payment models. This information, as well as the 10 established criteria for PFPMs and CMS' model selection factors, have informed my review of and responses to the comments and recommendations transmitted by PTAC on 12 proposed PFPMs.

- 1. HHS seeks models that demonstrate potential for significant impact on the Medicare population in ways where we can conduct a robust evaluation.** PTAC has recommended several proposed models for limited-scale testing. In its *Proposal Submission Instructions*, PTAC indicates that the limited-scale testing “category may be used when the PTAC determines a proposal meets all or most of the Secretary’s criteria but lacks sufficient data to (1) estimate potential costs, savings, or other impacts of the payment model and/or (2) specify key parameters in the payment model (such as risk adjustment or stratification), and the PTAC believes the only effective way to obtain those data would be through implementation of the payment model in a limited number of settings.” To the extent the limited-scale recommendation for a proposed model test precludes robust evaluation, we would be unlikely to implement such a recommendation.
- 2. Use of proprietary tools or tools that are not already developed in a proposed APM is an obstacle to HHS’ testing of the model.** In prior Secretarial responses, HHS has communicated concerns about proposed models that require the use of specific proprietary products. HHS cannot endorse, promote or rely on a unique product.
- 3. Providing care in accord with current standards of practice or accelerating adoption of emerging standards of care do not require an APM.** Although APMs often reward the provision of higher quality care, care that is provided should always meet current standards of care, regardless of the way in which a practitioner is paid. CMS would not implement a model that pays physicians solely for implementing standard practice and following established guidelines for care.

In summary, I look forward to reviewing proposals that present ideas that go beyond the scope of our current model portfolio, bringing in fresh and bold ideas for PFPMs from the field. I hope that this information, as well as my responses to all of the pending PTAC comments and recommendations (see Appendix) assist current and future PFPM submitters as they help drive transformative innovation in American health care.

I look forward to a continued partnership with PTAC and proposed PFPM submitters as we move toward a value-driven delivery system.

Sincerely,

/s/

Alex M. Azar II

Appendix

This appendix contains responses from the Secretary of HHS to 11 sets of PTAC comments and recommendations on 12 PFPM proposals from the following submitters:

- **Coalition to Transform Advanced Care (C-TAC)**
 - *Advanced Care Model (ACM)*
- **American Association of Hospice and Palliative Medicine (AAHPM)**
 - *Patient and Caregiver Support for Serious Illness (PACSSI)*
- **Icahn School of Medicine at Mount Sinai**
 - *“HaH-Plus” (Hospital at Home-Plus) Provider-Focused Payment Model*
- **Personalized Recovery Care, LLC**
 - *Home Hospitalization: An Alternative Payment Model for Delivering Acute Care in the Home*
- **American Academy of Family Physicians (AAFP)**
 - *Advanced Primary Care: A Foundational Alternative Payment Model (APCAPM) for Delivering Patient-Centered, Longitudinal, and Coordinated Care*
- **Hackensack Meridian Health and Cota Inc.**
 - *Oncology Bundled Payment Program Using CNA-Guided Care*
- **Avera Health**
 - *Intensive Care Management in Skilled Nursing Facility Alternative Payment Model*
- **New York City Department of Health and Mental Hygiene (NYC DOHMH)**
 - *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*
- **Large Urology Group Practice Association (LUGPA)**
 - *Advanced Payment Model for Initial Therapy of Newly Diagnosed Patients with Organ-Confined Prostate Cancer*
- **Renal Physicians Association (RPA)**
 - *Incident ESRD Clinical Episode Payment Model*
- **Mercy Accountable Care Organization (Mercy ACO)**
 - *Annual Wellness Visit at Rural Health Clinics*
- **Zhou Yang, PhD, MPH**
 - *Medicare 3 Year Value Payment Demonstration*

Coalition to Transform Advanced Care (C-TAC)

I express my gratitude to the Coalition to Transform Advanced Care (C-TAC) for its submission of the *Advanced Care Model (ACM)* proposal to the Physician-Focused Payment Model Technical Advisory Committee (PTAC). Together with PTAC's detailed and rigorous review, it has added much to the Department of Health and Human Services' (HHS) thinking about serious illness models and about alternative payment care models in general.

We agree with PTAC that a payment model addressing the unique needs of seriously ill beneficiaries should be tested by the Centers for Medicare & Medicaid Services (CMS). Improving care for this high need population is an important part of HHS' goal for delivery system reform and other key CMS objectives. However, we also share PTAC's concern about the proposed model's eligibility criteria, measures of quality and cost, payment methodology, and care coordination. Additional details regarding these considerations are identified below.

Eligibility Criteria

The proposed beneficiary eligibility criteria depend on a clinician's assessment of functional and nutritional status, performance scales, and life expectancy. It would be beneficial if eligibility requirements were aligned with Medicare administrative data, as clinician assessment-based criteria would be difficult for CMS to verify. This eligibility design may also enable participants in the model to selectively choose beneficiaries that are financially beneficial, leading to undesirable variability in patient characteristics. We also share PTAC's concerns about the use of prognosis as an eligibility criterion for serious illness care.

Quality Measures

Informed patient preferences can be difficult to measure and verify, especially regarding end-of-life care. Even though the ACM offers safeguards to ensure beneficiaries have a voice in their care, it is unclear whether the proposed model ensures beneficiaries and caregivers are consistently provided with the necessary information to make well-informed decisions.

In general, this proposal would benefit from further consideration and development of methods to assess quality performance. Specifically, the frequency and timing that quality measures would be collected for each beneficiary appear to vary, which could create challenges for both data collection and quality measurement.

Payment Methodology

Calculating the ACM participant's spending target for savings determinations would be challenging, as has been found in other CMS initiatives with similar enrollment criteria. It is unclear if the population proposed for calculating episode spending targets would sufficiently match the population actually included in the proposed model to calculate an accurate spending target. In addition, the lack of risk adjustment for the care management fee for patient acuity may create incentives for model participants to treat less severely-ill beneficiaries.

Care Coordination

The proposal does not address how members of care teams directly connected with the APM Entity would engage in collaboration with the beneficiary's other health care providers who are not formally affiliated with that APM Entity.

These concerns notwithstanding, we also agree with PTAC that a payment model could incorporate many positive aspects of the proposal submitted by C-TAC, in addition to aspects of the proposal submitted to PTAC by the American Association of Hospice and Palliative Medicine (AAHPM), *Patient and Caregiver Support for Serious Illness (PACSSI)*. For example, meaningful quality measures tied to payment, enhanced services for patients, and patient-centered care employed in the proposed models could be included in a CMS model test.

As HHS contemplates further model design in this area, we are considering the input and insights from PTAC's review of both the C-TAC and AAHPM proposals, as well as from other individuals and stakeholder entities. We sincerely appreciate the expertise and passion that C-TAC offers and acknowledge the dedication to this patient population and addressing their health care needs.

We all share a common goal of improving health care for all Americans. To do this, we must think creatively and leverage experience from across the nation, including from health care providers on the front lines who are changing care delivery to encourage better outcomes and patient experience of care. We recognize and value the contributions of practicing physicians in driving this transformation.

We look forward to the continued engagement of all stakeholders in developing payment models and to future recommendations of PTAC regarding PFPs that would reduce expenditures while preserving or enhancing the quality of care.

American Association of Hospice and Palliative Medicine (AAHPM)

I express my gratitude to the American Association of Hospice and Palliative Medicine (AAHPM) for its submission of the *Patient and Caregiver Support for Serious Illness (PACSSI)* proposal to the Physician-Focused Payment Model Technical Advisory Committee (PTAC). Together with PTAC's detailed and rigorous review, it has added much to the Department of Health and Human Services' (HHS) thinking about serious illness models and about alternative payment care models in general.

We agree with PTAC that a payment model addressing the unique needs of seriously ill beneficiaries should be tested by the Centers for Medicare & Medicaid Services (CMS). Improving care for this high-need population is an important part of HHS' goal for delivery system reform and other key CMS objectives. We do, however, share PTAC's concerns about the proposed model's measures of quality and cost and about the payment methodology. Additional details regarding HHS' comments are identified below.

Eligibility Criteria

The proposed beneficiary eligibility and assignment criteria are complex, and some involve Palliative Care Team (PCT) assessments of beneficiaries that are not easily verified through Medicare administrative data. Assessing beneficiary eligibility would likely be an administrative burden for PCTs, and it may be difficult to determine each beneficiary's functional status, which could affect the selection or reclassification of beneficiaries into higher paying tiers for financial gain. It would be beneficial if eligibility requirements were aligned with Medicare administrative data.

Quality Measures

The model proposes to measure certain patient-reported outcomes, such as the adequacy of treatment for pain and symptoms. However, it would be beneficial to assess patient-oriented outcomes that address the various and diverse aspects of pain and suffering that accompany patients in this population.

Payment Methodology

Since the proposed care management fees are generous, each participant's care coordination and palliative care interventions would need to generate substantial savings to the Medicare program for the model to break even on the total cost of care, including those fees. As noted above, the eligibility criteria would need to be carefully constructed to ensure that care management fee amounts are appropriate for the population.

These concerns notwithstanding, we agree with PTAC that a payment model could incorporate many positive aspects of the proposal submitted by AAHPM, in addition to aspects of the proposal submitted to PTAC by the Coalition to Transform Advanced Care (C-TAC), the *Advanced Care Model (ACM)*. For example, meaningful quality measures tied to payment, enhanced services for patients, and patient-centered care employed in the proposed models could be included in a CMS model test.

As HHS contemplates further model design in this area, we are considering the input and insights from PTAC's review of both AAHPM and C-TAC proposals, as well as from other individuals and stakeholder entities. We sincerely appreciate the expertise and passion that AAHPM offers and acknowledge the dedication to this patient population and addressing their health care needs.

We all share a common goal of improving health care for all Americans. To do this, we must think creatively and leverage experience from across the nation, including from health care providers on the front lines who are changing care delivery to encourage better outcomes and patient experience of care. We recognize and value the contributions of practicing physicians in driving this transformation.

We look forward to the continued engagement of all stakeholders in developing payment models and to future recommendations of PTAC regarding PFPs that would reduce expenditures while preserving or enhancing the quality of care.

Icahn School of Medicine at Mount Sinai

I express my gratitude to the Icahn School of Medicine at Mount Sinai for submitting the “*HaH-Plus*” (*Hospital at Home-Plus*) *Provider-Focused Payment Model* proposal to the Physician-Focused Payment Model Technical Advisory Committee (PTAC) for review and consideration as a physician-focused payment model (PFPM). The Icahn School of Medicine at Mount Sinai’s commitment to innovation and improving health care is evident in the proposed model which would enable patients with certain acute illnesses or exacerbated chronic diseases to receive hospital-level services in the home. I also thank the members of PTAC for the time and effort they invested in the rigorous review of this proposal and for providing their detailed comments and recommendations to me.

The Department of Health and Human Services (HHS) is keenly interested in ideas for home-based, hospital-level care, and agrees with PTAC that this proposal holds promise for testing. Promoting patient choice to receive care in the most optimal setting is a goal HHS shares with the Icahn School of Medicine at Mount Sinai.

As HHS evaluates results from similar existing models, we also want to reflect on the input and insights from PTAC, the Icahn School of Medicine at Mount Sinai, and other stakeholders to address the challenges of providing home-based care. We are particularly interested in establishing accountability for adverse events, ensuring proper clinical safeguards so only appropriate patients would be eligible, and understanding the financial implications stemming from the fact that qualifying *HaH-Plus* beneficiaries would generally be lower cost than beneficiaries with the same conditions who are hospitalized. Additional detail regarding HHS’ consideration of this proposal include:

Payment Methodology

One concern regarding the proposed payment methodology is the potential misalignment of incentives. Specifically, participants in the proposed model furnishing in-home hospital care would not be at risk for certain costs, such as hospitalizing patients before it is necessary or during the 30 days after an acute episode, nor would they be responsible for readmissions, skilled nursing facility services, emergency department services, or outpatient services. It is difficult to see how exempting participants completely from risk for these expenditure categories would not create incentives for participants to keep their episode costs down by shifting services toward these categories as there would be no financial risk to consider. Additionally, the proposal does not sufficiently address the financial implications stemming from the fact that qualifying *HaH-Plus* beneficiaries would likely be lower cost than beneficiaries who would be admitted to the hospital for the same conditions.

Patient Safety

HHS agrees with PTAC that additional beneficiary safeguards beyond those described in the proposal are needed. HHS finds that the proposed model provides no formal monitoring to ensure hospitalizations or readmissions occur as appropriate, or that health care providers are making scheduled visits during the acute phase. While the submitter asserts that beneficiaries would be carefully screened, there is uncertainty regarding an objective and safe strategy for beneficiary selection. The proposed model also lacks sufficient monitoring

of adverse events and a standardized plan for review. While HHS does find that stronger safeguards for beneficiary safety and incentives for quality are needed, it believes these shortcomings could be addressed with modifications to the proposed model design.

Patient Enrollment

The proposed model relies on financial incentives that may lead to inappropriate selection of patients for treatment under *HaH-Plus*. Patients who receive in-home hospital-level care under *HaH-Plus* are likely to differ systematically from patients with the same diagnoses who are hospitalized. This raises questions about target pricing for *HaH-Plus* episodes, incentives to selectively treat lower-acuity patients, and effective evaluation of the proposed model.

While we will not implement this model as proposed, we are exploring a model that allows beneficiaries with certain acute illnesses or exacerbated chronic diseases to receive hospital-level services in their homes. Therefore, I have requested that Centers for Medicare & Medicaid Services (CMS) staff leverage the valuable experiences the Icahn School of Medicine at Mount Sinai has had in this space and to contact them with any questions about components of their proposal that would inform future model development. I have also requested CMS staff to include the Icahn School of Medicine at Mount Sinai in outreach to stakeholders to engage them in development of PFPs that address the challenges of providing hospital-level care in a patient's home.

We share a common goal of improving health care for all Americans. To do this, we must think creatively and leverage experience from across the nation. We must learn from health care providers in the field who have changed care delivery to encourage better outcomes and patient experience of care. We recognize the valuable contributions of PTAC and practicing physicians in driving this transformation.

We look forward to the continued engagement of all stakeholders in developing payment models and to future recommendations from PTAC regarding PFPs that would reduce expenditures while preserving or enhancing the quality of care.

Personalized Recovery Care, LLC

I express my gratitude to Personalized Recovery Care, LLC (PRC), a joint venture between the Marshfield Clinic and Contessa Health, for its submission to the Physician-Focused Payment Model Technical Advisory Committee (PTAC) of a proposal for a new physician-focused payment model (PFPM) to cover the provision of acute hospital-level services to Medicare patients in their homes. The proposal, *Home Hospitalization: An Alternative Payment Model for Delivering Acute Care in the Home*, would allow beneficiaries with certain medical conditions that normally require admission to an inpatient hospital to instead be treated in the patient's home or a skilled nursing facility using physician services furnished via telehealth and focused, high-touch care coordination. PRC's work on this proposed model, together with the PTAC's detailed and rigorous review of it, has added much to the Department of Health and Human Services' (HHS) general thinking around models designed to improve care and lower cost by furnishing care in a patient's home.

HHS agrees with the findings of PTAC that this model offers promise for improving care and lowering cost. While we do have concerns with specific design aspects of the proposed model, we recognize that variations of this proposed model could be tested as a means to improve quality, lower costs, and reduce complications associated with hospitalization for a substantial number of patients that would otherwise be hospitalized. The generalizability of this type of model does pose a challenge, however, in terms of where it could be safely conducted and whether it would satisfy the criteria for expansion, should it prove effective.

While we acknowledge the advantages and feasibility of the model design within a large health care system or integrated network such as the Marshfield Clinic, the availability of local ancillary services such as home health providers, infusion providers, durable medical equipment vendors, patient transportation and others, when needed, is a concern, especially in rural areas. It may be difficult for health care providers in certain areas of the country to hire or easily contract with all the health care provider and vendor types, with the requisite levels of training and skill, needed to make participation in this model successful. Additional detail regarding these and other evaluation areas are provided below.

Scope of Proposal

The proposed model's success relies heavily on the availability of local ancillary service providers such as home health providers, durable medical equipment vendors, patient transport, and infusion service providers. Not every geographic area is likely to have all of these providers in place, willing and able to participate in the proposed model. To the extent the participating Alternative Payment Model (APM) Entity does not have such staff or contracts in place, this may limit how many participants are able to provide necessary services.

Quality and Cost

In the proposed model, quality measures affect payments in a binary way; once a target is met, there is no financial incentive for further improvement. Also, participants that are far below a quality target may have little incentive for improvement. Discretion in the patient screening process could put financial goals in conflict with patient safety. In addition, given

the fact that the proposed Clinical Quality Council does not appear to be independent of the APM Entity in the model proposal, the Clinical Quality Council's objective oversight could be brought into question. Related to these concerns, patient safety was a main topic of discussion during the PTAC meeting. While the discussions with PTAC alleviated some safety concerns, and PRC was open to including a wider range of quality measures and various improvements and safety checks, patient safety remains a concern until the specifics of these improvements are further developed.

In considering the design of a model where care is furnished in a patient's home, the specifics of additional quality measures, patient safety checks, and measures of adverse event reports are vital.

Payment Methodology

The proposal does not justify the episode payment amount being set at 70% of the associated diagnosis-related group (DRG) payment. This amount may overcompensate participants for the level of care expected for a patient who can be treated at home. In addition, the method for calculating benchmark episode costs is not clear. If benchmarks (and thus targets) are based on historical health care provider-specific costs, then historically inefficient providers could have higher target costs and greater opportunities for shared savings compared to historically more efficient providers. Although a participant would be at financial risk for readmissions and other adverse events, the 10 percent cap on liability relative to target costs significantly limits downside risk, weakening incentives to be efficient and avoid those adverse events.

Additionally, we note that as presented, the proposal does not clearly explain the methodology for calculating benchmark episode costs or empirically support the suggested payment level, and we believe further analysis around the appropriate payment targets, rates, included services, and episode lengths would be needed before a model could be tested. Although the proposal states that the APM Entity would be at some financial risk, we note that the downside risk is limited, thereby reducing incentives to be efficient and minimize adverse events. The risk design portion of the proposal would also likely need to be modified based on further study so that the model incentives would be better aligned to encourage efficiency and quality.

In light of these considerations, we hope PRC and other individuals and stakeholder entities will join the Centers for Medicare & Medicaid Services (CMS) in discussions on future payment models designed to test the potential of furnishing care at home.

We all share a common goal of improving health care for all Americans. To do this, we must think creatively and leverage experience from across the nation. We must learn from health care providers in the field who have changed care delivery to encourage better outcomes and patient experience of care. We recognize the contributions of practicing physicians in driving this transformation.

We look forward to the continued engagement of stakeholders to submit proposals to PTAC and the future recommendations of PTAC regarding physician-focused payment models that would reduce expenditures while preserving or enhancing the quality of care.

American Academy of Family Physicians (AAFP)

I express my gratitude to the American Academy of Family Physicians (AAFP) for its development of a proposal for a new physician-focused payment model (PFFM), the *Advanced Primary Care: A Foundational Alternative Payment Model (APCAPM) for Delivering Patient-Centered, Longitudinal, and Coordinated Care*, and for its submission of this proposal to the Physician-Focused Payment Model Technical Advisory Committee (PTAC). AAFP's strong commitment to innovation and improving health care is manifest in the proposed advanced primary care model that includes a capitated payment structure to support advanced primary care. AAFP's work on this proposed model, together with PTAC's detailed and rigorous review of it, has added much to the Department of Health and Human Services' (HHS) thinking about primary care models and about alternative payment care models in general. Like PTAC, HHS believes strengthening primary care is critical to promoting health and reducing overall health care costs in the nation.

Building on lessons learned from the Comprehensive Primary Care (CPC) initiative and input from the 2015 Request for Information on Advanced Primary Care Model Concepts, the Centers for Medicare & Medicaid Services (CMS) announced the Comprehensive Primary Care Plus (CPC+) model in 2016. HHS agrees with PTAC that this proposal from AAFP offers promise because of its emphasis on the expansion of beneficiary access to high quality primary care and its support of primary care physicians' ability to deliver advanced primary care more effectively.

In reviewing this proposal and PTAC's comments, however, we also agree that the proposed payment methodology, risk adjustment, beneficiary attribution, and performance metrics require further refinement. Additional detail regarding HHS' concerns includes:

Payment Methodology

We are concerned that the multiple proposed payment methodologies are unnecessarily complex for participants, model evaluation, and model operations. Further, the proposed model would benefit from specificity in pricing the prospective payments, as well as clarity on the services encapsulated within the global payment and those that are outside the scope of the global payment and for which physicians would be reimbursed fee for service. Additional consideration should be given to payment offsets or debits for services provided by non-participating primary care practitioners. To properly structure the payment model to focus physicians on working to reduce the cost of care, the proposed model should link added payments to reductions in other costs of care that primary care physicians might influence.

In view of the known risk to primary care practice performance when only a limited portion of the practice population is covered by additional payments, it is important to understand how the proposed Medicare payment positions practices for model success. Outside of a multi-payer model, participants in a model like the proposed AAFP model may find it challenging to fund and support significant practice transformation using model payments from Medicare alone, resulting in their inability to make necessary practice changes, deliver the anticipated care functionalities, and achieve better health outcomes for their patients.

Quality and Cost

The proposed model would increase payments for primary care practices without sufficient assurance that there would be proportionate savings. The time horizon for realizing savings is likely after the end of the proposed model. Participants in the proposed model are not held accountable for reducing total cost of care, but only to self-selected quality measures that may bear little relationship to total cost of care. The proposal suggests the possibility of employing robust utilization measures and patient experience measures, such as Consumer Assessment of Healthcare Providers and Systems (CAHPS®), that can safeguard against the underservice incentives associated with capitated payment for primary care services. However, the proposed quality requirements are limited, making it relatively easy for practices to be assessed on quality of care based only on a small subset of basic preventive and chronic care measures. Given the substantial increase in payment proposed, clarification of meaningful quality and patient experience measures, as well as inclusion of utilization or total cost of care measures would be needed.

Criteria for Model Eligibility and Ongoing Participation

The criteria for participation in the proposed model – such as an attestation that the practice performs the five key functions of primary care or has a plan to do so after a reasonable period of time after joining – are vague and assume that practices are willing and able to restructure the way they provide care for Medicare beneficiaries without technical assistance or other support activities. Additionally, these five functions are dependent on health information technology and, while the proposal states that Certified Electronic Health Record Technology (CEHRT) is required, it also estimates that only 50 percent of participants would use CEHRT. Finally, the proposal does not clearly define acceptable alternative payment model entities and their relationship to physicians and physician practices.

Ability to be Evaluated

It may be extremely difficult to draw data-based inferences on the direct effects of the proposed model if we are unable to select a good comparison group. Of added concern is the effect of this proposed model on the evaluation of the existing CPC+ model, exacerbating difficulties evaluators have had finding and retaining comparison group practices for CPC+.

We all share a common goal of improving health care for all Americans. To do this, we must think creatively and leverage experience from across the nation. We must learn from health care providers in the field who have changed care delivery to encourage better outcomes and patient experience of care. We recognize the contributions of practicing physicians in driving this transformation.

This proposal brings to light many important considerations and perspectives that are only possible through the efforts of health care providers at the front lines of primary care transformation. As with other existing CMS models, because of our goals for delivery system reform, we hope to continue to engage AAFP and other stakeholders in improving opportunities for primary care physicians to participate in future CMS model design. We encourage individuals and stakeholder entities to submit new innovative PFPM proposals to PTAC that would reduce expenditures while preserving or enhancing the quality of care.

Hackensack Meridian Health and Cota Inc.

I express my sincere gratitude to Hackensack Meridian Health (HMH) and Cota Inc. for their development of a thoughtful proposal for a new physician-focused payment model, the *Oncology Bundled Payment Program Using CNA-Guided Care*, and for their submission of this proposal to the Physician-Focused Payment Model Technical Advisory Committee (PTAC). HMH and Cota Inc.'s commitment to innovation and improving health care is manifest in the proposed bundled payment model aimed at optimizing clinical outcomes while reducing the total cost of care for patients receiving oncology care services. HMH and Cota Inc.'s work on this proposed model, together with PTAC's detailed and rigorous review of it, has added much to the Department of Health and Human Services' (HHS) thinking about this type of bundled payment model and about physician-focused specialty models in general.

We agree that there may be important advantages of using clinical data to inform payment for oncology care. However, HHS shares PTAC's concerns regarding the proposed model's limited scope, potential limitations on patient choice, the uncertainty regarding how quality measure performance would affect payment, and the proprietary nature of the Cota Nodal Address™ (CNA) system. We also share PTAC's concerns related to the proposed payment methodology, including how outside services and those unrelated to cancer care are handled in the model, as well as the connection between payment and performance on quality metrics.

We have previously conveyed our concerns about proposed models that prescribe the use of proprietary tools that may only be applicable for a single site, and similar concerns are present in this proposal. The proposed model relies on two notable proprietary systems: HMH's electronic health record and Cota Inc.'s CNA digital classification system. The CNA system may not be compatible with other health information technology (health IT) systems, tools, or platforms, which could be a significant obstacle for implementing the model among non-HMH-affiliated health care providers. Additional detail regarding HHS' concerns with this proposal include:

Scope

As proposed, this physician-focused payment model (PFPM) would only be implemented at a single site, HMH. The model would initially apply only to physicians participating in HMH's clinically integrated physician network (CIN), which includes 143 oncologists. The proposed beneficiary population includes Medicare beneficiaries who are newly diagnosed with one of four types of cancer (i.e., breast, colon, rectal, or lung) who are assigned a "CNA address." According to the proposal, an estimated 2,500 – 3,000 beneficiaries would be eligible for the PFPM in its initial implementation, with a potential extension over time to a maximum of 9,000 patients at HMH. HHS has concerns regarding the generalizability of this limited sample size at one single site.

Furthermore, since the proposal is centered on a CIN, there is no indication that independent oncology practices or non-integrated health systems would be able to implement the proposed model as designed. The submitter suggests that the model could be adapted to a much larger population; however, it does not describe how non-HMH practices would be able to participate in a model where the payment methodology relies on care being provided within a system that has limited or no receipt of care outside the system.

In addition, the proposal does not sufficiently address concerns regarding whether the payment methodology, which is based on the proprietary CNA classification system, could be adapted or applied in other settings using alternative algorithms for patient classification or bundle definition. Participants in the HHS Oncology Care Model (OCM) are using a variety of health IT solutions,

including 10 OCM practices that are using Cota Inc.'s technology, as well as others using a variety of other clinical pathway software and tools to facilitate care improvement. OCM's vendor pledge² facilitates connections between participating practices and organizations that offer tools to support OCM implementation; Cota Inc. may be able to connect with additional OCM practices through this mechanism.

Payment Methodology

In the proposed model, payment would be based on a prospective payment to HMH to cover a period of 12 post-diagnosis months of treatment for patients with cancer. HHS agrees that comprehensive bundles with prospectively set prices could provide a strong financial incentive to provide more efficient care. However, there is insufficient information in the proposal for HHS to evaluate the appropriateness of the proposed care bundles. Bundle assignment would rely solely on data that would be reported by HMH. There is no discussion in the proposal regarding how CMS would access and verify this data for model administration and evaluation. An additional concern is that overly narrow bundles, based on clinical diagnosis and treatment path, could weaken incentives to improve care. HHS also shares PTAC's concerns regarding the challenges of episode pricing for bundles that include non-cancer services and episodes with a low frequency of CNAs.

In addition, the inclusion of beneficiaries in the proposed model relies solely on the oncologists performing necessary tests and assessments to promptly assign a CNA. This may introduce the possibility of selective inclusion based on certain patients' complexity or expected costs within a particular diagnosis.

How Performance Ties to Payment

For each type of cancer diagnosis, the HMH model proposes numerous process and outcome quality measures that encompass care services ranging from surgery to oncology treatment and genetic testing. In addition, for all of the disease groups, HMH proposes over 40 measures related to oncology, including measures related to Cota Inc. analytics, risk management and process improvement, finance monitoring, reliability, patient experience and satisfaction, as well as patient-reported outcomes. Despite the emphasis on measurement, there is no indication of how performance on these metrics would be incorporated into the proposed payment model. HMH states that they would incentivize the provision of high quality care through health care provider compensation incentives and education; however, the proposed payment methodology does not explicitly link performance on these metrics to the bundled payments. In addition, it is unclear whether these quality measures have been validated.

Patient Choice

HHS shares PTAC's concerns regarding potential limitations in patient choice, and calls attention to the importance of respecting patient values as a component of patient choice and shared decision making. The proposal does not explicitly address shared decision making and how the model will accommodate and account for patient values and choice. The proposal's reliance on pre-specified treatment lanes that correspond to each specific CNA may not leave room for patient choice within those treatment lanes. As described, the proposed model does not appear to allow for treatment variation within any given CNA, or the associated treatment bundles or care pathway lanes. While the submitters made encouraging comments about this topic during their presentation at the September 2017 PTAC public meeting, the proposal makes no detailed mention of this process or the

² <https://innovation.cms.gov/Files/x/ocm-vendorpledge.pdf>

implications. The proposal does not address situations where beneficiaries may change their treatment preferences in the middle of an episode of care or where beneficiaries decide to leave HMH during the episode duration. HHS is also concerned that given the complexity, and the proprietary nature of software, there could be issues of transparency with beneficiaries as well as the possibility that the model could overly constrain practitioner behavior and, importantly, affect beneficiaries' ability to express their values and preferences for treatment options.

Accessibility of Essential Model Tools

The model relies on two proprietary systems, including HMH's electronic health record and Cota Inc.'s CNA digital classification system. Though both seem to be well-designed in terms of supporting HMH, there does not appear to be any allowance for deviation from these systems, particularly for practices that may use other health IT systems, tools, or platforms. This is a particular concern for the model's viability among non-HMH providers.

We are very interested in collaborating with HMH, Cota Inc., and other individuals and stakeholder entities in further exploration of how this proposed model or its components could potentially be incorporated into future payment models. The submitters' experience and progress in this space would be greatly valued. At this time, however, HHS will continue testing OCM and evaluate its results.

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We look forward to the continued engagement of stakeholders to submit proposals to PTAC and the future comments and recommendations of PTAC regarding physician-focused payment models that would reduce expenditures while preserving or enhancing the quality of care.

Avera Health

I express my sincere gratitude to Avera Health for their development and submission of a new physician-focused payment model (PFPM), the *Intensive Care Management in Skilled Nursing Facility Alternative Payment Model* to the Physician-Focused Payment Model Technical Advisory Committee (PTAC). Avera Health's commitment to innovation and improving health care is clear, as manifested in their proposal aimed at reducing avoidable emergency department (ED) visits and hospitalizations and lowering costs for patients in skilled nursing facilities (SNFs) and nursing facilities (NFs). Avera Health's work on this proposed model, together with PTAC's detailed and rigorous review of it, has added much to the Department of Health and Human Services' (HHS) thinking about this type of payment model and about physician-focused specialty models in general.

This proposed model would offer geriatricians the valuable opportunity to participate in an alternative payment model (APM). We agree with PTAC that providing beneficiaries and SNF/NF staff with constant access to a geriatrician via telehealth could improve quality and reduce costs by reducing avoidable ED visits and hospitalizations. However, HHS shares PTAC's concerns regarding the scope, quality, payment methodology, and risk adjustment in the proposal. Additional detail regarding HHS' concerns is outlined below.

Scope

We foresee that implementation on a large scale may not be feasible in the short term. Avera Health currently serves approximately 5,000 residents, while there are an estimated 2.5 million Medicare "short stay" beneficiaries in SNFs/NFs annually and an estimated 1 million dual-eligible beneficiaries (i.e., beneficiaries eligible for Medicare and Medicaid) residing in SNFs/NFs as "long stay" residents. Participants in the proposed model would need to commit significant time for their staffs to become familiar with the telemedicine equipment necessary for participation as well as apply it in diverse clinical situations. Although the proposal states that "geriatric care teams will be required to implement telemedicine infrastructure in the facilities they serve," it is unclear whether participants would need to fund the telemedicine technology cost themselves. Thus, many SNFs/NFs may not find participation attractive, which could also limit the practical scope of this proposed model.

Quality

While the proposal describes a robust set of quality measures to evaluate the value of care provided to beneficiaries, payers, and clinicians, it does not provide a clear rationale for which Nursing Home Compare measures it would use in its "Scored Quality Metrics" for payment adjustment.

Payment Methodology

Although the proposal describes that the care team will coordinate and collaborate with the beneficiary's primary care physician, HHS is concerned that no financial incentives exist for NFs to collaborate with those physicians to reduce avoidable ED visits and hospitalizations or for beneficiaries' primary care physicians to collaborate with the geriatrics teams participating in the proposed model.

As described in the proposal, the proposed payment methodology options do not require payments to be risk adjusted using rates of ED visits, hospital admissions, or spending based on the specific types of patient characteristics that can affect hospitalization rates for SNF/NF residents. We agree with PTAC's noted need for the development of risk adjustment for this patient population in general, and

specifically to ensure participants in the proposed model do not have an incentive to avoid including certain SNFs/NFs which may serve a higher-acuity patient population.

We sincerely value the submitters' experience and progress on improving quality for beneficiaries and increasing access to geriatricians via telehealth. At this time, however, HHS will continue testing existing CMS initiatives that incorporate care for beneficiaries in SNFs and NFs, such as the Initiative to Reduce Avoidable Hospitalizations among Nursing Facility Residents, and evaluate their results before implementing a different model or intervention with similar goals and beneficiary population. As we consider broader changes to telehealth policies, though, we will utilize the important considerations in Avera Health's proposal and PTAC's valuable comments and recommendations.

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We look forward to the continued engagement of stakeholders to submit proposals to PTAC and the future comments and recommendations of PTAC regarding physician-focused payment models that would reduce expenditures while preserving or enhancing the quality of care.

New York City Department of Health and Mental Hygiene (NYC DOHMH)

I express my gratitude to the New York City Department of Health and Mental Hygiene (NYC DOHMH) for its development and submission of a proposal for a new physician-focused payment model (PFP), the *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*, to the Physician-Focused Payment Model Technical Advisory Committee (PTAC). Your strong commitment to innovation and improving health care is manifest in this proposal. Together with PTAC's thoughtful review of it, the proposal has added much to the Department of Health and Human Services' (HHS) thinking about this proposed model and about care for this critical population.

HHS is keenly interested in new concepts to improve specialty care for Medicare beneficiaries with complex chronic illnesses such as HCV. We recognize HCV is a significant public health problem and that many Medicare beneficiaries with HCV have substantial comorbidities, including behavioral and mental health conditions. We agree with PTAC that this proposed model offers new opportunities for improving treatment for this high cost patient population through enhanced care coordination, treatment initiation and adherence, and tele-mentoring. However, we agree with PTAC that the proposed model should not be implemented due to significant model design issues. HHS has additional operational concerns with the proposed model, regarding its payment methodology, measures of quality and cost, and care coordination. Additional detail regarding these concerns is provided below.

Payment Methodology

The proposed payment methodology is based on future savings, calculated by estimating the cost of continued treatment for HCV infection and life-years gained. However, the proposal lacks detail in regard to how those costs are accurately determined. HHS also has concerns involving the proposed shared-risk arrangement, attribution methodology, and risk-adjustment.

Quality and Cost

Payment under the proposed model is tied to the proportion of beneficiaries who complete treatment and achieve sustained virologic response (SVR), an important outcome measure that indicates the patient is cured of HCV. However, the SVR is the sole measure of quality in the proposed payment model and actually provides incentive to select and treat beneficiaries with lower care coordination needs. In addition, the proposal does not include quality measures to assess the treatment of comorbid conditions or any patient-reported outcome measures or measures of beneficiary experience of care.

Care Coordination

The proposed model targets a high-cost, high-need cohort of beneficiaries. However, there does not appear to be continuity between care coordination for purposes of accomplishing HCV treatment and addressing comorbidities. For example, the proposal offers no mechanism or incentive to ensure coordination with health care providers treating patients for comorbid conditions when those health care providers are not affiliated with the APM Entity.

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We look forward to continued engagement of stakeholders like NYC DOHMH in submitting proposals to the PTAC, and future PTAC recommendations regarding PFPMs that would reduce health care expenditures while preserving or enhancing the quality of care.

Large Urology Group Practice Association (LUGPA)

I express my gratitude to the Large Urology Group Practice Association (LUGPA) for its development of a proposal for a new physician-focused payment model (PFPM), the *Advanced Payment Model for Initial Therapy of Newly Diagnosed Patients with Organ-Confined Prostate Cancer*, and for its submission of this proposal to the Physician-Focused Payment Model Technical Advisory Committee (PTAC).

LUGPA's strong commitment to innovation and improving health care is manifest in the proposed episode payment model that aims to increase the rates of active surveillance among patients with newly diagnosed localized prostate cancer through the alignment of financial incentives and improved shared decision making. LUGPA's work on this proposed model, together with PTAC's detailed and rigorous review of it, has added much to the Department of Health and Human Services' (HHS) thinking about this model and about episode payment models in general.

HHS is interested in opportunities to improve care for Medicare beneficiaries by reducing unnecessary intervention, particularly for preference-sensitive conditions like organ-confined prostate cancer, where active surveillance (AS) is often an appropriate alternative to active intervention (AI), such as surgery or radiation therapy. We agree with the submitters and PTAC that AS has been underutilized among newly diagnosed patients with organ-confined prostate cancer and that notable disparities exist in treatment of these patients.

However, we agree with PTAC's conclusion that the proposed payment model is not the best way to move forward in increasing AS utilization and it should not be tested. We also share PTAC's reservations about the payment model and uncertainty related to the specific activities to be covered by the care management fee, and we have concerns about the possibility of AI being delayed inappropriately. Additional detail regarding these reservations is provided below.

Payment Methodology

There are several concerns with the proposed payment methodology. First, the model may create an incentive to delay AI until after the 12-month AS episode ends to receive the care management fee and possibly to maximize the chance of achieving savings relative to the target price. In addition, the proposed model does not incorporate risk adjustment for comorbidities for those patients who receive AI. This could create a misaligned incentive to avoid assigning patients with multiple or expensive comorbid conditions to AI in situations where AI is appropriate.

Care Management

We agree with PTAC that clarity and specificity are lacking regarding the services included in—or excluded from—the care management fee. For example, some services (e.g., office visits, clinical laboratory testing, and advanced imaging) are currently reimbursed by Medicare. It is uncertain whether the care management fee would replace fee-for-service (FFS) payments for those services or supplement FFS payments. In addition, the proposal lacks detail on any specific mechanisms or strategies that would be employed by practices to transform care delivery, including care coordination among health care providers. Though we recognize that flexibility in how a practice implements care redesign is crucial, given the variety of practice structures and arrangements that currently exist, concrete expectations for participants would need to be established, as would a clear mechanism for change that links financial incentives and care transformation. Furthermore, the proposed quality measures do not capture whether care was well coordinated over time for patients on AS.

Patient Safety

Clinical appropriateness remains an issue, as the proposal does not specifically describe how it would determine the suitability of AS versus AI. There are financial incentives for avoiding provision of care for both AS and AI episodes, since the benchmark and actual expenditures proposed to calculate performance-based payments include both types of episodes. The proposed quality measures do not prevent stinting on care related to either the care management fee or the performance-based payment. The proposed monitoring methods related to stinting on care are not described in detail in the proposal, so how this monitoring would be implemented is not clear.

We appreciated the effort LUGPA has made to put forward this proposed payment model and welcome their input as we explore future payment models.

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Renal Physicians Association (RPA)

I express my gratitude to the Renal Physicians Association (RPA) for submitting the *Incident ESRD Clinical Episode Payment Model* to the Physician-Focused Payment Model Technical Advisory Committee (PTAC). RPA's strong commitment to innovation and improving health care for beneficiaries with kidney disease is manifest in this proposed payment model. RPA's work on this proposed model, together with PTAC's detailed and rigorous review of it, has added much to the Department of Health and Human Services' (HHS) thinking about renal health and care models for beneficiaries with kidney disease.

HHS is keenly interested in ideas that support our current work to promote care improvement for beneficiaries with end stage renal disease (ESRD). HHS agrees with PTAC that this valuable proposal from RPA offers promise. In reviewing this proposal and PTAC's comments, we also agree with PTAC that there are areas for improvement and further refinement to this proposed model. Additional detail regarding HHS' considerations can be found below.

Accuracy of Savings and Losses Calculation

HHS is concerned that the small number of beneficiaries proposed to be attributed to each nephrology practice proposed for participation in this model would be insufficient to ensure the statistical reliability of the model's savings and losses calculations. A robust population of attributed beneficiaries would be required to accurately calculate financial performance, as opposed to aligning beneficiaries through nephrologists, which may result in limited beneficiary inclusion in the model, with no minimum requirements for the number of beneficiaries attributed to model participants.

Inconsistency between Proposed Beneficiary Identification Methodology and Care Model

The proposed model identifies a number of care goals associated with the time period prior to and during the incident ESRD period. This model does not, however, identify beneficiaries as eligible for inclusion in the model prior to their starting dialysis, and the model's financial methodology does not consider savings associated with the pre-dialysis period. The decision not to attribute beneficiaries to model participants during this time period would prevent the care goals identified for the period prior to the onset of dialysis from being achieved. Similarly, significant lag in the time between onset of dialysis and Centers for Medicare & Medicaid Services (CMS) receiving verified notification that a beneficiary has ESRD would prevent participating health care providers from knowing which of their beneficiaries was included in the model, thus preventing participants from achieving the model's care goals associated with the start of dialysis treatment.

Potential for Perverse Incentives in Beneficiary Selection Process

HHS is concerned that this proposed model could create incentives for model participants to selectively pick lower cost patients for treatment, and to avoid beneficiaries with higher levels of comorbidities or other complexities. The proposed financial model could create incentives to move beneficiaries with late-stage chronic kidney disease (CKD) onto dialysis, even if they still have some remaining kidney function, because these beneficiaries' costs would be lower than a benchmark comprised solely of ESRD beneficiaries receiving dialysis. Without a highly sensitive risk adjustment approach, this practice could artificially inflate savings calculations and have negative effects on a beneficiary's quality of life.

Care Coordination

It is unclear how model participants would coordinate care with dialysis providers or other health care providers to improve beneficiary care if dialysis facilities -- which are a central part of care for dialysis patients -- are not identified as eligible model participants. In addition, many nephrology practices are small and may not have the necessary infrastructure to expand existing care coordination activities, especially given that shared savings payments would be received by nephrology practices several months after delivery of care. This delay in receipt of payment may prevent the necessary investments in care coordination and data infrastructure that will be necessary for health care providers to be successful participants in the model.

Medicare Eligibility

Beneficiaries with ESRD are eligible for Medicare, while many beneficiaries with chronic kidney disease (CKD) are not eligible for Medicare in the period prior to ESRD and for the first three months of dialysis. HHS is concerned that there may only be a small number of beneficiaries eligible under the criteria proposed by RPA.

We share a common goal of improving health care for all Americans. To do this, we must think creatively and leverage experience from across the nation. To encourage better outcomes and improve patient experience of care, HHS must learn from health care providers in the kidney disease field who have changed care delivery. We recognize the contributions of practicing physicians in driving this transformation and sincerely appreciate RPA contributing to this effort and participating in the PTAC process, and we look forward working with RPA and other stakeholders on designing future models related to kidney care in this country.

We look forward to the continued engagement of stakeholders to submit proposals to PTAC and the future recommendations of PTAC regarding physician-focused payment models that would reduce expenditures while preserving or enhancing the quality of care. Thank you for your time, and thank you for your efforts to improve the quality and value of health care for beneficiaries on Medicare and Medicaid.

Mercy Accountable Care Organization (Mercy ACO)

I express my gratitude to Mercy Accountable Care Organization (Mercy ACO) for its submission of the *Annual Wellness Visit at Rural Health Clinics* proposal to the Physician-Focused Payment Model Technical Advisory Committee (PTAC). This proposal and PTAC's thoughtful review have added to the Department of Health and Human Services' (HHS) consideration of strategies to improve preventative care for Medicare beneficiaries in underserved rural areas.

While we understand the request to modify certain Medicare billing rules for an Annual Wellness Visit (AWV) by rural health clinics (RHCs), HHS agrees with PTAC that this proposal does not constitute a physician-focused payment model (PFPM). Specifically, the proposal allows registered nurses and other licensed non-practitioner staff to provide an AWV, and permits RHCs to bill for an AWV in conjunction with a visit for other medical services during the same day. We agree with PTAC's recommendation that these modifications could be achieved through changes in current Medicare payment methods by existing regulatory processes. Moreover, since PTAC's charge is to review proposed PFPMs and provide comments and recommendations regarding whether those proposals meet certain criteria pertaining specifically to PFPMs, we agree this proposal should be considered not applicable.

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Zhou Yang, PhD, MPH

I express my gratitude to Zhou Yang, PhD, MPH, for sharing the idea of a new physician-focused payment model (PFPM), the *Medicare 3 Year Value Payment Demonstration* and for submitting this proposal to the Physician-Focused Payment Model Technical Advisory Committee (PTAC). Her strong commitment to innovation and improving health care is manifest in the work on this proposed model.

However, the Department of Health and Human Services (HHS) shares PTAC's concern that this is a proposal that requests changes to the health care system that are much broader than a PFPM. Rather, it proposes to establish a new system of competing health plan options for beneficiaries, with one option being direct negotiation between patients and physician organizations over current fee-for-service payment levels. Since PTAC's charge is to review proposed PFPMs and provide comments and recommendations regarding whether those proposals meet certain criteria pertaining specifically to PFPMs, we agree this proposal should be considered not applicable, as it does not satisfy the definition of a PFPM.

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We look forward to the continued engagement of individuals and stakeholder entities to submit proposals to PTAC and future recommendations of PTAC regarding physician-focused payment models that would reduce expenditures while preserving or enhancing the quality of care.