Physician-Focused Payment Model Technical Advisory Committee
PUBLIC SESSION MEETING MINUTES

September 16, 2016
9:00 am – 12:00 pm EST
Residence Inn Marriott
333 E. Street SW
Washington, D.C. 20024

ATTENDEES:

Physician-Focused Payment Model Technical Advisory Committee (PTAC) Members Present

- Jeffrey Bailet, MD (PTAC Chair; President, Aurora Health Care Medical Group)
- Elizabeth Mitchell (PTAC Vice Chair; President and CEO, Network for Regional Healthcare Improvement)
- Robert Berenson, MD (Institute Fellow, Urban Institute)
- Paul Casale, MD, MPH (Executive Director of New York Quality Care, New York Presbyterian)
- Rhonda M. Medows, MD (Executive Vice President of Population Health, Providence St. Joseph Health, Providence Health & Services)
- Harold D. Miller (President and CEO, Center for Healthcare Quality and Payment Reform)
- Len M. Nichols, PhD (Director, Center for Health Policy Research and Ethics, George Mason University)
- Kavita Patel, MD (Nonresident Senior Fellow, Brookings Institution)
- Grace Terrell, MD (Founder and Strategist, CHESS)

PTAC Members Not Present

- Tim Ferris, MD (Senior Vice President for Population Health Management, Partners HealthCare)

Assistant Secretary for Planning and Evaluation (ASPE) Staff Present

- Nancy De Lew, MA, MPA (Acting Deputy Assistant Secretary for Planning and Evaluation)
- Erin Dugan (Truman-Albright Fellow)
- Catherine Fontenot (Truman-Albright Fellow)
- Kathryn E. Martin (Acting Assistant Secretary for Planning and Evaluation)
- Sarah Selenich, MPP (Social Science Analyst)
- Scott R. Smith, PhD (Director, Health Care Quality and Outcome Division; Alternate Designated Federal Officer)
- Angela Tejeda (Staff Assistant)

ASPE Staff Not Present

- Ann Page (PTAC Designated Federal Officer, Social Science Analyst)

ASPE Contractor Team

- Cely Argueta (Social & Scientific Systems, Inc.)
- Alicia Berkowitz, MPH (Social & Scientific Systems, Inc.)
- Charlene Edwards (Social & Scientific Systems, Inc.)
- Tammie Holloway (Social & Scientific Systems, Inc.)
- Esteban Pabon (Social & Scientific Systems, Inc.)

Opening of Public Meeting

Scott R. Smith opened the meeting and welcomed the Committee members and public attendees.

Welcome

The PTAC Chair, Dr. Jeffrey Bailet, welcomed all attendees and thanked them for joining the third public meeting of the Physician-Focused Payment Model Technical Advisory Committee. He noted the high level of interest in physician-focused payment models (PFPMs), as illustrated by the attendance of so many stakeholders, both in person and by phone.

Dr. Jeffrey Bailet explained that the PTAC was established under the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) to provide comments and recommendations to the Secretary of Health and Human Services on PFPMs. Dr. Bailet made the following statements:

- The PTAC is a Federal Advisory Committee Act (FACA) Committee created by Congress, and is comprised of 11 members appointed by the U.S. Government Accountability Office (GAO) for their expertise in PFPMs and healthcare delivery.

- The PTAC will evaluate payment models proposals using criteria established by the Secretary through the rule-making process. Draft proposed criteria were published in April 2016, and final criteria are required to be released by November 1, 2016.

- Since its first meeting in January 2016, the PTAC has been developing the processes it will use to review and evaluate submitted proposals for PFPMs. In April 2016 the Committee posted its first draft of the proposal review process. It received comments on that document, and a week ago posted a draft of the information which it seeks from proposals submitters.

- The PTAC will next post a draft Request for Proposal (RFP) and template Letter of Intent (LOI) for stakeholder review and comment. The Committee invites comments on posted documents during this meeting and in the coming weeks as it continues to prepare to receive proposals by December.

Dr. Jeffrey Bailet asked stakeholders to become familiar with the PTAC website and to join the Committee's listserv to learn about processes; view and provide feedback on documents; become aware of meetings; and receive a notice to submit proposals for PFPMs. Those in the room who wanted to be added to the listserv were asked to raise their hands and/or connect with a staff member.

Dr. Jeffrey Bailet explained the meeting agenda. Stakeholders will hear presentations on the proposed proposal review process, the PTAC's informational requirements for proposals, and the vision for RFPs. He turned to PTAC Vice Chair, Ms. Elizabeth Mitchell, to moderate the presentations and the public comment period.

PTAC Vice Chair, Elizabeth Mitchell

Ms. Elizabeth Mitchell echoed Dr. Jeffrey Bailet's welcome, expressing gratitude for attendees' participation in the PTAC process. She noted the collective commitment to a very open, transparent, inclusive process, and the process is being designed from the ground up. PTAC members have spent significant amounts of time working through some complex issues, from bylaws, to RFPs, to information requirements. It is the Committee's aim to bring experience and innovation from the field and to learn about existing barriers and innovative successes from stakeholders. Input is invited and welcome.

The plan for this meeting included the presentation and review of the proposal submission process that was disseminated electronically on the website, through the listserv, and elsewhere. After the presentations, public comments would be accepted. Several stakeholders had already committed to share their thoughts, and as time permitted, the PTAC invited additional questions and feedback from anyone who wished to comment. Index cards were available for those who wished to remain anonymous.

Committee Member Introductions

Ten of the 11 members of the PTAC were in attendance, and they introduced themselves-eight in person and two by phone. Dr. Scott Smith, the DFO for the meeting, introduced himself.

Ms. Mitchell thanked the ASPE, staff, with a special acknowledgement to the Acting Assistant Secretary Kathryn E. (Katie) Martin and Ms. Ann Page, the DFO.

Status Report from the Committee

The PTAC is waiting for the final rule to be published. Members are using the draft rule for context; therefore, the documents presented at this meeting are working drafts and subject to revision based on the final rule.

Planned Proposal Review Process

Mr. Harold Miller presented a revised draft of the Proposal Review Process document, noting that the PTAC is in the process of receiving comments on the draft.

He solicited comments from the public during the meeting and said that comments will be welcome after the meeting. The process, and therefore the document, is in the preparatory phase until issuance of the final rule.

Mr. Harold Miller described each of the six steps of the 16-week timeline of the PFPM proposal review. These include:

1. Acceptance of comments on the draft process, proposal information requirements, and basis for recommendation (9/15/16)
2. Release of final HHS criteria for PFPMs (11/1/16)
3. PTAC begins accepting PFPM proposals (12/1/16)
4. Recommendations made on initial proposal submissions (Spring 2017)
5. HHS and Centers for Medicare & Medicaid Services (CMS) decisions and actions
6. Physicians being paid under initial PFPMs

PTAC recommendations will go to the Secretary. The goal is to implement processes as soon as possible, and the application process will be rolling. It is unclear how long it will take HHS to make a decision on proposals recommended by the PTAC, nor the timeframe in which CMS will take to pay physicians under a particular PFPM.

The Proposal Review process starts with a Letter of Intent (LOI) submitted 30 days in advance of proposal submission; PTAC recognized advanced notice of what stakeholders are considering will help the PTAC to be better prepared to receive and review proposals.

Mr. Harold Miller detailed the timeframe of the elements of the 16-week review process as follows, and said that there are no proposal submission deadlines (i.e., a rolling application process).

- Completeness review and identification of conflicts of interest by PTAC members (2 weeks)
- Appointment of preliminary review team (1 week)
- Identification of questions/concerns regarding proposal and determination if revised proposal is needed (3 weeks)
- Public comment and time for applicant responses (3 weeks)
- Preparation of report to PTAC based on applicant responses and public comment (2 weeks)

- Consideration of proposals at PTAC public meeting within 30 days if desired/feasible
- Submission of report on PTAC decision to HHS and posting on PTAC website (within 2 weeks of public meeting)

Proposal Information Requirements

Dr. Kavita Patel presented the draft proposal information requirements, sharing the background of the requirements as delineated in MACRA. She reviewed the following nine criteria, including three "high priority" criteria:

1. Scope of proposed payment model (high priority)
2. Promoting quality and value (high priority)
3. Flexibility for practitioners
4. Payment methodology (high priority)
5. Evaluation goals
6. Integration and care coordination
7. Patient choice
8. Patient safety
9. Health information technology

Information requirements build on the Secretary's proposed criteria for the process and are based on the draft rule; changes to these information requirements may be made based on the final rule.

Dr. Kavita Patel discussed the supplemental information that may be required as part of the application. For example, this allows submitters to describe and offer proposed governance structures, and/or if known any potential infrastructure investments needed from CMS, in addition to changes in the payment model (e.g. different mechanisms for claims processing, data flows, quality reporting).

Questions for discussion and potential public comment included:

- Are the information requirements clear, or do they need further explanation?
- Is there other information that the PTAC could receive to help address any of the criteria?
- Is any of the information requirements not feasible or appropriate? If so, why, and do remedies exist?
- Are there any other suggestions for improving these information requirements?

Public comments on the criteria will be accepted through October 10, and the PTAC highly recommends providing public comments in writing to the PTAC@hhs.gov.

Request for Proposal and Letter of Intent

Dr. Len Nichols provided a review of the PTAC RFP, which the Committee will issue a draft, as well as the final, after the final rule is published. A Letter of Intent (LOI) template will also be posted for public comment.

RFP

The Committee will post a draft RFP for public comment within one week and will incorporate the proposal information requirements as explained by Dr. Kavita Patel. The Committee seeks to have the RFP available as quickly as possible after the final rule is issued; the Committee anticipates that the criteria will not change dramatically, if at all.

The Committee is working to balance competing objectives. It does not want to overburden submitters with instructions, but does seek the required information. The goal is to make submission as smooth as possible; however, sufficient detail is needed to evaluate and make recommendations to the Secretary. The PTAC is working with the Center for Medicare & Medicaid Innovation (CMMI), CMS, and HHS to facilitate the overlap of evaluations.

The draft RFP currently is structured as follows:

- Introduction
- Guidance for preparing proposals
- Frequently asked questions
- Bibliography
- How to submit proposal
- Proposal contents
- Proposal submission checklist

The core of the proposal will be the narrative portion, which will include a page limit. Stakeholders will be asked to adhere to a specific outline; the outline will be used for systematic comparison across proposals. Applicants will be able to submit supplemental information.

Dr. Len Nichols asked that stakeholders provide feedback on the draft RFP. Questions for discussion included:

- Are the right elements included?
- Do you agree with what categories are labeled high priority?
- Do you have experiences that could benefit the review process?

LOI

Dr. Len Nichols noted the importance of the LOI, which is non-binding and required at least 30 days in advance of submitting a proposal. This requirement stems from the PTAC's need for

advance knowledge as to the volume of submissions and allocation of Committee members' time, and whether, and what, specific technical assistance is needed.

Wrap-Up

Dr. Jeffrey Bailet reminded attendees that the PTAC would be accepting comments until October 10 on the Proposal Review Process and Proposal Information Requirements documents at the email address: PTAC@hhs.gov. Once the RFP document is posted, the Committee will accept comments for 30 days.

Public Comment

Dr. Jeffrey Bailet introduced the public commenters.

Cory Laws, PhD, LIM Innovations

Dr. Cory Laws asked if the Committee has in mind a minimum number of participants or the scope of the bundle. He is curious about risk-share and savings sharing, and also provide some type of guarantee to CMS.

Mr. Harold Miller commented that the PTAC is interested in models that have impact and seeks those with a broad range of impact across the United States. This could also be something one individual physician does, if appropriate. The Committee is planning to release a draft document relatively quickly on the range of models to which the PTAC is interested. The overarching goal is to be open to as many innovative approaches as possible.

Dr. Grace Terrell explained that the PTAC is asking about scope to understand probable impact, not to place unnecessary limits.

Ms. Elizabeth Mitchell noted that, while the PTAC may not be able to provide a particular answer with precision in this meeting, questions will serve to help the Committee to understand what submitters need, and it will work to clarify a response to this question.

Dr. Cory Laws clarified his question, noting that he was asking about the number of healthcare providers included in a bundle, with a model that could be rolled out nationwide and to allow for a large potential for participation.

Dr. Robert Berenson mentioned that the PTAC will provide guidance on the kinds of proposal it seeks. However, such a model sounds like something for which it is looking.

Sandy Marks, American Medical Association (AMA)

Ms. Sandy Marks appreciated the way the criteria address ways to improve care and barriers to those in the current system, and that it addresses why people might need an alternative payment

model (APMs). She explained how specialties look at opportunities to improve care. They focus on patient activity and on preventing the progression of disease, then they try to identify barriers to making improvements under the current fee-for-service system.

Ms. Sandy Marks asked if physicians could provide services that lower emergency room visits and hospital admissions but that are not supported by the fee schedule, noting that the fee schedule does not support patient follow-up, physician-to-physician coordination of care, or hiring of nurses to educate patients.

Ms. Sandy Marks gave the example of headache treatment. Barriers in the current system include diagnostic work-ups, treatment planning, patient education and counseling, telephone support to patients, keeping slots open to quickly treat exacerbations, and communications between primary care physicians (PCPs) and neurologists/other specialists. She noted that other specialties are engaging in similar conversations.

Regarding the proposal to the PTAC, the AMA is aiming to develop one or more broad frameworks that could apply to multiple conditions.

For chronic conditions, the model could be described as a specialty medical home. For other conditions, initial work could be an outpatient bundled payment; then, once a condition is better controlled, there could exist a collaborative care model involving a specialist on an as-needed basis while the PCP takes over management.

One example is Opioid Use Disorder: The patient would work with an addiction specialist to start, then move to a PCP with access to the addiction specialist if a relapse were to occur.

Key elements of a common framework are:

- Payment for complete diagnostic work-up and treatment planning (1-3 months);
- Monthly payments to a specialist or specialty team for continued management of difficult-to-control conditions or complex co-morbidities;
- Monthly payments to PCPs for continued management of patients with well-controlled conditions plus rapid access to phone consults or e-consults with specialist(s) by the PCP, or to in-person consults if the patient's condition deteriorates;
- Proactive outreach to avoid exacerbations or to address patient problems early;
- Coordination with pharmacists, therapists, emergency services, clinical labs, imaging, and all other providers involved in diagnosis and treatment for the condition;
- Financial accountability for avoidable utilization and spending related to the condition, so payments would be reduced if physicians did not meet utilization standards;
- Quality accountability for following relevant care pathways and providing high-quality care;

- Moving patients from their condition being poorly controlled to being well controlled;
- Better adherence to the treatment plan; and
- Minimum standards for structure and processes to be eligible to participate in the model.

Some design issues will make it difficult to finalize this model proposal and others. Two issues are:

- *Risk-Adjustment:* Most risk-adjustment methods only explain a small percentage of total variation, and they are focused on variation in spending, not variation in patient need. Risk-adjustments such as Hierarchical Condition Categories do not take into account disease stages, the patient's functional status, or the factors that might determine from the physician's point of view whether a patient is a good candidate for a treatment. The AMA is exploring an alternative in which physicians involved in the model would risk-stratify the patients themselves; this will likely raise numerous issues with CMS and others about ensuring it is done properly.

- *Attribution:* In current methods, patients often get attributed incorrectly. Some specialties are looking at a voluntary approach, in which physician and patient would agree that the physician is the principal caretaker of that patient's condition, perhaps with a written contract. For example, endocrinologists want a list of responsibilities of diabetes patients and of their physicians. Problems exist with attribution methods that only rely on claims; for example, in Comprehensive Primary Care Plus (a model not yet implemented), patients can be attributed to a CPC+ physician based on submission of codes for chronic care management, but once in CPC+ cannot submit chronic care management codes due to the different payment model for care management. Also, if physicians do fewer face-to-face visits, patients could be attributed to the wrong physicians.

Ms. Elizabeth Mitchell remarked that a benefit of the PTAC process is that proposals will include alternative approaches for solutions to current barriers. The Committee has discussed codes for new things, including types of consults, and will be looking to balance that on the total-cost-of-care front. The PTAC will prefer that proposals involve a broad total-cost-of-care approach, and the RFP guidance will include that.

Mr. Harold Miller asked Ms. Sandy Marks if the AMA is facing common problems in putting together proposals that the PTAC should be anticipating.

Ms. Sandy Marks answered that, beyond those she already outlined, one of the biggest problems is a lack of access to data; this includes data to help design the model (i.e., knowing costs to be able to set target spending amounts and payment rates within the model to make sure you get discounts from current spending) and for coordination of care if a patient goes outside

accountable care organizations (i.e. having access to ongoing data to intervene/ensure adherence to the treatment plan). She recommended developing rules for coordination for services.

Dr. Jeffrey Bailet noted that the PTAC is spending a lot of time addressing and exploring data and how it could potentially facilitate accessing certain data sets and provide them to stakeholders as the proposals are being developed. This is ongoing work.

Regarding the mechanics, he explained that flow, tracking, rigor of parameters around a patient, ensuring that physicians and providers follow rules within the model, and going outside of the model are key issues of which the Committee is keenly aware. It hopes to have concrete steps to address them.

Dr. Grace Terrell asked Ms. Sandy Marks how the AMA responds to criteria about patient choice inherent in the rules and in the patient-choice philosophy of fee-for-service Medicare while needing joint accountability for that choice and consequences affecting patient care coordination. The industry and policymakers need clarity, so any help is welcome by the PTAC on how to approach this.

Ms. Sandy Marks suggested that the Committee draw on some PFPM programs that have been implemented. In one example, Lawrence Kosinski, MD of the (Chicago) Illinois Gastroenterology Group has a program entitled SONAR, which provides a PFPM to help patients with Crohn's Disease. Twenty practices are involved in the program, which is essentially a specialty medical home. There is monthly contact that includes structured questions to patients about their symptoms; from the answers, the physician can determine whether to intervene. Similar models exist around the country, including an oncology medical home in New Mexico.

Dr. Len Nichols asked Ms. Sandy Marks to encourage colleagues to include such creativity in their proposal. Because it must be mindful of safety and choice, he asked that submitters explain how they would deal with that issue in the context of a proposal.

Mr. Harold Miller asked stakeholders to share what kinds of data are currently needed and inaccessible, so that the PTAC is aware as it considers what help could be provided. In particular, he asked them to share any commonly needed types of data analyses.

Dr. Rhonda Medows asked that any entity or organization that is already assisting physicians, is not an applicant, and is willing to partner to expand that resource to the groups trying to do this work identify itself to the PTAC.

Dr. Jeffrey Bailet mentioned that the PTAC would post after this meeting a document focused on publicly available data; it will help to provide a framework.

Anne Hubbard, American Society for Therapeutic Radiology and Oncology (ASTRO)
Ms. Anne Hubbard said that when the PTAC met in May, ASTRO was working on two APMs—a palliative care model and an early-stage breast cancer model. She stated that ASTRO met with CMMI for insight and guidance, and they were told that the models were heading in a good direction but were not big or broad enough, and did not offer enough impact.

Additionally, Ms. Hubbard said that ASTRO has a new revised PFPM that it will share in the coming weeks. It is a larger model that is not disease stage-specific, and the framework would apply to up to nine disease sites. The model would establish a discounted target rate based on historical experience: Physicians would bill and adjudicate claims for the fee schedule as they currently do, and payments would be reconciled each six months with a target rate. Physicians exceeding the target rate would be required to pay CMS up to 20%, and physicians coming in as much as 20% below the target would be eligible to participate in a gain-sharing program based on quality measures performance.

She shared that ASTRO has established quality measures in this model in four key areas:

1. Communications and care coordination;
2. Person- and caregiver-centered experience;
3. Clinical quality of care; and
4. Patient safety.

The organization had a positive meeting with CMMI but has a lot more work to do. It will go back to CMMI with total cost of care, including costs associated with symptoms management. It is having a hard time collecting data on management and complications.

ASTRO is exploring the possibility of considering a mechanism to verify that technology used in radiation therapy is being used appropriately in the model. This is beyond guidelines adherence for technology.

Regarding rapid technology development, Mr. Harold Miller noted that many are proposing payment models based on what exists today. One challenge is how they get updated over time, and there is concern about that in various CMS models. He asked if ASTRO is thinking about that issue.

Ms. Anne Hubbard answered that models that are flexible over time and allow for reviewing and for assessing what is an appropriate methodology to be used for disease sites need to be built. For

example, treatment with protons is growing significantly, and the clinical application for its use is expanding.

Sybil Green, American Society of Clinical Oncology (ASCO)

Ms. Sybil Green said that ASCO is currently testing a model and plans to submit it to the PTAC. She asked the following two process-related questions:

1. Would public comments be necessary on the back-and-forth with the submitter?
2. In what context will the PTAC's recommendations be made? Is it a recommendation to implement? A recommendation to amend to another model?

Discussion on Question 1:

Mr. Harold Miller responded that the PTAC will take time to figure out the questions and concerns of a proposal. The proposal would go out for public comment if those questions and/or concerns were small. The goal is to overlap processes and keep the timeframe short. The Committee welcomes feedback on this plan.

Ms. Sybil Green commented that data availability is critical in evaluating a model, and she expressed appreciation for the PTAC's facilitation of data. She asked that the Committee reconsider providing technical assistance for all submitters, as so many will be new to this process.

Discussion on Question 2:

Dr. Jeffrey Bailet noted that the PTAC is charged with making recommendations for models for consideration by the Secretary. The Secretary could prioritize a particular model over others. PTAC is working with Center for Medicare & Medicaid Innovation (CMMI) colleagues to determine the quality of the recommendation and the downstream ramifications. The Committee is trying to find areas in which its work assists the work of CMS, and vice versa. The two bodies are working to build a very strong collaboration.

Dr. Len Nichols added that the PTAC is considering how to calibrate the intensity of the PTAC's recommendations.

In response to Ms. Sybil Green's comment on data, Mr. Harold Miller explained that to provide technical assistance the PTAC needs to understand what is needed and whether the Committee can provide it. This includes time frames and the necessary level of resources. Dr. Rhonda Medows said that organizations that can help in this area are welcome.

Ms. Elizabeth Mitchell added that the PTAC seeks an understanding of not just Medicare data that may be needed, but multi-payer claims data; how clinical data will relate to the measures; and how data will be shared across sites, facilities, and regions.

Dr. Grace Terrell noted that the Committee needs to determine the process and data pieces together, and she asked submitters to provide examples for discussion within the PTAC and with CMS.

Joanne Lynn, Altarum Institute

Ms. Joanne Lynn commented that there exists a population, the very old and frail, in Medicare that does not exist elsewhere. CMS, the Agency for Healthcare Research and Quality, the National Quality Forum, and others skip over the special needs of this population and the advanced disease/severe illness characterizing this population. Most Medicare funding goes to this population and long-term care. She asked the PTAC specifically look at whether the proposer has addressed issues related to the frail and multiply-ill in mind, and the need for a comprehensive care planning.

Ms. Joanne Lynn cleared up some confusion around the MediCaring Communities proposal. Initially CMMI said that model was not possible under current law and regulation; however, upon follow-up with CMMI, it was noted that initial guidance was incorrect.

Ms. Joanne Lynn applauded the openness and efforts by the PTAC.

Mr. Harold Miller asked Ms. Joanne Lynn what data challenges or other challenges the Altarum Institute faces in putting together a proposal for the advanced, frail population. Ms. Joanne Lynn explained data challenges for this population differ from other populations because electronic medical records (EMRs) and claims data do not identify this population. When the IMPACT Act takes effect in 2018, all post-acute care providers will need to use a common set of assessments; this will make it easier to find people, but the data will only include those who go through the hospital system. One year's Minimum Data Set and OASIS data covers one-half of that population. It is not easy to find the rest as they may be in Veteran's Affairs hospitals, nursing homes, or home care.

Mr. Harold Miller suggested that some transition period may be needed to collect this data, if it does not currently exist. Mr. Harold Miller remarked that it would need to be determined which plans have data and how to get it. Some Medicare Advantage plans now routinely conduct mental and functional status evaluations, so information is in the records.

Sharita Jennings, American Physical Therapy Association (APTA)
Ms. Sharita Jennings asked where the PTAC foresees non-physician providers, such as physical therapists, fitting into this landscape.

Mr. Harold Miller replied that the right way to have physical therapists and physicians work together differently to manage that service delivery will need to be determined. In some cases, physical therapists can help with the diagnosis process as well as the treatment process. It is important to identify conditions and opportunities in which multiple practitioners can participate—nurses, physical therapists, occupational therapists, speech therapists, et. al. Mr. Harold Miller suggested thinking about other groups with which to potentially partner on situations that need coordination of activity.

Dr. Grace Terrell added that the PTAC is paying very close attention to the final rule, and will work creatively within the broader context to understand how we can create models that are physician focused (as interpreted in the final rule) that do not hamper better, more appropriate models of care and/or innovative ways of thinking about it. The final rule will allow for more clarity.

Dr. Rhonda Medows asked if members of APTA are already working with physician groups on a model. Ms. Sharita Jennings explained that the association was not yet working with physician groups. It is in the initial stages of exploring certain chronic conditions around which it can reach out to those groups and possibly to sister therapy organizations. APTA is exploring whether it wants to approach physician groups to be a part of their models, or to create its own model into which it invites physicians. Dr. Rhonda Medows recommended that APTA continue to explore both avenues.

Eileen Shannon Carlson, American Psychiatric Association (APA)
Ms. Eileen Carlson echoed others' comments on the thoughtfulness and flexibility regarding the timeline process and proposal framework. Psychiatry is heavily involved in developing models of care integration to help the 80% of patients with mental health and/or substance abuse disorders who receive treatment in primary care. The APA has been working with Medicare, Current Procedural Terminology (CPT), and the AMA to get codes and reimbursement for psychiatric collaborative care management services, which represent a bundled payment that allows PCPs to work with psychiatrists directly. APA is also in the process of providing education to psychiatrists about this model across the country.

The APA doubts that this model will fit with the MACRA model requirements. Ms. Eileen Carlson asked where the PTAC sees its role vis á vis APMs that do not fit the MACRA criteria. Does it encourage societies to come forward for the PTAC to create a record of models that would have huge value but may not meet those criteria?

The APA is very encouraged about the possibility of technical assistance, and Ms. Eileen Carlson suggested that the PTAC could produce helpful materials on do's and don'ts, FAQs, and lessons learned.

Regarding data, one of the most difficult things to do is to prove cost savings of avoided interventions, such as hospitalization and other services. It would be helpful to gain clarity on how CMS calculates cost savings, due to lack of transparency.

In the proposal requirements, one specific item asks for why a model cannot be tested under current payment methodologies or CMMI models. Ms. Eileen Carlson encouraged the Committee to rethink the word "cannot", as numerous models could be tested, and requests may have already been made to CMMI.

MACRA gives the PTAC the authority to recommend revisions to models to CMS once it receives them from physicians or physician groups. Ms. Eileen Carlson noted that the PTAC may want buy-in by those being called upon to participate in a model before it makes recommendations to CMS for major changes to that model.

Mr. Harold Miller explained that, regarding clarification on the "cannot be tested" language, if what APA is proposing is the same thing that CMMI is already doing, one way to do these things under law is through the CMMI authority. He noted that the PTAC needs to clarify that language.

Mr. Harold Miller stated that the group is discussing whether it should consider a proposal that merely changes the fee schedule. He pointed out that what Ms. Eileen Carlson described is a fee schedule change with no specific accountability attached to what would be achieved. He asked if the APA has thought about something that would be a complementary APM model that with a fee change, something new that could have not been done otherwise could be done.

Ms. Eileen Carlson answered that the APA is considering that. One major barrier is the required use of certified EHR technology. Many psychiatrists do not have certified EHR systems; the association awaits the final rule on this issue. Barriers exist within the market of EHR systems with respect to mental health services, including privacy and patient interoperability. Another major barrier is the assumption of risk. Mr. Harold Miller called that insight very helpful for the PTAC to know.

Dr. Grace Terrell discussed the question of whether the PTAC process will reverse the process around integrated behavioral medicine in primary care, perhaps with very patient-centered foci in which patients would have psychiatry medical home for the most critically mentally ill patients

who never see a PCP. Ms. Eileen Carlson thanked Dr. Terrell for raising that point. The APA is looking into such "reverse integration" models.

Dr. Jeffrey Bailet opened the floor to comments and questions by members of the public not included on the public comment participant list.

Sheila Madhani, McDermott+Consulting

Ms. Sheila Madhani asked the Committee to expand on the difference between high-priority and other criteria listed in the proposal guidelines. For example, will high-priority criteria represent more points in a scoring methodology?

Dr. Jeffrey Bailet said that the PTAC is working through how best to rate and review the proposals. As that gets crystallized, it will be reflected back to the stakeholders and proposal submitters.

Sandy Marks, AMA

Ms. Sandy Marks asked if the department has indicated its plan for acting on recommendations (i.e. one at a time as they are submitted, or as a group at a certain point in time). An option HHS could take is to have CMMI design a test for a model, and a small scale several-state pilot test to be expanded if successful, as opposed to a PTAC-recommended model leading to a large-scale program immediately.

Ms. Elizabeth Mitchell noted that Ms. Sandy Marks has identified several key topics of discussion for the PTAC and asked a representative from CMMI or CMS to address her questions regarding HHS action.

CMMI Health Insurance Specialist Alison Falb, JD explained that she is part of the HHS/CMS group that has been supporting the PTAC. The group is aware of the questions raised here by Ms. Sandy Marks and hopes to shed more transparency on the process. HHS staff is working to make the process as transparent, clear, and accessible as possible.

Ms. Elizabeth Mitchell remarked that the PTAC and HHS staff have held highly collaborative discussions, working to coordinate and align the processes. The two bodies share the objective of having a least a few new models in the field as quickly as possible. The PTAC is working to develop its process in a way that ensures it is not creating redundancy.

Ms. Alison Falb explained that the statutory obligation of the Secretary is to provide a detailed response to comments and recommendations; therefore, a detailed response to the comments and recommendations of the PTAC will be posted on the HHS website. Information regarding the timing of those legally required responses is forthcoming.

Mr. Harold Miller added that HHS and the PTAC have a shared interest in seeing some models put into place in 2018. Comments on whether certain things should be tested on a limited scale vs. a broader scale are welcomed and will inform the PTAC's recommendations.

Walead Latif, D.O.

Dr. Walead Latif, a nephrologist in private practice, noted that many providers—small practices, particularly, but large organizations as well—have financial risk concerns related to APMs. He asked if an applicant would be able to submit an APM that would limit risk if it demonstrates good value. He also expressed concern around bundling for chronic disease management, as numerous office visits could be less expensive than a fewer number of hospital visits.

Dr. Len Nichols advised that Dr. Walead Latif note the distinction outlined in the proposed rule between an APM and an Advanced APM. It seems that a "regular" APM would make more sense in such a case; the proposer simply needs to clearly lay out the benefits and the rules around accountability. An APM does not have to be advanced to be physician focused. Risk is highly relevant and is a necessary condition for Advanced APMs; risk is expected to be a part of most proposals.

Mr. Harold Miller suggested that a new APM would not create new risk but would transition from risk that is not aligned with patient outcomes to risk that is. How to make that happen and make the risk manageable for physicians is to be addressed. This starts with deciding what the physician can be accountable for in terms of patient outcomes and other factors, and leads to attaching a financial reward or penalty. The goal is the improvement of patient outcomes, and a model does not have to have a particular bundled structure. Stakeholders are asked to bring forward innovative ideas based on their experiences.

Dr. Grace Terrell clarified the point that Advanced APMs, are defined as those that have more-than-nominal risk (CMS has released a list of six of those that currently qualify.), exempt people from the Merit-Based Incentive Payment System (MIPS), and have different types of potential bonuses and fee schedules. Over time, other new Advanced APMs with respect to risk may emerge that would exempt physicians from MIPS and place them in the APM category. The PTAC can serve as a creative space to go beyond the APM/Advanced APM "either/or". Within that context, there may be a place for very different APMs than those that exist presently.

Regarding bundling, submitters are asked to consider the patient-centered point of view, with a payment scenario that grows from the best possible outcomes for patients (irrespective of facility fees, etc.), what would it look like for a physician? It might involve partnering with others in the community around social determinants of health, or it might involve an innovative method the

physician envisions. The PTAC is a space for the medical community to think about novel, innovative methods from the field.

Written Question

The Committee received the following written question: From where does the PTAC draw specialty-specific subject matter experts (SMEs)?

Dr. Jeffrey Bailet noted that the PTAC will address this issue based on the proposals it receives. The goal is to ensure that submitters feel that the specialty-specific information in their proposals is appropriately considered and analyzed during the review process.

The Committee receives support from contractors. Dr. Scott Smith, DFO, explained that, through ASPE, the PTAC support team awarded a contract which includes several subcontracts that allow the Committee to tap into the expertise of one academic medical center; however, the PTAC is not limited to that one institution. The Committee may choose to draw on external expertise and will review the expert for potential conflicts of interest. Whether clinical experts, statisticians, or actuarial specialists are needed, one or more will be invited to review a proposal or a specific portion of the proposal as determined by the Committee, such as a set of technical questions. The existing contract provides prompt options for review, but the ASPE may go outside that contract to identify SMEs.

Dr. Jeffrey Bailet thanked everyone for joining the meeting and for their continued participation as the PTAC continues to prepare to accept proposals in December. He said that the Committee hopes that attendees are getting a sense of its goals of transparency and collaboration. The PTAC will pay close attention to the very helpful comments, questions, and feedback from this session and will incorporate them moving forward.

The Committee is working to schedule one additional public meeting prior to the end of 2016. Information regarding that meeting will be published in the Federal Register, on the PTAC website, and through the listserv. Dr. Jeffrey Bailet asked that stakeholders subscribe to the listserv and to stay engaged with the work of the Committee.

Dr. Jeffrey Bailet adjourned the public session.

Approved and Certified by:

Scott Smith

Scott R. Smith, PhD

12-16-16

Date

Physician-Focused Payment Model Technical Advisory Committee
Alternate Designated Federal Officer

12-16-16

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

Date