Physician-Focused Payment Model Technical Advisory Committee

February 28, 2018

Alex M. Azar II, Secretary
U.S. Department of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20201

Dear Secretary Azar:

On behalf of the Physician-Focused Payment Model Technical Advisory Committee (PTAC), I am pleased to submit PTAC's comments and recommendation to you on a Physician-Focused Payment Model (PFPM) submitted by Large Urology Group Practice Association (LUGPA) entitled *LUGPA Advanced Payment Model for Initial Therapy of Newly Diagnosed Patients with Organ-Confined Prostate Cancer*. These comments and recommendations are required by the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) which directs PTAC to: 1) review PFPM models submitted to PTAC by individuals and stakeholder entities; 2) prepare comments and recommendations regarding whether such models meet criteria established by the Secretary of Health and Human Services (HHS); and 3) submit these comments and recommendations to the Secretary.

With the assistance of HHS' Office of the Assistant Secretary for Planning and Evaluation (ASPE), PTAC members carefully reviewed LUGPA's proposed model (submitted to PTAC on July 5, 2017), additional information on the model submitted by LUGPA in response to questions from a PTAC Preliminary Review Team (PRT) and PTAC as a whole, and public comments on the proposal. At a public meeting of PTAC held on December 19, 2017, PTAC deliberated on the extent to which this proposal meets the criteria established by the Secretary in regulations at 42 CFR § 414.1465 and whether it should be recommended.

PTAC believes that increasing the utilization of active surveillance (AS) for low-risk prostate cancer patients, particularly among minority communities, should be a priority for HHS. However, PTAC was not convinced that providers should receive an "incentive" to deliver guideline-supported care that is in the best interests of their patients.

PTAC agrees that either changes to the Medicare Physician Fee Schedule or an alternative payment model if necessary may be desirable to enable and encourage increased use of AS. However, PTAC has a number of concerns about the proposed payment methodology in the *LUGPA Advanced Payment Model for Initial Therapy of Newly Diagnosed Patients with Organ-Confined Prostate Cancer* and so it does not recommend implementation.

The members of PTAC appreciate your support of our shared goal of improving the Medicare program for both beneficiaries and the physicians who care for them. The Committee looks forward to your detailed response to be posted on the CMS website and would be happy to assist you or your staff as you develop your response. If you need additional information, please have your staff contact me at Jeff.Bailet@blueshieldca.com.

Sincerely,

Jeffrey Bailet, MD
Chair

Attachments

Physician-Focused Payment Model Technical Advisory Committee

REPORT TO THE SECRETARY OF HEALTH AND HUMAN SERVICES

Comments and Recommendation on

LUGPA Advanced Payment Model for Initial Therapy of Newly Diagnosed Patients with Organ-Confined Prostate Cancer

February 28, 2018

About This Report

The Physician-Focused Payment Model Technical Advisory Committee (PTAC) was established by the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) to: 1) review physician-focused payment models (PFPMs) submitted by individuals and stakeholder entities; 2) prepare comments and recommendations regarding whether such models meet criteria established by the Secretary of Health and Human Services (Secretary, HHS); and 3) submit these comments and recommendations to the Secretary. (See Appendix 1 for a list of PTAC members and their terms of appointment.) PTAC reviews submitted proposals using criteria established by the Secretary in regulations at 42 CFR § 414.1465. (See Appendix 2 for the Secretary's criteria.) As directed by MACRA, HHS' Office of the Assistant Secretary for Planning and Evaluation (ASPE) provides operational and technical support to PTAC.

This report includes: 1) a summary of PTAC's review of a PFPM submitted by Large Urology Group Practice Association (LUGPA) entitled *LUGPA Advanced Payment Model for Initial Therapy of Newly Diagnosed Patients with Organ-Confined Prostate Cancer*; 2) a summary of this model; 3) PTAC's comments on the proposed model and its recommendation to the Secretary; and 4) PTAC's evaluation of the proposed PFPM against each of the Secretary's criteria for PFPMs. The appendices to this report include a record of the voting by the PTAC on this proposal (Appendix 3); the proposal submitted by LUGPA (Appendix 4); and additional information on the proposal submitted by LUGPA subsequent to the initial proposal submission (Appendix 5).

SUMMARY STATEMENT

PTAC does not recommend the *LUGPA Advanced Payment Model for Initial Therapy of Newly Diagnosed Patients with Organ-Confined Prostate Cancer* for implementation. While PTAC agreed that the goal of the proposal is important, particularly its potential to reduce racial and ethnic disparities in the treatment of prostate cancer, PTAC has concerns about the proposed payment methodology. PTAC felt that a model with shared risk based on total cost of care did not accurately reflect the urologist's role in managing active surveillance (AS) for newly diagnosed patients with prostate cancer. The proposal does provide support for coordinated care related to AS, but the integration does not extend to the management of patients' other, non-urologic, health conditions. In essence, the submitter's proposed care model did not match the financial model. Finally, PTAC was not convinced that providers should receive an "incentive" to deliver guideline-supported care that is in the best interests of their patients. PTAC encouraged LUGPA to incorporate PTAC feedback from the meeting and submit a revised proposal for review. PTAC also encourages HHS to determine whether there are other tools to support AS rather than active intervention (AI) for clinically appropriate patients with prostate cancer.

PTAC REVIEW OF PROPOSAL

The *LUGPA Advanced Payment Model for Initial Therapy of Newly Diagnosed Patients with Organ-Confined Prostate Cancer* was submitted to PTAC by the Large Urology Group Practice Association (LUGPA) on July 5, 2017. The proposal was first reviewed by a PTAC Preliminary Review Team (PRT) composed of three PTAC members, two of whom are physicians. These members reviewed the proposal; secured additional clarifying information on the proposal from LUGPA; reviewed all comments on the proposal submitted by the public; and spoke with a clinical expert, a urologist at the University of Pennsylvania, about the treatment of localized prostate cancer. The PRT also talked with CMS' Center for Medicare and Medicaid Innovation (CMMI) to understand the difference between the proposed model and CMMI's Oncology Care Model. The PRT's findings and conclusions were documented in a *Preliminary Review Team Report to the Physician-Focused Payment Model Technical Advisory Committee (PTAC),* dated November 16, 2017, and sent to the full PTAC on November 22, 2017 along with the proposal and all related information. At a public meeting held on December 19, 2017, PTAC deliberated on the extent to which the proposal meets the criteria established by the Secretary in regulations at 42 CFR § 414.1465, and whether it should be recommended. Below are a summary of the *LUGPA Advanced Payment Model for Initial Therapy of Newly Diagnosed Patients with Organ-Confined Prostate Cancer*, PTAC's comments and recommendation to the Secretary on this proposal, and PTAC's evaluation of the proposal compared to the Secretary's criteria for PFPMs.

PROPOSAL SUMMARY

This proposal focuses on treatment for Medicare patients diagnosed with organ-confined prostate cancer, with the intention of incentivizing providers away from AI toward AS. The submitters argue this supports the triple aim of improving beneficiary care and experience, improving health, and reducing expenditures. The submitters acknowledge in their proposal that recent guidelines from the American Urological Association, the American Society for Radiation Oncology, and the Society of Urologic Oncology support the recommendation of AS as "the best available care option for very low-risk localized prostate cancer patients" and "the preferable care option for most low-risk localized prostate cancer patients." In addition, the submitters highlight that the National Comprehensive Cancer Network (NCCN) guidelines suggest a preference for AS for men with very low-risk prostate cancer and life expectancy below 21 years and certain men with Gleason scores of 7. The submitter estimates that about 63,000 Medicare FFS beneficiaries are diagnosed with localized prostate cancer annually; 77% receive AI such as radiation therapy, prostatectomy, and/or hormonal therapy. The average cost of AI is $32,788, and treatments can result in diminished sexual function, urinary incontinence, bowel dysfunction, and urinary irritation for patients.

This model aims to align provider incentives for increased use of AS for appropriate patients with a two-part payment model: a $75 monthly care management fee during AS episodes and a performance-based payment reflecting provider performance on quality measures and total costs of care during the AS episode compared to a historical benchmark. The model focuses on urologists as eligible professionals; PAs/NPs at participating practices as well as other medical specialists are not, however, excluded from participating. Medicare patients who are diagnosed with localized prostate cancer after a biopsy constitute the population eligible for initial episodes and could continue subsequent 12-month episodes on AS.

The monthly care management fee is relatively straightforward and is structured to support the enhanced services not currently reimbursed by FFS Medicare, such as tracking AS beneficiaries to ensure compliance, tracking lab results longitudinally in a consistent format, educating beneficiaries about disease progression, social services, and reviewing the care plan. Providers would receive a $75 monthly payment during each initial or subsequent 12-month clinical episode ($900 total annually); payments could be split among providers based on their role in managing active surveillance. The submitter clarified that the payment is not intended to support comprehensive care management for all of a patient's comorbidities.

The performance-based payments would retrospectively compare actual expenditures on total Part A and B services during the initial 12-month episode against a target amount, calculated using a complex formula. The model divides patients diagnosed with localized prostate cancer after biopsy into 12 sub-categories: three AS sub-categories and nine AI subcategories reflecting treatments delivered (e.g., prostatectomy only, hormone and radiation therapy, etc.), to align financial incentives toward AS yet also ensure practices are not penalized for appropriate use of AI. Ultimately, each APM Entity would receive a single composite benchmark price based on practice-specific and regional historical utilization of AS and practice-specific performance year composition of episodes within AS and AI episode categories. The regional (Census Division) benchmark is derived from three regional provider strata: academic medical centers, hospital-based providers, and office-based providers. The model creates case-mix weighted practice and regional historical episode expenditures that are blended to create the benchmark price, giving greater weight to the regional historical expenditures over time (25% regional in years 1 and 2, 50% regional in year 3, 75% regional in years 4 and 5). The benchmark would be 100% regionally-based for practices with fewer than 36 historical initial episodes. A benchmark price would be set for each of the 12 subcategories, but the APM Entity would receive performance-based payments based on a combined benchmark price based on all of the practice's performance year episodes. The composite benchmark is created by first summing AS and AI composite benchmark prices and then weighting by the proportion of AS and AI episodes at the practice and regional level. The target price would be 98% of the composite benchmark price. APM Entities that reduce actual expenditures below the geographically adjusted target amount would be eligible for a performance-based payment of up to 100% of the difference between target and actual expenditures, depending on performance on quality measures, subject to a 20% stop-gain limit. APM Entities that do not reduce expenditures would pay back up to 125% of the difference, up to a stop-loss limit of 20% of the practice's target amount.

The shared savings and shared risk calculations would only apply to the first 12-month episode, but the monthly care management payments could continue for additional episodes.

RECOMMENDATION AND COMMENTS TO THE SECRETARY

PTAC believes that increasing utilization of AS for appropriate prostate cancer patients should be a high priority for HHS. A shift in treating low-risk prostate cancer patients from AI to AS presents an opportunity for both improved quality and reduced costs. In addition, PTAC stresses that the disparities in prostate cancer treatment are unacceptable, and action must be taken to address these inequities. However, PTAC concluded that the payment model as currently designed is not the best way to move forward in increasing AS utilization.

Overall, PTAC determined the proposal met eight of the ten criteria. It did not meet the criteria for payment methodology (criterion 3) or care coordination and integration (criterion 7). These two major areas of concerns are related. PTAC determined that a model with shared risk based on total cost of care did not accurately reflect the urologist's role in managing AS for newly diagnosed patients with prostate cancer. The proposal does provide support for coordinated care related to AS, but the integration does not extend to the management of patients' other, non-urologic, health conditions. In essence, the submitter's proposed care model did not match the financial model.

PTAC also was concerned about unintended consequences associated with requiring cost accountability only for the first year-long clinical episode. This would give physicians a financial incentive to postpone AI to just after the 12-month episode ends, even for patients who should receive treatment, because it would both increase the probability of receiving shared savings and provide the care management fee for 12 months.

Patients newly diagnosed with prostate cancer may interact with multiple providers shortly after their diagnosis, including a primary care physician, urologist, oncologist, and radiologist. It is important that these various providers consult on and agree to treatment plans for the patient. Patients may be likely to default to AI if there is a lack of consensus among their providers. PTAC was disappointed that the proposal did not describe any mechanism for achieving such a consensus.

PTAC discussed the extent to which physicians could use existing codes, such as the chronic care management fees, or other tools to support increased utilization of AS. Even if the development of new codes is necessary, PTAC felt this approach may be faster than the implementation of a new APM. PTAC was not convinced that providers should receive an "incentive" to deliver guideline-supported care that is in the best interests of their patients, but is mindful that AS requires physician effort through sustained patient engagement and counseling to ensure compliance. PTAC would like to see an articulation of the unique role and function of urologists and the care team during the AS episode, particularly if current tools are insufficient to support AS.

PTAC encouraged LUGPA to incorporate PTAC feedback from the meeting and submit a revised version for review. PTAC strongly encourages HHS to assess whether additional tools could be used to support active surveillance rather than active intervention for clinically appropriate patients with prostate cancer. PTAC also strongly urges HHS to take action to address disparities in prostate cancer treatment.

EVALUATION OF THE PROPOSAL USING THE SECRETARY'S CRITERIA

PTAC Rating of Proposal by Secretarial Criteria

Criteria Specified by the Secretary (at 42 CFR §414.1465)	Rating
1. Scope of Proposed PFPM (High Priority)[1]	Meets Criterion
2. Quality and Cost (High Priority)	Meets Criterion
3. Payment Methodology (High Priority)	Does not meet Criterion
4. Value over Volume	Meets Criterion
5. Flexibility	Meets Criterion
6. Ability to be Evaluated	Meets Criterion
7. Integration and Care Coordination	Does not meet Criterion
8. Patient Choice	Meets Criterion
9. Patient Safety	Meets Criterion
10. Health Information Technology	Meets Criterion

Criterion 1. Scope (High Priority Criterion)

Aim to broaden or expand the CMS APM portfolio by addressing an issue in payment policy in a new way, or including APM Entities whose opportunities to participate in APMs have been limited.

Rating: Meets Criterion

PTAC considered whether the Oncology Care Model (OCM) already provides an opportunity for urologists who treat prostate cancer to participate in an APM. The OCM only applies to patients who receive chemotherapy. Patients diagnosed with localized prostate cancer generally do not receive chemotherapy; more frequently, providers pursue radiation therapy, hormone therapy or prostatectomy for these patients. In addition, patients who receive AS would not be eligible for OCM since they would not be receiving treatment. Consequently, patients with localized prostate cancer do not have eligible clinical episodes in the OCM. Participation of urologists in the OCM, as well as other active APMS, is low—88 urologists were participants in 2017.

Each year, approximately 63,000 Medicare fee-for-service beneficiaries are newly diagnosed with localized prostate cancer. Among these newly diagnosed patients, 77 percent receive AI although clinical guidelines indicate AS may be the most appropriate course of treatment for many of these men. Uptake of AS is uneven across communities. For example, rates of AS are

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

much higher at academic medical centers, where institutional resources or research funding could support AS activities to a greater degree than resources that are available in community practices. Though rates of AS have increased in recent years, PTAC felt that passively waiting for AS to reach the optimal level was inadequate. HHS needs to take action to accelerate the use of AS when appropriate, particularly among racial and ethnic minority communities who are disproportionately burdened by higher rates of prostate cancer and higher rates of AI for localized disease compared with non-Hispanic White men.

While PTAC believed this proposal meets the Secretary's criterion for Scope, it discussed the extent to which existing tools might be used or adapted to encourage AS instead of creating an APM. For example, the Chronic Care Management fee could apply to some patients with organ-confined prostate cancer, reimbursing providers for some portion of the time and effort related to AS activities. These codes may be insufficient to fully cover AS costs; an evaluation of the available tools could be useful in assessing whether new codes should be developed or an APM is needed. PTAC would also like to better understand how some practices have achieved higher AS utilization rates under current payment policies, for example by exploring whether AS revenue over several years is adequate to balance revenue lost from fewer AIs, or whether "work-arounds" were commonly used by providers to support AS.

Criterion 2. Quality and Cost (High Priority Criterion)

Are anticipated to improve health care quality at no additional cost, maintain health care quality while decreasing cost, or both improve health care quality and decrease cost.

Rating: Meets Criterion

Evidence suggests that a significant share of patients with localized prostate cancer could be initially enrolled in AS, avoiding or delaying the costs of AI until medically appropriate without compromising patients' health. Patients on AS would also delay or avoid the potential complications of AI, which would improve patient satisfaction and quality of life. The proposed model would likely accelerate adoption of AS in the short term, but PTAC notes that care delivery is already trending toward AS as recommended in current guidelines. At some point in the future, the ideal rates of AS will be achieved and incentives may no longer be necessary, but adequate financial support to sustain the AS services may still be needed.

Improvements in quality associated with increased rates of AS may be particularly valuable for communities where AS utilization has lagged. Patients and caregivers in these communities disproportionately experience the burden of physical and emotional complications that can follow AI. PTAC heard several public comments during the meeting attesting to the importance

of addressing disparities in the treatment of prostate cancer. While PTAC agreed that the proposal would likely lead to improvements in cost and quality as well as disparities, PTAC also strongly urges HHS to assess whether other tools could be rapidly deployed to accelerate the adoption of AS.

Criterion 3. Payment Methodology (High Priority Criterion)

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.

Rating: Does Not Meet Criterion

PTAC commends the submitter on a thoughtful, detailed proposal that reflects a commendable goal of increasing rates of AS. However, PTAC felt the proposal did not meet this criterion for several reasons. First, the shared savings payments are based on total Medicare spending, yet the model does not address how urologists will integrate with other providers to manage *total* spending. In the year after diagnosis, the cost of prostate cancer treatment does comprise a significant share of total Medicare spending on average, so it is plausible that total spending will decrease. However, PTAC felt there was a significant disconnect between the care model, which focuses solely on care for prostate cancer, and the payment model, which focuses on the total cost of care for all conditions. PTAC does not believe it is desirable for APMs to include shared savings based on total cost of care when the proposed care coordination activities are limited to the management of one condition and therefore unlikely to control total costs. PTAC thought this model would be strengthened by focusing on costs related to the treatment of prostate cancer rather than total cost of care.

PTAC also considered whether tools that exist in current payment methodologies might be used or adapted to support AS. Medicare's chronic care management fee or complex care management fee could potentially be used for some patients, although these fees cannot be shared among providers. Other CPT codes for additional services not covered in evaluation and management (E&M) visits might also be used to support AS. If these codes do not adequately support AS activities, PTAC encourages HHS to consider whether the development of a new payment code to support AS might more rapidly help address the disparities in prostate cancer treatment.

PTAC discussed whether a single care management fee for all patients in all months was the most effective approach. The proposed fee would be the same for all months in the episode, even though the work associated with AS is likely be more intermittent and intense at certain

points. Also, the care management fee could be stratified or risk-adjusted so that more resources are directed to support the care of more vulnerable or complex prostate cancer patients.

Finally, PTAC was not convinced that providers should receive an "incentive" to deliver guideline-supported care that is in the best interests of their patients. PTAC did not feel that it fully understood where payment changes were really needed, and so it urges HHS to use information such as disease registries to assess why so many patients with localized prostate cancer continue to receive AI.

Criterion 4. Value over Volume

Provide incentives to practitioners to deliver high-quality health care.

Rating: Meets Criterion

Urologists have a financial incentive under current reimbursement policy to steer patients toward AI, which involves the delivery of higher volume, more intense services such as radiation therapy, hormone therapy, prostatectomy, or cryoablation and thus yields more revenue for the provider. The average annual cost of AI is over $32,700, while AS costs approximately $12,600 annually. The model provides incentives for providers to shift toward increased use of AS through the care management fee and potential for shared savings. Clinical guidelines suggest that AS is optimal care for some newly diagnosed patients with localized prostate cancer. This model encourages greater use of AS, which is associated with lower costs and improved quality for appropriate patients.

Criterion 5. Flexibility

Provide the flexibility needed for practitioners to deliver high-quality health care.

Rating: Meets Criterion

The care management fee provides flexibility for model participants to design their AS activities, tailoring them to fit patient populations, practice structure and culture, and local resources. It also provides financial support to deliver enhanced services for AS.

Criterion 6. Ability to be Evaluated

Have evaluable goals for quality of care, cost, and any other goals of the PFPM.

Rating: Meets Criterion

PTAC found that the proposal clearly specifies quality measures and performance targets. Almost all proposed measures are based on validated, accepted measures of quality.

Criterion 7. Integration and Care Coordination

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.

Rating: Does Not Meet Criterion

One major factor in PTAC's conclusion that the proposal did not meet this criterion is the mismatch between the proposed care model, which is focused on coordinating urologic treatment, and a payment model that is based on total Medicare spending. PTAC felt participating providers should not be held responsible for the management of a patient's comorbidities like high blood pressure or diabetes when the model is not designed to support integration at this level.

PTAC also stressed the importance of achieving consensus regarding the patient's treatment plan among the various providers counseling a newly diagnosed prostate cancer patient, which might include a primary care physician, urologist, oncologist, and a radiologist. Without agreement among these providers, the patient may be likely to default to AI as the option that "gets the cancer out." PTAC did not feel the proposal sufficiently addressed this element of care coordination.

The proposal did show promise to support coordinated urologic care for patients once the AS episode begins through ongoing counseling, tracking disease progression, and shared decision making. The care management fee could be split among providers to reflect the allocation of work, whereas legal restrictions may limit the ability of existing care management fees to be shared among providers.

Criterion 8. Patient Choice

Encourage greater attention to the health of the population served while also supporting the unique needs and preferences of individual patients.

Rating: Meets Criterion

PTAC was pleased with the inclusion of the quality measure for shared decision making in this proposal. The shared decision making measure would encourage providers to educate patients

about treatment options for localized prostate cancer and would likely increase patient comfort with AS versus AI. The model would support the needs and preferences of individual patients and facilitate patient choice in their treatment. Ongoing, active engagement with the patient is essential to ensure patients are comfortable with AS and are willing to continue with surveillance.

Criterion 9. Patient Safety

Aim to maintain or improve standards of patient safety.

Rating: Meets Criterion

AI for prostate cancer carries the risk of significant side effects, including incontinence and sexual dysfunction, which can have a sizeable effect on patients' quality of life and that of their families. Shifting treatment patterns toward increased use of AS could avoid unnecessary surgery, radiation, or hormone therapies that produce harmful side effects and compromise patient safety.

PTAC noted there is a potential for unintended consequences that compromise patient safety. The proposed model could encourage providers to postpone treatment for newly diagnosed patients until a year after diagnosis, enabling the provider to receive care management fees for one year and a potential shared savings payment while still subjecting patients to the potential costs and harms of AI. However, for some patients, immediate intervention may be the best option, and a year-long delay could result in adverse outcomes.

Criterion 10. Health Information Technology

Encourage use of health information technology to inform care.

Rating: Meets Criterion

PTAC determined the proposed model meets this criterion. The tracking of lab results and other AS activities during the episode would require health information technology. For example, urologists would need to review consistent patient lab results ordered by various providers in their community contributing to the surveillance activities. PTAC acknowledges the submitter's desire to impose minimal restrictions on HIT so that processes and systems may be adapted to the local environment, but PTAC encourages LUGPA to elaborate on ways the model could potentially use HIT to inform care delivery in subsequent revisions.

APPENDIX 1. COMMITTEE MEMBERS AND TERMS

Jeffrey Bailet, MD, *Chair*

Elizabeth Mitchell, *Vice-Chair*

Term Expires October 2018

Jeffrey Bailet, MD
Blue Shield of California
San Francisco, CA

Elizabeth Mitchell
Network for Regional Healthcare Improvement
Portland, ME

Robert Berenson, MD
Urban Institute
Washington, DC

Kavita Patel, MD
Brookings Institution
Washington, DC

Term Expires October 2019

Paul N. Casale, MD, MPH
NewYork Quality Care
NewYork-Presbyterian
Columbia Weill Cornell
New York, NY

Bruce Steinwald, MBA
Independent Consultant
Washington, DC

Tim Ferris, MD, MPH
Massachusetts General Physicians Organization
Boston, MA

Term Expires October 2020

Rhonda M. Medows, MD
Providence Health & Services
Seattle, WA

Len M. Nichols, PhD
Center for Health Policy Research and Ethics
George Mason University
Fairfax, VA

Harold D. Miller
Center for Healthcare Quality and Payment Reform
Pittsburgh, PA

Grace Terrell, MD, MMM
Envision Genomics
Huntsville, AL

APPENDIX 2. PFPM CRITERIA ESTABLISHED BY THE SECRETARY

PFPM CRITERIA ESTABLISHED BY THE SECRETARY
1. Scope. Aim to either directly address an issue in payment policy that broadens and expands the CMS APM portfolio or include APM Entities whose opportunities to participate in APMs have been limited.
2. Quality and Cost. Are anticipated to improve health care quality at no additional cost, maintain health care quality while decreasing cost, or both improve health care quality and decrease cost.
3. Payment Methodology. 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 Physician-Focused Payment Model cannot be tested under current payment methodologies.
4. Value over Volume. Provide incentives to practitioners to deliver high-quality health care.
5. Flexibility. Provide the flexibility needed for practitioners to deliver high-quality health care.
6. Ability to be Evaluated. Have evaluable goals for quality of care, cost, and any other goals of the PFPM.
7. Integration and Care Coordination. 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.
8. Patient Choice. Encourage greater attention to the health of the population served while also supporting the unique needs and preferences of individual patients.
9. Patient Safety. Aim to maintain or improve standards of patient safety.
10. Health Information Technology. Encourage use of health information technology to inform care.

APPENDIX 3. DISTRIBUTION OF MEMBER VOTES ON EXTENT TO WHICH PROPOSAL MEETS CRITERIA AND OVERALL RECOMMENDATION

Criteria Specified by the Secretary (at 42 CFR §414.1465)	N/A	Does not meet		Meets		Priority consideration		Rating
	*	1	2	3	4	5	6	
1. Scope of Proposed PFPM (High Priority)[1]	0	0	2	8	0	1	0	Meets criterion
2. Quality and Cost (High Priority)	0	0	2	8	1	0	0	Meets criterion
3. Payment Methodology (High Priority)	0	1	6	4	0	0	0	Does not meet criterion
4. Value over Volume	0	0	0	7	4	0	0	Meets criterion
5. Flexibility	0	0	0	5	5	1	0	Meets criterion
6. Ability to be Evaluated	0	0	1	8	2	0	0	Meets criterion
7. Integration and Care Coordination	0	1	6	3	1	0	0	Does not meet criterion
8. Patient Choice	0	0	1	4	5	1	0	Meets criterion
9. Patient Safety	0	0	0	6	5	0	0	Meets criterion
10. Health Information Technology	0	1	3	4	2	1	0	Meets criterion

Not Applicable	Do not recommend	Recommend for limited-scale testing	Recommend for implementation	Recommend for implementation as a high priority	Recommendation
0	8	3	0	0	Do not recommend

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