Physician-Focused Payment Model Technical Advisory Committee
Public Meeting Minutes

December 18, 2017
9:00 a.m. – 7:00 p.m. EST
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)
Timothy 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)
Bruce Steinwald, MBA (Consultant, Bruce Steinwald Consulting)
Grace Terrell, MD, MMM (CEO, Envision Genomics)

PTAC Member in Partial Attendance
Kavita Patel, MD, MSHS (Nonresident Senior Fellow, Brookings Institution)

Handouts for This Meeting
The following materials were distributed for each proposal, if they were created for each proposal:

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

List of Proposals, Submitters, and Public Commenters

1. **Renal Physicians Association (RPA): Incident ESRD Clinical Episode Payment Model**

   Submitter's Representatives:
   Jeffrey Giullian, MD, MBA (Chief Medical Officer of Hospital Services, DaVita Kidney Care)
   Robert Kenney, MD (Vice President of Medical Operations, Baton Rouge General Medical Center Campuses)
   Terry Ketchersid, MD, MBA (Chief Medical Officer, Integrated Care Group at Fresenius Medical Care)

Michael Shapiro, MD, MBA (President, RPA)
Dale Singer, MHA (Executive Director, RPA)

Public Commenter:
David White (Policy and Communications Specialist, American Society of Nephrology)

2. **New York City Department of Health and Mental Hygiene (NYC DOHMH): Multi-Provider, Bundled Episode-of-Care Payment Model for Treatment of Chronic Hepatitis C Virus (HCV) Using Care Coordination by Employed Physicians in Hospital Outpatient Clinics**

Submitter's Representatives:
Czarina Navos Behrends, PhD, MPH (Instructor in Healthcare Policy and Research, Weill Cornell Medical College)
Lauren Benyola, MBA, PMP (Product Manager, Visiting Nurse Service of New York)
Marie Bresnahan, MPH (Director of Project INSPIRE, NYC DOHMH)
Kyle Fluegge, PhD (Health Economist, NYC DOHMH)
Rashi Kumar, MUP (Senior Program Manager, Healthfirst)
Alain H. Litwin, MD, MPH (Vice Chair of Department of Medicine, University of South Carolina School of Medicine and Greenville Health System and Clemson University)
Paul Meissner, MSPH (Program Administrator, Montefiore Medical Center)
Ponni Perumalswami, MD (Liver Disease Specialist, Mount Sinai Medical Center)
Bruce R. Schackman, MD (Associate Professor of Public Health, Weill Cornell Medical College)
Shuchin Shukla, MD (Primary Care Physician, Montefiore Medical Center)
Jeffrey Weiss, PhD (Behavioral Health Specialist, Mount Sinai Medical Center)
Ann Winters, MD (Project INSPIRE Principal Investigator; NYC DOHMH)

Public Commenters
Annette Gaudino (Project Co-Director, Treatment Action Group)
Edwin Corbin-Gutierrez (Senior Manager of the Health Systems Integration Team, National Alliance of State and Territorial AIDS Directors)

3. **Zhou Yang, PhD, MPH: Medicare 3-Year Value-Based Payment Plan (Medicare 3VBPP)**

Submitter:
Zhou Yang, MPH, PhD (Assistant Professor, Emory University)

Public Commenters:
None

4. **Mercy Accountable Care Organization (ACO): Annual Wellness Visit Billing at Rural Health Clinics**

Submitter's Representatives:
Sandra Christensen (Financial Executive, Mercy Health Network)
Anne Wright, MBA (Director of Rural Operations, Mercy ACO)

Public Commenters:
None

NOTE: A transcript of all statements made by PTAC members, the proposal submitters, 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 December 18, 2017, public meeting.

Welcome and Deliberations and Voting Procedures
Jeffrey Bailet, PTAC Chair, and Elizabeth Mitchell, PTAC Vice Chair, welcomed attendees to the PTAC meeting. The Chair reminded the public that PTAC as a whole deliberates and discusses proposals in public meetings only and has informed the submitting organizations that the deliberations and voting proceedings would occur in the following order for each proposal:

1. PTAC members will introduce themselves and disclose any potential conflicts of interests and threats to impartiality.
2. The designated Preliminary Review Team (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. Submitters 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 submitters 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 that will accompany their recommendation to the Secretary.

Renal Physicians Association (RPA): Incident ESRD Clinical Episode Payment Model

Committee Member Disclosures
Harold Miller stated that he gave a presentation on a concept paper that RPA was developing about bundled payments for chronic kidney disease at the March 2016, RPA annual meeting. He received travel compensation for the trip. He has had no further involvement with RPA in the last 12 months and has had no specific involvement in the proposed model.

PTAC members had no other disclosures related to this proposal, and the Chair announced that PTAC members had determined that all PTAC members would be able to fully participate in deliberations and voting.

PRT Report to the Full PTAC
The PRT for the *Incident ESRD Clinical Episode Payment Model* proposal consisted of Paul Casale (the PRT Lead), Jeffrey Bailet, and Harold Miller.

The PRT Lead described the PRT's role, summarized the PRT's review, and presented a report to PTAC. He reminded the public that the PRT reports are not binding and that the full PTAC may reach different conclusions and recommendations than those of the PRT during the deliberation and voting process. The PRT Lead also noted that the PRT proceeded with their review with the assumption that the transplant bonus component of the model could be separated from the rest of the proposal.

Dr. Casale reviewed the proposal, a clinical episode payment model for Medicare patients with end-stage renal disease (ESRD) who have begun receiving dialysis for the first time. The proposed model focused on optimal transition to dialysis. Each episode of care is defined as six months long. The first component is shared savings and losses based on total cost of care during the episode and on the performance according to the proposed quality metrics. The second component is a transplant bonus, which doubles its incentive payout if high performance (such as renal transplant) is accomplished pre-dialysis as opposed to during the episode. The PRT supported the proposal's overall goal of improving the transition to dialysis for patients with incident ESRD.

The PRT concluded that the proposed model met nine out of 10 of the Secretary of Health and Human Services' (the Secretary's) criteria. In addition, the PRT emphasized that one out of the nine fulfilled criteria ("Payment Methodology") was provisionally met on the condition that the transplant bonus component not be included. The PRT determined, however, that the proposal did not meet the "Integration and Care Coordination" criterion. The PRT was unanimous on all decisions.

[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. Issues discussed included the following:

- The scope of the eligible participants in the model given that the model includes patients already enrolled in Medicare prior to beginning dialysis.
- The model's lack of upfront payments to providers, which may create a barrier to entry into the model for smaller organizations.
- The difficulty of coordinating care or ensuring high quality care prior to dialysis given the varying acuity and mechanisms by which dialysis begins, and that the majority of patients may have limited or no nephrology care prior to dialysis.
- The flexibility of the model for non-Medicare payers.
- The relative value of process metrics compared to patient-centered outcome measures.
- The clinical heterogeneity of the population resulting in difficulty identifying generalizable, high-quality outcome measures.

- The lack of details regarding care coordination between nephrologists and other providers (e.g. primary care).
- Payment distribution when multiple providers/nephrologists are involved in a single episode of care.

Submitter's Statement
The Chair invited the submitters, Jeffrey Giullian, Robert Kenney, Terry Ketchersid, Michael Shapiro, and Dale Singer, to make a statement to PTAC.

Following introductions, the submitters stated that the top tenets of the proposal included increased physician flexibility, care coordination, patient education and shared decision-making, and optimal transition to dialysis regardless of preceding nephrology care. In addition, the key tenets included reducing cost and eliminating unintended consequences. The submitters discussed that they estimated that nearly 80% of patients begin dialysis sub-optimally, which causes high hospitalization and emergency room visit rates with their resultant high costs in the first few months of dialysis. The submitters emphasized that they believe only a small part of this is due to nephrologists or their billing, but rather due to inadequate continuity of care and risk of complications such as infections. This model is designed to enhance the alignment of care coordination issues and provide incentives to eliminate them. The submitters clarified that acute kidney disease patients are not included in the proposed model. Although the submitters did not believe there would be the need for drastic changes in infrastructure to accommodate the model, they did note that reporting metrics would be needed immediately to identify appropriate benchmarks.

The submitters discussed the manner by which the model could lead to greater patient choice, and better upstream and downstream care through increased possibilities for home dialysis and non-dialysis options. The submitters stated that addressing incident ESRD patients with this payment model would ultimately affect the numbers of patients needing dialysis. The submitters indicated that although transplants were the gold standard of care, they understood the concerns of the PRT and were prepared to remove the transplant bonus component. The submitters also indicated an openness to making changes to the "Integration and Care Coordination" aspect of their model to allow for more flexibility among providers, while simultaneously addressing clinically heterogeneous patients.

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

- Whether the payment model could be triggered in advance of dialysis such as by Glomerular Filtration Rate (GFR).
    - State of development of a GFR test that gives accurate and stable results.
    - Use of ICD-10 codes for GFR in claims data.
    - Data from patient registries.
- Improving incident dialysis care (e.g., fewer catheter placements and avoiding dialysis for terminal patients).
- The need for and appropriateness of a nephrologist to assume the position of "principal" care provider for patients with ESRD.

- Incentivizing home dialysis by making its use a quality metric.
- The possibility of splitting the shared savings bonus into a per member per month (PMPM) system to aid smaller practices with upfront costs.
- The importance and need for the transplant bonus.
- The resources needed upfront by small practices, for patient education for example.

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

1. David White, American Society of Nephrology

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 Criterion Voting
PTAC discussed and voted on the extent to which the *Incident ESRD Clinical Episode Payment Model* proposal meets each of the Secretary's criteria. (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 were present for the proposal deliberation on December 18, 2017, six PTAC votes constituted a simple majority. The PTAC criterion votes were anonymous.

PTAC Member Votes on Incident ESRD Clinical Episode 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	2
	4 – Meets the criterion	5
	5 – Meets the criterion and deserves priority consideration	3
	6 – Meets the criterion and deserves priority consideration	1
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	0
	3 – Meets the criterion	4
	4 – Meets the criterion	4

	5 – Meets the criterion and deserves priority consideration	2
	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	0
	3 – Meets the criterion	2
	4 – Meets the criterion	9
	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	8
	5 – Meets the criterion and deserves priority consideration	3
	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	2
	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 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	2

	4 – Meets the criterion	9
	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	1
	3 – Meets the criterion	7
	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 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	8
	5 – Meets the criterion and deserves priority consideration	1
	6 – Meets the criterion and deserves priority consideration	0
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	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 9.		
10. Health Information Technology	* – Not Applicable	0
	1 – Does not meet criterion	0
	2 – Does not meet criterion	0

	3 – Meets the criterion	8
	4 – Meets the criterion	3
	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

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 11 PTAC members were present for the proposal deliberation and voting on the proposal, a total of eight PTAC votes was 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	Tim Ferris
Recommend proposed payment model to the Secretary for implementation	Jeffrey Bailet Robert Berenson Paul Casale Kavita Patel Rhonda Medows Elizabeth Mitchell Bruce Steinwald
Recommend proposed payment model to the Secretary for implementation as a high priority	Len Nichols Harold Miller Grace Terrell

As a result of the vote, PTAC recommended the *Incident ESRD Clinical Episode Payment Model* 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. In attempting to support proposals that include the largest number of individuals, is PTAC discouraging proposals that could quickly and advantageously make a difference to a significant subgroup? What is PTAC's position on one-size-fits-all models?
2. The proposed model is only recommended without the transplant bonus.

3. Early transplants should still be encouraged, possibly through quality metrics such as referral for transplant metric.
4. Generalizable practices such as patient education, care coordination, and integration should be included during implementation.
5. Regarding renal care, the Centers for Medicare & Medicaid Services (CMS) should consider both nationwide quality benchmarks and benchmarks with gradations or stratified by regional or clinical factors.
6. The model's risk adjustment methodology must be continually monitored and modified as appropriate. Monitoring is also needed to ensure dialysis is not discouraged to achieve savings among patients who may benefit from dialysis. The Department of Health and Human Services (HHS) should determine whether two distinct patient populations and payment methodologies are warranted for this model.
7. An exploration of incentives to improve patient care and patient health well in advance of dialysis is needed.
8. Concern was expressed regarding the requirement for simply reporting metrics as inadequate; instead, higher performance thresholds should be measured to assess quality.
9. Multi-payer models may reveal insights regarding overlap among models and payers.
10. Standards or benchmarks for quality metrics should be dynamic and not a static ideal achievable only by a subset. There is potential for all participants to improve on quality indicators within this model.
11. The Secretary should consider using his authority to better identify, through coding patients in advance of dialysis, who may benefit from improved care.
12. HHS should consider how this proposed model integrates with other models, such as Comprehensive ESRD Care (CEC), or a larger ACO.
13. Median and average costs may differ in this model.
14. Patient choice must remain the guiding principle of this model.

The comments in PTAC's Report to the Secretary will reflect any disagreement as appropriate and relevant.

The Committee recessed at 11:55 a.m. for approximately 65 minutes.

New York City Department of Health and Mental Hygiene (NYC DOHMH): Multi-Provider, Bundled Episode-of-Care Payment Model for Treatment of Chronic Hepatitis C Virus (HCV) Using Care Coordination by Employed Physicians in Hospital Outpatient Clinics

Committee Disclosures

The Committee reconvened at 1:04 p.m.

Paul Casale stated that he directs the ACO for New York-Presbyterian, Columbia, Weill Cornell, which is mentioned in NYC DOHMH's proposal.

No additional PTAC members had any disclosures related to this proposal, and the Chair announced that PTAC members had determined that all present PTAC members would fully participate in deliberations and voting.

PRT Report to the Full PTAC
The PRT for the *Multi-Provider, Bundled Episode-of-Care Payment Model for Treatment of Chronic Hepatitis C Virus (HCV) Using Care Coordination by Employed Physicians in Hospital Outpatient Clinics* proposal consisted of Robert Berenson (the PRT Lead), Jeffrey Bailet, and Grace Terrell.

The PRT Lead described the PRT's role, summarized the PRT's review, and presented their report to PTAC. He reminded the public that the PRT reports are not binding, and that PTAC may reach different conclusions and recommendations than those of the PRT during the deliberation and voting process. He also thanked the submitters for their participation.

The PRT Lead stated that NYC DOHMH's proposal is based on Project INSPIRE (Innovate and Network to Stop HCV and Prevent complications via Integrating care, Responding to needs, and Engaging patients and providers), which is a Health Care Innovation Award (HCIA) Round Two Demonstration Project. The proposed model focused on integrated care coordination of patients with behavioral health and substance abuse disorders to treat HCV. A care team would use results from a patient's comprehensive psychosocial evaluation to understand and help a patient overcome barriers to accessing medical services. Hepatologists and other gastroenterologists via telementoring will train the primary care physicians that manage the patient's care. Additionally, the proposal indicates that nonclinical care coordinators are to be involved in the care of HCV patients; however, they cannot bill for services rendered using the chronic care management codes. The bundled episode payment of $760 per eligible participant includes three phases: 1) pretreatment assessment involving care coordination, 2) treatment period, and 3) report of sustained virological response at 12 weeks post treatment (SVR12). The episode often lasts for nine months, and is not expected to exceed 10 months. The model proposed that the SVR rate, compared to a benchmark set by CMS, would determine bonus payments and penalties.

The PRT concluded that the proposed model met six out of 10 of the Secretary's criteria. The PRT determined that the proposal did not meet the "Scope", "Payment Methodology", "Ability to be Evaluated", and "Integration and Care Coordination" criteria. The PRT was unanimous on 9 of 10 criteria, with a majority decision on one criterion.

[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 highlighted concerns of the payment aspect of the proposed model. The issues included the potential use of chronic care management codes (in place of the proposed model) and the calculation to determine a bonus or penalty payment.

Submitter's Statement
The Chair invited the submitters of NYC DOHMH, who were present in-person and via teleconference, to make a statement to PTAC. The submitters included Czarina Navos Behrends, Lauren Benyola, Marie

Bresnahan, Kyle Fluegge, Rashi Kumar, Alain Litwin, Paul Meissner, Ponni Perumalswami, Bruce Schackman, Shuchin Shukla, Jeffrey Weiss, and Ann Winters.

Following introductions, the submitters explained their proposal's aim to optimize management and treatment of hepatitis C patients by increasing coordination with physicians and care coordinators. The model allows for hepatologists, through telementoring, to train other clinical staff, including primary care providers, addiction medicine physicians, and infectious disease physicians, to expand hepatitis C treatment into primary care settings. Additionally, the submitters emphasized that care coordination would promote better practices concerning mental health, diet and exercise, substance or alcohol abuse, and use of medicine and medical services.

The submitters addressed the PRT's concerns about their proposed payment model. Regarding the risk component of the payment model, they stated that future medical cost savings, based on only the presence of cirrhosis and age, determines the shared savings associated with the curative treatment for hepatitis C. They believed a reimbursement approach using the current Physician Fee Schedule (PFS) and the Outpatient Prospective Payment System (OPPS) would not support telementoring and care coordination services as well as the bundled payment would in order to streamline care to patients with complex needs.

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

- Resources to appropriately identify and treat patients with chronic HCV.
- The need for two tiers of patient complexity and corresponding payments.
- Adherence of patients to chronic HCV treatment protocols and barriers to completion of treatment.
- The tele-mentoring aspect of the model.
- Variation in market prices of HCV medication.
- The aim to reduce emergency department (ED) visits.
- Features for the proposed payment model including:
    - Having a bonus or payback, or a cap on savings.
    - The lack of specificity around the shared-savings approach, its rate, and degree of risk.
    - The shared savings based on projected savings instead of cost of care.
    - The need for chronic care management for an extended period of time.
    - Challenges implementing chronic care management codes.
    - The lack of coverage for services, including labs, imaging, mental health services, and medications.
    - Incentives for providers caring for patients with HCV.

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

1. Annette Gaudino, Treatment Action Group
2. Edwin Corbin-Gutierrez, National Alliance of State and Territorial AIDS Directors

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.

PTAC Criterion Voting

The Committee discussed and voted on the extent to which NYC DOHMH's *Multi-Provider, Bundled Episode-of-Care Payment Model for Treatment of Chronic Hepatitis C Virus (HCV) Using Care Coordination by Employed Physicians in Hospital Outpatient Clinics* proposal meets each of the Secretary's criteria. (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 were present for the proposal deliberation on December 18, 2017, six PTAC votes constituted a simple majority. The PTAC criterion votes remained anonymous.

PTAC Member Votes on Multi-Provider, Bundled Episode-of-Care Payment Model for Treatment of Chronic Hepatitis C Virus (HCV) Using Care Coordination by Employed Physicians in Hospital Outpatient Clinics

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 criteria	1
	2 – Does not meet criteria	3
	3 – Meets the criteria	6
	4 – Meets the criteria	0
	5 – Meets the criteria and deserves priority consideration	0
	6 – Meets the criteria and deserves priority consideration	0
PTAC DECISION: Proposal Meets Criterion 1.		
2. Quality and Cost (High Priority)	* – Not applicable	0
	1 – Does not meet criteria	0
	2 – Does not meet criteria	1
	3 – Meets the criteria	7
	4 – Meets the criteria	2
	5 – Meets the criteria and deserves priority consideration	0
	6 – Meets the criteria and deserves priority consideration	0
PTAC DECISION: Proposal Meets Criterion 2.		
3. Payment Methodology (High Priority)	* – Not applicable	0
	1 – Does not meet criteria	4
	2 – Does not meet criteria	5
	3 – Meets the criteria	1
	4 – Meets the criteria	0
	5 – Meets the criteria and deserves priority consideration	0

	6 – Meets the criteria and deserves priority consideration	0
PTAC DECISION: Proposal Does Not Meet Criterion 3.		
4. Value over Volume	* – Not applicable	0
	1 – Does not meet criteria	0
	2 – Does not meet criteria	0
	3 – Meets the criteria	6
	4 – Meets the criteria	3
	5 – Meets the criteria and deserves priority consideration	1
	6 – Meets the criteria and deserves priority consideration	0
PTAC DECISION: Proposal Meets Criterion 4.		
5. Flexibility	* – Not applicable	0
	1 – Does not meet criteria	0
	2 – Does not meet criteria	1
	3 – Meets the criteria	3
	4 – Meets the criteria	6
	5 – Meets the criteria and deserves priority consideration	0
	6 – Meets the criteria and deserves priority consideration	0
PTAC DECISION: Proposal Meets Criterion 5.		
6. Ability to be Evaluated	* – Not applicable	0
	1 – Does not meet criteria	1
	2 – Does not meet criteria	5
	3 – Meets the criteria	3
	4 – Meets the criteria	1
	5 – Meets the criteria and deserves priority consideration	0
	6 – Meets the criteria and deserves priority consideration	0
PTAC DECISION: Proposal Does Not Meet Criterion 6.		
7. Integration and Care Coordination	* – Not applicable	0
	1 – Does not meet criteria	1
	2 – Does not meet criteria	1
	3 – Meets the criteria	7
	4 – Meets the criteria	0
	5 – Meets the criteria and deserves priority consideration	1
	6 – Meets the criteria and deserves priority consideration	0
PTAC DECISION: Proposal Meets Criterion 7.		
8. Patient Choice	* – Not applicable	0
	1 – Does not meet criteria	0
	2 – Does not meet criteria	0
	3 – Meets the criteria	6
	4 – Meets the criteria	4
	5 – Meets the criteria and deserves priority consideration	0

	6 – Meets the criteria and deserves priority consideration	0
PTAC DECISION: Proposal Meets Criterion 8.		
9. Patient Safety	* – Not applicable	0
	1 – Does not meet criteria	0
	2 – Does not meet criteria	1
	3 – Meets the criteria	6
	4 – Meets the criteria	3
	5 – Meets the criteria and deserves priority consideration	0
	6 – Meets the criteria and deserves priority consideration	0
PTAC DECISION: Proposal Meets Criterion 9.		
10. Health Information Technology	* – Not applicable	0
	1 – Does not meet criteria	0
	2 – Does not meet criteria	0
	3 – Meets the criteria	9
	4 – Meets the criteria	1
	5 – Meets the criteria and deserves priority consideration	0
	6 – Meets the criteria and deserves priority consideration	0
PTAC DECISION: Proposal Meets Criterion 10.		

PTAC Vote on Recommendation to the Secretary

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 were present for the proposal deliberation and voting on the *Multi-Provider, Bundled Episode-of-Care Payment Model for Treatment of Chronic Hepatitis C Virus (HCV) Using Care Coordination by Employed Physicians in Hospital Outpatient Clinics* proposal, a total of seven PTAC votes was 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	Jeffrey Bailet Robert Berenson Paul Casale Tim Ferris Harold Miller Elizabeth Mitchell Len Nichols Bruce Steinwald Grace Terrell
Recommend proposed payment model to the Secretary for limited-scale testing	Rhonda Medows
Recommend proposed payment model to the Secretary for implementation	*No PTAC members voted for this recommendation category.*
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 not to recommend the *Multi-Provider, Bundled Episode-of-Care Payment Model for Treatment of Chronic Hepatitis C Virus (HCV) Using Care Coordination by Employed Physicians in Hospital Outpatient Clinics* 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. The Committee is interested in more support for telementoring, highlighting the present and ongoing lack of access to specialty care.
2. Screening hepatitis C patients should be part of coordinated care.
3. Physician payment should be more aligned with public health policy.
4. The payment model should not be based on prospective value of lifetime savings.
5. The chronic care management codes may need to be defined more broadly for ease of implementation.
6. PTAC would like to see more clarification from the Center for Medicare & Medicaid Innovation (CMMI) regarding funding and evaluation results for Health Care Innovation Awards (HCIA) projects. These projects could benefit from increased coordination between PTAC and CMMI to clarify the sustainability of the promising projects and PTAC's role in reviewing those that are physician-focused payment models (PFPMs).

The comments in PTAC's Report to the Secretary will reflect the disagreement as appropriate and relevant.

The Committee recessed for approximately 10 minutes.

Zhou Yang, PhD, MPH: Medicare 3-Year Value-Based Payment Plan (Medicare 3VBPP)

Committee Member Disclosures

The Committee reconvened.

No PTAC members had any disclosures related to this proposal, and the Chair announced that PTAC members had determined that all PTAC members would fully participate in deliberations and voting.

PRT Report to the Full PTAC

The PRT for the *Medicare 3-Year Value-Based Payment Plan (Medicare 3VBPP)* proposal consisted of Bruce Steinwald (the PRT Lead), Robert Berenson, and Elizabeth Mitchell.

The PRT Lead described the PRT's role, summarized the PRT's review, and presented their report to PTAC. He reminded the public that the PRT reports are not binding and that PTAC may reach different conclusions and recommendations than those of the PRT during the deliberation and voting process. The PRT Lead also noted that the PRT proceeded with their review with the assumption that the PRT must refrain from evaluating the merits or detractors of proposals outside of PTAC's official mandate. He stated that Dr. Zhou Yang's proposal, *Medicare 3VBPP*, was written as a defined contribution plan rather than a PFPM. The proposed model focused on Medicare beneficiaries under the age of 85, without cognitive or severe mental illnesses. In Dr. Yang's proposed approach, each participant is given a Medicare Account with an adjusted balance of three times the average annual FFS expenditure with the option to opt out at any point. The account is intended to cover three years of expenditures by the participant. Each participant may choose one of four possible CMS-approved plan types that would be provided by private entities. All plans would cover Medicare Parts A and B. Wellness-care would be fully covered and linked to a bonus Medicare Account credit based on adherence. If the Medicare Account balance is depleted prior to three years, Medicare contributions for the patient will reduce, whereas a balance surplus will be given as credit for future Medicare-covered expenditures. The catastrophic coverage will be spread over the entirety of the three-year period. There will also be a financial incentive for postponing Medicare initiation past the age of 65.

The PRT concluded that it would be inappropriate for the PRT and PTAC to evaluate the proposed model. The proposed model did not fall within the purview of PTAC because it focuses on Medicare coverage and benefits rather than on payment methodology. The PRT determined that the proposal was not applicable for 10 out of 10 of the Secretary's criteria. The PRT emphasized that their conclusions are not meant to imply any qualitative opinion about the merits of the proposal. The PRT was unanimous on all decisions.

[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. Issues discussed included the following:

- The proposed changes in the model pertaining to Medicare beneficiaries instead of physicians.

- Determining whether the proposed model was within PTAC's purview, given that it was a benefit design change rather than a PFPM.
- PTAC's ability to evaluate and make recommendations on models that suggest fundamental restructuring of CMS.

Submitter's Statement
The Chair invited the submitter, Dr. Yang, to make a statement to PTAC.

The submitter stated that the proposal aims to better align financial incentives for providers and patients. The submitter discussed four issues to explain her disagreement with the PRT's assessment. First, the proposal is a small demonstration meant to be pilot-tested. Second, the added benefits are for more choice, better value services, and more patient empowerment. Third, the combination of expenditure threshold and catastrophic coverage provides the financial protection to guarantee that the proposed copayment and coinsurance will be lower on average than the traditional Medicare FFS. Lastly, the postponement of Medicare eligibility past the age of 65 is voluntary.

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

- The model's attempt to address concerns from physicians regarding federal government involvement in payment transactions for Medicare beneficiaries.
- The low-premium FFS plans with multispecialty physician groups.
- Concerns about frontloading three years' worth of payment to fund Medicare Parts A, B, and D benefits through a single account.
    - Funding a single account based on average cost of care could lead to a lack of patient access to appropriate prescription medicines and other treatment.
    - Setting the monetary amount available for a three-year period would cause a lack of patient access to medical advances as new costs not known at the time of payment.
- The low-income population as potential participants.
- Whether or not the model is an example of "defined contribution."

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

PTAC Criterion Voting
PTAC discussed and voted on the extent to which the *Medicare 3 Year Value Based Payment Plan (Medicare 3VBPP)* proposal meets each of the Secretary's criteria. (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 were present for the proposal deliberation on December 18, 2017, six PTAC votes constituted a simple majority. The PTAC criterion votes remained anonymous.

PTAC Member Votes on Medicare 3VBPP

Criteria Specified by the Secretary (42 CFR§414.146)	PTAC Vote Categories	PTAC Vote Distribution
1. Scope (High Priority)	* – Not Applicable	9
	1 – Does not meet criterion	1
	2 – Does not meet criterion	0
	3 – Meets the criterion	0
	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 Not Applicable for Criterion 1.		
2. Quality and Cost (High Priority)	* – Not Applicable	7
	1 – Does not meet criterion	3
	2 – Does not meet criterion	0
	3 – Meets the criterion	0
	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 Not Applicable for Criterion 2.		
3. Payment Methodology (High Priority)	* – Not Applicable	7
	1 – Does not meet criterion	3
	2 – Does not meet criterion	0
	3 – Meets the criterion	0
	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 Not Applicable for Criterion 3.		
4. Value over Volume	* – Not Applicable	7
	1 – Does not meet criterion	3
	2 – Does not meet criterion	0
	3 – Meets the criterion	0
	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 Not Applicable for Criterion 4.		
5. Flexibility	* – Not Applicable	9
	1 – Does not meet criterion	1
	2 – Does not meet criterion	0
	3 – Meets the criterion	0
	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 Not Applicable for Criterion 5.		
6. Ability to be Evaluated	* – Not Applicable	8
	1 – Does not meet criterion	2
	2 – Does not meet criterion	0
	3 – Meets the criterion	0
	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 Not Applicable for Criterion 6.		
7. Integration and Care Coordination	* – Not Applicable	7
	1 – Does not meet criterion	3
	2 – Does not meet criterion	0
	3 – Meets the criterion	0
	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 Not Applicable for Criterion 7.		
8. Patient Choice	* – Not Applicable	8
	1 – Does not meet criterion	0
	2 – Does not meet criterion	2
	3 – Meets the criterion	0

	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 Not Applicable for Criterion 8.		
9. Patient Safety	* – Not Applicable	7
	1 – Does not meet criterion	3
	2 – Does not meet criterion	0
	3 – Meets the criterion	0
	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 Not Applicable for Criterion 9.		
10. Health Information Technology	* – Not Applicable	7
	1 – Does not meet criterion	3
	2 – Does not meet criterion	0
	3 – Meets the criterion	0
	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 Not Applicable for Criterion 10.		

PTAC Vote on Recommendation to the Secretary

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 were present for the proposal deliberation and voting on proposal, a total of seven PTAC votes was required for the final PTAC recommendation vote.

PTAC Recommendation Category	PTAC Member Recommendation Vote
Not Applicable	Jeffrey Bailet Robert Berenson Paul Casale Tim Ferris Rhonda Medows Bruce Steinwald
Do not recommend proposed payment model to the Secretary	Harold Miller Elizabeth Mitchell Len Nichols Grace Terrell
Recommend proposed payment model to the Secretary for limited-scale testing	*No PTAC members voted for this recommendation category*
Recommend proposed payment model to the Secretary for implementation	*No PTAC members voted for this recommendation category*
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 determined the *Medicare 3VBPP* proposal was not applicable to be evaluated by PTAC for the Secretary.

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. The proposal does not propose a PFPM and is therefore not applicable.
2. PTAC does not have the purview to review models that restructure Medicare.

The comments in PTAC's Report to the Secretary will reflect the disagreement as appropriate and relevant.

Mercy Accountable Care Organization: Annual Wellness Visit Reimbursement in Rural Health Clinics

Committee Member Disclosures
No PTAC members had any disclosures related to this proposal, and the Chair announced that PTAC members had determined that all PTAC members would fully participate in deliberations and voting.

PRT Report to the Full PTAC
The PRT for the *Annual Wellness Visit Reimbursement in Rural Health Clinics* proposal consisted of Robert Berenson (the PRT Lead), Tim Ferris, and Len Nichols.

The PRT Lead described the PRT's role, summarized the PRT's review, and presented their report to PTAC. He reminded the public that the PRT reports are not binding and that PTAC may reach different conclusions and recommendations than those of the PRT during the deliberation and voting process.

The PRT stated that the proposal was written to increase Annual Wellness Visits (AWVs) and thereby realize cost savings due to an increase in identified and mitigated health risks. The proposal emphasizes making an additional payment for providing AWVs and allowing non-practitioners to provide AWVs.

The PRT concluded that the proposed model was not an alternative physician payment model. Accordingly, the proposed model did not fall within the purview of PTAC because it focuses on rule changes within a well-established payment methodology rather than a new payment methodology. Therefore, nine out of 10 of the Secretary's criteria were not applicable. In addition, the PRT determined that the proposal did not meet the "Payment Methodology" criterion. The PRT was unanimous on all decisions.

[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. Issues discussed included the following:

- Whether it was appropriate to determine criteria, or a hierarchy of criteria, deeming proposals to be not applicable to PTAC.
- Determination regarding the proposed model and whether it falls within the purview of PTAC.
- Aspects of the proposed payment model including:
    - The changes to the existing Physician Fee Schedule are perceived as minimal; and
    - The use of the all-inclusive rate (AIR).
- The difficulty of repeat visits for a single patient due to transportation barriers.
- Maintenance of accountability if non-physicians, specifically RNs, are allowed to provide AWVs.

Submitter's Statement
The Chair invited the submitters, Anne Wright and Sandra Christiansen, who participated by teleconference, to make a statement to PTAC.

The submitters stated that the proposal aims to provide more preventive care, such as AWVs. They stated that this could be accomplished by providing additional incentives, especially incentives to engage rural sites into FFS payments. Under current policy, payment for AWVs are included in the AIR. Therefore, providers can only bill for the same amount regardless of whether they conduct an AWV. The only exception to this is if patients return for the AWV on a separate day. However, it is difficult for patients to return a second time for an AWV and especially difficult in rural areas. This proposal will incentivize the completion of AWVs by allowing providers to bill for them in addition to the AIR even when conducted on the same day.

The submitters stated they have registered nurses whose specific roles are wellness visits for which they are able to bill. Yet, access to preventive care is still limited. Wellness and prevention models such as the proposed model require incentives or other means to attract additional providers to deliver outpatient care.

PTAC and Submitter Q&A and Discussion
PTAC engaged in Q&A and discussion with the submitters on the following topics:

- Differences in the costs of AWVs and the ability to bill for visits by providers at rural health clinics located in critical access hospitals compared to those at independent clinics.
- The variability in billing for preventive care by registered nurses versus other providers.
- The difference in payment between critical access hospital-based (CAH) clinics and independent rural health clinics.
- Interaction between participants of the proposed model and ACOs.
- The disadvantages of the current cost-based methodology—the AIR— for rural health clinics who function independently of CAHs.
- The lack of performance measures for AWVs.
- Aspects of the AWV that cannot be delivered via telehealth modalities.

Public Comments
The Chair thanked the submitters and opened the floor for public comments. There were no public comments made.

PTAC Criterion Voting
PTAC discussed and voted on the extent to which the *Annual Wellness Visit Reimbursement in Rural Health Clinics* proposal meets each of the Secretary's criteria. (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 were present for the proposal deliberation on December 18, 2017, six PTAC votes constituted a simple majority. The PTAC criterion votes remained anonymous.

PTAC Member Votes on Annual Wellness Visit Reimbursement in Rural Health Clinics

Criteria Specified by the Secretary (42 CFR§414.146)	PTAC Vote Categories	PTAC Vote Distribution
1. Scope (High Priority)	* – Not Applicable	9
	1 – Does not meet criterion	1
	2 – Does not meet criterion	0
	3 – Meets the criterion	1
	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 Not Applicable for Criterion 1.		
2. Quality and Cost (High Priority)	* – Not Applicable	9

	1 – Does not meet criterion	1
	2 – Does not meet criterion	0
	3 – Meets the criterion	1
	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 Not Applicable for Criterion 2.		
3. Payment Methodology (High Priority)	* – Not Applicable	6
	1 – Does not meet criterion	5
	2 – Does not meet criterion	0
	3 – Meets the criterion	0
	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 Not Applicable for Criterion 3.		
4. Value over Volume	* – Not Applicable	9
	1 – Does not meet criterion	1
	2 – Does not meet criterion	0
	3 – Meets the criterion	1
	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 Not Applicable for Criterion 4.		
5. Flexibility	* – Not Applicable	9
	1 – Does not meet criterion	0
	2 – Does not meet criterion	1
	3 – Meets the criterion	1
	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 Not Applicable for Criterion 5.		

6. Ability to be Evaluated	* – Not Applicable	10
	1 – Does not meet criterion	0
	2 – Does not meet criterion	0
	3 – Meets the criterion	1
	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 Not Applicable for Criterion 6.		
7. Integration and Care Coordination	* – Not Applicable	9
	1 – Does not meet criterion	1
	2 – Does not meet criterion	0
	3 – Meets the criterion	1
	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 Not Applicable for Criterion 7.		
8. Patient Choice	* – Not Applicable	10
	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	0
	6 – Meets the criterion and deserves priority consideration	0
PTAC DECISION: Proposal Not Applicable for Criterion 8.		
9. Patient Safety	* – Not Applicable	10
	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	0
	6 – Meets the criterion and deserves priority consideration	0

PTAC DECISION: Proposal Not Applicable for Criterion 9.		
10. Health Information Technology	* – Not Applicable	10
	1 – Does not meet criterion	0
	2 – Does not meet criterion	0
	3 – Meets the criterion	1
	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 Not Applicable for Criterion 10.		

PTAC Vote on Recommendation to the Secretary

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 11 PTAC members were present for the proposal deliberation and voting on proposal, a total of eight PTAC votes was required for the final PTAC recommendation vote.

PTAC Recommendation Category	PTAC Member Recommendation Vote
Not Applicable	Jeffrey Bailet Robert Berenson Paul Casale Tim Ferris Rhonda Medows Elizabeth Mitchell Len Nichols Kavita Patel Bruce Steinwald Grace Terrell
Do not recommend proposed payment model to the Secretary	Harold Miller
Recommend proposed payment model to the Secretary for limited-scale testing	*No PTAC members voted for this recommendation category*
Recommend proposed payment model to the Secretary for implementation	*No PTAC members voted for this recommendation category*
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 determined the *Annual Wellness Visit Reimbursement in Rural Health Clinics* proposal was not applicable to be evaluated by PTAC for the Secretary.

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. This model was voted as not applicable because it was a change in technical regulations to an existing model rather than a proposal of a new model.
2. This model's payment methodology was not recommended because it does not meet the Secretary's criteria. However, some of the individual criteria may be applicable.

The comments in PTAC's Report to the Secretary will reflect the disagreement as appropriate and relevant.

Atypical Proposals

PTAC discussed needing a framework for responding to proposals that may be deemed not applicable. There must be a more clearly defined threshold and process for deciding not to conduct a full review of a submitted proposal. Such a framework would be helpful to PTAC, potential submitters, the Secretary, and CMS. Currently, the framework for proposals to be reviewed by PTAC is in the Proposal Submission Instructions, which outline types and qualities of proposals that PTAC is more inclined to recommend. This language was chosen after it was concluded that PTAC could not refuse to accept any submitted proposals.

There is now the need for additional language to address atypical proposals that may not meet the definition of a PFPM. The options discussed included:

- Stronger emphasis and clarity regarding types and aspects of models that are not considered a PFPM.
- Identifying proposals as not applicable when a new payment model is not needed in the face of an easier approach, such as creating or modifying billing codes or payment rules.
- The committee itself considering whether PTAC is the best venue for the proposal's goals to be realized.
- Language within the Proposal Submission Instructions to guide submitters away from submitting proposals that are either so small (code changes) or so large (restructuring of CMS) in scope that they fall outside the purview of PTAC.
- Identifying proposals as not applicable if the model's focus is not on Medicare populations.

PTAC determined that:

- An approach to atypical proposals will be further discussed at an upcoming PTAC administrative session.
- PTAC will collectively write and publish online a document addressing an approach to atypical proposals, which will be open for public comment.

PTAC approved this course of action unanimously.

The public meeting adjourned at 6:34 p.m. EST

Approved and certified by:

___/Ann Page/_____ __3/26/2018_____
Ann Page, Designated Federal Officer — Date
Physician-Focused Payment Model Technical
Advisory Committee

__/Jeffrey Bailet/_____ __3/26/2018_____
Jeffrey W. Bailet, MD, Chair — Date
Physician-Focused Payment Model Technical
Advisory Committee