

Physician-Focused Payment Model Technical Advisory Committee (PTAC)

**Hubert H. Humphrey Federal Building
200 Independence Avenue, SW
Washington, DC 20237**

Meeting Summary

**Administrative Meeting - Public Session
February 1, 2016**

Physician-Focused Payment Model Technical Advisory Committee

Jeffrey Bailet, MD, President, Aurora Health Care Medical Group; Chair, Aurora Physician Compensation Committee; Chair, PTAC

Robert Berenson, MD, Institute Fellow, Urban Institute

Paul Casale, MD, MPH, Chief of Cardiology, Lancaster General Health; Clinical Professor of Medicine, Temple University School of Medicine; Senior Scholar, Department of Health Policy, Sidney Kimmel Medical College, Thomas Jefferson University

Tim Ferris, MD, Medical Director, Mass General Physicians Organization; Senior Vice President for Population Health Management, Partners HealthCare; Associate Professor of Medicine and Pediatrics, Harvard Medical School

Rhonda M. Medows, MD, Executive Vice President of Population Health, Providence Health & Services

Harold D. Miller, President and CEO, Center for Healthcare Quality and Payment Reform

Elizabeth Mitchell, President and CEO, Network for Regional Healthcare Improvement; Vice Chair, PTAC

Len Nichols, PhD, Director, Center for Health Policy Research and Ethics; Professor of Health Policy, George Mason University

Kavita Patel, MD, Sibley Memorial Hospital; Nonresident Senior Fellow, Brookings Institution

Bruce Steinwald, MBA, President, Bruce Steinwald Consulting

Grace Terrell, MD, President and CEO, Cornerstone Health Care

Assistant Secretary for Planning and Evaluation (ASPE) Staff

Nancy De Lew, MA, MAPA, Associate Deputy Assistant Secretary, Office of Health Policy

Arnold Epstein, MD, Deputy Assistant Secretary, Office of Health Policy

Clara Filice, MD, MPH, MHS, Medical Officer

Scott R. Smith, Ph.D., Director, Health Care Quality and Outcome Division

Centers for Medicare & Medicaid Services Staff

Amy Bassano, MA, Director, Patient Care Models Group, Center for Medicare and Medicaid Innovation (CMMI)

Hoangmai Pham, MD, MPH, Director, Seamless Care Models Group, CMMI

Dr. Smith, the designated federal official (DFO) for this committee, opened the meeting at 1:01 p.m.

Welcome

Arnold Epstein, MD, Deputy Assistant Secretary, Office of the Assistant Secretary for Planning and Evaluation (ASPE), Department of Health and Human Services (HHS)

Dr. Epstein explained that he and Ms. De Lew lead the Office of Health Policy at ASPE, which provides support to the Physician-Focused Payment Model Technical Advisory Committee (PTAC). PTAC meetings will have public-comment sessions, and public input will be critical to the committee at this meeting and in the future.

Public Opening of Meeting and DFO Statement

Scott R. Smith, Ph.D., Director, Health Care Quality and Outcome Division, ASPE, HHS

Dr. Smith pronounced the meeting to be officially open. This would be a public meeting, and the transcript of this meeting was to be published. Meeting materials are available on the registration site. PTAC was established by the Medicare Access and CHIP Reauthorization Act (MACRA) of 2015. PTAC is charged with reviewing physician-focused payment models submitted to HHS and with preparing comments and recommendations regarding whether these models meet the criteria established by the HHS Secretary.

Chairperson and Vice Chairperson Statements

Jeffrey Bailet, MD, President, Aurora Health Care Medical Group; Chair, Aurora Physician Compensation Committee; Chair, PTAC

Elizabeth Mitchell, President and CEO, Network for Regional Healthcare Improvement; Vice Chair, PTAC

Dr. Bailet welcomed the audience to the first public meeting of PTAC. He emphasized his commitment to open meetings, transparency, and public input into PTAC's work. PTAC is mostly likely to be successful if it develops a transparent and credible process for providing technical advice to the HHS Secretary so that stakeholders who wish to develop alternative payment models (APMs) understand how PTAC will conduct its reviews and can develop models with a high likelihood of success. PTAC will apply the criteria that the Secretary develops and help the public understand where the models meet or exceed those criteria and where they fall short. Ultimately, HHS will select models to test and might move those with favorable results into the Medicare program. PTAC's success will be measured by the extent to which effective APMs are available for adoption by the Medicare program after rigorous testing.

Ms. Mitchell said that she believes that the time has come for the country to change the way it pays for health-care services to obtain the efficiency, quality, and value that the country needs. Payment reform offers the best example of the need for multi-stakeholder collaboration between those who pay for care and those who provide care on behalf of those who receive care. She invited public input on the template that PTAC will develop for stakeholders to use when they submit models for review, areas where models are needed, and opportunities for alignment between public and private purchasers.

Members Introductions and Statements

PTAC members introduced themselves and gave opening statements.

Mr. Miller said that a great deal of frustration exists around the country because people want a better payment system, but most payment models do not solve today's problems and some make things worse. Mr. Miller commended Congress for focusing on physicians because too much effort has focused on good systems and not on how to improve care on the front line. Mr. Miller hoped that PTAC can lead to the creation of alternative payment models (APMs) that work for physicians and all stakeholders. He is committed to making sure that PTAC facilitates openness and innovation, gives stakeholders a fair hearing, and supports and advocates for the implementation of effective models to help reform America's health-care system in a way that works for everyone.

Dr. Nichols said that he believes that health-care reform requires realigning incentives. The core of any system improvement for incentives must be physician-focused payment models. The U.S. health-care system is large and diverse, and part of PTAC's job is to enable small practices to thrive in a health-care system that delivers care to all Americans in efficient ways.

Dr. Patel's goal was to think about the practitioners and clinicians who make up the country's medical care system but do not have time to understand MACRA and its components. Dr. Patel is interested in ways to associate the definition of quality with APMs. The financial incentives and measures need to align to meet common goals.

Mr. Steinwald hoped that PTAC will contribute to the development of policy solutions that the sustainable growth rate was unable to accomplish.

Dr. Terrell said that what PTAC is trying to do is important for today's patients and those of the future. Accomplishing the Secretary's goals will require changing the ways of providing care, developing an integrated clinical and information delivery system that can use successful models of care, and paying differently for care. MACRA and PTAC will make it possible to develop solutions at the system level that can achieve the aspirations under discussion for at least a generation.

Dr. Berenson said that stakeholders need to develop APMs as competently as possible. These APMs need to eliminate the frustrations of physicians while achieving better results. At the same time, these payment models must be operationally and administratively feasible and be adoptable by most payers, not only Medicare or Medicaid. Payment models must be relevant to small

independent practices and take into account the fact that many patients, especially Medicare beneficiaries, will be followed by specialists for long periods for chronic conditions.

Dr. Casale described the common frustration with fragmentation of care. The ways in which payment models are currently set up drives some of that frustration for patients and physicians. The creation of payment models that work well can eliminate this frustration.

Dr. Ferris hoped to bring his experience at the intersection of payment policy and care delivery to help the Secretary and PTAC.

Dr. Medows said that an emphasis on value over volume and the use of payment models that reward such efforts will improve outcomes for individuals and populations. The health-care system needs to move away from volume to value, and these efforts must be quantified and sustainable. Dr. Medows looked forward to learning about the HHS criteria that PTAC will use in its work and to receiving ideas and evidence from stakeholders.

Initial Discussion on Proposal Submission Framework

Clara Filice, MD, MPH, MHS, Medical Officer, ASPE, HHS

One of the first questions for PTAC and stakeholders is, what principles should guide the development of PTAC's process for submitting and reviewing proposals? These principles could include, for example, efficiency, analytic rigor, or productivity, and PTAC will need to make tradeoffs in applying these principles. PTAC will determine its review process over the next year, but the major steps are likely to be stakeholder submission of proposals, preparation for review of the proposals, reviews of proposals and recommendations to the Secretary, and reviews of PTAC's recommendations by the Secretary. Many questions need to be answered about each of these steps.

Dr. Filice asked for public comments on these questions:

- What principles should guide PTAC's development of a process for proposal submission and review?
- What elements of the process are most important?

Public Comment Session 1

Dr. Bailet asked members of the public to limit their remarks to 3 minutes. He invited those with more extensive comments to submit them to PTAC in writing.

Sandy Marks, MBA, American Medical Association (AMA)

Helping patients get better must be the focus of APMs. Many barriers in the payment system are in the way of opportunities to improve care while reducing spending for Medicare and other payers. APMs can lower these barriers so that patients can benefit. Many opportunities are available to improve treatment planning, coordination, and self-management for such common conditions as diabetes, heart disease, addiction, and asthma in ways that can enhance patient care while reducing the use of expensive tests and procedures, hospitalizations, and emergency department admissions.

However, the current system does not support investments in taking calls from patients after hours, coordination with emergency services and hospitals, care managers, or time to consult with other physicians. Many specialties are developing models that can solve these problems. But concern exists about whether HHS will make it possible to implement these models.

An important criterion for physician-focused APMs is to let physicians take accountability for the costs and outcomes they can influence through the patient care that they provide and not make them responsible for costs they cannot control or impose new administrative burdens.

Congress provided the incentive payments in MACRA because physicians need support to transition to APMs. PTAC and the Center for Medicare and Medicaid Innovation (CMMI) must work together to make sure that the models that specialties are developing can count as qualified APMs. With the right implementation strategies, these APMs will proliferate, just as prescription-only health plans and accountable care organizations did after HHS implemented the applicable laws. AMA encourages PTAC to set aside time at its meetings to hear from some of the specialties that are developing physician-focused APMs to recognize their true potential.

Robert Dowling, MD, ION Solutions and IntrinsicQ Specialty Solutions

MACRA has the potential to transform provider performance and patient outcomes, but only if HHS takes into account perspectives from across the health-care system. Dr. Dowling made the following requests to PTAC:

- Give special attention to models proposed by the medical specialty community, whose unique needs are often overlooked in the design of quality measures, electronic health record (EHR) incentive programs, and other programs. APM success will depend on specialists having meaningful options that reflect actual clinical practice and challenges.
- Continue to represent the perspective of specialists on future PTAC agendas and appointments of committee members.
- Incorporate flexibility into PTAC's recommendations for the design of physician-focused APMs because one size does not fit all in health care. Available models are lagging in all areas of practice, but especially on the specialty side. The Oncology Care Model is a promising start but has limitations in the number of providers who can participate, strict eligibility criteria for participation, and a risk-sharing model that might discourage long-term participation. It will be difficult to develop and manage models for every specialty, and PTAC's independent role in this process is essential.
- Recognize the ongoing burden of technology adoption for providers and its impact on APM success. The meaningful use regulations have arguably encouraged the implementation of EHRs but have stifled the successful adoption of those systems. Electronic quality measures for specialists are limited, no outcome measures are available, and population health management platforms in specialty care are in their infancy.

Anne Hubbard, American Society for Radiation Oncology (ASTRO)

ASTRO has taken Secretary's Burwell's goal of shifting reimbursements from volume to value and the passage of MACRA as a call to action. As a result, ASTRO developed APMs in 2015 for the palliative care of bone metastases and for the treatment of early-stage breast cancer. These

models seek to drive value in health-care delivery by focusing on four key priorities that will inform the principles that PTAC is developing:

- Establish defined episodes of care for which there are known evidence-based practices regarding the most appropriate treatment
- Address underuse and overuse of therapy
- Preserve the flexibility of patients and physicians to select the most appropriate modality of treatment based on the patient's medical needs
- Implement a quality approach that incorporates standard and disease-specific quality metrics

ASTRO plans to develop other models that it hopes will dovetail with APMs developed by other oncology professions. The success of this effort will require consideration of how different specialties deliver care as well as flexibility in model design and implementation. A broader discussion is needed of the true value of health-care delivery and how it is measured.

Jenna Kappel, American Academy of Otolaryngology–Head and Neck Surgery (AAO-HNS)
The Centers for Medicare & Medicaid Services (CMS) needs to allow for the widest range of innovative ideas to ensure that the greatest number of physicians can both participate and succeed in future payment models. CMS should define “financial risk” in the broadest sense to allow the greatest number of eligible APM entities to participate in the APM program. AAO-HNS hopes that there will be opportunity for specialists, such as otolaryngologists, to participate and thrive in APMs in the future. However, the current CMS definition of “APMs” provides little opportunity for models that include specialists as eligible APM entities. AAO-HNS therefore urges CMS to allow for innovative APMs that include providers who have not had the opportunity to participate in other APMs.

AAO-HNS agrees with other societies that Congress intended to allow physician-focused APMs to provide an alternative, more transparent avenue for the development of qualified APMs than the existing CMS process. Congress did not intend for the models recommended by PTAC to receive comments from CMS only and never be implemented. CMS should comply with congressional intent and establish an easy pathway for physician-focused APM proposals to be adopted as eligible APMs. CMS and PTAC need to develop direction, definitions, and funding opportunities as soon as possible to give physicians enough time to prepare and implement changes needed to participate in APMs.

Barbara Tomar, American College of Emergency Physicians (ACEP)
Like other specialty societies, ACEP believes that most of the previous APMs that CMS supported left out specialists. Emergency physicians can participate in APMs in many ways to help improve care delivery and reduce spending. An ACEP task force is developing some models that are quite promising. Unlike other specialties, emergency physicians do not follow patients longitudinally or provide procedures that lend themselves to bundling. Emergency physicians provide a large volume of services, often to Medicaid beneficiaries. A significant number of CMMI grants and state Medicaid proposals have included emergency department visits as a failure metric. ACEP supports efforts to reduce some emergency department visits by helping patients find a regular source of care. However, some patients have serious diseases or conditions with exacerbations that require emergency department visits. This should be

acknowledged in APMs by including plans for managing patients in emergency departments. ACEP wants to coordinate care for the improvement of outcomes, which requires working toward real-time information sharing to reduce duplicate testing and hospital admissions.

Shawn Martin, American Academy of Family Physicians (AAFP)

AAFP encouraged PTAC to keep the focus of APMs on patient-centeredness. APMs should be team based, provide comprehensive and longitudinal care, focus on the individual but be mindful of the population, and eliminate the episodic fragmentation in the health-care system. APMs should be scalable at all levels and be blind to geography, practice size, and practice type. APMs should not drive employment or affiliation agreements against the wishes of physicians or groups of physicians and their teams, and all physicians should have the opportunity to participate in an APM. However, AAFP cautioned against making multiple APMs available to every discipline. APMs should not extrapolate the shortcomings of the current fee-for-service system or continue to reward activities that drive volume. CMS should improve investments, align investments across all payers, and encourage longitudinal care models.

Courtney Yohe, MPP, Society of Thoracic Surgeons (STS)

STS is in a unique position to show how quality measurement and improvement can enhance patient outcomes and decrease costs. STS can combine the information in its database with Medicare and other claims data to develop a clinical financial tool that can be used to ensure that physicians can identify the most effective and appropriate treatments and have the incentives to do so. STS urges CMS to use PTAC as Congress intended to help evaluate payment models, especially those relevant to medical specialties; to test the models that PTAC endorses; and to provide feedback and guidance to those developing APMs.

Arielle Zina, Healthsperien

APMs are needed that are suitable for small-group and solo practices, especially combined specialty and small-group practices that lack specialty-specific models and face administrative and financial burdens in adopting APMs. PTAC should ensure that a range of provider types across specialties, settings of care, and practice sizes has the ability to design and develop robust APMs for PTAC's review, especially given that much of the payment data needed for APM development might be outside specialty or small-group practices' scope.

Sara Brown, MPA, Medical Group Management Association (MGMA)

MGMA believes that physicians should be able to earn incentive payments without having to meet the criteria established under MACRA for eligible APMs. CMS needs to establish transparent criteria and a clear pathway for models recommended by PTAC to HHS to be implemented by CMS as qualified APMs. CMS and PTAC should work collaboratively with medical societies and other organizations to develop criteria, provide continuous feedback on drafts, and provide data to help these groups model impacts. The physician-focused APMs should support innovative approaches that give physicians the flexibility to deliver a more unique set of services than the current payment systems allow. The APMs need to minimize administrative burdens to reduce administrative costs and maximize the resources used to help patients. CMS should not tie the hands of APMs by defining them through the Merit-based Incentive Payment System (MIPS) lens, which is a separate program. MGMA recommends that APMs use quality measures that align with organizational goals. MGMA underscores the

importance of clinical relevance in establishing the definition of comparability, and it recommends that CMS establish minimum clinical standards across its programs, including incorporating some of the physician-focused APMs. This will be particularly important in considering payment alignment. MGMA asked PTAC to consider the financial risk aspect of incorporating certain physician-focused APMs and asked that these models be structured in a way that ties physician incentives to processes of care they can influence and not what they can contribute to reducing the size of the Medicare trust fund.

PTAC Member Comments

Mr. Miller explained that PTAC does not yet have the criteria it will use to evaluate proposals for physician-focused APMs. However, PTAC can discuss the types of information it is seeking in the proposals it will review. Mr. Miller identified types of information he would like to see in proposals:

- The nature of the improvement in care that is envisioned through the model
- The barriers in the current payment system that the model will overcome
- The nature of accountability that physicians would and would not have in this model based on what they can and cannot control
- How the model would work for small and independent practices
- How the model, if it is specialty specific, will ensure coordination with other specialties to avoid fragmentation for patients whose care needs cut across specialties

Mr. Miller emphasized that these are his personal views and are not necessarily those of PTAC as a whole.

Dr. Terrell commented that most of the speakers in the public comment session represent physician groups. However, APMs affect the entire health-care system, and she would welcome a range of advice and counsel from many people, including consumers, hospital systems, and pharmaceutical companies.

Mr. Miller called for ensuring that the burden on applicants is as manageable as possible. Too many requests for proposals ask for large amounts of information and set stringent page limits. PTAC and CMS need to make resource demands for proposals manageable and avoid all “gotchas” that eliminate proposals for purely administrative reasons and not because of their substance.

Introduction to MACRA and CMMI Model Development

Amy Bassano, MA, Director, Patient Care Models Group, CMMI, CMS

Hoangmai Pham, MD, MPH, Director, Seamless Care Models Group, CMMI, CMS

Since President Obama signed the Patient Protection and Affordable Care Act into law, CMS has worked to develop the infrastructure and policies needed to move the health-care delivery system from paying for volume to paying for value. HHS has set a goal of tying 30 percent of Medicare fee-for-service payments to quality or value through APMs by 2016 and 50 percent by 2018. The Affordable Care Act created CMMI to develop, test, and implement new payment and delivery models with the potential to reduce program expenditures while preserving or enhancing quality

of care. CMMI has developed more than 30 APMs in the last 5 years. CMS categorizes payments to providers into four groups, ranging from fee for service with no link to value to population-based management. The CMMI model life cycle framework has five stages, each with many steps. MACRA helps HHS meet its payment-reform goals by linking fee-for-service payments to quality and value through the MIPS.

Discussion

Ms. Mitchell asked about the place of models recommended by PTAC in the CMS model life cycle framework. Dr. Pham replied that the answer depends on several factors. If PTAC recommends a proposal that is basically sound but needs a substantial amount of fleshing out, it would fall into the first stage (idea/concept). Models that are more detailed might fall into the second stage (planning and design). Ms. Mitchell said that PTAC would like to find out what is required for models to reach the second stage as quickly as possible.

Ms. Mitchell asked about determinations regarding physician-focused APMs. Dr. Pham said that MACRA is new, and CMS has not applied its model life cycle framework yet. At each of the five stages, especially the first two, CMS will make preliminary assessments of whether a model appears to meet the criteria for eligible APMs.

Mr. Miller asked whether all CMS Medicare administrative contractors (MACs) are prepared or preparing to put in place true bundles and what they are prepared or not prepared to do with respect to physician/physician bundles or physician/hospital bundles for prospective payments. Ms. Bassano replied that CMMI and other components of CMS are working on this matter, which involves many administrative issues that go beyond the MACs.

Mr. Miller asked whether the CMS model life cycle framework, which is not required by law, is being refined based on experience. Ms. Bassano replied that CMS is continually refining the process, and the agency has every interest in making the policy clearance conversations and operations as efficient as possible. One early lesson was the need to bring key stakeholders on board as early as possible, especially if they need to solve complex problems.

Mr. Miller said that it would be helpful to PTAC to obtain copies of CMS's completed Innovation Center Investment Proposals (ICIPs) for the models that CMS has implemented and those that it decided not to implement. PTAC could use this information to determine how CMS decided that a model was or was not feasible. Ms. Bassano suggested that PTAC review the proposed and final rule for the Comprehensive Care for Joint Replacement Model because it lays out CMS's argument for implementing the model, alternatives considered, and its approach.

Mr. Miller commented that PTAC had heard at this meeting that several specialties are concerned about the lack of models for them. It would be helpful for PTAC to know if CMS has evaluated other specialty-focused models and the nature of its concerns. This information would help PTAC educate those developing new models on how to overcome the barriers they have experienced in the past. Dr. Pham replied that almost all models that reach the ICIP-development stage are successful. CMS invests a massive amount of staff time to develop an ICIP, and it only does this if it has a high level of confidence that the model will succeed.

Dr. Nichols asked CMS to share its top lessons to date from the model review process with PTAC. Dr. Pham replied that CMS could compile some of its “greatest hits” for PTAC.

Dr. Nichols asked whether any programs that meet the criteria will be implemented nationally. Dr. Pham reported that all of the models tested under CMMI’s authority are considered APMs under MACRA. CMS will learn which ones have the potential to become eligible APMs when the MACRA final rule is published. She added that the Pioneer ACO model was the first model to meet the statutory criteria. Several other models with promising early results will be evaluated this year or early next year for potential expansion. Dr. Nichols said that this information could help PTAC focus on classes of models that appear to be progressing.

Ms. Bassano, who has worked on the development of some specialty models, emphasized that CMS wants its models to be as broad as possible. For example, some stakeholders suggested that CMS develop a stage IV lung cancer model that had many strong design elements. But developing a model takes a great deal of resources, and CMS can only move a limited number through the clearance process. As a result, the agency wants its models to be broader and include as many physicians as possible. CMS often discards or does not move forward models for one particular procedure or intervention. A model is more likely to succeed, for example, if it addresses three or four interventions or procedures for one specialty or several similar procedures that cross several specialties to maximize efficiency. For this reason, CMS asks PTAC to favor comprehensiveness.

Dr. Berenson asked whether the MACRA threshold for payment percentage for APMs determines model size. For example, if an APM targeted stage IV lung cancer, it is unlikely that many oncologists would qualify because of the thresholds. Dr. Pham said that it would be easier to answer this question after the notice of proposed rulemaking is issued. However, MACRA will have implications for the design of eligible APMs. CMS believes that many models that are important to test will not be eligible APMs under MACRA.

Dr. Medows asked whether any of the models that CMS is evaluating address long-term care or mental health. Dr. Pham said that CMS would like to receive proposals for viable models for long-term care. CMMI is developing models that do not focus specifically on mental health but do address mental and behavioral health care integration.

Mr. Steinwald commented that the CMS language on incentive payments appears to be oriented toward fee-for-service payments. He asked whether models not built on a fee-for-service platform can provide incentive payments. Dr. Pham agreed that the language is oriented toward fee-for-service payments. MACRA is a traditional Medicare program and it does not affect Medicare Advantage Plan rates, or at least not directly, and does not dictate the cash flow mechanism that may be included in a model. For example, the Next Generation ACO Model offers a capitation workflow under which it can suppress reimbursement for all of the claims submitted by providers for their patients and instead provide monthly lump-sum payments. This model is built on a fee-for-service base because CMS continues to collect these claims and uses them to calculate the 5 percent lump sum payments.

Public Comment Session 2

No public comments were offered.

Adjournment

Dr. Smith reported that the transcript of this meeting will be posted on the ASPE website. The goal is to have that within seven days. The slides from this meeting have already been posted. He invited interested stakeholders to subscribe to the PTAC email list for updates and to submit questions and comments to ptac@hhs.gov. Dr. Smith adjourned the meeting at 4:25 p.m.