Physician-Focused Payment Model Technical Advisory Committee
Public Meeting Minutes

September 7, 2017
9:00 a.m. – 5:00 p.m. EDT
Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201

Attendance

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

Jeffrey W. Bailet, MD (PTAC Chair; Executive Vice President of Health Care Quality and Affordability, Blue Shield of California)
Robert Berenson, MD (Institute Fellow, Urban Institute)
Paul N. Casale, MD, MPH (Executive Director, New York Quality Care)
Tim Ferris, MD, MPH (Chairman and CEO, Massachusetts General Physicians Organization)
Rhonda M. Medows, MD (Executive Vice President of Population Health, Providence Health & Services)
Harold D. Miller (President and CEO, Center for Healthcare Quality and Payment Reform)
Elizabeth Mitchell (PTAC Vice Chair; President and CEO, Network for Regional Healthcare Improvement)
Len M. Nichols, PhD (Director, Center for Health Policy Research and Ethics, George Mason University)
Kavita Patel, MD, MSHS (Nonresident Senior Fellow, Brookings Institution)
Bruce Steinwald, MBA (Consultant, Bruce Steinwald Consulting)

PTAC Member Not in Attendance

Grace Terrell, MD, MMM (Founding CEO, Envision Genomics)

Presenters: PTAC Remarks

John R. Graham, MBA (Acting Assistant Secretary for Planning and Evaluation)
John Michael O’Brien, PharmD, MPH (Deputy Assistant Secretary for [Health Policy] Planning and Evaluation)

Submitter’s Representatives: Icahn School of Medicine at Mount Sinai: “HaH-Plus” (Hospital at Home Plus) Provider-Focused Payment Model

Linda V. DeCherrie, MD (Clinical Director, Mount Sinai HaH-Plus Program; Associate Professor of Geriatrics and Palliative Medicine, Mount Sinai Health System)
Bruce Leff, MD (Professor of Medicine, Johns Hopkins University School of Medicine)
Pamela M. Pelizzari, MPH (Senior Healthcare Consultant, Milliman)
Albert L. Siu, MD (Professor and System Chair of Geriatrics and Palliative Medicine, Mount Sinai Health System)

Public Commenters:

Patricia Barrett (Vice President of Product Design and Support, National Committee for Quality Assurance)
Karrie Decker, MHS, OTLR (Home and Transition Services Administrator, Presbyterian Health Services)
Stephanie Glover (Senior Health Policy Analyst, National Partnership for Women and Families)

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Arnold Milstein, MD, MPH (Director, Clinical Excellence Research Center, Stanford University School of Medicine)
Andrew Molosky, MBA, CHPCA (President and COO, UnityPoint at Home)
Marc B. Westle, DO, FACP (Senior Vice President of Innovation, Mission Health System)

Submitter's Representatives: Coalition to Transform Advanced Care (C-TAC): Advanced Care Model (ACM) Service Delivery and Advanced Alternative Payment Model (AAPM)
Gary Bacher, JD (Founding Member of Healthsperien; Co-Director, Smarter Healthcare Coalition; Adjunct Assistant Professor, Georgetown University)
Tom Koutsoumpas (Co-Founder and Co-Chair, C-TAC)
Khue Nguyen, PharmD (COO, C-TAC Innovations)
Brad Smith (Co-Founder and CEO, Aspire Health)
Kristofer Smith, MD (Senior Vice President, Population Health Management, Northwell Health & Medical Director, Northwell Health Solution)

Public Commenters:
Lori Bishop (Chief Advanced Illness Management Program Executive, Sutter Health)
Allison Brennan, MPP (Vice President of Policy, National Association of ACOs)
Gregory Gadbois, MD (Medical Director, Priority Health)
Maria Gatto (Health System Director for Palliative Care, Trinity Health)
Suzanne Johnson, MPH, RN (Vice President, Sharp HospiceCare, Sharp Healthcare)
Randy Krakauer, MD, FACP, FACR (Strategic Advisor, C-TAC)
Brad Stuart, MD (Founder, Advanced Illness Management; CMO, C-TAC; Senior Medical Director, Sutter VNA and Hospice, Sutter Health)

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

This website also includes copies of all presentation slides and a video recording of the meeting.

PTAC Opening Remarks
Dr. John Michael O'Brien, Deputy Assistant Secretary for (Health Policy) Planning and Evaluation (the Deputy Assistant Secretary), welcomed the public to the PTAC meeting and expressed his appreciation to the Committee on behalf of the Secretary of the U.S. Department of Health and Human Services (the Secretary) for all of their contributions and work.

Welcome
Jeffrey Bailet, PTAC Chair, called the meeting to order at 9:07 a.m. The Chair welcomed attendees, commenting that it was PTAC's second public meeting, including deliberations and voting, on proposed physician-focused payment models (PFPMs) submitted by members of the public.

PTAC Updates
The Chair reviewed the Committee's work and provided the following updates:

- The submission of a PTAC letter to the Secretary outlining key lessons learned.
- Revisions made to the PTAC proposal submission instructions to accommodate process changes, which included changes to the proposal review process.

- Revisions made to PTAC bylaws and operating procedures.

The PTAC letter to the Secretary and updated procedural documents are available on the PTAC website: https://aspe.hhs.gov/ptac-physician-focused-payment-model-technical-advisory-committee

The Chair announced that a total of 15 proposals and 31 Letters of Intent (LOIs) had been received (16 remaining LOI submitters have yet to submit a proposal) and that submitters included small and large group practices, as well as various medical associations representing a variety of medical specialties. The Chair also stated that, although the majority of the models proposed included bundled payments, some LOIs and proposals have put forward capitated and other payment approaches.

Deliberations and Voting Procedures

The Chair informed the attendees that deliberations and voting would take place on two proposed PFPMs in the following order:

1. PTAC members will disclose any potential conflicts of interests and threats to impartiality.
2. The designated Preliminary Review Team (PRT) 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 permitted to make a statement to PTAC, if desired.
5. The meeting will be opened up for public comments.
6. PTAC will deliberate and vote on how well the proposed model meets each of the Secretary's criterion.
7. PTAC will deliberate and vote on a final recommendation to the Secretary.
8. PTAC will provide instructions to staff on drafting comments to accompany their recommendation to the Secretary.

The Chair reminded the public that the PRT reports are not binding and do not represent the consensus or positions of PTAC. The Chair further stated that the Committee abides by the Federal Advisory Committee Act (FACA) rules and does not deliberate on any of the proposals, except in public. Therefore, with the exception of the PRT, no discussion about any of the proposals had taken place. As such, PTAC may reach different conclusions and a different recommendation from the one contained in the PRT report. In addition, the Chair stated that the report to the Secretary would include PTAC's public deliberations and decisions.

Icahn School of Medicine at Mount Sinai: "HaH-Plus" (Hospital at Home Plus) Provider-Focused Payment Model

Committee Member Disclosures

Robert Berenson disclosed that he is a Mount Sinai School of Medicine graduate and made past charitable contributions to the institution. He stated that he has no other relationship to Mount Sinai.

Timothy Ferris disclosed that he attended several national and international conferences with proposal submitter, Dr. Al Sui, and that he invited the submitter to make a presentation to clinicians and senior management at Massachusetts General Hospital. He stated that he had no previous involvement in the development of the Mount Sinai School of Medicine proposal.

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

PRT Report to PTAC

The PRT for the HaH-Plus proposal consisted of Harold Miller (PRT Lead), Rhonda Medows, and Len Nichols.

The PRT Lead described the PRT's role in the proposal review process and further summarized the findings from the PRT's review and report to PTAC. He stated that the proposed HaH-Plus model allows Medicare beneficiaries with acute illness or exacerbated chronic disease, who would otherwise require inpatient hospitalization, to receive hospital-level acute care services in the home plus 30 days of transition services (akin to post-acute care) following "discharge" from the acute care phase. The proposal also described two variants of the model called Observation at Home and Palliative Care at Home, both of which the PRT did not consider in the review. The PRT Lead stated that the goal of the HaH-Plus model is to increase quality of care and to reduce costs by reducing complications and readmissions.

The PRT concluded that the proposed model met nine out of 10 of the Secretary's criteria; however, the one criterion that the proposal did not meet was "Patient Safety." The PRT was unanimous on all decisions. Although the PRT noted many strengths of the payment model, they also felt that there were areas where the proposed model needed to be strengthened.

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

Clarifying Questions from PTAC

The Chair opened the floor for PTAC member questions to the PRT and the following issues were discussed:

- Known barriers to the implementation of the model.
- Challenges and opportunities of creating a new system and new provider entity and the feasibility of implementation among small patient populations.
- Financial feasibility of having a diverse multispecialty team available to provide health care services in the home.
- The methodology utilized to calculate and determine cost savings.
- Feasibility of non-hospital entities and those entities unaffiliated with a hospital to incorporate this model successfully due to the resource barriers to entry, including the infrastructure cost.
- Possibility of a multipayer model.
- Variability in the Diagnosis-Related Groups (DRGs), the amount of resources it takes to care for patients, the level of home support that the patient has, and how these could significantly affect the cost and approach to care for patients.
- The rationale behind the identification of the payment amount.
- Clinical conditions proposed for treatment at home provided by the submitter.

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Submitter Statements

The Chair invited the submitters from the Icahn School of Medicine at Mount Sinai, Albert Siu, Linda DeCherrie, Bruce Leff, and Pamela Pelizzari, to make their statement to PTAC.

Following introductions, the submitters discussed the scope of the proposed model, indicating that the model was designed to enable implementation in entities other than Mount Sinai. The submitters stated that the goal is to target patients who are sick enough to be hospitalized, but not so sick that it would not be safe to treat them at home. The submitters emphasized the use of quality metrics to ensure patient care quality under a bundled payment approach and noted that the proposal has a detailed safeguard to ensure that patients are receiving the appropriate care in the appropriate settings.

The submitters also stated that despite the fact that the hospital-at-home care delivery model has existed for many years, it does not neatly fit into a hospital, physician, or home health service category, and so regulatory agencies and payers such as CMS do not know how to deal with it.

PTAC and Submitter Q&A and Discussion

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

- The reasoning behind the currently proposed structure and why a payment structure inside a total population total medical expense (TME) approach was not proposed.
- The need to conduct audits to mitigate overutilization and, specifically, defining the entities that would be conducting such audits to ensure that patients are being enrolled in the model/program appropriately.
- Challenges and opportunities of implementing a prospective bundled payment instead of shared savings.
- Given that the proposed model does not operate under physician services or home care, the shift required in the health care system culture.
- The positive and negative aspects of shared risk.
- Whether any entities outside of an integrated delivery system (such as smaller physician groups) are implementing the proposed model/program.
- The extent to which improved health care outcomes are due to the effects of the care delivery model or the types of patients selected.
- The need to train health care professionals to conduct the initial clinical evaluations.

Public Comments

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

1. Patricia Barrett, National Committee for Quality Assurance
2. Marc B. Westle, Mission Health System
3. Karrie Decker, Presbyterian Health Services
4. Andrew Molosky, UnityPoint at Home
5. Stephanie Glover, National Partnership for Women and Families
6. Arnold Milstein, Clinical Excellence Research Center, Stanford University School of Medicine

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

The meeting recessed at 11:31 a.m. for 15 minutes.

PTAC Criterion Voting
The meeting reconvened at 11:45 a.m. at which time PTAC proceeded with voting on the proposal.

The Chair asked the Committee if there were any comments prior to deliberation and voting. Individual member comments are located in the meeting transcript located at: https://aspe.hhs.gov/meetings-physician-focused-payment-model-technical-advisory-committee. PTAC then proceeded to vote on whether the proposed HaH-Plus model meets each of the Secretary's criterion.

Given that 10 PTAC members were present for the proposal deliberation and voting on September 7, 2017, six PTAC votes constituted a simple majority. PTAC Member votes on how well the proposal meets the Secretary's criteria were made electronically and anonymously. The vote tallies and PTAC decision on each criterion are presented below.

PTAC Member Votes on "HaH-Plus" (Hospital at Home Plus) Provider-Focused Payment Model

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

Criteria Specified by the Secretary (42 CFR§414.146)	PTAC Vote Categories	PTAC Vote Distribution
3. Payment Methodology (High Priority)	1 – Does not meet criterion	0 votes
	2 – Does not meet criterion	1 vote
	3 – Meets the criterion	3 votes
	4 – Meets the criterion	4 votes
	5 – Meets the criterion and deserves priority consideration	1 vote
	6 – Meets the criterion and deserves priority consideration	1 vote
PTAC DECISION: Proposal Meets Criterion 3.		
4. Value over Volume	1 – Does not meet criterion	0 votes
	2 – Does not meet criterion	0 votes
	3 – Meets the criterion	1 vote
	4 – Meets the criterion	8 votes
	5 – Meets the criterion and deserves priority consideration	1 vote
	6 – Meets the criterion and deserves priority consideration	0 votes
PTAC DECISION: Proposal Meets Criterion 4.		
5. Flexibility	1 – Does not meet criterion	0 votes
	2 – Does not meet criterion	0 votes
	3 – Meets the criterion	2 votes
	4 – Meets the criterion	3 votes
	5 – Meets the criterion and deserves priority consideration	5 votes
	6 – Meets the criterion and deserves priority consideration	0 votes
PTAC DECISION: Proposal Meets Criterion 5.		
6. Ability to be Evaluated	1 – Does not meet criterion	0 votes
	2 – Does not meet criterion	0 votes
	3 – Meets the criterion	3 votes
	4 – Meets the criterion	7 votes
	5 – Meets the criterion and deserves priority consideration	0 votes

Criteria Specified by the Secretary (42 CFR§414.146)	PTAC Vote Categories	PTAC Vote Distribution
	6 – Meets the criterion and deserves priority consideration	0 votes
PTAC DECISION: Proposal Meets Criterion 6.		
7. Integration and Care Coordination	1 – Does not meet criterion	0 votes
	2 – Does not meet criterion	0 votes
	3 – Meets the criterion	1 vote
	4 – Meets the criterion	3 votes
	5 – Meets the criterion and deserves priority consideration	5 votes
	6 – Meets the criterion and deserves priority consideration	1 vote
PTAC DECISION: Proposal Meets Criterion 7 and Deserves Priority Consideration.		
8. Patient Choice	1 – Does not meet criterion	0 votes
	2 – Does not meet criterion	0 votes
	3 – Meets the criterion	0 votes
	4 – Meets the criterion	1 vote
	5 – Meets the criterion and deserves priority consideration	7 votes
	6 – Meets the criterion and deserves priority consideration	2 votes
PTAC DECISION: Proposal Meets Criterion 8 and Deserves Priority Consideration.		
9. Patient Safety	1 – Does not meet criterion	0 votes
	2 – Does not meet criterion	0 votes
	3 – Meets the criterion	8 votes
	4 – Meets the criterion	2 votes
	5 – Meets the criterion and deserves priority consideration	0 votes
	6 – Meets the criterion and deserves priority consideration	0 votes
PTAC DECISION: Proposal Meets Criterion 9.		
10. Health Information Technology	1 – Does not meet criterion	0 votes
	2 – Does not meet criterion	0 votes
	3 – Meets the criterion	6 votes

Criteria Specified by the Secretary (42 CFR§414.146)	PTAC Vote Categories	PTAC Vote Distribution
	4 – Meets the criterion	4 votes
	5 – Meets the criterion and deserves priority consideration	0 votes
	6 – Meets the criterion and deserves priority consideration	0 votes
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 HaH-Plus proposal, seven 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	*No PTAC members voted for this recommendation category*
Recommend proposed payment model to the Secretary for limited-scale testing of the proposed payment model	*No PTAC members voted for this recommendation category*
Recommend proposed payment model to the Secretary for implementation	Jeffrey Bailet Robert Berenson Rhonda Medows Kavita Patel
Recommend proposed payment model to the Secretary for implementation as a high priority	Paul Casale Tim Ferris Harold Miller Elizabeth Mitchell Len Nichols Bruce Steinwald

As a result of the vote, PTAC recommended the HaH-Plus payment model to the Secretary for implementation.

Additional PTAC Member Comments on the Proposal
In addition to stating their votes, individual PTAC members made the following comments on the model:

1. The model needs to be tested, but it is important to get the payment model right, and potentially to try different versions, since it is not clear whether rewards should be based on savings on total cost of care or on quality and appropriateness.
2. The feasibility and appropriateness of this model for small organizations with limited capital reserves should be clarified.
3. The testing process should allow for flexibility on the parameters, such as testing a range of models or creating a pathway toward greater risk or prospective bundled payments over time.

4. It might also be possible to conduct some testing of the model more quickly inside ACOs and other advanced APMs.
5. In addition to internal monitoring by the APM entity, there should be external patient safety audits of admission criteria and adverse events (to ensure appropriate patient selection and safety). These audits would ensure the entities are meeting standards for safety for each individual patient, rather than having payers and patients rely solely on the accreditation of the entity to ensure safety.
6. There should be a formal process for staff training and certification to ensure patient safety.
7. Health information systems need to be designed to more easily share information across communities in order to support services such as this.
8. The evaluation of this model should include evaluation of how patients who are hospitalized and the costs of caring for them change as a result of the program.
9. There may be ways to combine this model with other home-based care models that would make such models more feasible in smaller communities.
10. It would be preferable to make quality performance adjustments to the DRG-based payments rather than only adjusting shared savings payments.

Additional PTAC Member Comments for Inclusion in the Report to the Secretary
PTAC staff asked members to clarify points related to criterion 9 [Patient Safety] that they wanted incorporated into the report to the Secretary. In response, PTAC members identified the following:

1. That standardized external monitoring of admissions and of adverse events should be a core component of patient safety;
2. Training needs to be formalized;
3. The appropriate use of accreditation should be explored.

The Committee recessed for lunch at 12:32 p.m. and reconvened at 1:36 pm.

Public Remarks
John R. Graham, Acting Assistant Secretary of Planning and Evaluation in the U.S. Department of Health and Human Services, greeted PTAC and the meeting attendees. The Acting Assistant Secretary of Planning and Evaluation emphasized the Secretary's interest in improving the quality of health care and testing payment models and expressed gratitude to ASPE for providing PTAC with the technical and operational support to conduct their statutory charge. On behalf of the Secretary, he expressed his appreciation for PTAC's work.

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

Committee Member Disclosures
Harold Miller disclosed that he assisted the American Academy of Hospice and Palliative Medicine (AAHPM) in developing an APM for palliative care, similar to the C-TAC proposal and would recuse himself from voting. The Chair communicated PTAC's decision that while Harold Miller would not participate in voting, he would fully participate in deliberations.

Jeffrey Bailet, PTAC Chair, serves as the executive vice president for Health Care Quality and Affordability at Blue Shield of California (BSC). The Chair disclosed that BSC has been a member of C-TAC

for the past four years. However, Blue Shield's membership recently ended and it was not renewed. He also stated that BSC has accepted a request to speak at the C-TAC summit in November and is collaborating with C-TAC on multiple *Blues* workshops on palliative care. The Chair further commented that BSC has a home-based palliative care model on which C-TAC has publicly commented. BSC endorsed the concept of an APM for palliative care in the survey referenced in the C-TAC: ACM Service Delivery and AAPM proposal.

The Chair also stated that he had not been personally involved nor aware of any of these efforts. Given the amount of new information, the Committee voted and unanimously approved the Chair's full participation in deliberations and voting.

No additional PTAC members disclosed any information on potential conflicts of interests, and the Chair announced that all PTAC members would fully participate in deliberation. However, only nine of the 10 members in attendance would participate in voting.

PRT Report to PTAC

The PRT for the ACM Service Delivery and AAPM proposal consisted of Bruce Steinwald PRT Lead, Elizabeth Mitchell, and Paul Casale.

The PRT Lead described the PRT's role in the proposal review process, summarized the PRT's report to PTAC, and provided an overview of the PRT's activities. He announced the receipt of a letter dated August 30, 2017, in which C-TAC responded to the PRT report. Given that the August 30, 2017, response letter presented new information, the PRT indicated that they did not have enough time to thoroughly review the letter. The PRT Lead stated that he would identify instances in which changes (as identified in the letter) were different from the original proposal. However, the PRT presentation would proceed as intended for the original proposal based on the PRT review and recommendation of the proposed model.

The PRT Lead proceeded with an overview of the model, stating that the target population consisted of Medicare beneficiaries in their last 12 months of life. To be eligible, participants had to meet two of the four criteria related to acute care utilization, functional decline, nutritional decline, and performance. Payment would be made to ACM Entities who offer both palliative and curative treatment, including ACOs, hospitals, medical groups, home health agencies, and hospices among others. The payment model is two-pronged, consisting of a $400.00 wage-adjusted per member per month (PMPM) and a shared risk component based on total cost of care in the last 12 months of life.

The PRT determined that the proposed model met eight out of 10 of the Secretary's criteria and met two out of eight of the Secretary's criteria with priority consideration. However, two criteria "Quality and Cost" and "Payment Methodology" did not meet the Secretary's criteria (by majority decision). The PRT Lead stated that the PRT was unanimous on seven decisions. The two criteria that met the Secretary's criteria with priority consideration included "Scope of Proposed PFPM" (by majority decision) and "Integration and Care Coordination" (by unanimous decision).

The PRT recognized the importance of the model and its inclusion of both curative and palliative care. However, the PRT noted their concerns with the shared savings and risk. The PRT appreciated the items addressed in the August 30, 2017 letter from C-TAC in response to the PRT report. However, the PRT felt that the contents in the response letter constituted substantial modifications to the proposal.

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

Clarifying Questions from PTAC

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

- The scope of changes presented in the response letter with regard to the Secretary's criteria.
- The methodology utilized to calculate shared savings.

Submitter Statements

The Chair invited the submitters, Tom Koutsoumpas, Khue Nguyen, Kristofer Smith, Brad Smith, and Gary Bacher to make a statement.

The submitters introduced themselves and discussed how the proposed model intended to deliver care to Medicare beneficiaries suffering from advanced illness by bridging medical and social services and bringing together health plans, health systems, hospice providers, and clinicians to provide better care. To help illustrate how the proposed model bridges these gaps, the submitters discussed the following three core principles: (1) improving quality of care, (2) flexibility, and (3) ensuring fiscal responsibility through aligning incentives.

PTAC and Submitter Q&A and Discussion

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

- The clinical services aspect of the model as compared to hospice.
- The challenges in structuring a financial model tied to end of life.
- The effectiveness of the quality metrics identified and how they prevent any misuse of health care services.
- The importance of patients having independence at home and tying a shared risk payment to the model to incentivize high-quality care.
- The staffing structure and the role of physicians who are not board-certified in palliative care.
- The shared savings calculation method and the entity adjustment factor.
- Annual modifications and improvements to the target pricing and to the risk adjustment.
- Determining which method to use for informing a patient about his/her enrollment in the proposed model/program and the implications of the different options.
- The feasibility of triggering payment based on patient agreement to participate in the program.
- The mechanics, complexities, justification, and communication with patients about the $400 wage-adjusted PMPM.
- Clarity on when the proper patient notification of program enrollment is received and how patients make an informed decision.
- The focus and accompanying challenges of designing a care model and APM for the last 12 months of life and gaining a full understanding of the mechanics and administration of such a program.

In conclusion, the Chair drew PTAC's attention to the substantive changes made to the original model

submitted, noting that these changes are reflected in C-TAC's August 30, 2017 letter to PTAC and the recent Q&A discussion. The Committee considered having C-TAC revise their proposal for resubmission.

Prior to voting on next steps, the Chair recessed the meeting at 4:00 p.m. for a 10-minute break. The meeting reconvened at 4:10 p.m. and proceeded to the public comments.

Public Comments

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

1. Randy Krakauer, C-TAC
2. Gregory Gadbois, Priority Health
3. Allison Brennan, National Association of ACOs
4. Maria Gatto, Trinity Health
5. Suzanne Johnson, Sharp Healthcare
6. Brad Stuart, Sutter Health
7. Lori Bishop, Sutter Health

A transcript of these commenters' remarks is available on the PTAC website at:
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PTAC Deliberation Continued

Given the substantive changes to the original proposal submitted by C-TAC, the Chair proposed that the submitter revise and resubmit their proposal for an expedited PTAC review. PTAC voted and approved the recommendation to revise and resubmit.

The Committee highlighted their major concerns with the proposal and identified the following items PTAC thought should be included in the revised proposal:

- Information detailing C-TAC's experience with private health plans with the proposed model and details on the risk adjustment approach.
- Discussion on how they propose to link the payment model to a clinical model and whether modifications over time are acceptable.
- Further explanation and insight on the national ACM episode price and the methodology for calculating the baseline and the shared savings.
- Information on protections that may be needed to help avoid any misuse of health care services.

The Chair thanked the public and the submitters for their interest and hard work.

The public meeting adjourned at 4:50 p.m. EDT.

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Approved and certified by:

/Ann Page/	3/26/2018
Ann Page, Designated Federal Officer Physician-Focused Payment Model Technical Advisory Committee	Date

/Jeffrey W. Bailet/	3/26/2018
Jeffrey W. Bailet, MD, Chair Physician-Focused Payment Model Technical Advisory Committee	Date