

**Physician-Focused Payment Model Technical Advisory Committee
Public Meeting Minutes**

**March 13, 2017
1:00 p.m. – 3:45 p.m. EDT
Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201**

Attendance

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

Robert Berenson, MD (Institute Fellow, Urban Institute)
Paul Casale, MD, MPH (Executive Director, New York Quality Care)
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)
Len M. Nichols, PhD (Director, Center for Health Policy Research and Ethics, George Mason University)
Kavita Patel, MD (Nonresident Senior Fellow, Brookings Institution)
Bruce Steinwald, MBA (Consultant, Bruce Steinwald Consulting)
Grace Terrell, MD, MMM (Founder and Strategist, Cornerstone Health Enablement Strategic Solutions)

PTAC Members via Teleconference

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

PTAC Members in Partial Attendance

Jeffrey W. Baillet, MD (PTAC Chair; Executive Vice President of Health Care Quality and Affordability, Blue Shield of California) (departed meeting at 2:45)
Tim Ferris, MD (Senior Vice President for Population Health Management, Partners HealthCare) (departed meeting at 2:45)

Speakers

Bundled Payments for Care Improvement (BPCI) CMS Presenters

Renee Mentnech (Director, Research and Rapid Cycle Evaluation Group, Center for Medicare and Medicaid Innovation [CMMI], Centers for Medicare & Medicaid Services [CMS])
Christina Ritter (Director, Patient Care Models Group, CMMI, CMS)

BPCI Participant Presenters

Danielle A. Lloyd (Vice President, Policy & Advocacy, Deputy Director DC Office, Premier Healthcare Alliance)
Carolyn Magill (CEO, Remedy Partners)
Steve Wiggins (Founder and Chairman, Remedy Partners)

Public Commenters

Blair Atkinson (Moffitt Cancer Center)
David Introcaso (American Medical Group Association)
Carolyn Magill (Remedy Partners)

Sandy Marks (American Medical Association)

Welcome and Chairman's Update

The Chair called the meeting to order at 1:02 p.m. and welcomed the members of the public to the first public meeting of 2017. Following Committee introductions, the Chair updated the public on the status of proposal submissions, stating that PTAC has received 21 Letters of Intent (LOIs) spanning a broad spectrum of medical specialty and primary care. PTAC also has received the following five proposals:

- 1) The COPD and Asthma Monitoring Project (CAMP) submitted by Pulmonary Medicine, Infectious Disease and Critical Care Consultants Medical Group, Inc. (PMA)
- 2) The Comprehensive Colonoscopy Advanced Alternative Payment Model for Colorectal Cancer Screening, Diagnosis, and Surveillance submitted by the Digestive Health Network, Inc. (DHN)
- 3) Project Sonar submitted by the Illinois Gastroenterology Group (IGG) and SonarMD, LLC (SonarMD)
- 4) The American College of Surgeons (ACS)-Brandeis Advanced APM submitted by ACS
- 5) The Advanced Care Model (ACM) Service Delivery and Advanced Alternative Payment Model submitted by the Coalition to Transform Advanced Care (C-TAC)

The Chair stated that PTAC will deliberate and vote on four proposals (CAMP, DHN, SonarMD, and the ACS-Brandeis Advanced APM) during the PTAC's public meeting taking place on April 10 and 11, 2017. Two weeks prior to public deliberation of proposals the following items will be available to the public for each proposal via the PTAC website: Preliminary Review Team (PRT) reports, PRT questions to the submitters and submitter responses, public comments on the proposals, and any additional data analyses or research conducted per the PRT request. The Chair ended his remarks by reminding the public that PTAC has public meetings scheduled for June 2017, September 2017, December 2017, and March 2018. PTAC may add meetings as needed based on the number of proposals submitted.

Bundled Payments for Care Improvement Initiative (BPCI)

To assist in informing PTAC and the proposal review process, PTAC requested the Center for Medicare and Medicaid Innovation (CMMI) to provide an overview of BPCI in order to understand which providers have been participating in the model and the model's progress in meeting its goals.

Overview of BPCI

Christina Ritter, Director, Patient Care Models Group, CMMI, CMS, provided an overview of BPCI.

[The slide presentation used by Ms. Ritter is available at PTAC's website at:

<https://aspe.hhs.gov/meetings-physician-focused-payment-model-technical-advisory-committee.>]

BPCI represents CMMI's first bundled payment model and encompasses a single payment for an episode of care. BPCI is intended to help streamline care and has a requirement to examine the entire episode of care under a self-designed improvement plan with no formal quality metrics tied to payment. There are four models in BPCI:

- Model 1 focused on the inpatient setting and all DRGs (Diagnostic Related Groups). The model ended December 2016.
- Model 2 is a retrospective model that encompasses inpatient acute care hospitalizations and post-acute care for related services up to 90 days after hospital discharge.

- Model 3 is a retrospective, episode-of-care model triggered by an acute care hospital stay. The model begins at initiation of post-acute care services with a skilled nursing facility, inpatient rehabilitation facility, long-term care hospital or home health agency.
- Model 4 is a single, prospectively determined bundled payment to the hospital that encompasses all services furnished by the hospital, physician, and other practitioners during the episode of care, which lasts the entire inpatient stay.

BPCI includes 48 clinical episodes. Baseline prices are target prices derived from historical data between 2009 and 2012 and are updated on a quarterly basis using an annual trend factor. CMS stated that their trend factor is not adjusted for inflation. The final target price is the baseline price with an adjustment of two to three percent, depending on model risk.

Overview of the BPCI Evaluation Results

Renee Mentnech, Director, Research and Rapid Cycle Evaluation Group, CMMI, CMS, provided an overview of the BPCI evaluation results.

CMS stated that the models with the best results have been ones in which an opportunity exists to make decisions about post-acute care placement (i.e., a shift from skilled nursing facilities to home health agencies). CMS is currently in the process of drafting the next evaluation report. Given the timing of the release of that report (estimated for summer 2017), CMS could not speak to the results but indicated elements that will be covered in the evaluation report, including an analyses of the impact of Models 2, 3, and 4 on costs, quality, and unintended consequences. The evaluation will compare participants in the model to non-participants.

BPCI Question and Answer (Q&A) Discussion

In response to questions from PTAC, CMMI indicated that:

- The most common models involved use of hospitalists and orthopedists;
- No appropriateness assessments are included in BPCI; as a model, BPCI does not formally address appropriateness of care. While some analyses have been completed on this, they have been limited. However, CMS did note that in the next evaluation report they will be examining volume in a few different ways, including looking at the participants and the market that the participants are offering.
- Feedback from participating providers is that BPCI takes a much bigger effort than anticipated to get underway. Coordination and discharge planning have been problematic.
- Additional issues addressed during the BPCI Q&A discussion included evaluation challenges (e.g., identifying the right comparison group), physician specialties participating in the model, technical assistance offered by CMS, Accountable Care Organizations (ACOs) operations, regional pricing incentives, timeliness of data reports to participants, and total cost of care methods.

BPCI Participants Perspectives: Successes and Challenges – Premier Healthcare Alliance

Danielle A. Lloyd, Vice President, Policy & Advocacy, Deputy Director DC Office, presented on behalf of the Premier Healthcare Alliance. [The slide presentation used by Ms. Lloyd is available at PTAC's website at: <https://aspe.hhs.gov/meetings-physician-focused-payment-model-technical-advisory-committee>]

Premier Healthcare Alliance serves as a BPCI facilitator convener representing 3,700 hospitals nationwide and 120,000 alternate sites. In addition, as part of their bundling collaborative, Premier Healthcare Alliance has organizations participating in the Comprehensive Care for Joint Replacement (CJR) model and other episode-based payment models.

Danielle A. Lloyd discussed the conditions in which the bundles have saved money, saved money but not achieved the discount, and ones that have overspent. She further expressed her appreciation for CMMI, stating that the data feed has been good and that Premier Healthcare Alliance is pleased with receiving the baseline data in advance to help determine if an organization should participate in the program and which bundles to participate in, and to support care planning.

Danielle A. Lloyd also discussed the following issues: target pricing/trending methodology, implementation protocol, precedence rules, uniform discount rates, risk adjustment, quality metrics, legal waivers, and transparency.

BPCI Participants' Perspectives: Successes and Challenges – Remedy Partners

Steve Wiggins, Founder and Chairman, and Carolyn Magill, CEO, presented on behalf of Remedy Partners. [The slide presentation used by Mr. Wiggins is available at PTAC's website at:

[\[https://aspe.hhs.gov/meetings-physician-focused-payment-model-technical-advisory-committee\]](https://aspe.hhs.gov/meetings-physician-focused-payment-model-technical-advisory-committee)

Steve Wiggins discussed the role of an awardee convener under the BPCI model, stating that providers that participate with an awardee convener are more likely to continue in the model and less likely to withdraw from a clinical episode. Steve Wiggins stated that nearly 62 percent of BPCI participants are participating with an awardee convener. In addition, he discussed Remedy Partners' partnership with physician groups and hospitals and savings from acute and post-acute settings from 2014 through 2016.

Remedy Partners indicated that while physician groups generally modify workflows faster and have better performance, hospitals and skilled nursing facilities (SNFs) can also be successful in BPCI. Participants are successful with both surgical and medical episodes. Last, Steve Wiggins noted that quarterly reconciliation is critical to offset the material working capital requirements to adopt software, analytics, training, and administrative capabilities required to participate in BPCI.

PTAC followed up with the BPCI participants with questions about their experience with risk adjustment, gainsharing models, patient care, timeliness of data reports from CMS, and trends in bundled payment rollout.

CMS Update on the Health Care Innovation Awards (HCIA)

Renee Mentnech, Director, Research and Rapid Cycle Evaluation Group, CMMI, CMS, provided an update on HCIA. She was joined by Tim Day, Social Science Research Analyst, who also serves as the evaluation team lead and support to Renee Mentnech.

CMS indicated that they are working on the annual report for the second round of HCIA and anticipates that it will be released late summer 2017. CMS stated that the annual report would not include impact analyses due to small sample sizes, the time it takes to get identifiers from awardees, and difficulty in constructing comparison groups.

The third annual report for Round 1 was issued in early March 2017. This report includes impact analyses where CMS was able to produce such analyses. Additionally, four manuscripts were released in Health Affairs in early March 2017 that included specific findings for a few of the awardees covering home visiting models, oncology care models, the Y-USA diabetes model program, and a meta-analyses of ambulatory care models.

CMS stated that the awardees focused on a diverse number of things, including care coordination, care management, patient navigation, shared decision-making, patient-centered medical homes, patient engagement and support, workflow redesign, telemedicine, and medication therapy management. In summary, 27 awardees demonstrated positive results and reported savings in the right direction. Of those 27 awardees, 19 displayed statistically significant savings. Furthermore, a large portion of the 107 awardees are planning on sustaining their models in some form through additional funding received elsewhere.

The main difference between Round 1 and Round 2 was that Round 1 awardees were not asked to think about what their work would look like if it were changed to a payment model, whereas Round 2 awardees have been asked to propose, as part of their testing, what a payment model could look like.

HCIA Q&A Discussion

PTAC proceeded with a number of questions for CMMI. The following items were included: concept of generalizing HCIA results, scalability, sustainability, awardee expansions, and telemedicine innovations.

Public Comments and Questions

Four individuals provided comments and questions for PTAC, including representatives from the American Medical Association (AMA), Remedy Partners, Moffitt Cancer Center, and the American Medical Group Association (AMGA). The following information was shared:

- The AMA emphasized the importance of defining episode triggers and indicated that consideration should be given to triggers that begin before an admission as a way to avoid unnecessary hospitalizations.
- The AMA commended PTAC for providing data tables and encouraged PTAC to provide the public with more condition-specific data to assist in proposal development.
- PTAC asked the AMA representative about the feasibility of the BPCI methodology for smaller physician practices that might want to propose APMs. AMA stated that the biggest opportunities are being able to produce savings from Part A or from the costs incurred for things other than physician services.
- Remedy Partners stated that they are seeking to avoid fragmentation of care and that one way of achieving this would be by incorporating drugs, noting that including Part D would expand the scope of models. CMS stated that they do not include Part D in BPCI because they are looking at the payments made within the fee-for-service program. CMS noted that the Oncology Care Model (OCM) does look at Part D. In addition, CMS noted that including Part D is a consideration but that it would be challenging.
- Moffitt Cancer Center asked how PTAC is interpreting the criteria of scope and scalability. PTAC stated that it is looking for models that would fill gaps in what CMMI and CMS currently do and that could be scaled beyond one site. This does not exclude models focused on a particular condition or for which there are a limited number of patients from consideration. In addition,

PTAC is interested in projects that will attract various physician specialties and smaller physician groups.

- AMGA encouraged the Committee to pay particular attention to how proposed models would overlap or work with ACOs.
- PTAC stated that they do not necessarily have standards regarding gainsharing but welcomed any comments related to the criteria the PTAC would be utilizing to evaluate proposals.

Adjournment

PTAC thanked those members of the public who attended the meeting. The meeting was adjourned at 3:37 p.m.

A transcription of this meeting can be found on the PTAC website at: [<https://aspe.hhs.gov/meetings-physician-focused-payment-model-technical-advisory-committee>]

Approved and certified by:

/Ann Page/
Ann Page, Designated Federal Officer
Physician-Focused Payment Model Technical
Advisory Committee

8/14/2017
Date

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

7/20/2017
Date