Physician-Focused Payment Model Technical Advisory Committee
Public Meeting Minutes

December 19, 2017
9:00 a.m. – 6:00 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)
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 (Founding CEO, Envision Genomics)

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

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:

- Letter of Intent
- Proposal
- Preliminary Review Team (PRT) Report
- Committee Member Disclosures

Materials for Public Comments, Additional Information from the Submitter, and Additional Information and Analyses were distributed for:

- American Academy of Family Physicians (AAFP): Advanced Primary Care: A Foundational Alternative Payment Model (APC-APM) for Delivering Patient-Centered, Longitudinal, and Coordinated Care
- Large Urology Group Practice Association: LUGPA APM for Initial Therapy of Newly Diagnosed Patients with Organ-Confined Prostate Cancer

Materials for Public Comments and Additional Information and Analyses were distributed for:

- Minnesota Birth Center: A Single Bundled Payment for Comprehensive Low-Risk Maternity and Newborn Care Provided by Independent Midwife-Led Birth Center Practices that Are Clinically Integrated with Physician and Hospital Services

List of Proposals, Submitters, and Public Commenters

1. **American Academy of Family Physicians (AAFP): Advanced Primary Care: A Foundational Alternative Payment Model (APC-APM) for Delivering Patient-Centered, Longitudinal, and Coordinated Care**

   Submitter's Representatives:
   Shawn Martin (Senior Vice President of Advocacy, Practice Advancement, and Policy; AAFP)
   Kent Moore (Senior Strategist for Physician Payment, AAFP)
   Amy Mullins, MD (Medical Director of Quality Improvement, AAFP)
   Michael Munger, MD (President, AAFP)

   Public Commenters:
   Jean Antonucci, MD (Family Medicine Physician)
   Sandra Berkowitz (National Nurse Practitioner Entrepreneur Network [NNPEN])
   Rebecca Love, MD (Family Medicine Physician)

2. **Large Urology Group Practice Association: LUGPA APM for Initial Therapy of Newly Diagnosed Patients with Organ-Confined Prostate Cancer**

   Submitter's Representatives:
   Deepak A. Kapoor (Chairman and CEO, Integrated Medical Professionals; Chairman of Health Policy of LUGPA)
   Kathleen Latino, MD (Medical Director, Integrated Medical Professionals)
   Dan Muldoon (Health Care Consultant, Milliman)
   Pamela Pelizzari (Health Care Consultant, Milliman)
   Neal D. Shore, MD (President, LUGPA)

   Public Commenters:
   Thomas Ferrington (Prostate Heath Education Network)
   Anne Hubbard (American Society for Radiation Oncology)
   Wendy Poage (Prostate Conditions Education Council)
   Andrew Saelens (ZERO - The End of Prostate Cancer)
   Stephanie Stinchcomb (American Urological Association)

3. **Minnesota Birth Center: A Single Bundled Payment for Comprehensive Low-Risk Maternity and Newborn Care Provided by Independent Midwife-Led Birth Center Practices that Are Clinically Integrated with Physician and Hospital Services**

   Submitter's Representative:
   Steve Calvin, MD (Medical Director, Minnesota Birth Center)

   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 19, 2017, public meeting.

Welcome and Deliberations and Voting Procedures

Jeffrey Bailet, PTAC Chair, welcomed attendees to the PTAC meeting. The Chair reminded the public that PTAC deliberates and discusses proposals only in public meetings and informed the participants that the deliberations and voting proceedings 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 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. 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 the 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 that will accompany their recommendation to the Secretary.

American Academy of Family Physicians (AAFP): Advanced Primary Care: A Foundational Alternative Payment Model (APC-APM) for Delivering Patient-Centered, Longitudinal, and Coordinated Care

Committee Member Disclosures

Robert Berenson stated that he has been funded by AAFP to do payment model analysis. The most recent analysis was four years ago. Additionally, he was recently part of a failed bid in response to an AAFP request for proposal (RFP) on single payer programs. He had no involvement with the development of the proposed model. Furthermore, Dr. Berenson was the second author on a paper used as a basis for AAFP's APC-APM efforts.

Rhonda Medows stated that she is a family medicine physician, has been a member of AAFP for years, is not currently practicing medicine, and has had no involvement in the proposed model.

Harold Miller stated that he gave presentations to the AAFP Board and AAFP Annual Leadership Forum in 2009 and 2012, respectively. He received travel reimbursement for both trips and a speaking fee for the 2012 presentation. He has no current relationship with AAFP nor has he been involved in the development of the proposed model.

Kavita Patel stated that she has worked informally with AAFP in the past and attended AAFP-sponsored sessions on payment reform. She also has a working relationship with AAFP staff in Washington, DC. She has not been involved in the development of this 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 *Advanced Primary Care: A Foundational Alternative Payment Model (APC-APM) for Delivering Patient-Centered, Longitudinal, and Coordinated Care* proposal consisted of Kavita Patel (the PRT Lead), Tim Ferris, and Harold Miller.

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

The PRT Lead stated that the proposed model focused on family medicine, general practice, geriatric medicine, pediatric medicine, and internal medicine. The proposal emphasized primary care practices as the APM Entity. The APM Entity would have to meet six quality measures in order to keep the incentive payment. Patient choice is the primary method of determining for which patients the primary care practice would receive payment and be accountable.

Primary care practices would receive payment in four parts: an evaluation and management risk-adjusted payment per beneficiary per month (PBPM), a care management risk-adjusted PBPM, an incentive payment, and continued Medicare Physician Fee Schedule payments for services not included in the two risk-adjusted PBPM payments.

The PRT Lead then described the issues and concerns discussed by the PRT and its conclusions that the proposed model met eight out of 10 of the Secretary's criteria. She reported that the PRT unanimously agreed the proposal met six criteria, a majority of the PRT members felt the proposal met two additional criteria ("Quality and Cost" and "Payment Methodology") and that the PRT unanimously determined the proposal did not meet the "Ability to be Evaluated" and "Integration and Care Coordination" criteria.

[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:

- Lack of details on certain aspects of the model;
- The expansive size of the proposed program and concern that a single set of parameters may not work for diverse providers and beneficiaries affected by the model;

- Lack of details regarding evaluability; e.g.,
    - Challenges with identifying appropriate control groups.
    - Complexity of potential evaluation methodology related to a variety of options for payment, patient enrollment, and patient attribution within the model.
- Potential for biased attribution, "cherry-picking," and stinting on care under capitation.
- Necessity of clinical/encounter data to perform appropriate risk-adjustment within a capitated model.
- Uncertainty regarding state-level bans on primary care capitation outside of health maintenance organizations (HMOs).

Submitter's Statement

The Chair invited the submitter representatives (Michael Munger, Shawn Martin, Kent Moore, and Amy Mullins) to make a statement to PTAC.

Following introductions, the submitter representatives stated that the proposal aims to increase family physician participation in APMs. They acknowledged similarities to the CPC+ model, but highlighted several key differences. They stated that the proposed model expands access for beneficiaries and physicians, increases investment in primary care, reduces administrative burden, and moves away from fee-for-service (FFS) towards prospective payment for predictable revenue streams. The model includes basic, rather than complex, Health Information Technology (HIT) elements.

The submitter representatives emphasized both that the model evaluation would include a true longitudinal assessment of care and their willingness to work with the Centers for Medicare & Medicaid Services (CMS) on design adjustments. The submitter representatives stated the model should remain patient-focused and with integration and care coordination at its heart to enhance feedback. Additionally, if other evaluation issues arose, they proposed defaulting to the approach used to evaluate the CPC+ model.

PTAC and Submitter Q&A and Discussion

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

- Comparisons between the proposed model and CPC+, including:
    - Administrative and cost-related barriers to entry;
    - Documentation guidelines, flexibility, and requirements;
    - Data collection requirements;
    - FFS components;
    - Incentives for providers;
    - Electronic health record (EHR) meaningful use requirements; and
    - E-visits, group visits, and telehealth consultations.
- Models attributing total cost of care to primary care providers.
- Evaluation and outcome options, including total cost of care.
- Proprietary nature of payments to providers.
- Predictive modeling capacity to identify and stratify patients by clinical complexity.
- Potential reductions in spending related to enhanced adherence, and medical and behavioral health treatment.

- Delay in ability to demonstrate health care savings as increased entry into the health system initially will increase initial costs.
- Willingness to use encounter data and medical records for model reporting and evaluation.
- Degree and type of patient cost-sharing.
- The appropriateness of a fixed payment irrespective of utilization for patients with the same risk level.
- The use of CAHPS (Consumer Assessment of Healthcare Providers and Systems) to prevent stinting.
- The potential benefits of increased primary care access, including reducing unnecessary referrals and care duplication.

The public meeting recessed at 11:30 a.m. and reconvened at 11:41 a.m.

Public Comments

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

1. Sandra Berkowitz, National Nurse Practitioner Entrepreneur Network (NNPEN)
2. Jean Antonucci, Family Medicine Physician
3. Rebecca Love, Family Medicine Physician

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

PTAC discussed and voted on the extent to which the *Advanced Primary Care: A Foundational Alternative Payment Model (APC-APM) for Delivering Patient-Centered, Longitudinal, and Coordinated Care* 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 19, 2017, six PTAC votes constituted a simple majority. The PTAC criterion votes remained anonymous.

PTAC Member Votes on Advanced Primary Care: A Foundational Alternative Payment Model (APC-APM) for Delivering Patient-Centered, Longitudinal, and Coordinated Care

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	1
	4 – Meets the criterion	3
	5 – Meets the criterion and deserves priority consideration	6
	6 – Meets the criterion and deserves priority consideration	1
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	6
	4 – Meets the criterion	4
	5 – Meets the criterion and deserves priority consideration	1
	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	6
	4 – Meets the criterion	4
	5 – Meets the criterion and deserves priority consideration	1
	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	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 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	6
	5 – Meets the criterion and deserves priority consideration	5
	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	2
	3 – Meets the criterion	8
	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 Meets Criterion 6.		
7. Integration and Care Coordination	* – Not Applicable	0
	1 – Does not meet criterion	0
	2 – Does not meet criterion	3
	3 – Meets the criterion	4
	4 – Meets the criterion	2
	5 – Meets the criterion and deserves priority consideration	2
	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	7
	5 – Meets the criterion and deserves priority consideration	2
	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	1
	3 – Meets the criterion	7
	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 9.		
10. Health Information Technology	* – Not Applicable	0
	1 – Does not meet criterion	0
	2 – Does not meet criterion	0
	3 – Meets the criterion	9
	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 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	Jeffrey Bailet Paul Casale Tim Ferris Elizabeth Mitchell Len Nichols Bruce Steinwald
Recommend proposed payment model to the Secretary for implementation	Grace Terrell
Recommend proposed payment model to the Secretary for implementation as a high priority	Robert Berenson Rhonda Medows Harold Miller Kavita Patel

As a result of the vote, PTAC recommended the *Advanced Primary Care: A Foundational Alternative Payment Model (APC-APM) for Delivering Patient-Centered, Longitudinal, and Coordinated Care* proposal to the Secretary for limited-scale testing.

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. There is an immediate need to support and improve primary care.
2. There must be accountability to patients/taxpayers for preventing stinting on care. EHRs can be employed to ensure additional monitoring does not burden or overregulate clinicians.
3. The proposed model must be treated as a high priority. This means it should be moved forward from limited-scale testing to full implementation as quickly and responsibly as possible. The limited-scale testing must be on a large enough scale to accommodate this goal because access to high-quality primary care is critical to the future of the health care system.
    a. This is the first time PTAC votes have split almost evenly in votes between recommending the model for limited-scale testing and recommending the model for implementation as a high priority. The consensus of the limited-scale recommendation thus indicates a sense of urgency to implement the model.
4. The monthly payment allows for creativity among providers to deliver the care that is needed.
5. Unnecessary complexity in the proposed model includes two separate per member per month (PMPM) payments and approaches to evaluation and management (E&M) codes.
6. Appropriate approaches for risk adjustment or risk stratification should be used, such as stratification or grouping by clinical complexity rather than Hierarchal Condition Category (HCC) adjustment.
7. Improving accountability for both quality and cost in the model, including accounting for total cost of care.
8. Plan for coordination with specialty care providers needed.
9. Patient choice as a method of attribution can be considered.

10. The impact on vulnerable populations should be assessed and monitored to prevent both cherry-picking and stinting.
11. The complexity of model evaluation may be challenging.

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

The public meeting recessed at 12:34 p.m. and reconvened at 1:19 p.m.

Large Urology Group Practice Association (LUGPA): LUGPA APM for Initial Therapy of Newly Diagnosed Patients with Organ-Confined Prostate Cancer

Committee Disclosures
All PTAC members introduced themselves and declared conflicts of interest if appropriate.

Kavita Patel stated she was not involved with the proposal submitted by LUGPA; however, she has had prior professional relationships with individuals who may have aided with drafting the 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 *LUGPA APM for Initial Therapy of Newly Diagnosed Patients with Organ-Confined Prostate Cancer* proposal consisted of Len Nichols (the PRT Lead), Kavita Patel, and Paul Casale.

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 PTAC may reach different conclusions and recommendations than the PRT during the deliberation and voting process.

The PRT lead stated that LUGPA's *APM for Initial Therapy of Newly Diagnosed Patients with Organ-Confined Prostate Cancer* proposal is based on a 12-month active surveillance (AS) episode with possible subsequent episodes, with a $75 management fee per month or PMPM payment. The model encourages patient education about AS. The PRT Lead stated that the majority of the PRT members believed that urologic care is evolving toward increased use of AS as a standard of care, and the proposed model allows for patients with localized prostate cancer, who are not eligible for the Oncology Care Model, to be enrolled in this model.

The PRT concluded that the proposed model met seven out of 10 of the Secretary's criteria. The PRT determined that the proposal did not meet the "Scope," "Integration and Care Coordination," and "Health Information Technology" criteria.

[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 including the following:

- The appropriateness of including the total cost of care as an outcome metric.
- The intermittent nature of urologic services for low risk prostate cancer and the appropriateness of monthly payment as compensation.
- The need for primary care physician involvement as part of low-risk prostate cancer management.
- The applicability of existing chronic care management (CCM) codes and other existing payment tools for AS.
- The differences in care between active intervention and AS, including the need for care coordination, shared decision making, and impact on total cost of care.

Submitter's Statement
The Chair invited the submitter representatives, (Deepak Kapoor, Kathleen Latino, Neal Shore, Pamela Pelizzari, and Dan Muldoon), to make a statement to PTAC.

Following introductions, the submitter representatives stated that the goals of their model are to include patients in the shared decision-making process, to engage a vast number of physicians who are currently excluded from value-based care and alternative payment models, and to reduce the cost of care. The submitter representatives stated that aligning provider incentives would facilitate and expedite the adoption of AS in urologic practices. The submitter representatives pointed out potential misinterpretation regarding the financial features of the proposal. They clarified that the patients expected to be enrolled in the model are not explicitly shown in data, since candidates for the model are not yet receiving care following AS protocols. The estimated savings of $28 million, as noted in the PRT report, does not include the savings for patients not yet enrolled in AS. Thus, the expected program savings could be as much as nine times greater or about $252 million.

Additionally, the submitter representatives stated that the existing CCM codes were not feasible to use since the additional payment cannot be directed towards the services needed to ensure adherence with AS protocols. Furthermore, the submitter representatives emphasized racial disparities in those who receive AS, since African American males and patients with lower socioeconomic status are found to have markedly lower rates of use of AS approaches.

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

- The number of urologists expected to participate in the model.
- The differences in AS versus active intervention, including:
    - The applicability of CCM codes;
    - Determination of optimal treatment approach (AS vs. active intervention); and
    - The costs associated with each treatment approach.
- The potential for telemedicine in communities where access to urologists is limited.
- The potential use of Patient-Reported Outcome Measures (PROMs) as quality metrics in the model.
- The number and demographics of patients eligible for and enrolled in AS.

- The components of continuity of care for patients, including:
    - Different types of providers who compose the care team;
    - Delivery of counseling services; and
    - Ensuring follow-up, for example, monitoring of prostate-specific antigen (PSA).
- Elements of the payment model including:
    - Consideration of other payment models aligned with cost of services;
    - Services covered within the $75 monthly care management fee; and
    - Allocation of shared savings among the care team for urologic practices (larger practices may have radiologic services).

Public Comments

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

1. Anne Hubbard, American Society for Radiation Oncology
2. Thomas Ferrington, Prostate Heath Education Network
3. Wendy Poage, Prostate Conditions Education Council
4. Andrew Saelens, ZERO - The End of Prostate Cancer
5. Stephanie Stinchcomb, American Urological Association

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 the *LUGPA APM for Initial Therapy of Newly Diagnosed Patients with Organ-Confined Prostate Cancer* 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, six PTAC votes constituted a simple majority. The PTAC criterion votes remained anonymous.

PTAC Member Votes on LUGPA APM for Initial Therapy of Newly Diagnosed Patients with Organ-Confined Prostate Cancer

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	0
	2 – Does not meet criteria	2
	3 – Meets the criteria	8
	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 1.		
2. Quality and Cost (High Priority)	* – Not applicable	0

	1 – Does not meet criteria	0
	2 – Does not meet criteria	2
	3 – Meets the criteria	8
	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 2.		
3. Payment Methodology (High Priority)	* – Not applicable	0
	1 – Does not meet criteria	1
	2 – Does not meet criteria	6
	3 – Meets the criteria	4
	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	7
	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 4.		
5. Flexibility	* – Not applicable	0
	1 – Does not meet criteria	0
	2 – Does not meet criteria	0
	3 – Meets the criteria	5
	4 – Meets the criteria	5
	5 – Meets the criteria and deserves priority consideration	1
	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	0
	2 – Does not meet criteria	1
	3 – Meets the criteria	8
	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 6.		
7. Integration and Care Coordination	* – Not applicable	0

	1 – Does not meet criteria	1
	2 – Does not meet criteria	6
	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 7.		
8. Patient Choice	* – Not applicable	0
	1 – Does not meet criteria	0
	2 – Does not meet criteria	1
	3 – Meets the criteria	4
	4 – Meets the criteria	5
	5 – Meets the criteria and deserves priority consideration	1
	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	0
	3 – Meets the criteria	6
	4 – Meets the criteria	5
	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	1
	2 – Does not meet criteria	3
	3 – Meets the criteria	4
	4 – Meets the criteria	2
	5 – Meets the criteria and deserves priority consideration	1
	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 11 PTAC members were present for the proposal deliberation and voting on the *LUGPA APM for Initial Therapy of Newly Diagnosed Patients with Organ-Confined Prostate Cancer* proposal, a total of eight PTAC votes was required for the final PTAC recommendation vote.

PTAC Recommendation Category	PTAC Member Recommendation Vote
Do not recommend proposed payment model to the Secretary	Jeffrey Bailet Robert Berenson Paul Casale Harold Miller Elizabeth Mitchell Len Nichols Bruce Steinwald Grace Terrell
Recommend proposed payment model to the Secretary for limited-scale testing	Tim Ferris Rhonda Medows Kavita Patel
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 did not recommend the *LUGPA APM for Initial Therapy of Newly Diagnosed Patients with Organ-Confined Prostate Cancer* proposal to 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. There are barriers to addressing low rates of active surveillance that could be addressed either through an alternative payment model or changes in the existing fee-for-service system.
2. The importance and need to address racial disparities.
3. Emphasize the need for models to be patient-centered.
4. When multiple specialties are involved in the care of patients in a model, the roles of each specialty and coordination among providers should be detailed in the model.
5. Models proposing to impact and account for total cost of care are a concern.
6. The need for stratification of payments according to clinical need.
7. HHS should continue to consider ways to increase AS for low-risk prostate cancer.

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

Several PTAC members encouraged the submitters to revise and resubmit their proposal.

The public meeting recessed at 4:23 p.m. and reconvened at 4:33 p.m.

Minnesota Birth Center: A Single Bundled Payment for Comprehensive Low-Risk Maternity and Newborn Care Provided by Independent Midwife-Led Birth Center Practices that Are Clinically Integrated with Physician and Hospital Services

Committee Member Disclosures
Harold Miller stated that he has provided pro bono assistance to the Minnesota Birth Center for the past eight years, and has promoted and encouraged the birth bundle concept for the Minnesota Birth Center and related entities. As a result, Mr. Miller stated he would recuse himself from voting on this proposal.

No other PTAC members had disclosures related to this proposal.

PRT Report to the Full PTAC
The PRT for the *A Single Bundled Payment for Comprehensive Low-Risk Maternity and Newborn Care Provided by Independent Midwife-Led Birth Center Practices that Are Clinically Integrated with Physician and Hospital Services* proposal consisted of Rhonda Medows (the PRT Lead), Len Nichols, and Grace Terrell.

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

The PRT Lead described the proposed bundled payment for maternity and newborn care for low-risk pregnancies. She noted that the perinatal episode of care includes services to women during their nine months of pregnancy and eight weeks postpartum, and services to newborns for the first 24 hours of life. Certified nurse midwives would be the leaders in this care, and the model would also have integral physician involvement and subcontracts with hospitals and hospital-based clinicians. Other members of the team could include certified nurse midwives, doulas, patient educators, and lactation specialists. The PRT noted that the payment methodology was not described in detail other than invoking the concept of a bundled payment, but the PRT felt that there was potential for a bundled payment model to improve patient choice, quality, and costs for pregnancy and birth care.

The PRT Lead concluded that the proposed model was not suited for the Medicare program because there are only a small number of births, and a small number of low-risk births in particular, among the Medicare-insured population. The PRT concluded that the proposed model met the "Patient Choice" criterion, but that it did not meet the other nine of the Secretary's 10 criteria. 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 need for clarification of the problem(s) that this model is aiming to solve;
- The small number of Medicare beneficiaries with low-risk pregnancies;
- The extent to which the model has support from relevant practitioners, facilities, and birth centers;
- The extent to which the submitters engaged commercial payers and Medicaid in the proposed model;
- The extent to which the proposed model is within PTAC's purview, given its limited applicability to the Medicare program; and the absence of an approach to payment in the proposed model.

Submitter's Statement
The Chair invited the submitter's representative, Steve Calvin, to make a statement to PTAC.

The submitter's representative stated that the proposal aims to maximize the chance of a healthy birth for both mother and child, while appropriately aligning payment. The submitter's representative explained that the driving factor behind the lack of details on the bundled payment aspect was lack of resources to design a model in detail.

The submitter's representative understood the PRT's comments on the model. The submitter's representative agreed that this model would work better for Medicaid than for Medicare. He stated he knew prior to submission that there were few mothers who gave birth as Medicare beneficiaries, but that he had hoped Medicaid patients would be within PTAC's purview.

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

- PTAC discussed the implications for the future of the proposal if PTAC voted "Not Applicable" versus "Does Not Meet" and allowed the submitter's representative to state his preference. The submitter's representative stated that a committee vote of "Not Applicable" on any criteria would be of greater benefit compared to a vote of "Does Not Meet."
- The potential positive impact of PTAC's engagement with and exposure to the proposal on its uptake by commercial insurers.

The Chair described the formal proposal withdrawal process. The submitter's representative formally asked to withdraw the proposal. The Chair accepted the withdrawal.

The public meeting adjourned at 5:26 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