Physician-Focused Payment Model Technical Advisory Committee
Public Meeting Minutes

March 26, 2018
8:30 a.m. – 5:00 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

Jeffrey W. Bailet, MD (PTAC Chair; Executive Vice President of Health Care Quality and Affordability, Blue Shield of California)
Robert Berenson, MD (Institute Fellow, Urban Institute)
Paul N. Casale, MD, MPH (Executive Director, New York Quality Care)
Tim Ferris, MD, MPH (CEO, Massachusetts General Physicians Organization)
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 (PTAC Vice Chair; President and CEO, Network for Regional Healthcare Improvement)
Len M. Nichols, PhD (Director, Center for Health Policy Research and Ethics, George Mason University)
Kavita Patel, MD, MSHS (Nonresident Senior Fellow, Brookings Institution)
Bruce Steinwald, MBA (Consultant, Bruce Steinwald Consulting)
Grace Terrell, MD, MMM (CEO, Envision Genomics)

List of Proposals, Submitter Representatives, Public Commenters, and Handouts

1. **American Academy of Hospice and Palliative Medicine (AAHPM): Patient and Caregiver Support for Serious Illness (PACSSI)**

   Submitter Representatives

   Janet H. Bull, MD, MBA, HMDC (Chief Medical Officer, Four Seasons Compassion for Life)
   Arif H. Kamal, MD, MBA, (Associate Professor of Medicine and Business Administration and Physician Director of Quality at the Duke Cancer Institute)
   Jacqueline M. Kocinski, MPP (Director of Health Policy and Government Relations, AAHPM)
   Cindy H. Moon, MPP, MPH (Vice President of Health Care Payment and Delivery Reform, Hart Health Strategies)
   Phillip E. Rodgers, MD (Associate Professor of Family Medicine and Internal Medicine; Director of Adult Palliative Care Clinical Program, University of Michigan)
   Joe Rotella, MD, MBA, HMDC (Chief Medical Officer, AAHPM)

   Public Commenters

   Lori Bishop (Vice President of Palliative and Advanced Care, National Hospice and Palliative Care Organization)
   Betty Ferrell, PhD, RN (Hospice and Palliative Nurses Association)
   Dana Lustbader, MD (Chairman of Department of Palliative Care, ProHEALTH)

Sandy Marks (Assistant Director of Federal Affairs, American Medical Association)
Diane Meier, MD (President, National Coalition for Hospice and Palliative Care)
Martha Twaddle, MD (Medical Director of Palliative Medicine and Supportive Care, Northwestern Medicine)

Handouts

- Letter of Intent
- Proposal
- Preliminary Review Team (PRT) Report
- Committee Member Disclosures
- Materials for Public Comments
- Additional Information from the Submitter
- Additional Information and Analyses

2. Coalition to Transform Advanced Care (C-TAC): Advanced Care Model (ACM) Service Delivery and Advanced Alternative Payment Model

Submitter Representatives

Gary Bacher (Founding Member, Healthsperien)
Tom Koutsoumpas (Co-Chair, C-TAC)
Khue Nguyen, PharmD (Chief Operating Officer, C-TAC Innovations)
Brad Smith (Co-Founder and Chief Executive Officer, Aspire Health)
Kristofer Smith, MD (Senior Vice President for Population Health Management, Northwell Health)

Public Commenter

Bradley Stuart, MD (Chief Medical Officer, C-TAC)

Handouts

- Letter of Intent
- Proposal
- Preliminary Review Team (PRT) Report
- Committee Member Disclosures
- Materials for Public Comments
- Additional Information from the Submitter
- Additional Information and Analyses

3. Personalized Recovery Care, LLC: Home Hospitalization: An Alternative Payment Model for Delivering Acute Care in the Home

Submitter Representatives

Travis Messina (Chief Executive Officer and Co-Founder, Contessa Health)
Mark Montoney, MD (Chief Medical Officer, Contessa Health)
Narayana Murali, MD (Executive Director, Marshfield Clinic)
Aaron Stein (Chief Operating Officer, Contessa Health)

Public Commenters
None

Handouts

- Letter of Intent
- Proposal
- Preliminary Review Team (PRT) Report
- Committee Member Disclosures
- Materials for Public Comments
- Additional Information from the Submitter
- Additional Information and Analyses

NOTE: A transcript of all statements made by PTAC members, submitter representatives, and public commenters at this meeting is available on the ASPE PTAC website located at: https://aspe.hhs.gov/meetings-physician-focused-payment-model-technical-advisory-committee.

The website also includes copies of all presentation slides and a video recording of the March 26, 2018 PTAC public meeting.

Welcome and Deliberations and Voting Procedures
Jeffrey Bailet, PTAC Chair, welcomed the public to the fourth PTAC meeting at which PTAC will have deliberated and voted on submitted proposals. He thanked the public for its interest and stakeholders for their hard work and dedication to payment reform. He noted that since December 1, 2016, PTAC has received 24 proposals and another 13 letters of intent (LOIs). The Chair informed the public that recommendations on the six proposals discussed during the December 2017 public meeting have been submitted to the Secretary of Health and Human Services (the Secretary), and that these are available on the ASPE PTAC website.

The Chair also informed the public of the recently enacted Bipartisan Budget Act of 2018 that affords PTAC with new authority to deliver feedback in the early stages of the review process. PTAC is looking forward to working with and supporting Secretary Alex Azar as he has identified value-based transformation of the health care system as one of his top priorities.

The Chair reminded the public to submit any concerns or questions to the PTAC email mailbox, and the ASPE PTAC staff will work with the Chair and Co-Chair to address them. He expressed gratitude to the ASPE PTAC staff in supporting PTAC.

The Chair noted that PTAC deliberates and discusses proposals only during public meetings and informed the public that the deliberations and voting procedures would occur in the following order:

1. PTAC members will introduce themselves and disclose any potential conflicts of interests and threats to impartiality.
2. The designated PRT for each proposal will present their report to the full Committee.
3. PTAC members will have an opportunity to ask PRT members questions concerning the reviewed proposal.
4. The submitter representatives will be invited to make a statement to PTAC, if desired.
5. PTAC members will have an opportunity to ask questions and hear responses from submitter representatives concerning their proposal.

6. Public comments will be permitted.
7. PTAC will deliberate and vote on the extent to which the proposal meets each of the Secretary's criteria.
8. PTAC will deliberate and vote on a final recommendation to the Secretary.
9. PTAC will provide instructions to ASPE staff regarding comments to be included within the report accompanying their recommendation to the Secretary.

American Academy of Hospice and Palliative Medicine (AAHPM): Patient and Caregiver Support for Serious Illness (PACSSI)

Committee Member Disclosures
Harold Miller stated that he assisted AAHPM in the early phases of its development of a payment model for palliative care, but was not involved in the preparation of this specific proposal. He stated he would recuse himself from deliberation and voting on this proposal.

No additional PTAC members had disclosures related to this proposal.

PRT Report to the Full PTAC
The PRT for the *PACSSI* proposal consisted of Paul Casale (the PRT Lead), Bruce Steinwald, and Elizabeth Mitchell.

The PRT Lead summarized and presented the PRT's report to PTAC and summarized the proposed model, including that it would:

- Be a five-year demonstration of delivery of palliative care services that aim to make palliative care more widely available.
- Employ palliative care teams (PCTs) as Alternative Payment Model (APM) Entities. PCTs would consist of, at a minimum, a physician, a nurse, and a spiritual care provider–and one of these three core PCT member must be certified in palliative care.
- Pay APM Entities a per member per month (PMPM) payment to replace Evaluation and Management (E/M) payments to PCTs. The PMPM payment amounts would be one of two different amounts ("Tiers") based on a patient's chronic condition diagnoses, functional status, and health care utilization.
- Have two additional payment tracks. Track 1 would use a percentage of the total PMPM as an incentive payment. Track 2 would be an advanced APM (AAPM) based on total cost of care. He noted that the model has asymmetry between the caps on shared savings (capped at 20%) versus shared losses (capped at 3%).
- Require provider interaction with a patient once per month.

The PRT Lead described issues and concerns discussed among the PRT and then stated the PRT's conclusion that the proposed model unanimously met and deserved priority consideration for one out of 10 of the Secretary's criteria ("Scope") and met another seven criteria. The PRT Lead reported six of seven criteria were agreed upon unanimously, while the remaining criterion ("Health Information Technology") was met by a majority vote. He reported that the PRT unanimously determined the proposal did not meet the "Quality and Cost" or "Payment Methodology" high priority criteria.

Clarifying Questions from PTAC to the PRT
The Chair opened the floor for PTAC members' questions to the PRT. Topics discussed included:

- Asymmetrical risk in the model, including the need for upfront investments in infrastructure.
- The lack of information in the model about how PBPM payments were calculated.
- Shared savings based on total cost of care may create perverse incentives for a patient population with a high risk of dying.
- The difficulty of accurately measuring patient engagement in end-of-life care.
- Six-month intervals between the evaluations for tier placement and reassignment may be lengthy for this vulnerable population.
- Challenge and necessity of determining appropriate benchmarks and comparison groups (those eligible for but not enrolled in the model) for model participants.
- The need for robust quality and utilization measures.

[NOTE: The PRT's presentation slides and full report are available on the ASPE PTAC website located at: https://aspe.hhs.gov/proposal-submissions-physician-focused-payment-model-technical-advisory-committee.]

Submitter's Statement
The Chair invited the submitter representatives to make a statement to PTAC. They introduced themselves as Janet Bull, Arif Kamal, Jacqueline Kocinski, Cindy Moon, Phil Rodgers, and Joe Rotella.

The submitter representatives stated the model's guiding principle was to transform quality of life for patients and families; therefore, eligibility should be based on patients' need rather than prognosis. For model sustainability in diverse settings–including among rural and underserved populations–payments must be sufficient to cover costs.

The submitter representatives agreed that details of the model would require testing and working with the Centers for Medicare & Medicaid Services (CMS) on implementation. Some priority areas for testing include:

- Aligning requirements and measures with the variations currently present in palliative care.
- Determining appropriate risk-adjustment for benchmarks.
- Validating benchmarks via pay-for-reporting.

PTAC and Submitter Questions and Answers (Q&A) and Discussion
PTAC and submitters engaged in Q&A and discussion on the following topics:

- Challenge of determining appropriate benchmarks for palliative care.
- Need for and frequency of assessing patient perspectives at the start of and during care.
- Likelihood of reducing total cost given the current high cost of end-of-life care.
- Appropriateness of shared savings for this patient population.
- Linkages between payments, cost of care, and expected reductions in hospitalizations and emergency room (ER) visits.
- Basis upon which the PMPM payments were determined for each of the two tiers.
- Complexity of having multiple payment tiers.
- Infrastructure needed for palliative care and how the results of testing this model could inform those needs while allowing flexibility but ensuring safety by using quality measures.

Public Comments

The Chair thanked the submitter representatives and opened the floor for public comments, which were made by:

1. Lori Bishop, National Hospice and Palliative Care Organization
2. Betty Ferrell, Hospice and Palliative Nurses Association
3. Dana Lustbader, ProHEALTH
4. Sandy Marks, American Medical Association
5. Diane Meier, National Coalition for Hospice and Palliative Care
6. Martha Twaddle, Northwestern Medicine

[NOTE: A transcript of these commenters' remarks is available on the ASPE PTAC website located at: https://aspe.hhs.gov/meetings-physician-focused-payment-model-technical-advisory-committee.]

The public meeting recessed at 10:45 a.m. and reconvened at 10:51 a.m.

PTAC Criterion Voting

PTAC discussed and voted on the extent to which the *PACSSI* proposal meets each of the Secretary's criteria.

[NOTE: PTAC's "*Processes for Reviewing and Evaluating Proposed Physician-Focused Payment Models and Making Recommendations to the Secretary for the Department of Health and Human Services"* state that a simple majority vote will establish PTAC's determination for each of the Secretary's criteria. The PTAC criterion votes remained anonymous and are presented in the table below. Individual member comments also are available in the meeting transcript located on the ASPE PTAC website at: http://aspe.hhs.gov/meetings-physician-focused-payment-model-technical-advisory-committee.]

Given that 10 PTAC members participated in deliberation and voting on the proposal, six PTAC votes constituted a simple majority.

PTAC Member Votes on the PACSSI Model

Criteria Specified by the Secretary (42 CFR§414.146)	PTAC Vote Categories	PTAC Vote Distribution
1. Scope (High Priority)	* – Not Applicable	0
	1 – Does not meet criterion	0
	2 – Does not meet criterion	0
	3 – Meets the criterion	2
	4 – Meets the criterion	1
	5 – Meets the criterion and deserves priority consideration	0
	6 – Meets the criterion and deserves priority consideration	7
PTAC DECISION: Proposal Meets and Deserves Priority Consideration for Criterion 1.		
2. Quality and Cost (High Priority)	* – Not Applicable	0
	1 – Does not meet criterion	0
	2 – Does not meet criterion	6
	3 – Meets the criterion	1

	4 – Meets the criterion	0
	5 – Meets the criterion and deserves priority consideration	2
	6 – Meets the criterion and deserves priority consideration	1
PTAC DECISION: Proposal Does not Meet Criterion 2.		
3. Payment Methodology (High Priority)	* – Not Applicable	0
	1 – Does not meet criterion	1
	2 – Does not meet criterion	6
	3 – Meets the criterion	1
	4 – Meets the criterion	2
	5 – Meets the criterion and deserves priority consideration	0
	6 – Meets the criterion and deserves priority consideration	0
PTAC DECISION: Proposal Does not Meet Criterion 3.		
4. Value over Volume	* – Not Applicable	0
	1 – Does not meet criterion	0
	2 – Does not meet criterion	1
	3 – Meets the criterion	4
	4 – Meets the criterion	3
	5 – Meets the criterion and deserves priority consideration	1
	6 – Meets the criterion and deserves priority consideration	1
PTAC DECISION: Proposal Meets Criterion 4.		
5. Flexibility	* – Not Applicable	0
	1 – Does not meet criterion	0
	2 – Does not meet criterion	0
	3 – Meets the criterion	1
	4 – Meets the criterion	6
	5 – Meets the criterion and deserves priority consideration	1
	6 – Meets the criterion and deserves priority consideration	2
PTAC DECISION: Proposal Meets Criterion 5.		
6. Ability to be Evaluated	* – Not Applicable	0
	1 – Does not meet criterion	0
	2 – Does not meet criterion	0
	3 – Meets the criterion	6
	4 – Meets the criterion	2
	5 – Meets the criterion and deserves priority consideration	1
	6 – Meets the criterion and deserves priority consideration	1
PTAC DECISION: Proposal Meets Criterion 6.		

7. Integration and Care Coordination	* – Not Applicable	0
	1 – Does not meet criterion	0
	2 – Does not meet criterion	0
	3 – Meets the criterion	2
	4 – Meets the criterion	4
	5 – Meets the criterion and deserves priority consideration	3
	6 – Meets the criterion and deserves priority consideration	1
PTAC DECISION: Proposal Meets Criterion 7.		
8. Patient Choice	* – Not Applicable	0
	1 – Does not meet criterion	0
	2 – Does not meet criterion	1
	3 – Meets the criterion	0
	4 – Meets the criterion	3
	5 – Meets the criterion and deserves priority consideration	5
	6 – Meets the criterion and deserves priority consideration	1
PTAC DECISION: Proposal Meets and Deserves Priority Consideration for Criterion 8.		
9. Patient Safety	* – Not Applicable	0
	1 – Does not meet criterion	0
	2 – Does not meet criterion	1
	3 – Meets the criterion	5
	4 – Meets the criterion	3
	5 – Meets the criterion and deserves priority consideration	1
	6 – Meets the criterion and deserves priority consideration	0
PTAC DECISION: Proposal Meets Criterion 9.		
10. Health Information Technology	* – Not Applicable	0
	1 – Does not meet criterion	0
	2 – Does not meet criterion	2
	3 – Meets the criterion	8
	4 – Meets the criterion	0
	5 – Meets the criterion and deserves priority consideration	0
	6 – Meets the criterion and deserves priority consideration	0
PTAC DECISION: Proposal Meets Criterion 10.		

PTAC Vote on Recommendation to the Secretary
[NOTE: PTAC members' votes on the recommendation to the Secretary are presented in the table below. PTAC's "*Processes for Reviewing and Evaluating Proposed Physician-Focused Payment Models and Making Recommendations to the Secretary for the Department of Health and Human Services"* state that a two-thirds majority vote will determine PTAC's recommendation to the Secretary.]

Given that 10 PTAC members participated in deliberation and voting on the proposal, seven PTAC votes were required for the final PTAC recommendation vote.

PTAC Recommendation Category	PTAC Member Recommendation Vote
Not Applicable	*No PTAC members voted for this recommendation category*
Do not recommend proposed payment model to the Secretary (2)	Robert Berenson Elizabeth Mitchell
Recommend proposed payment model to the Secretary for limited-scale testing (7)	Jeffrey Bailet Tim Ferris Rhonda Medows Len Nichols Kavita Patel Bruce Steinwald Grace Terrell
Recommend proposed payment model to the Secretary for implementation (1)	Paul Casale
Recommend proposed payment model to the Secretary for implementation as a high priority	*No PTAC members voted for this recommendation category*

As a result of the vote, PTAC recommended the *PACSSI* proposal to the Secretary for limited-scale testing.

Instructions on the Report to the Secretary
After PTAC voting, individual PTAC members made comments for incorporation into PTAC's Report to the Secretary. All comments of individual members can be found in full in the meeting transcript located on the ASPE PTAC website at: http://aspe.hhs.gov/meetings-physician-focused-payment-model-technical-advisory-committee.

PTAC members agreed that the comments in PTAC's Report to the Secretary will reflect disagreement among PTAC members as appropriate and relevant.

Coalition to Transform Advanced Care (C-TAC): Advanced Care Model (ACM) Service Delivery and Advanced Alternative Payment Model

Committee Member Disclosures
The Chair invited members to state disclosures related to the *ACM Service Delivery and Advanced Alternative Payment Model*.

Timothy Ferris stated he was an unpaid presenter at a C-TAC conference, and oversees palliative care programs at Partners HealthCare.

Harold Miller stated he assisted AAHPM on the early development of an APM for palliative care, which is similar to this model submitted by C-TAC. He stated he would recuse himself from voting on this proposal.

Jeffrey Bailet, PTAC Chair, stated he serves as the executive vice president for Health Care Quality and Affordability at Blue Shield of California (BSC), and that BSC had been a member of C-TAC for the past four years, but the membership has not been renewed. He also stated that BSC still works closely with C-TAC, and partners with a workgroup centered on palliative care. While BSC leadership communicated with C-TAC about an APM over one year ago, BSC has not made any formal commitment to C-TAC, and the Chair himself did not participate in communication with C-TAC regarding the proposed APM.

No additional PTAC members had disclosures related to the proposal.

PRT Report to the Full PTAC

The PRT for the *ACM Service Delivery and Advanced Alternative Payment Model* consisted of Bruce Steinwald (the PRT Lead), Paul Casale, and Elizabeth Mitchell.

The PRT Lead summarized the PRT's review of the proposal. He emphasized that the same PRT members reviewed the proposal submitted by C-TAC and the previous proposal submitted by AAHPM, to ensure a thorough and consistent evaluation of both palliative care proposed models. He reviewed the proposed model's criteria for identifying eligible patients and its approach to care delivery including use of an ACM team, which would include at least one board-certified palliative care expert, and additional staff to coordinate services for the patient and family. The PRT Lead noted that APM Entities could be hospices for which payments could be complicated by Medicare's hospice benefit. The PRT noted improvements with the revised model, including expansion of quality metrics linked to bonus payments and limiting the PMPM payment period to months of model enrollment.

The PRT concluded the proposed model met eight out of 10 of the Secretary's criteria. The PRT determined the proposal did not meet the high priority criteria of "Quality and Cost" and "Payment Methodology." The PRT found the proposal met the "Scope" and "Integration and Care Coordination" criteria with priority consideration.

[NOTE: The PRT's presentation slides and full report are available on the ASPE PTAC website located at: https://aspe.hhs.gov/proposal-submissions-physician-focused-payment-model-technical-advisory-committee.]

Clarifying Questions from PTAC to the PRT

The Chair opened the floor for PTAC members' questions to the PRT. The topics included:

- The APM Entity's accountability for cost of care in the last 12 months of receiving health care services.
- Comparing aspects between C-TAC's *ACM* model and AAHPM's *PACSSI* model, and reasons the same PRT rated the models differently.
- Coordination with primary care using health information technology.
- Comprehensiveness of quality measures and simplicity of the overall model.
- The threshold and potential for four percent savings or losses compared to the benchmark before shared savings or shared losses would impact payments to the APM Entity.

- Determining the size of the risk corridor—based on number of enrolled patients in the model or size of the submitting organization.
- The reliability of the prognostic indicator to define the eligible patient population.

Submitter's Statement
The Chair invited the submitter representatives to make a statement to PTAC. They introduced themselves as Tom Koutsoumpas, Kris Smith, Khue Nguyen, Gary Bacher, and Brad Smith.

The submitter representatives stated that C-TAC took seriously PTAC's feedback on C-TAC's initial proposed model and that the new, revised proposed model addresses PTAC's earlier comments. The model aims to provide necessary medical and social services for Medicare beneficiaries living with advanced illnesses to ensure they receive high quality, patient-centered care.

The submitter representatives thanked PTAC for their comments and thanked their fellow colleagues for work on the revised model.

PTAC and Submitter Q&A and Discussion
PTAC engaged in Q&A with the submitter representatives including discussing the following topics:
- The total cost of care calculation based on the last 12 months of life including:
    - The calculations and basis for total savings or losses and for the PMPM fee.
    - Appropriateness of a $250 monthly payment bonus to incentivize high-quality patient care.
    - How payments would account for patients who die or disenroll from the model.
- The extent to which prognosis should determine eligibility for the model.
- Asymmetrical risk in the model.
- Interdisciplinary team composition and quality metrics.

Public Comments
The Chair thanked the submitter representatives and opened the floor for public comments made by:
1. Bradley Stuart, C-TAC

[NOTE: A transcript of this commenter's remarks is available on the ASPE PTAC website located at: https://aspe.hhs.gov/meetings-physician-focused-payment-model-technical-advisory-committee.]

PTAC Vote on Criterion
PTAC discussed and voted on the extent to which the *ACM Service Delivery and Advanced Alternative Payment Model* proposal meets each of the Secretary's criteria.
[NOTE: PTAC's "*Processes for Reviewing and Evaluating Proposed Physician-Focused Payment Models and Making Recommendations to the Secretary for the Department of Health and Human Services"* state that a simple majority vote will establish PTAC's determination for each of the Secretary's criteria. The PTAC criterion votes remained anonymous and are presented in the table below. Individual member comments are available in the meeting transcript located on the ASPE PTAC website at: http://aspe.hhs.gov/meetings-physician-focused-payment-model-technical-advisory-committee.]

Given that 10 PTAC members participated in deliberation and voting on the proposal, six PTAC votes constituted a simple majority.

PTAC Member Votes on the ACM Service Delivery and Advanced Alternative Payment Model

Criteria Specified by the Secretary (42 CFR§414.146)	PTAC Vote Categories	PTAC Vote Distribution
1. Scope (High Priority)	* – Not Applicable	0
	1 – Does not meet criterion	0
	2 – Does not meet criterion	0
	3 – Meets the criterion	0
	4 – Meets the criterion	1
	5 – Meets the criterion and deserves priority consideration	4
	6 – Meets the criterion and deserves priority consideration	5
PTAC DECISION: Proposal Meets and Deserves Priority Consideration for Criterion 1.		
2. Quality and Cost (High Priority)	* – Not Applicable	0
	1 – Does not meet criterion	0
	2 – Does not meet criterion	0
	3 – Meets the criterion	1
	4 – Meets the criterion	7
	5 – Meets the criterion and deserves priority consideration	2
	6 – Meets the criterion and deserves priority consideration	0
PTAC DECISION: Proposal Meets Criterion 2.		
3. Payment Methodology (High Priority)	* – Not Applicable	0
	1 – Does not meet criterion	0
	2 – Does not meet criterion	0
	3 – Meets the criterion	5
	4 – Meets the criterion	5
	5 – Meets the criterion and deserves priority consideration	0
	6 – Meets the criterion and deserves priority consideration	0
PTAC DECISION: Proposal Meets Criterion 3.		
4. Value over Volume	* – Not Applicable	0
	1 – Does not meet criterion	0
	2 – Does not meet criterion	0
	3 – Meets the criterion	0
	4 – Meets the criterion	9
	5 – Meets the criterion and deserves priority consideration	1
	6 – Meets the criterion and deserves priority consideration	0
PTAC DECISION: Proposal Meets Criterion 4.		
5. Flexibility	* – Not Applicable	0
	1 – Does not meet criterion	0

	2 – Does not meet criterion	0
	3 – Meets the criterion	0
	4 – Meets the criterion	9
	5 – Meets the criterion and deserves priority consideration	1
	6 – Meets the criterion and deserves priority consideration	0
PTAC DECISION: Proposal Meets Criterion 5.		
6. Ability to be Evaluated	* – Not Applicable	0
	1 – Does not meet criterion	0
	2 – Does not meet criterion	0
	3 – Meets the criterion	3
	4 – Meets the criterion	7
	5 – Meets the criterion and deserves priority consideration	0
	6 – Meets the criterion and deserves priority consideration	0
PTAC DECISION: Proposal Meets Criterion 6.		
7. Integration and Care Coordination	* – Not Applicable	0
	1 – Does not meet criterion	0
	2 – Does not meet criterion	0
	3 – Meets the criterion	0
	4 – Meets the criterion	5
	5 – Meets the criterion and deserves priority consideration	3
	6 – Meets the criterion and deserves priority consideration	2
PTAC DECISION: Proposal Meets Criterion 7.		
8. Patient Choice	* – Not Applicable	0
	1 – Does not meet criterion	0
	2 – Does not meet criterion	0
	3 – Meets the criterion	1
	4 – Meets the criterion	6
	5 – Meets the criterion and deserves priority consideration	2
	6 – Meets the criterion and deserves priority consideration	1
PTAC DECISION: Proposal Meets Criterion 8.		
9. Patient Safety	* – Not Applicable	0
	1 – Does not meet criterion	0
	2 – Does not meet criterion	0
	3 – Meets the criterion	3
	4 – Meets the criterion	7
	5 – Meets the criterion and deserves priority consideration	0
	6 – Meets the criterion and deserves priority consideration	0

PTAC DECISION: Proposal Meets Criterion 9.		
10. Health Information Technology	* – Not Applicable	0
	1 – Does not meet criterion	0
	2 – Does not meet criterion	0
	3 – Meets the criterion	4
	4 – Meets the criterion	5
	5 – Meets the criterion and deserves priority consideration	1
	6 – Meets the criterion and deserves priority consideration	0
PTAC DECISION: Proposal Meets Criterion 10.		

PTAC Vote on Recommendation to the Secretary
[NOTE: PTAC member votes on their recommendation to the Secretary are presented in the table below. PTAC's "*Processes for Reviewing and Evaluating Proposed Physician-Focused Payment Models and Making Recommendations to the Secretary for the Department of Health and Human Services"* state that a two-thirds majority vote will determine PTAC's recommendation to the Secretary.]

Given that 10 PTAC members participated in deliberation and voting on the proposal, seven PTAC votes were required for the final PTAC recommendation vote.

PTAC Recommendation Category	PTAC Member Recommendation Vote
Not Applicable	*No PTAC members voted for this recommendation category*
Do not recommend proposed payment model to the Secretary	*No PTAC members voted for this recommendation category*
Recommend proposed payment model to the Secretary for limited-scale testing (5)	Tim Ferris Elizabeth Mitchell Len Nichols Bruce Steinwald Grace Terrell
Recommend proposed payment model to the Secretary for implementation (5)	Jeffrey Bailet Robert Berenson Paul Casale Rhonda Medows Kavita Patel
Recommend proposed payment model to the Secretary for implementation as a high priority	*No PTAC members voted for this recommendation category*

As a result of the vote, PTAC recommended the *ACM Service Delivery and Advanced Alternative Payment Model* proposal to the Secretary for limited-scale testing.

Instructions on the Report to the Secretary
After voting, PTAC members identified issues to be incorporated into the Report to the Secretary. PTAC members also discussed whether to send two separate reports to the Secretary on both the ACM model and the PACSSI model, or if one Report to the Secretary to address the overlapping and complementary aspects of these two proposals was preferable. The Chair called for a voice vote on this question and PTAC members unanimously agreed to issue a single Report to the Secretary on the two palliative care

models reviewed at this meeting. Additionally, PTAC members directed staff to include in the Report to the Secretary the issues that surfaced from both PRT reports on these two models.

[NOTE: Individual member comments are available in the meeting transcript is located on the ASPE PTAC website at: http://aspe.hhs.gov/meetings-physician-focused-payment-model-technical-advisory-committee.]

The public meeting recessed at 1:27 p.m. and reconvened at 2:21 p.m.

Personalized Recovery Care, LLC (PRC): Home Hospitalization: An Alternative Model for Delivering Acute Care in the Home

Committee Member Disclosures
Jeffrey Bailet stated that during his employment at Aurora Health Care in Wisconsin, he served on the Wisconsin Chamber of Commerce board with and met with the CEO of Marshfield Clinic Health System, who is a submitter representative. However, he was not involved in the development of the proposed model.

No additional PTAC members had disclosures related to this proposal.

PRT Report to the Full PTAC
The PRT for the *Home Hospitalization: An Alternative Model for Delivering Acute Care in the Home* proposal consisted of Harold Miller (the PRT Lead), Rhonda Medows, and Len Nichols.

The PRT Lead described the PRT's role and summarized the PRT's review in a presentation to PTAC. He reminded the public that the proposal had not been discussed previously among all PTAC members.

The PRT Lead stated the proposed model focuses on providing payments to allow Medicare beneficiaries to receive some types of inpatient care in their home. Patients are eligible for this model if they have a condition appropriate for hospital admission but can be safely cared for at home, have an appropriate home environment, and consent to participate.

The model supports home hospitalization and provides payment for a 30-day episode of care. The acute-care phase would mimic the care patients receive as inpatients. They would receive a daily telehealth visit from an admitting physician, a twice-daily in-person visit from a registered nurse, 24/7 access to a recovery care coordinator (a registered nurse) who monitors patients' needs, and 24/7 telehealth access to a physician. The post-acute care phase begins when the patient no longer needs acute care and the rest of the care is typical of post-discharge care although the recovery care coordinator will stay involved.

This model has three payment components. First, a bundled payment (set at 70 percent of the hospital CMS-Diagnosis-Related Group [DRG] payment) is paid to the entity providing the initial acute care. This bundled payment covers physician telehealth visits, nursing visits, social services, and services of the recovery care coordinator. Second, additional patient care needs, such as imaging, durable medical equipment, or specialty physician visits, would be reimbursed separately under current Medicare payment rules. Third, the payment model includes both upside and downside risk based on overall spending during the 30-day episode, with bonus payments reduced if quality metrics are not met.

The PRT Lead discussed how the PRC model compares to the *"HaH Plus" (Hospital at Home Plus) Provider-Focused Payment Model* submitted by the Icahn School of Medicine at Mount Sinai (ISMMS) that PTAC deliberated on during the September 2017 public meeting. The PRC model potentially covers a broader range of DRGs and has the potential for smaller practices to participate. The PRT Lead discussed the strengths and weaknesses of the proposal.

The PRT Lead described the PRT's discussions and conclusions that the proposed model unanimously met nine out of 10 of the Secretary's criteria. He reported that the PRT unanimously determined, however, that the proposal did not meet the "Patient Safety" criteria.

[NOTE: The PRT's presentation slides and full report are available on the ASPE PTAC website located at: https://aspe.hhs.gov/proposal-submissions-physician-focused-payment-model-technical-advisory-committee.]

Clarifying Questions from PTAC to the PRT

The Chair opened the floor for PTAC members' questions to the PRT. The discussion included the following topics:

- Concerns regarding patient safety in the model.
- The challenge of identifying an appropriate comparison group given that hospitals themselves are not necessarily safe for patients—thus both inappropriate hospitalizations and inappropriate home care can occur.
- How the model handles patients who require inpatient hospitalization during home hospitalization.
- Clarifying payment methodology and costs covered during patient's 30-day episodes.
- Data availability from other hospital-at-home models to inform the approach to patient safety.
- Large range of DRGs included in this model.
- Role of the recovery care coordinator during the acute-care and post-acute phase.
- The model's potential impact on Medicare DRGs as a result of shifting patients to home hospital care.

Submitter's Statement

The Chair invited the submitter representatives to make a statement to PTAC. They introduced themselves as Narayana Murali, Travis Messina, Mark Montoney, and Aaron Stein.

Following introductions, the submitter representatives described the Marshfield Clinic Health System and its participation in innovative care models including programs that move surgical patients to an ambulatory surgery center or a comfort and recovery suite, which reduced the patients' length of stay. They also described their lengthy experience using telehealth and indicated that the PRC model is a natural extension of these previous models for patients that present to the ER.

The submitter representatives addressed concerns mentioned by the PRT on patient safety and discussed possible modifications to their proposal. They also stated their goal is to increase utilization of home hospitalization care models and generating savings for CMS, while not increasing financial risk for independent practices. They also indicated a 10 percent savings cap in the model, with additional savings going to CMS.

PTAC and Submitter Q&A and Discussion

PTAC engaged in Q&A and discussion with the submitter representatives on the following topics:

- Appropriateness of the payment setting at 70 percent of the DRG for the home hospitalization services.
- The ability to admit directly to skilled nursing facilities.
- Appropriateness of the DRGs included in the model.
- How PRC's model compares to ISMMS's *HaH Plus* model.
- Criteria for ER admissions.
- Roles and training of the recovery care coordinator, clinical staff, and home care staff.
- Proprietary technology used and whether it is essential to the model.
- Process for getting information about adverse events from patients and caregivers.
- Assessing the need for observation stays.
- Ability of participants (particularly smaller practices) to provide home services under this model.

Public Comments

The Chair thanked the submitter representatives and opened the floor for public comments. There were no public comments made.

PTAC Vote on Criterion

PTAC discussed and voted on the extent to which the *Home Hospitalization: An Alternative Payment Model for Delivering Acute Care in the Home* proposal meets each of the Secretary's criteria.

[NOTE: PTAC's "*Processes for Reviewing and Evaluating Proposed Physician-Focused Payment Models and Making Recommendations to the Secretary for the Department of Health and Human Services"* state that a simple majority vote will establish PTAC's determination for each of the Secretary's criteria. The PTAC criterion votes remained anonymous and are presented in the table below. Individual member comments are available in the meeting transcript located on the ASPE PTAC website at: http://aspe.hhs.gov/meetings-physician-focused-payment-model-technical-advisory-committee.]

Given that 11 PTAC members participated in deliberation and voting on the proposal, six PTAC votes constituted a simple majority.

PTAC Member Votes on Home Hospitalization: An Alternative Payment Model for Delivering Acute Care in the Home

Criteria Specified by the Secretary (42 CFR§414.146)	PTAC Vote Categories	PTAC Vote Distribution
1. Scope (High Priority)	* – Not Applicable	0
	1 – Does not meet criterion	0
	2 – Does not meet criterion	0
	3 – Meets the criterion	3
	4 – Meets the criterion	4
	5 – Meets the criterion and deserves priority consideration	1
	6 – Meets the criterion and deserves priority consideration	3
PTAC DECISION: Proposal Meets Criterion 1.		

2. Quality and Cost (High Priority)	* – Not Applicable	0
	1 – Does not meet criterion	0
	2 – Does not meet criterion	1
	3 – Meets the criterion	3
	4 – Meets the criterion	3
	5 – Meets the criterion and deserves priority consideration	3
	6 – Meets the criterion and deserves priority consideration	1
PTAC DECISION: Proposal Meets Criterion 2.		
3. Payment Methodology (High Priority)	* – Not Applicable	0
	1 – Does not meet criterion	0
	2 – Does not meet criterion	1
	3 – Meets the criterion	5
	4 – Meets the criterion	3
	5 – Meets the criterion and deserves priority consideration	1
	6 – Meets the criterion and deserves priority consideration	1
PTAC DECISION: Proposal Meets Criterion 3.		
4. Value over Volume	* – Not Applicable	0
	1 – Does not meet criterion	0
	2 – Does not meet criterion	0
	3 – Meets the criterion	4
	4 – Meets the criterion	5
	5 – Meets the criterion and deserves priority consideration	1
	6 – Meets the criterion and deserves priority consideration	1
PTAC DECISION: Proposal Meets Criterion 4.		
5. Flexibility	* – Not Applicable	0
	1 – Does not meet criterion	0
	2 – Does not meet criterion	1
	3 – Meets the criterion	2
	4 – Meets the criterion	5
	5 – Meets the criterion and deserves priority consideration	1
	6 – Meets the criterion and deserves priority consideration	2
PTAC DECISION: Proposal Meets Criterion 5.		
6. Ability to be Evaluated	* – Not Applicable	0
	1 – Does not meet criterion	0
	2 – Does not meet criterion	0
	3 – Meets the criterion	6
	4 – Meets the criterion	4

	5 – Meets the criterion and deserves priority consideration	0
	6 – Meets the criterion and deserves priority consideration	1
PTAC DECISION: Proposal Meets Criterion 6.		
7. Integration and Care Coordination	* – Not Applicable	0
	1 – Does not meet criterion	0
	2 – Does not meet criterion	0
	3 – Meets the criterion	5
	4 – Meets the criterion	3
	5 – Meets the criterion and deserves priority consideration	2
	6 – Meets the criterion and deserves priority consideration	1
PTAC DECISION: Proposal Meets Criterion 7.		
8. Patient Choice	* – Not Applicable	0
	1 – Does not meet criterion	0
	2 – Does not meet criterion	0
	3 – Meets the criterion	2
	4 – Meets the criterion	3
	5 – Meets the criterion and deserves priority consideration	4
	6 – Meets the criterion and deserves priority consideration	2
PTAC DECISION: Proposal Meets and Deserves Priority Consideration for Criterion 8.		
9. Patient Safety	* – Not Applicable	0
	1 – Does not meet criterion	0
	2 – Does not meet criterion	3
	3 – Meets the criterion	5
	4 – Meets the criterion	2
	5 – Meets the criterion and deserves priority consideration	1
	6 – Meets the criterion and deserves priority consideration	0
PTAC DECISION: Proposal Meets Criterion 9.		
10. Health Information Technology	* – Not Applicable	0
	1 – Does not meet criterion	0
	2 – Does not meet criterion	0
	3 – Meets the criterion	6
	4 – Meets the criterion	3
	5 – Meets the criterion and deserves priority consideration	2
	6 – Meets the criterion and deserves priority consideration	0
PTAC DECISION: Proposal Meets Criterion 10.		

PTAC Vote on Recommendation to the Secretary
[NOTE: PTAC members' votes on the recommendation to the Secretary are presented in the table below. PTAC's "*Processes for Reviewing and Evaluating Proposed Physician-Focused Payment Models and Making Recommendations to the Secretary for the Department of Health and Human Services"* state that a two-thirds majority vote will determine PTAC's recommendation to the Secretary.]

Given that 11 PTAC members participated in deliberation and voting on the proposal, eight PTAC votes were required for the final PTAC recommendation vote.

PTAC Recommendation Category	PTAC Member Recommendation Vote
Not Applicable	*No PTAC members voted for this recommendation category*
Do not recommend proposed payment model to the Secretary	*No PTAC members voted for this recommendation category*
Recommend proposed payment model to the Secretary for limited-scale testing (3)	Robert Berenson Rhonda Medows Bruce Steinwald
Recommend proposed payment model to the Secretary for implementation (5)	Jeffrey Bailet Paul Casale Tim Ferris Elizabeth Mitchell Len Nichols
Recommend proposed payment model to the Secretary for implementation as a high priority (3)	Harold Miller Kavita Patel Grace Terrell

As a result of the vote, PTAC recommended the *Home Hospitalization: An Alternative Payment Model for Delivering Acute Care in the Home* proposal to the Secretary for implementation.

Instructions on the Report to the Secretary
After PTAC voting, PTAC members made the following comments for incorporation into PTAC's Report to the Secretary:

1. Patients want access to the care this model proposes.
2. CMS should propose home hospitalization payment models (testing more than one model) in the very near future with broad implementation. Commercial payers are waiting for CMS leadership on this issue.
3. This model should be integrated with other home-based programs, which may prevent patients from developing conditions that mandate hospitalization.
4. CMS will need to consider how to address unintended consequences, such as reducing the viability of smaller hospitals that depend on inpatient hospitalization.
5. CMS should consider the appropriateness of payments under this model to ensure home care is not being overpaid and inpatient care is not being underpaid.
6. Some hospital-based accountable care organizations (ACOs) are already using the home hospitalization model. Physician-based ACOs may also benefit from the home hospitalization model.

The meeting adjourned at 5:06 p.m. EDT.

Approved and certified by:

___/Ann Page/_____ _____6/14/2018_____

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

Date

__/Jeffrey Bailet/_____ _____6/14/2018_____

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

Date