Physician-Focused Payment Model Technical Advisory Committee
Public Meeting Minutes

June 22, 2020
10:01 a.m. – 3:06 p.m. EDT
Virtual Meeting

Attendance*

Physician-Focused Payment Model Technical Advisory Committee (PTAC) Members
Jeffrey Bailet, MD, PTAC Chair (President and Chief Executive Officer, Altais)
Grace Terrell, MD, MMM, PTAC Vice Chair (President and Chief Operating Officer, Eventus WholeHealth)
Paul N. Casale, MD, MPH (Executive Director, NewYork Quality Care ACO)
Charles DeShazer, MD (Senior Vice President and Chief Medical Officer, Highmark Health Plan)
Kavita Patel, MD, MSHS (Vice President, Payer and Provider Integration, Johns Hopkins Health System)**
Angelo Sinopoli, MD (Chief Clinical Officer, Prisma Health)
Bruce Steinwald, MBA (President, Bruce Steinwald Consulting)
Jennifer Wiler, MD, MBA (Chief Quality Officer Denver Metro, UCHealth, and Professor of Emergency Medicine, University of Colorado School of Medicine)

U.S. Department of Health and Human Services (HHS) Guest Speakers
Seema Verma (Administrator, Centers for Medicare & Medicaid Services [CMS])
Brad Smith (Deputy Administrator, CMS, and Director, Center for Medicare & Medicaid Innovation [CMMI]; Senior Advisor to the Secretary on Value-Based Transformation and Innovation)

Office of the Assistant Secretary for Planning and Evaluation (ASPE) Staff
Stella (Stace) Mandl, PTAC Staff Officer
Audrey McDowell, Designated Federal Officer
Sally Stearns, PhD

ASPE Contractor Team, NORC at the University of Chicago (NORC)
Adele Shartzer, PhD (Urban Institute)
Laura Skopec (Urban Institute)

Via Webex Webinar unless otherwise noted

***** Via Conference Call (partial)***

List of Proposals, Submitters, Public Commenters, and Handouts

1. **Eye Care Emergency Department Avoidance (EyEDA) submitted by the University of Massachusetts Medical School**

   Submitter Representatives
   David F. Polakoff, MD, MSc
   Clifford Scott, OD, MPH
   Jay Flanagan, MHL

Public Commenters
Stephen Eiss, OD (Optometrist, American Optometric Association)
Lori L. Grover, OD, PhD (Director, Center for Eye and Health Outcomes, American Optometric Association)

Handouts
- Agenda
- Committee Member Disclosures
- Preliminary Review Team (PRT) Presentation
- PRT Report
- Submitter's Response to PRT Report
- Additional Information from Submitter
- Additional Information or Analyses/Data Tables
- Public Comments
- Proposal

2. **Patient-Centered Asthma Care Payment (PCACP) submitted by the American College of Allergy, Asthma & Immunology (ACAAI)**

Submitter Representatives
James Tracy, DO, FACAAI
James Sublett, MD
Bill Finerfrock

Public Commenters
Harold Miller (President and CEO, Center for Healthcare Quality and Payment Reform)
Sandy Marks (Senior Assistant Director, Federal Affairs, American Medical Association)
Stephen Imbeau, MD (Allergist and Immunologist, Chair, Advocacy Council of the American College of Allergy, Asthma & Immunology)
J. Allen Meadows, MD (President, American College of Allergy, Asthma & Immunology)

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[NOTE: A transcript of all statements made by PTAC members, submitter representatives, and public commenters at this meeting is available on the ASPE PTAC website located at: http://aspe.hhs.gov/meetings-physician-focused-payment-model-technical-advisory-committee].

The PTAC website also includes copies of the presentation slides and a video recording of the June 22, 2020 PTAC public meeting.

Welcome and Introduction of the CMS Administrator
Jeffrey Bailet, PTAC Chair, welcomed the public to the first virtual PTAC public meeting, which the Committee chose to hold in order to avoid further delaying the evaluation of submitted proposals. Next, the Chair introduced Seema Verma, Administrator of the Centers for Medicare & Medicaid Services (CMS). He noted that Administrator Verma is one of the longest-serving Administrators in modern history and was ranked as the number one most influential person in health care in 2019 by *Modern Healthcare*.

The CMS Administrator's Remarks
Administrator Verma began by expressing her appreciation and acknowledging the service of front line workers during the health care crisis. She discussed how CMS has responded to the coronavirus pandemic by expanding flexibility and removing various regulatory barriers to enable health care workers and facilities to address patient needs. For example, Administrator Verma indicated that CMS has increased access to telehealth visits, which has allowed seniors to access needed care without leaving their homes. She also noted that CMS has taken multiple steps to allow hospitals to provide services in other health care facilities and sites that are not necessarily part of the physical existing hospital and set up temporary expansion sites and to allow ambulatory surgery centers with capacity to register as hospitals under the Hospital Without Walls initiative.

Administrator Verma also indicated that in response to the crisis, CMS has approved over 365 requests from states for waivers, amendments, and flexibilities in Medicaid state plans. Additionally, she noted that CMS has announced important flexibilities relating to its existing alternative payment models, including data reporting, as well as payment methodology adjustments that seek to mitigate provider risk.

Administrator Verma stated that as CMS assesses the flexibilities that have been made, and which should and could become permanent through regulatory changes, such as telehealth, the Agency will also be looking at flexibilities offered in payment models. She noted that CMS continues to think about how to continue to encourage value-based care through the development and release of payment models, with improving value being central to and a top priority for CMS. Administrator Verma acknowledged the vulnerabilities of the current health care system and fee-for-service payment in contrast to population-based payment models and the role that CMS plays in the transition to value-based care via the models that CMS develops and releases. She noted that PTAC plays a vital role in CMS's development of models, expressed appreciation for PTAC's efforts and input, and stated that CMS has had some informative conversations with submitters who have gone through the PTAC process. Administrator Verma indicated that CMS is particularly interested in working with PTAC to better understand stakeholder perspectives about how value-based care can be used to address various care delivery issues and about increasing provider adoption of alternative payment models.

Chairman's Update and Deliberation and Voting Procedures
Chair Bailet thanked Administrator Verma for her remarks and provided an update on PTAC's recent work. He noted that PTAC sent a report to the Secretary of Health and Human Services (HHS) that included its comments and recommendations on the *ACCESS Telemedicine: An Alternative Healthcare Delivery Model for Rural Cerebral Emergencies* Physician-Focused Payment Model proposal, which PTAC voted on during its last public meeting on September 16, 2019. Chair Bailet also welcomed Dr. Charles DeShazer, who was appointed to PTAC by the Government Accountability Office (GAO) in October 2019, and indicated that PTAC expects three additional GAO appointments in the coming weeks.

Chair Bailet noted that PTAC has been reviewing models for three and a half years, with this being PTAC's tenth public meeting that includes voting on proposed Medicare Physician-Focused Payment Models (PFPMs). He indicated that the Office of the Assistant Secretary for Planning and Evaluation's (ASPE's) contractor has prepared two reports that summarize common elements and themes across the proposals that have been submitted to PTAC and describe patterns in how PTAC has assessed them.

With the public health emergency highlighting challenges within the current healthcare system, and the potential role that value-based alternative payment models can play in addressing some of those weaknesses, Chair Bailet indicated that PTAC has drafted a Vision Statement to better communicate how the Committee's work fits into the transition to value-based care. He also indicated that PTAC would be releasing an updated version of its Proposal Submission Instructions that are designed to encourage stakeholder engagement and to expand the number and types of PFPM proposals that are submitted to PTAC.

Additionally, Chair Bailet stated that PTAC anticipates having theme-based discussions during future public meetings to foster dialogue and insights on specific issues that are not limited to a single proposal. He indicated that the Committee anticipates having its first theme-based discussion in September, focusing on previous proposals that have included elements related to telehealth and the role that alternative payment models and telehealth can play in transforming the future healthcare system.

Chair Bailet also announced that PTAC would be seeking public input on some questions relating to challenges in care delivery and payment model design, to further inform the work of the Committee. He also indicated that PTAC currently has several proposals under review, including two that the Committee is scheduled to deliberate and vote on today.

The Chair reminded the audience of the steps in the deliberation and voting process, introduced the full Committee, and introduced the Preliminary Review Team (PRT) that reviewed the *Eye Care Emergency Department Avoidance (EyEDA)* proposal submitted by the University of Massachusetts Medical School.

University of Massachusetts Medical School: Eye Care Emergency Department Avoidance (EyEDA)

Committee Member Disclosures
All eight Committee members disclosed no conflicts.

PRT Report to the Full PTAC
The PRT for the *Eye Care Emergency Department Avoidance (EyEDA)* proposal consisted of Paul Casale (PRT Lead), Kavita Patel, and Harold Miller. Dr. Casale stated that the input of Mr. Miller, who resigned from the Committee in November 2019, is reflected in the PRT report that is being shared with the full Committee. Dr. Casale presented an overview of the proposed Physician-Focused Payment Model (PFPM), which:

- Is based on a Transforming Clinical Practices Initiative (TCPI) award that provided technical assistance to over 1,600 optometry practices across the nation, to increase the number of patients with eye-related symptoms who make visits to a practice rather than an emergency department (ED) for urgent eye conditions.
- Aims to encourage treatment of selected eye-related symptoms through office visits with optometrists and ophthalmologists rather than visits to hospital EDs.

- Has a payment model that includes financial risk in the form of an eight percent reduction for all urgent care visits (identified by ICD-10 diagnosis codes) relative to payments under the normal Medicare physician fee schedule. There is a shared savings payment at the conclusion of the performance year, based on: the participating provider or practice's number of qualifying urgent office visits relative to a target level (historical volume of visits for these conditions); and the reduction in ED visits in area hospitals for the same diagnoses relative to the base year.
- Requires that in order to receive shared savings bonus payments, providers must meet minimum thresholds on two quality measures related to patient experience and patient safety.

Key issues identified by the PRT included the following:

- The eight percent reduction in fees for urgent care visits may discourage participation and cause problematic financial losses for providers and practices that cannot successfully meet targets for increased number of visits.
- Payment is still fee-for-service (FFS) based on office visits, with no flexibility in payment to support different approaches to services. Payment reductions and visit targets tied to specific diagnosis codes could result in undesirable incentives to code incorrectly.
- The proposed model does not attribute patients to practices. The methodology for determining shared savings and attributing the savings to participating providers is not clearly defined.
- The proposed model does not require or encourage care coordination with primary care providers or other specialists.
- Many of the problems with the payment model reflect challenges that the submitter faced in trying to craft a model to meet the requirements that Centers for Medicare & Medicaid Services (CMS) has established for an Advanced Alternative Payment Model (Advanced APM).

The PRT unanimously agreed that the proposed model meets four of the Secretary's 10 criteria ("Quality and Cost," "Value over Volume," "Patient Choice," and "Health Information Technology"). A majority of PRT members agreed that the proposed model meets two of the Secretary's 10 criteria ("Flexibility," and "Ability to Be Evaluated"). The PRT unanimously agreed that the proposal does not meet three of the Secretary's 10 criteria ("Payment Methodology," "Integration and Care Coordination," and "Patient Safety"). The majority of the PRT agreed that the proposed does not meet one of the Secretary's 10 criteria ("Scope").

[NOTE: The PRT's presentation slides and full report are available on the ASPE PTAC website located at: [https://aspe.hhs.gov/meetings-physician-focused-payment-model-technical-advisory-committee.](https://aspe.hhs.gov/meetings-physician-focused-payment-model-technical-advisory-committee)]

Clarifying Questions from PTAC to the PRT

The Chair opened the floor for PTAC members' questions to the PRT. The discussion focused on the following topics:

- The appropriate scope and number of diagnoses to be targeted for the proposed model.
- The time-sensitive and emergent nature of some eye conditions that may mean adverse outcomes if a patient goes to an office setting rather than the ED. A related concern was that of potentially limited access to a physician's office unless expanded hours and patient education were to be provided.
- The importance of acknowledging the origins of the proposed model in a TCPI pilot with an interdisciplinary approach that featured coordination (hub and spoke approach) among ED physicians, urgent care, and ophthalmologists.

- Clarifying differences in concerns about patient safety raised by optometrists compared with those raised by ophthalmologists and about whether the proposed model is safe for most patients.
- The implications of the proposed FFS payment model for office visits, linkage with triage, referrals, virtual care, and other strategies to support more proactive, flexible approaches not fully specified in the proposed model.

Submitter's Statement
The Chair invited the submitter representatives, Dr. David Polakoff, Dr. Clifford Scott, and Jay Flanagan, to make a statement to PTAC.

The submitter representatives stated that the proposed model seeks to encourage and financially incentivize eye care professionals to have a conversation with their established patients about the availability of urgent care services for ocular symptoms in the office or clinical setting and to expand the availability of those services. The submitter representatives indicated that the University of Massachusetts Medical School served as a practice transformation network under CMS's Transforming Clinical Practices Initiative (TCPI), with over 1,600 practices. Based on the submitter's TCPI experience, the majority of the participating practices were able to implement the care model with minimal upfront investment and demonstrate increases in urgent care visits that averaged 20 to 25 percent over baseline without the financial incentives associated with a payment model. The submitter representatives described what they see as some of the strengths of the proposed model, which include its relative simplicity, its patient-centered approach to reducing ED visits, its potential to link eye care professionals more closely to patient-centered medical neighborhoods, and its potential replicability for other conditions in other specialties. The submitter representatives also discussed several issues that have been raised relating to the model, including whether it is sufficient to meet the criteria for an advanced APM, the criteria for determining the ICD-10 codes that are included in the model, and potential concerns relating to patient safety.

PTAC Questions for the Submitters and Discussion
PTAC and the submitters engaged in Q&A on the following topics:

- Whether the patients would be limited to established patients of the participating practices.
- How urgent care visits would be identified.
- The feasibility of access to office-based care during nontraditional hours, at the discretion of individual clinical practices.
- Barriers to implementing this care delivery model under the existing FFS system.
- Whether sufficient volumes of Medicare FFS visits are anticipated to encourage participation in the proposed model.
- The extent to which the proposed model would be more effective in the bigger context of a medical neighborhood.

Public Comments
Chair Bailet thanked the submitter representatives and opened the floor for public comments. The following individuals made comments on the *Eye Care Emergency Department Avoidance (EyEDA)* proposal:

1. Steven Eiss, OD (Optometrist, American Optometric Association)
2. Lori L. Grover, OD, PhD (Director, Center for Eye and Health Outcomes, American Optometric Association)

[NOTE: A transcript of commenters' remarks is available on the ASPE PTAC website located at: https://aspe.hhs.gov/meetings-physician-focused-payment-model-technical-advisory-committee.]

PTAC Voting on Secretary's Criteria

Eight PTAC members deliberated and voted on the extent to which the *Eye Care Emergency Department Avoidance (EyEDA)* proposal meets each of the Secretary's 10 criteria.

[NOTE: A simple majority vote will establish PTAC's determination for each of the Secretary's criteria. Members' individual criterion votes remain anonymous. However, the distribution of votes and the voting outcomes are presented in the table below. Individual member comments are available in the meeting transcript located on the ASPE PTAC website at: http://aspe.hhs.gov/meetings-physician-focused-payment-model-technical-advisory-committee.]

Given that eight PTAC members participated in deliberation and voting on the proposal, five PTAC votes constituted a simple majority.

PTAC Member Votes on *Eye Care Emergency Department Avoidance (EyEDA)*

Criteria Specified by the Secretary (42 CFR§414.146)	PTAC Vote Categories	PTAC Vote Distribution
1. Scope (High Priority)	* – Not Applicable	0
	1 – Does not meet criterion	1
	2 – Does not meet criterion	6
	3 – Meets the criterion	1
	4 – Meets the criterion	0
	5 – Meets the criterion and deserves priority consideration	0
	6 – Meets the criterion and deserves priority consideration	0
PTAC DECISION: Proposal Does Not Meet Criterion 1.		
2. Quality and Cost (High Priority)	* – Not Applicable	0
	1 – Does not meet criterion	0
	2 – Does not meet criterion	0
	3 – Meets the criterion	7
	4 – Meets the criterion	1
	5 – Meets the criterion and deserves priority consideration	0
	6 – Meets the criterion and deserves priority consideration	0
PTAC DECISION: Proposal Meets Criterion 2.		

Criteria Specified by the Secretary (42 CFR§414.146)	PTAC Vote Categories	PTAC Vote Distribution
3. Payment Methodology (High Priority)	* – Not Applicable	0
	1 – Does not meet criterion	4
	2 – Does not meet criterion	4
	3 – Meets the criterion	0
	4 – Meets the criterion	0
	5 – Meets the criterion and deserves priority consideration	0
	6 – Meets the criterion and deserves priority consideration	0
PTAC DECISION: Proposal Does Not Meet Criterion 3.		
4. Value over Volume	* – Not Applicable	0
	1 – Does not meet criterion	0
	2 – Does not meet criterion	1
	3 – Meets the criterion	6
	4 – Meets the criterion	1
	5 – Meets the criterion and deserves priority consideration	0
	6 – Meets the criterion and deserves priority consideration	0
PTAC DECISION: Proposal Meets Criterion 4.		
5. Flexibility	* – Not Applicable	0
	1 – Does not meet criterion	0
	2 – Does not meet criterion	0
	3 – Meets the criterion	6
	4 – Meets the criterion	2
	5 – Meets the criterion and deserves priority consideration	0
	6 – Meets the criterion and deserves priority consideration	0
PTAC DECISION: Proposal Meets Criterion 5.		
6. Ability to Be Evaluated	* – Not Applicable	0
	1 – Does not meet criterion	0
	2 – Does not meet criterion	1
	3 – Meets the criterion	7
	4 – Meets the criterion	0

Criteria Specified by the Secretary (42 CFR§414.146)	PTAC Vote Categories	PTAC Vote Distribution
	5 – Meets the criterion and deserves priority consideration	0
	6 – Meets the criterion and deserves priority consideration	0
PTAC DECISION: Proposal Meets Criterion 6.		
7. Integration and Care Coordination	* – Not Applicable	0
	1 – Does not meet criterion	3
	2 – Does not meet criterion	2
	3 – Meets the criterion	3
	4 – Meets the criterion	0
	5 – Meets the criterion and deserves priority consideration	0
	6 – Meets the criterion and deserves priority consideration	0
PTAC DECISION: Proposal Does Not Meet Criterion 7.		
8. Patient Choice	* – Not Applicable	0
	1 – Does not meet criterion	0
	2 – Does not meet criterion	0
	3 – Meets the criterion	6
	4 – Meets the criterion	2
	5 – Meets the criterion and deserves priority consideration	0
	6 – Meets the criterion and deserves priority consideration	0
PTAC DECISION: Proposal Meets Criterion 8.		
9. Patient Safety	* – Not Applicable	0
	1 – Does not meet criterion	2
	2 – Does not meet criterion	5
	3 – Meets the criterion	0
	4 – Meets the criterion	1
	5 – Meets the criterion and deserves priority consideration	0
	6 – Meets the criterion and deserves priority consideration	0
PTAC DECISION: Proposal Does Not Meet Criterion 9.		

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

PTAC Vote on Recommendation to the Secretary
[NOTE: A two-thirds majority is required to determine the final recommendation to the HHS Secretary. If a two-thirds majority votes to not recommend the proposal for implementation as a PFPM or to refer the proposal for other attention by HHS, that category is the Committee's final recommendation to the Secretary. If the two-thirds majority votes to recommend the proposal, the Committee proceeds to a secondary vote with four categories to determine the final, overall recommendation to the Secretary. PTAC members' votes on the recommendation to the Secretary are presented in the table below.]

Given that eight PTAC members participated in deliberation and voting on the proposal, a two-thirds majority of six votes was required for the final PTAC recommendation vote.

PTAC Recommendation Category	PTAC Vote Distribution	PTAC Member Recommendation Vote
Not recommended for implementation as a PFPM	7	Jeffrey Bailet Paul Casale Charles DeShazer Kavita Patel Angelo Sinopoli Grace Terrell Jennifer Wiler
Recommended for implementation as a PFPM	0	*No PTAC members voted for this recommendation category*
Referred for other attention by HHS	1	Bruce Steinwald

As a result of the vote, PTAC did not recommend the *Eye Care Emergency Department Avoidance (EyEDA)* proposal for implementation as a PFPM.

Instructions on the Report to the Secretary

For PTAC's report to the Secretary regarding this proposal, Committee members made the following comments:

- The proposed model is promising in terms of increased access and improved quality of care outside of the ED, with extended hours, a robust triage and referral process to divert cases from the ED, alignment with telemedicine approaches, and attention to care coordination that one Committee member described as appropriate.
- The proposal did not include adequately detailed specifications regarding payment, integration of care coordination, and patient safety concerns. Regarding patient safety, one Committee member noted that the metrics described in the proposal do not crosswalk with standard complications related to ambulatory care-sensitive conditions.
- The payment model lacked sufficient detail, leading to concerns that the proposed model would not encourage sufficient practice participation, especially as it is seen as office-based payment. In addition, there was concern about the likelihood of an insufficient number of qualifying encounters. Committee members noted that the aims of the proposed model might be better achieved through care coordination fees or other types of payment models other than discounted volume.
- While Committee members acknowledged the importance of an eye care model, there were concerns about the scope of the proposal and whether it might be preferable to embed this proposed model or model elements in other primary care models.
- It will be important to mention that this proposed model emerged from experiences of the submitters with the CMMI TCPI initiative.
- The TCPI experience showed that small practices have the interest and ability to expand to provide urgent care for five conditions, and the current public health emergency further emphasizes the value of telehealth-based services.

The public meeting recessed at 12:19 p.m. and reconvened at 12:45 p.m.

Introduction of the CMS Deputy Administrator and CMMI Director

Grace Terrell, PTAC Vice Chair welcomed Brad Smith, Deputy Administrator, CMS, and Director, CMMI, and Senior Advisor to the Secretary on Value-Based Transformation and Innovation. She noted that Mr. Smith has extensive experience innovating in the care delivery and value-based care spaces – having co-founded and served as the CEO of Aspire Health, a healthcare company focused on providing home-based palliative care services to patients facing serious illnesses.

The CMS Deputy Administrator and CMMI Director's Remarks

Mr. Smith began by stating that he has had the opportunity to see the importance of PTAC's work for informing providers as well as CMMI and CMS firsthand–having previously served as the head of a palliative care company that was part of the Coalition to Transform Advanced Care (C-TAC), which submitted a proposed model to PTAC and received helpful feedback. He indicated that subsequently, after C-TAC-s participation in the PTAC process, CMMI ultimately included some elements of the C-TAC model and another palliative care model that was recommended by PTAC in the recently-announced Serious Illness Population (SIP) payment model.[1]

[1] The SIP payment model is a sub-model under Primary Care First.

Mr. Smith indicated that he has been focusing on reviewing the models that CMMI has implemented and identifying important lessons learned relating to benchmarking and operations. Mr. Smith stated that moving forward, CMMI will be focusing on making sure that participants are supported and that existing models are successful—specifically, that they are helping to lower costs or improve quality. He also indicated that CMMI will evaluate the COVID-related flexibilities for potential incorporation into CMMI's models.

Mr. Smith thanked PTAC for being great partners and expressed interest in continuing to work with the Committee in several ways. First, he discussed the continued importance of PTAC's role in providing helpful feedback to providers and other stakeholders on proposed models. Mr. Smith also expressed an interest in having PTAC and the ideas that are generated by providers across the country to inform CMMI in thinking about new areas where they should consider launching models (for example, such as behavioral health, as well as social determinants of health and post-acute bundles). He also expressed CMMI's interest in meeting with submitters. Additionally, Mr. Smith discussed the possibility of sharing some of CMMI's lessons learned about its existing models with PTAC.

The American College of Allergy, Asthma & Immunology (ACAAI): Patient-Centered Asthma Care Payment (PCACP)

Committee Members Disclosures
All eight Committee members disclosed no conflicts.

PRT Presentation to the Full PTAC
The PRT for *the American College of Allergy, Asthma & Immunology (ACAAI): Patient-Centered Asthma Care Payment (PCACP)* proposal consisted of Angelo Sinopoli (PRT Lead), Jeffrey Bailet, and Bruce Steinwald. Dr. Sinopoli presented an overview of the proposed Physician-Focused Payment Model (PFPM), which:

- Intends to give physicians specializing in asthma care (primarily allergists and immunologists) the resources and flexibility they need to better diagnose and manage patients with asthma.
- Seeks to save costs and improve quality by avoiding unnecessary hospitalizations and ED visits through better diagnosis and management of patients with asthma.
- Divides asthma care into three categories for varying levels of care: 1) diagnoses and initial treatment for patients with poorly-controlled asthma; 2) continued care for patients with difficult-to-control asthma; and 3) continued care for patients with well-controlled asthma.
- Has different beneficiary eligibility and payment amounts for participating Asthma Care Teams (ACTs) for each category.
- Excludes asthma patients with certain comorbidities such as COPD and lung cancer; and excludes participating asthma patients from all performance assessment measures if they fail to stop smoking, obtain prescribed medications, or attend scheduled appointments.
- Assesses performance on service utilization/spending and quality is assessed relative to other participating ACTs, with adjustments to PCACP payments based on performance.
- Requires ACTs to meet minimum quality standards to receive bundled payments in Categories 1 and 2.

Key issues identified by the PRT included the following:

- The proposed model does not have sufficient scope for implementation as a stand-alone APM.
- The proposed model is highly complex, due to: 1) the three separate phases, each having monthly evaluation and up to five payment levels within each phase; and 2) the potential to maximize bundled payments through selection rather than a simpler payment approach that applies to all asthma.
- The proposed model falls short in its approach to care coordination and does not address core factors that are likely to reduce excess utilization (e.g., social determinants of health and copayments), other than through education and evidence-based practice.
- The proposal does not clearly identify how the Medicare FFS payment system, as it exists today, causes failures in the ability for a doctor to make an accurate diagnosis; the proposal frequently refers to a focus on the need for an increased fee schedule rate.
- The proposal may overstate the possibility for savings in the Medicare population, citing a 50 percent reduction in ED visits and hospitalization among nonelderly asthma patients.
- The inclusion of some but not all tests increases complexity and could further reduce the potential for savings.
- Allocation of the payment from the specialist to the primary care provider in the second phase (continued care for patients with difficult-to-control asthma) was left unspecified.

The PRT unanimously agreed that the proposed model meets four of the Secretary's 10 criteria ("Flexibility," "Patient Choice," "Patient Safety," and "Health Information Technology"). The PRT unanimously agreed that the proposal does not meet six of the Secretary's 10 criteria ("Scope," "Quality and Cost," "Payment Methodology," "Value over Volume," "Ability to Be Evaluated," and "Integration and Care Coordination").

[NOTE: The PRT's presentation slides and full report are available on the ASPE PTAC website located at: https://aspe.hhs.gov/meetings-physician-focused-payment-model-technical-advisory-committee.]

Clarifying Questions from PTAC to the PRT

Vice Chair Terrell opened the floor for PTAC members' questions to the PRT. The discussion focused on the following topics:

- The proposed model's complexity, whether there were any ways to simplify the proposed model, and whether the proposed approach was less complex than the ICD-10 system of documentation used today.
- The significance of the submitter's effort to get a specialty-based model for allergists and pulmonologists into the field.

Submitter's Statement

Vice Chair Terrell invited the submitter representatives, Dr. James Tracy, Dr. James Sublett, and Bill Finerfrock to make a statement to PTAC.

The submitters stated that the proposed model is the first to support the timely and accurate diagnosis of a chronic condition while supporting collaboration between patients' primary care physicians and asthma care specialists and holding the asthma team accountable for outcomes and costs. The

submitters also summarized the objectives of the PCACP model, which include seeking to: 1) ensure the accurate diagnosis of asthma; 2) promote local delivery of health care; 3) promote involvement of specialists most able to care for difficult-to-control asthma patients; 4) improve overall outcomes (e.g., reduce premature deaths, ED visits, and hospitalizations); 5) reduce overall costs; and 6) provide a value-driven and integrated asthma care team that is held accountable for meeting quality and cost measures. The submitters also responded to several of the concerns that the PRT raised regarding the PCACP model – particularly relating to the model's scope, quality and cost, and payment methodology. For example, the submitters emphasized that the proposed model might be attractive to small practices that do not have the opportunity to participate in Accountable Care Organizations. While acknowledging that there are things that could be improved in the proposal, the submitters encouraged the idea of moving forward with putting the model through a "field test" and making adjustments where appropriate.

PTAC Questions for the Submitters and Discussion

PTAC and the submitters engaged in Q&A on the following topics:

- Whether the process of patient selection might incentivize risk profiling that is favorable to the provider but not the patient, and how the model can control for unintended incentives.
- The submitters' justification for not expanding the model to include other respiratory conditions (such as chronic obstructive pulmonary disorder).
- Whether any aspects of the proposed model have been adopted by private payers, given the prevalence of asthma in commercial populations.
- The submitters' justification for excluding patients with certain behaviors such as failure to stop smoking from the proposed model's quality and outcome measures, and the universe of patients the model would apply to.
- Patients with certain behaviors such as failure to stop smoking.
- Whether the current Medicare FFS model impedes doctors' ability to make an accurate diagnosis of asthma, and how the proposed model would enable doctors to make an accurate diagnosis.
- The roles of the other team members that may need to be involved in the care of patients with asthma (e.g., ear, nose, and throat specialists; pulmonologists; and gastroenterologists) in this proposed model.

Public Comments

Vice Chair Terrell thanked the submitter representatives and opened the floor for public comments. The following individuals made comments on the *Patient-Centered Asthma Care Payment (PCACP)* proposal:

- Harold Miller (President and CEO, Center for Healthcare Quality and Payment Reform)
- Sandy Marks (Senior Assistant Director, Federal Affairs, American Medical Association)
- Stephen Imbeau, MD (Allergist and Immunologist, Chair, Advocacy Council of the American College of Allergy, Asthma & Immunology)
- J. Allen Meadows, MD (President, American College of Allergy, Asthma & Immunology)

[NOTE: A transcript of commenters' remarks is available on the ASPE PTAC website located at: https://aspe.hhs.gov/meetings-physician-focused-payment-model-technical-advisory-committee.]

PTAC Voting on Secretary's Criteria
Eight PTAC members deliberated and voted on the extent to which the *Patient-Centered Asthma Care Payment (PCACP)* proposal meets each of the Secretary's 10 criteria.

[NOTE: A simple majority vote will establish PTAC's determination for each of the Secretary's criteria. Members' individual criterion votes remain anonymous. However, the distribution of votes and the voting outcomes are presented in the table below. Individual member comments are available in the meeting transcript located on the ASPE PTAC website at: http://aspe.hhs.gov/meetings-physician-focused-payment-model-technical-advisory-committee.]

Given that eight PTAC members participated in deliberation and voting on the proposal, five PTAC votes constituted a simple majority.

PTAC Member Votes on *Patient-Centered Asthma Care Payment (PCACP)*

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

Criteria Specified by the Secretary (42 CFR§414.146)	**PTAC Vote Categories**	**PTAC Vote Distribution**
	2 – Does not meet criterion	5
	3 – Meets the criterion	1
	4 – Meets the criterion	1
	5 – Meets the criterion and deserves priority consideration	0
	6 – Meets the criterion and deserves priority consideration	0
PTAC DECISION: Proposal Does Not Meet Criterion 3.		
4. Value over Volume	* – Not Applicable	0
	1 – Does not meet criterion	1
	2 – Does not meet criterion	3
	3 – Meets the criterion	3
	4 – Meets the criterion	1
	5 – Meets the criterion and deserves priority consideration	0
	6 – Meets the criterion and deserves priority consideration	0
PTAC DECISION: Proposal Does Not Meet Criterion 4.		
5. Flexibility	* – Not Applicable	0
	1 – Does not meet criterion	0
	2 – Does not meet criterion	0
	3 – Meets the criterion	6
	4 – Meets the criterion	2
	5 – Meets the criterion and deserves priority consideration	0
	6 – Meets the criterion and deserves priority consideration	0
PTAC DECISION: Proposal Meets Criterion 5.		
6. Ability to Be Evaluated	* – Not Applicable	0
	1 – Does not meet criterion	1
	2 – Does not meet criterion	5
	3 – Meets the criterion	2
	4 – Meets the criterion	0
	5 – Meets the criterion and deserves priority consideration	0

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

Criteria Specified by the Secretary (42 CFR§414.146)	PTAC Vote Categories	PTAC Vote Distribution
	3 – Meets the criterion	6
	4 – Meets the criterion	2
	5 – Meets the criterion and deserves priority consideration	0
	6 – Meets the criterion and deserves priority consideration	0
PTAC DECISION: Proposal Meets Criterion 10.		

PTAC Vote on Recommendation to the Secretary
[NOTE: A two-thirds majority is required to determine the final recommendation to the HHS Secretary. If a two-thirds majority votes to not recommend the proposal for implementation as a PFPM or to refer the proposal for other attention by HHS, that category is the Committee's final recommendation to the Secretary. If the two-thirds majority votes to recommend the proposal, the Committee proceeds to a secondary vote with four categories to determine the final, overall recommendation to the Secretary. PTAC members' votes on the recommendation to the Secretary are presented in the tables below.]

Given that eight PTAC members participated in deliberation and voting on the proposal, a two-thirds majority of six votes was required for the final PTAC recommendation vote.

PTAC Recommendation Category	PTAC Vote Distribution	PTAC Member Recommendation Vote
Not recommended for implementation as a PFPM	0	*No PTAC members voted for this recommendation category*
Recommended for implementation as a PFPM	0	*No PTAC members voted for this recommendation category*
Referred for other attention by HHS	8	Jeffrey Bailet Paul Casale Charles DeShazer Kavita Patel Angelo Sinopoli Bruce Steinwald Grace Terrell Jennifer Wiler

As a result of the vote, PTAC referred the *Patient-Centered Asthma Care Payment (PCACP)* proposal for other attention by HHS.

Instructions on the Report to the Secretary
For PTAC's report to the Secretary regarding this proposal, individual PTAC members made the following comments:

- There is evidence of stakeholder interest in the proposed model. Asthma is a complicated and costly diagnosis that is often misdiagnosed and that can be a complicated diagnosis in older patients; as such, there is value in payments and savings that encourage collaboration between specialists and primary care physicians.
- PTAC recognizes the importance of developing a specialty-focused model that involves a team-based approach that could be beneficial for patients with related conditions (other than asthma), an approach that may not be part of an Accountable Care Organization or another APM. One Committee member noted that the target population is not as large a percentage of all Medicare beneficiaries as for other conditions addressed in proposals that the Committee has previously considered and that the proposal would be strengthened if it were to include chronic obstructive pulmonary disorder (COPD).
- Committee members believed that the proposed model needed greater specification, and consideration regarding whether payment issues could be addressed under the Medicare physician fee schedule, but by referring the model some of these concerns could be worked out. Committee members noted that with a more narrow scope, the proposed model could be feasible for CMMI or could facilitate the inclusion of the target population of patients in another payment model. One member noted that the proposed model would be relatively easy to administer.
- The proposed model has the potential to support smaller and rural practices, as well as larger practices.

Discussion: Reflecting on Models Deliberated on By PTAC

Adele Shartzer and Laura Skopec from ASPE's NORC contractor support team presented highlights from two reports analyzing 24 proposed models that PTAC has deliberated and voted on as of December 2019. The full reports are available on the Resources page of the ASPE PTAC website. The presenters described: 1) the types of stakeholders who submitted proposals to PTAC; 2) the proposed care delivery changes (for example, care integration across providers and settings); 3) the proposed innovations in APM development; 4) whether the proposed models included risk accountability (noting that almost all of the models proposed approaches involving two-sided risk); and 5) the role of the PTAC review process as an opportunity for stakeholders to raise policy issues. The presenters also discussed the methods used to develop each of the two reports and the key takeaways for policy development, based on PTAC's review of the proposed models against the Secretary's evaluative criteria.

Closing Remarks

Chair Bailet thanked NORC and the Urban Institute for the presentation. He also thanked the public for participating in PTAC's first virtual meeting.

Chair Bailet announced that PTAC is seeking to expand the information included in the environmental scans that are prepared as part of the PTAC proposal review process. He indicated that in order to facilitate these efforts, PTAC is requesting stakeholder input on what issues are considered relevant to enhance the Committee's review and recommendations to the Secretary. Toward this end, PTAC will post several questions to the PTAC website on the For Public Comment page, and these questions will also be emailed to the PTAC distribution listserv so that the public can submit responses via e-mail. PTAC plans to post the input received online.

The public meeting adjourned at 3:06 p.m. EDT.

Approved and certified by:

//Audrey McDowell//   8/10/2020

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Audrey McDowell, Designated Federal Officer
Physician-Focused Payment Model Technical
Advisory Committee

Date

//Jeffrey Bailet//   8/7/2020

______________________________________   ________________________

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

Date