Physician-Focused Payment Model Technical Advisory Committee

Request for Proposals: Medicare Physician-Focused Payment Models

Revised February 21, 2017

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A. Introduction

1. MACRA Statute

The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) creates new ways for the Medicare program to pay physicians for the care they provide to Medicare beneficiaries. MACRA also creates incentives for physicians to participate in Alternative Payment Models (APMs), and it specifically encourages the development of physician-focused payment models (PFPMs).

2. Role of PTAC in Making Recommendations to Secretary

Section 101 (e)(1) of MACRA creates the Physician-Focused Payment Model Technical Advisory Committee (PTAC) to make comments and recommendations to the Secretary of the Department of Health and Human Services (the Secretary, HHS) on proposals for PFPMs submitted by individuals and stakeholder entities. The Secretary is required by MACRA to establish criteria for PFPMs and to respond to the recommendations of PTAC. Ten criteria were outlined in the MACRA final rule with comment period (at 42 CFR §414.1465) published in the *Federal Register* on November 4, 2016.

The criteria are described in the Supporting Information section of this request for proposals (RFP). PTAC will evaluate whether the proposed models meet the Secretary's criteria. The full Committee will discuss and deliberate their assessment of proposals in public meetings. Information regarding the characteristics of PFPMs likely to be recommended by PTAC is also described in this RFP.

3. APMs, Advanced APMs, and PFPMs

The MACRA final rule defines a PFPM as an APM in which:

- Medicare is a payer;
- Eligible clinicians that are eligible professionals as defined in section 1848(k)(3)(B) of the Social Security Act (SSA) are participants and play a core role in implementing the APM's payment methodology; and
- Targets are the quality and costs of services that eligible professionals participating in the APM provide, order, or can significantly influence.

MACRA defines an APM as a model under section 1115A of SSA (other than a health care innovation award), a model in the shared savings program under section 1899, a demonstration under section 1866C, or a demonstration required by federal law. To be an Advanced APM, an APM must—consistent with MACRA—require participants to use certified electronic health record technology (CEHRT), provide for payment for covered professional services based on quality measures comparable to those in the quality performance category under the Merit-Based Incentive Payment System (MIPS) and either

require that participating APM Entities bear risk for monetary losses of a more than nominal amount under the APM or be a Medical Home Model expanded under section 1115A(c) of SSA.

B. Characteristics of PFPMs Likely to Be Recommended by PTAC

In order to assist stakeholders who are considering submitting proposals for PFPMs and to facilitate its own deliberations, PTAC has developed some initial guidance as to the kinds of payment models that are more likely to receive favorable recommendations. However, PTAC will consider all proposals on their merits, and it reserves the right to make decisions on individual proposals that differ from this guidance. It also reserves the right to modify this guidance as necessary based on experience in reviewing proposals, based on comments and recommendations offered by stakeholders, and based on the regulations governing PFPMs that are issued by the Secretary of HHS.

PTAC will use the information submitted in a proposal to determine whether a PFPM has the characteristics described in this document. The information needed to make this determination is defined in detail in the Supporting Information section of this RFP.

1. Goals and Focus of PFPMs

PTAC encourages innovative proposals for PFPMs that will control health care spending and/or improve health care quality. In general, PTAC will only consider PFPMs that change the method of payment for physicians or other eligible professionals[*] if the payment model also requires those eligible professionals or the entity receiving the payment to take accountability for (1) reducing spending without reducing the quality care, (2) improving the quality of care without increasing spending, or (3) improving the quality of care and reducing spending.

The types of PFPM proposals that will be considered by PTAC include, but are not limited to:

- Payments designed to enable an individual eligible professional or group of eligible professionals to improve care for patients who are receiving a specific treatment or procedure. These "treatment-based payments" could focus only on services delivered on the day(s) of treatment or on services delivered during a longer episode of care.
- Payments designed to enable an individual eligible professional or group of eligible professionals to improve care during a period of time for patients who have a specific health condition or combination of conditions. These "condition-based payments" could focus on either acute conditions or chronic conditions.
- Payments designed to enable teams of eligible professionals to deliver more coordinated, efficient care for patients who have a specific condition or are receiving a specific treatment or procedure.

[*]As defined in MACRA and the regulations issued by HHS, an "eligible professional" is a physician, physician assistant, nurse practitioner, clinical nurse specialist, physical therapist, occupational therapist, qualified speech-language pathologist, qualified audiologist, certified registered nurse anesthetist, certified nurse-midwife, clinical social worker, clinical psychologist, or registered dietitian or nutrition professional.

- Payments designed to improve the efficiency of care and/or outcomes for patients receiving both services delivered by physicians or other eligible professionals and related services ordered by eligible professionals that are delivered by other providers.
- Payments designed to enable physicians or other eligible professionals to improve care for particular subgroups of patients (e.g., patients with a severe form of a condition, patients who have an early stage of a condition where progression can be more easily prevented, patients who need special services after treatment, or patients living in frontier or rural communities.)
- Payments designed to enable a primary care physician or a multi-specialty group of eligible professionals to improve care for most or all of the health conditions of a population of patients, or to prevent the development of health problems in a population of patients with particular risk factors.
- Revisions to the codes and fee levels for a broad range of services delivered by physicians and other eligible professionals that are designed to support delivery of a different mix of services in conjunction with accountability for measures of utilization, spending, or outcomes for a group of patients.
- Payments in which the amount of payment depends on patient outcomes, with or without changes to the units of payment for individual physicians or other eligible professionals.

2. Services Supported by a PFPM

In general, PTAC will only recommend PFPMs that directly affect the method and/or amount of payments for one or more services delivered, ordered, managed, or coordinated by one or more types of physicians or other eligible professionals.

If a proposed payment model changes the method and/or amount of payments to both eligible professionals and other types of health care providers (e.g., hospitals, home health agencies, skilled nursing facilities), PTAC will be more likely to recommend the model as a PFPM if a substantial portion of the payment supports services that are delivered or ordered by physicians or other eligible professionals.

3. How the Method of Payment Differs from the Physician Fee Schedule

Payment for Individual Services Not Billable under the Physician Fee Schedule

In general, PTAC will be unlikely to recommend a proposed PFPM if the only change it makes is to give a physician or other eligible professional the ability to bill for a single type of service that is not currently eligible for payment under the Medicare Physician Fee Schedule or to alter the fee level for a service that is currently billable, particularly if there is no change in the measures or methods of accountability that would otherwise apply under

MIPS. There is already a process for proposing and making these types of changes through the regulations governing the Medicare Physician Fee Schedule.

Payments for Packages and Bundles of Services

If a proposed PFPM would create a new payment for a physician or other eligible professional that replaces or includes the payments for two or more services that are currently paid for separately under the Physician Fee Schedule, PTAC will be more likely to recommend the proposed PFPM if the new payment replaces all or most of the eligible professional's current payments for individual services that are related to (1) a specific health condition or risk factor, or combination of conditions and risk factors; (2) a specific treatment; or (3) all of the health care needs of a population of patients (e.g., a monthly payment that covers all office visits, phone calls, emails, and office-based procedures needed by a patient, replacing separate payments for Evaluation and Management services and procedures). The new payment could allow flexibility to deliver services that are not currently billable in addition to services that are billable, and the amount of the payment could be stratified or adjusted based on characteristics of the patients, rather than based on the number or types of services delivered.

If the physician or other eligible professional would continue to be paid separately for any individual services related to a condition, risk factor, or treatment covered by the new payment, the PFPM proposal should explain why those services cannot or should not be included in the new payment. In these cases, PTAC will be more likely to recommend the PFPM if it also includes a mechanism for accountability for spending on the services that are not included in the new payment. For example, the PFPM might include a performance-based payment component using a measure of total spending on all services related to the condition, risk factor, or treatment (both the services that are included in the new payment and those that are still paid separately) or a measure of total spending on all aspects of the patient's care.

PTAC will be more likely to recommend a PFPM if it defines a process for updating the definitions of what is included and excluded in a new payment and the amount of the new payment as changes in technology and evidence occur over time.

4. Relationship of Eligible Professionals to Entity Receiving the Payment

PTAC recognizes that there are many different organizational structures through which physicians and other eligible professionals deliver services to patients and through which eligible professionals are paid for those services. PTAC will not limit the types of entities that can submit proposed PFPMs and it will consider proposals for PFPMs that would need to be implemented through entities other than practices or groups consisting of one or more physicians or other eligible professionals. PTAC encourages submission of proposals that could be successfully implemented by small, independent physician practices.

If a PFPM requires that the payment be made to an entity other than a physician practice or entity that is owned by physicians or other eligible professionals, information should be submitted explaining:

- The role that physicians or other eligible professionals will play in implementing the PFPM payment methodology;
- What requirements there would be as to how the physicians and other eligible professionals who will be compensated through the PFPM will be involved in the governance of the organization or entity;
- How the payments or incentives for the individual physicians and other eligible professionals who are part of the organization or entity would change; and
- How the payments or incentives for individual physicians and other eligible professionals would encourage high performance on the accountability measures that are part of the PFPM.

5. Accountability for Spending and Quality

In general, PTAC will only consider PFPMs that change the method of payment for physicians or other eligible professionals if the payment model also requires the eligible professionals or the entity receiving the payment to take accountability for controlling the costs and quality of care for the patients affected.

Measures of Utilization, Spending, Quality, and/or Outcomes

PTAC will be more likely to recommend a PFPM that is focused on a condition, risk factor, or treatment if the PFPM requires the eligible professionals or the entity receiving the payment to take accountability for (1) controlling total Medicare spending on all services the patients receive that are related to the condition, risk factor, or treatment, (2) controlling total Medicare spending on all services the patients receive, or (3) improving performance on measures of spending, utilization, and/or quality that are primary drivers of total Medicare spending or of the spending related to the condition, risk factor, or treatment.

PTAC will be more likely to recommend a PFPM in which the eligible professionals or the entity receiving the payment can demonstrate that the services to be delivered and the projected savings for the Medicare program are sustainable without any increases in spending by other payers.

PTAC will be more likely to recommend a PFPM that changes payment related to a treatment if the eligible professionals or the entity receiving the payment take accountability for ensuring that the treatment is appropriate for the patient.

PTAC will be more likely to recommend a PFPM that changes payment related to a health condition if the payment model defines a consistent method of identifying the condition for

which payment would be made and if the eligible professionals or the entity receiving the payment take accountability for ensuring the accuracy of the diagnosis of the condition.

PTAC will be more likely to recommend a PFPM that changes payment related to a health condition if it addresses how care will be delivered to patients who have health conditions in addition to the condition on which the PFPM is focused.

PTAC will be more likely to recommend a PFPM if it includes specific mechanisms for ensuring that patients receive evidence-based services for the health condition(s) or for the delivery of the preventive or treatment service(s) that are the focus of the PFPM.

PTAC will be more likely to recommend a PFPM if the eligible professionals or the entity receiving the payment take accountability for some or all of the outcomes of the care delivered.

PTAC will be more likely to recommend a PFPM if it proposes evidence-based quality measures that are feasible to collect and use to monitor performance, or, if such quality measures are not available, if the proposal presents a compelling case for how quality would be maintained or improved and how research or periodic monitoring could be used to demonstrate positive quality outcomes.

PTAC will be more likely to recommend a PFPM if it specifically identifies potential unintended consequences and includes mechanisms for preventing or mitigating them.

If a PFPM is designed to support services that would prevent future health problems, slow the progression of disease, or achieve other outcomes that will occur over a multi-year period, and if additional spending is needed in the short run to achieve savings in the future, PTAC will be more likely to recommend the PFPM if it (1) requires accountability for improving a current clinical measure that has been shown to have a close direct linkage to the long-term outcome, and (2) requires accountability for ensuring spending does not increase more than the amount projected to be needed to achieve the improved outcome.

Financial Risk

PTAC will be more likely to recommend a PFPM in which the eligible professionals or the entity receiving the payment accept more than nominal financial risk for achieving the desired results on the measures of spending and quality/outcomes. PTAC will consider and may recommend PFPMs that do not meet the specific requirements for financial risk or other requirements for qualification as an "Advanced Alternative Payment Model" under the regulations issued by HHS. The fact that the financial risk components or other characteristics of a PFPM lead to a recommendation by PTAC does not necessarily mean that the PFPM will be approved as an Advanced Alternative Payment Model by HHS.

PTAC will consider proposals for PFPMs that define financial risk in different ways, including, but not limited to:

- The amount of payment that could be lost by the eligible professionals or the entity if the desired results are not achieved;
- The increase in unreimbursed costs the eligible professionals or entity would incur if the desired results are not achieved; or
- The amount that the eligible professionals or entity would be expected to pay to the Centers for Medicare & Medicaid Services (CMS) if the desired results are not achieved.

PTAC will be more likely to recommend a PFPM in which the amount of financial risk and the way in which the risk is structured are (1) likely to be financially feasible for physicians and eligible professionals to accept, including small practices, and (2) likely to adequately encourage changes in care delivery needed to achieve the desired results on the measures of spending and quality/outcomes. This includes, but is not limited to, PFPMs that have one of the following characteristics:

- When the desired results are not achieved, the potential reduction in payments to a participating eligible professional practice is at least as great as the maximum penalty the practice would face if it were being paid under MIPS rather than under the PFPM; or
- When the desired results are not achieved, payments to the eligible professional practice or entity could be reduced by more than any increase in payments the practice or entity received compared to the standard amounts it would have received under the Physician Fee Schedule; or
- Payments to the eligible professional practice or entity could be reduced by an amount sufficient to ensure there is no net increase in Medicare spending for the condition(s) or treatment(s) that are the focus of the payment model.

PTAC will be more likely to recommend a PFPM that includes a method of adjusting payments, measures, and financial risk based on the differences in the needs of patients. PTAC will consider PFPMs in which the amount of financial risk during an initial period of time is smaller than the amount of risk in later periods.

C. Guidance for Submitters

1. Eligibility

Any individual or organization may submit a proposal and there is no limit on the number of proposals stakeholders may submit. If the submitter is an organization, a letter of support from the governing board or responsible officer is required. Stakeholders who are planning to submit a proposal to PTAC must submit a non-binding letter of intent at least 30 days in advance of submitting a proposal.

2. Proposal Review Process and Timeline

Stakeholders may submit proposals at any time and submissions will be accepted on an ongoing basis. In general, proposals should be submitted at least 14 weeks in advance of a PTAC public meeting in order for the Committee to complete all of the steps necessary to formally consider the proposal at that meeting. PTAC will review and act on proposals as quickly as possible, but the time necessary to evaluate a proposal will be affected by the volume of proposals received and the completeness of those proposals. PTAC intends to hold public meetings no less frequently than quarterly. The frequency of meetings may be modified to ensure proposals are considered in an efficient and timely manner.

3. Resubmission Policies

Upon receipt, proposals will be reviewed for completeness and adherence to submission guidelines. Proposals that require revisions to address incomplete or non-adherent elements will be returned to the submitter with an explanation of what is missing or non-adherent and advised of the opportunity to revise and resubmit.

If a proposal is complete, the individual or entity that submitted the proposal may be invited to respond to questions or provide additional information as requested by PTAC.

PTAC will provide feedback to anyone whose proposal is not recommended by PTAC, and applicants are welcome to resubmit proposals with revisions to address PTAC's comments. If a proposal is recommended by PTAC but is not implemented by the Secretary, there is no appeals process provided in statute.

4. Public Access to Submitted Documents

PTAC is governed by the Federal Advisory Committee Act (FACA) which requires that,

> *"Subject to section 522 of Title 5, United States Code [The Freedom of Information Act] the records, reports, transcripts, minutes, appendices, working papers, drafts, studies, agenda, or other documents which were made available to or prepared for or by each*

advisory committee shall be available for public inspection . . . until the advisory committee ceases to exist."

PTAC adheres to these requirements and seeks to make its work as transparent and open as possible. Further, PTAC does not want to make a recommendation regarding a PFPM based on information that the public is not permitted to see. PTAC believes that the input of all types of stakeholders — consumers and their advocates, clinicians and practitioners, health care organizations, health plans and insurers, and purchasers and regulators — will ensure that the information used by PTAC in making its recommendations is as accurate and complete as possible.

Proposals submitted to the Committee will be posted on the PTAC website for public review and comment. Proposal-related information including the LOI and the submitter's answers to questions from PTAC on the submitter's proposal also will be posted to the PTAC website. Therefore, a party submitting a proposal, comments on a proposal, or other information to the PTAC should not submit information that it considers confidential or proprietary or does not otherwise want publicly disclosed. In addition, it is the responsibility of the submitter or other party submitting material to PTAC to obtain any permission that may be necessary to reproduce and redistribute any copyrighted articles they may want to include in their proposal or other submission to the PTAC.

5. Resources for Submitters

PTAC will provide public education sessions and informational materials, such as webinars and FAQs, regarding the requirements of the RFP and the proposal review process. PTAC will also make other resources available, such as technical papers and data tables, to aid stakeholders with model development. This information can be found on the PTAC website.

D. Letter of Intent Format

A non-binding letter of intent (LOI) must be submitted to PTAC at least 30 days prior to submission of a proposal. An LOI should be two pages or less, single-spaced, and include the following information (a template is available on the PTAC website):

1. Expected participants: (1) the types of patients expected to participate in the proposed payment model; and (2) the estimated number and types of physicians and other providers expected to participate in the proposed payment model
2. Goals of the payment model: the improvements in clinical quality, patient outcomes, and/or health care spending that would result from the proposed payment model compared to the current payment system
3. Model overview: (1) a description of the basic structure of the payment model (e.g., creating payments for currently unpaid services, bundling of current payments for specific patients in a defined episode, risk adjusted global capitation for specific patients, etc.), and (2) an indication of whether the submitting organization believes the proposed payment model would be likely to meet MACRA requirements for an alternative payment model
4. Implementation strategy: a brief description of the organization submitting the proposal, and if the submitting organization is not a provider organization, the names of any provider organizations that are committed to implementing the proposed payment model
5. Timeline: (1) the date that the organization expects to submit the proposal, and (2) the earliest date the provider organizations involved believe they could be ready to implement the payment model if it is approved

All LOIs will be posted on the PTAC website.

E. Proposal Format

1. Cover/Transmittal Letter

The proposal must include the name and address of the submitting individual or organization as well as the name, mailing address, phone number, and e-mail for the primary point of contact. This information may be conveyed in a cover/transmittal letter which will not count against the page limit discussed below.

2. Title Page, Table of Contents, and Abstract

The proposal must include a title page, table of contents, and abstract. This information will not count against the page limit discussed below.

3. Main Body

Submitters must use paper size no larger than standard letter paper size (8.5" x 11"). All text should be Arial or Times New Roman font, no less than 12 point, with one-inch margins and single-spaced lines. Pages should be numbered. Graphics and tables may be included.

The main body of the proposal must be organized according to the outline below and must not exceed 20 pages, including citations. Citations may be included as footnotes or endnotes; any style that enables clear identification of the source material is acceptable. More details on the type of information the Committee expects is addressed in the Supporting Information section of this RFP.

Outline:

I. Background and Model Overview
II. Scope of Proposed PFPM (High Priority Criterion[†])
III. Quality and Cost (High Priority Criterion)
IV. Payment Methodology (High Priority Criterion)
V. Value over Volume
VI. Flexibility
VII. Ability to be Evaluated
VIII. Integration and Care Coordination
IX. Patient Choice
X. Patient Safety
XI. Health Information Technology
XII. Supplemental Information

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

4. Appendices

Essential information must be covered in the main body of the proposal. Additional information may be included in appendices, which do not count toward the page limit, with the understanding that PTAC members are not obliged to review it. Letters of support and submission checklists (if included) should be placed in appendices.

All Proposals will be posted on the PTAC website.

F. Supporting Information

PTAC will assess the extent to which each submitted proposal meets criteria for PFPMs established by the Secretary of HHS in regulations at 42 CFR §414.1465. The Secretary is required by MACRA to establish these PFPM criteria. MACRA also requires PTAC to review proposed models and submit comments and recommendations to the Secretary regarding whether each model meets the Secretary's criteria. PTAC will do so by reviewing information submitted as part of each proposal.

For each of the Secretary's criteria (copied below), PTAC has considered the types of information that it could use to evaluate the extent to which submitted PFPMs meet the Secretary's criteria. These "Information Items" are listed below, as a guide for submitters, showing what types of information could be used to show how a model meets the Secretary's criteria. With respect to these Information Items, please note:

- If an information item is relevant to your proposal, please provide it, if possible.
- You may include other information items not listed below that explain how the proposed model meets the Secretary's criteria.
- PTAC recognizes that not every information item may be relevant to your proposal. If an item of information does not apply to your proposed PFPM, you may designate this item as "Not Applicable" (NA). If you believe it will help PTAC better evaluate your proposal, you may provide a brief explanation of why the information item does not apply.
- PTAC recognizes that an Information Item may apply to more than one criterion (although for economy PTAC has listed it only under one criterion). When any submitted information applies to more than one criterion, a proposal need not submit the information twice. A cross reference to information presented under another criterion will be sufficient.

Based on the information submitted, PTAC will determine the extent to which the proposal:

- Does not meet the criterion;
- Meets the criterion; or
- Meets the criterion and deserves priority consideration.

Based upon the extent to which a proposed PFPM appears to meet the criteria, PTAC will assign the proposal to one of four categories of recommendation to the Secretary:

- Do not recommend proposed payment model to the Secretary; or
- Recommend proposed payment model to the Secretary for:
    - Limited-scale testing of the proposed payment model. This 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.

- Implementation of the proposed payment model; or
- Implementation of the proposed payment model as a high priority. High priority models will be those that are rated as "meets the criterion and deserves priority consideration" on multiple criteria, particularly the criteria designated by the PTAC as "high priority" criteria.

Please note that PTAC has designated the first three criteria below as "High Priority Criteria." In order for a submitted model to be recommended by PTAC to the Secretary, the proposal must meet each of the three criteria identified as high priority criteria by PTAC.

Criterion 1 of 10. Scope of Proposed PFPM (High Priority Criterion[‡]): The proposal aims to broaden or expand CMS' APM portfolio by either: (1) addressing an issue in payment policy in a new way, or (2) including APM Entities whose opportunities to participate in APMs have been limited.

The goal of this section is to explain the scope of the PFPM by providing PTAC with a sense of the overall potential impact of the proposed model on physicians or other eligible professionals and beneficiary participation. Proposals should describe the scope and span of the payment model and discuss practice-level feasibility of implementing this model as well as clinical and financial risks.

Information Items*:*

- Related to physician or other eligible professionals' practices:
  - What types of physician or other eligible professionals' practices would be able to participate in this payment model?
  - How many physician or other eligible professionals' practices or numbers of physicians or other eligible professionals have expressed interest and willingness to participate in the model if it is approved?
  - How many physicians or other eligible professionals and patients could participate if the model was expanded to scale?
  - How would the payment model work for physicians or other eligible professionals who are employed and for those that are independent, and what changes in compensation might be necessary for employed physicians or other eligible professionals, if applicable?
  - Has the model been implemented by other payers, and if so, what was the experience?

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

    - Are the costs or financial risks associated with the payment model feasible for small practices?
- Related to patient population(s):
    - What is the size of the population anticipated to benefit from the model in its initial stages and if the model were expanded to scale?
    - How are patients expected to benefit and how would they be protected against unintended consequences? For example, what protections would be in place to protect against the denial of needed care, overutilization, or less than optimal patient outcomes?
- What are the overall anticipated impacts on Medicare spending?
- What are the expected spillover effects on Medicaid, CHIP, TRICARE/VA, or private health spending, or on those beneficiaries/enrollees, if any?

<u>Criterion 2 of 10. Quality and Cost (High Priority Criterion)</u>: The proposal is anticipated to (1) improve health care quality at no additional cost, (2) maintain health care quality while decreasing cost, or (3) both improve health care quality and decrease cost.

The goal of this section is to better understand the "value proposition" that will be addressed by the proposed PFPM. Please describe how the components of the value proposition will be achieved. For example, how will clinical quality, health outcomes, patient experience, and health care cost management be addressed within the model and how will performance be measured? Please describe any current barriers to achieving desired value/quality goals and how they would be overcome by the payment model. Please identify any novel clinical quality and health outcome measures that will be included in this proposed model. In particular, measures related to outcomes and beneficiary experience should be noted.

Information Items:

- How is care delivery expected to improve in order to achieve savings or improve quality, including:
    - Where and by how much will health care services or costs be reduced, and/or
    - If quality will be improved beyond a baseline, how and by how much will quality be improved? If quality will not be improved, how will quality be maintained?
- What are the nature and magnitude of barriers and risks to the model's success and how will they be overcome?
- What metrics will be used to assess performance under the model including the impact of the model on total cost of care, and will any of the metrics include patient-reported outcome measures or measures of beneficiary experience of care?
- What approach will be used to develop any innovative metrics proposed for inclusion in the model, such as specialty-specific measures or patient-reported outcome

measures, and how will this approach leverage existing measures, standards, value sets, etc.?

- What approach will be used to incorporate data from multiple sources to support total cost of care, resource utilization, or clinical quality metrics?
- What approach to electronic reporting of and timely feedback on performance measures will be used? How will the approach take into account capturing and sharing data from the EHRs of all clinicians who provide relevant care for the attributed patient population, aggregation and calculation of measures, and provision of timely feedback to support performance improvement?
- What level of monitoring or auditing will be required?
- Are there any prior or planned statistical analyses to estimate the impact of the model on spending and quality of care?

<u>Criterion 3 of 10. Payment Methodology (High Priority Criterion)</u>: Pay APM Entities with a payment methodology designed to achieve the goals of the PFPM Criteria. Addresses in detail through this methodology how Medicare, and other payers if applicable, pay APM Entities, how the payment methodology differs from current payment methodologies, and why the PFPM cannot be tested under current payment methodologies.

The goal of this section is to better understand the payment methodology for the proposed model, including how it differs from both existing payment methodologies and current alternative payment models. Include in your description how the proposed PFPM will incorporate the performance results in the payment methodology. Please describe the role of physicians or other eligible professionals in setting and achieving the PFPM objectives, as well as the financial risk that the entity/physicians will bear in the model. Please also differentiate between how services will be reimbursed by Medicare versus how individual physicians or other eligible professionals might be compensated for being a part of this model. Finally, a goal of this section is to better understand any regulatory barriers at local, state, or federal levels that might affect implementation of the proposed model.

Information Items:

- Payment methodology:
    - How would entities be paid under the proposed model, including the amount of new payments (e.g., per beneficiary per month, shared savings payments, etc.), and what is the methodology for calculating such payments?
    - Will the proposed model include other payers in addition to Medicare, and if so, is a different payment methodology needed for those payers?
    - How will the model enable entities to sustain the expected changes in care delivery over time?
    - How are the targets for success defined, and what are the penalties for failure?
    - What methodology will be used for risk adjustment (if relevant)?

- How does the payment methodology differ from current Medicare payment methodologies/Center for Medicare and Medicaid Innovation (CMMI) models for physicians or other eligible professionals and why cannot it be tested under current payment methodologies/CMMI models?
- What degree of financial risk will the entity and its physicians or other eligible professionals bear as a consequence of this proposed model (i.e., will physicians be at financial risk for their portion of care within the framework of the model, and how will this be determined)?
- Where relevant, how will the model address:
    - Establishing the accuracy and consistency of identification/coding of diagnoses/conditions?
    - Clinical appropriateness of the payment unit (e.g., procedure or other treatment for which payment would be made)?
    - Accurately assigning claims for payment to particular episodes of care?
- Barriers that make a new payment methodology necessary:
    - Are there any barriers in the current payment system that prevent or discourage the change in care delivery?
    - Are you aware of any barriers that exist in state or federal laws or regulations (such as current coverage limitations in Medicare or state-specific scope of practice limitations)?
        - If no barriers exist, why is the proposed model the appropriate solution?
    - Will the proposed model have an impact if regulatory barriers (if present) are not addressed?

<u>Criterion 4 of 10. Value over Volume</u>: The proposal is anticipated to provide incentives to practitioners to deliver high-quality health care.

The goal of this section is to better understand how the model is intended to affect practitioners' behavior to achieve higher value care through the use of payment and other incentives. PTAC acknowledges that a variety of incentives might be used to move care towards value, including financial and nonfinancial ones; please describe any unique and innovative approaches to promote the pursuit of value including nonfinancial incentives such as unique staffing arrangements, patient incentives, etc.

Information Items:

- What financial incentives will be provided to encourage physicians and other eligible professionals to deliver high-value health care?
    - How will these incentives influence physician or other eligible professionals' behavior? Please be clear about how you expect changing incentives to be manifested throughout the delivery system.

    - Has the submitter had prior experience with the use of these incentives? If yes, what have been the effects (both salutary and adverse)? Were there any unintended consequences of the use of these incentives?
- Will non-financial incentives (e.g., use of behavioral incentives) be used to promote physicians and other eligible professionals' delivery of high-value health care? If yes, please describe them.
    - How will these incentives influence practitioner behavior? Please be clear about how you expect changing incentives to be manifested throughout the delivery system.
    - Has the submitter had prior experience with the use of these incentives? If yes, what have been the effects (both salutary and adverse)? Were there any unintended consequences of the use of these incentives?

<u>Criterion 5 of 10. Flexibility</u>: Provide the flexibility needed for practitioners to deliver high-quality health care

The goal of this section is to better understand (1) how the proposed payment model could accommodate different types of practice settings and different patient populations, (2) the level of flexibility incorporated into the model to include novel therapies and technologies, and (3) any infrastructure changes that might be necessary for a physician or other eligible professionals to succeed in the proposed model.

Information Items:

- Can the proposed model be adapted to accommodate the breadth and depth of differences in clinical settings and patient subgroups (e.g., rural physicians and/or patients, physicians in a tertiary/quaternary setting, specific subgroups of patients, etc.)?
- How can the proposed model be adapted to account for changing technology, including new drug therapies or devices?
- To what extent will practitioners have to adapt to operational burdens and reporting requirements that result from the proposed payment model?
- How will model participants prepare and build the infrastructure to implement the proposed model?

<u>Criterion 6 of 10. Ability to be Evaluated</u>: Have evaluable goals for quality of care, cost, and any other goals of the PFPM.

The goal of this section is to describe the extent to which the proposed model or the care changes to be supported by the model can be evaluated and what, if any, evaluations are currently under way that identify evaluable goals for individuals or entities in the model. If there are inherent difficulties in conducting a full evaluation, please identify such difficulties and how they are being addressed.

Information Items:

- Is the impact of the PFPM on metrics that are included as part of the proposed model able to be evaluated? If so please describe how.
- What are the evaluable goals at various levels (e.g., for a population, for a provider entity, for individual physicians, etc.)?
- Are there any evaluations of the proposed model under development, underway or that have been conducted and that have not been referenced in other sections? If yes, please identify them and state whether findings from those evaluations can be shared.
- Are there other questions beyond the impact on core metrics which the evaluation should focus on, including through the use of qualitative methods?

<u>Criterion 7 of 10. Integration and Care Coordination</u>: Encourage greater integration and care coordination among practitioners and across settings where multiple practitioners or settings are relevant to delivering care to the population treated under the PFPM.

The goal of this section is to describe the full range of personnel and institutional resources that would need to be deployed to accomplish the proposed model's objectives. Please describe how such deployment might alter traditional relationships in the delivery system, enhance care integration, and improve care coordination for patients.

Information Items:

- What types of physicians, non-physicians, and other eligible professionals would likely be included in the implementation of this model in order to achieve desired outcomes?
- How would the model lead to greater integration and care coordination among practitioners and across settings?
- To what extent would the proposed model result in changes in workforce requirements compared to more traditional arrangements?
- How will the model address coordination with care team members that are not financially accountable (e.g., through program requirements around care processes or voluntary agreements to share in savings/losses)?

<u>Criterion 8 of 10. Patient Choice</u>: Encourage greater attention to the health of the population served while also supporting the unique needs and preferences of individual patients.

The goal of this section is to describe how patient choice and involvement will be integrated into the proposed PFPM. Describe how differences among patient needs will be accommodated and how any current disparities in outcomes might be reduced. For example, please share how the demographics of the patient population and social determinants of care may be addressed.

Information Items:

- How is patient choice preserved under the model by accommodating individual differences in patient characteristics (including social needs, etc.), conditions, and health-related preferences while furthering population health outcomes?
- How would the payment model affect disparities among Medicare beneficiaries by race, ethnicity, gender, disability, and geography?
- How would the payment model expand the demographic, clinical, or geographic diversity of participation in alternative payment models beyond existing CMS models (e.g., would the proposed payment model address populations which are not currently addressed in current CMMI models)?

<u>Criterion 9 of 10 Patient Safety</u>: How well does the proposal aim to maintain or improve standards of patient safety?

The goal of this section is to describe how patients would be protected from potential disruptions in health care delivery brought about by the changes in payment methodology and provider incentives. Please describe how disruptions in care transitions and care continuity will be addressed. Safety in this instance should be interpreted to be all-inclusive and not just facility-based.

Information Items:

- How would the proposed model ensure that patients are not harmed by efforts to achieve savings or to improve specific aspects of quality/outcomes?
- What measures would be used to ensure the provision of necessary care and monitor for any potential stinting of care?
- To what degree will the proposed model ensure the integrity of its intended benefits and what embedded monitoring and potential adjustments are under consideration, should unintended or other incongruent behaviors occur?

<u>Criterion 10 of 10. Health Information Technology</u>: Encourage use of health information technology to inform care.

The goal of this section is to understand the role of information technology in the proposed payment model. In this section please describe how information technology will be utilized to accomplish the model's objectives with an emphasis on any innovations that improve outcomes, improve the consumer experience and enhance the efficiency of the care delivery process. Please also describe goals for better data sharing, reduced information blocking and overall improved interoperability to facilitate the goals of the payment model.

Information Items:

- How would patients' privacy be protected if new providers or caregivers will have access to personal health information (PHI)?

- How would the model facilitate or encourage transparency related to cost and quality of care to patients and other stakeholders?
- Will interoperability of electronic health records be needed to guide better decision-making?
- Will any information technology innovations be used to support improved outcomes, improve the consumer experience, or enhance the efficiency of the care delivery process?
- How will any health IT requirements included in the model ensure that clinicians have the flexibility to choose from a variety of solutions to meet their needs and leverage existing technology assets where possible?

Supplemental Information

- If the entity submitting the proposal wishes to serve as a recipient of the proposed payment, please describe the proposed governance structure for the entity.
- If known, please describe any infrastructure investments that might need to be made by CMS, in addition to changes in the payment model (e.g., different mechanisms for claims processing, data flows, quality reporting, etc.).

G. Submission

1. Letter of Intent Submission

LOIs should be uploaded to the PTAC submission system website in MS Word or PDF Format. A guide on how to upload to the system is available on the PTAC website. Submitters may contact PTAC@hhs.gov with any problems uploading their LOI. All LOIs will be posted on the PTAC's website for availability to the public.

2. Proposal Submission

Complete proposals should be uploaded to the PTAC submission system website. MS Word, MS Excel (appendices), or PDF formats are acceptable. A guide on how to upload to the system is available on the PTAC website. Submitters may contact PTAC@hhs.gov with any problems uploading their proposal. Once received, all proposals will be posted on the PTAC website for availability to the public.

3. Submission Checklist

The submission checklist is intended to aid submitters in reviewing their proposals for completeness and adherence to RFP requirements. It is not necessary to submit the checklist with the proposal. However, submitters may include a completed checklist as an appendix.

RFP Requirement	**Checkbox**	**Pages**
Letter of intent submitted 30 days before the proposal	☐	[redacted]
Name and address of the submitter (individual or organization)	☐	
Name, address, phone number, and e-mail address for the primary point of contact	☐	
Title Page	☐	
Table of Contents	☐	
Abstract	☐	
If the submitter is an organization, a letter of support from the governing board or responsible officer is included.	☐	
Main body of the proposal is ordered by and includes the following sections:		
Background and Model Overview	☐	
Scope of Proposed PFPM	☐	
Quality and Cost	☐	
Payment Methodology	☐	

Value over Volume	☐	
Flexibility	☐	
Ability to be Evaluated	☐	
Integration and Care Coordination	☐	
Patient Choice	☐	
Patient Safety	☐	
Health Information Technology	☐	
Supplemental Information	☐	
Main body of the proposal does not exceed 20 pages and formatting requirements are met.	☐	