Overview of PTAC Proposal Submission Process

The Physician-Focused Payment Model Technical Advisory Committee (PTAC) was created under the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA). PTAC is comprised of 11 experts with national recognition for their expertise in physician-focused payment models (PFPMs) and related delivery of care. Members are appointed by the Comptroller General of the United States for three-year terms and include both physicians and non-physicians.

PTAC is charged with reviewing PFPM proposals submitted by individuals and stakeholder entities, and providing comments and recommendations to the Secretary of Health and Human Services (the Secretary) regarding whether each proposal meets the criteria for PFPMs established by the Secretary. The Secretary must then review PTAC's comments and recommendations and post a detailed response on the Centers for Medicare and Medicaid Services' (CMS) website. CMS then considers testing the proposed models.

PTAC will periodically ask for public feedback on draft documents, proposals, and/or processes. Members of the public may also publicly comment on proposals at PTAC meetings. Generally, public comment on proposals will be open for three weeks.

Timeline

PTAC finalized its Request for Proposals on November 9, 2016, and began accepting full proposals for PFPMs on December 1, 2016. Submissions will continue to be accepted on an ongoing basis.

Proposals should generally be submitted at least 16 weeks in advance of a PTAC public meeting for the Committee to complete all the steps necessary to formally consider the proposal at that meeting. PTAC intends to hold public meetings no less frequently than quarterly.

List of Current Proposals

- ACS-Brandeis Advanced APM
- COPD and Asthma Monitoring Project
- Project Sonar
- The Comprehensive Colonoscopy Advanced APM for Colorectal Cancer Screening, Diagnosis and Surveillance

More detailed summaries on each proposal below.

ACS-Brandeis Advanced APM

Sponsor: American College of Surgeons (ACS)

Submission Date: December 13, 2016

Comments Due: January 5, 2017; extended to January 12, 2017

Voting Update: April 11, 2017, model recommended for limited-scale testing

Brief Summary:

- *Overview*: Episode-based model that is built on an updated version of the Episode Grouper for Medicare (EGM) software currently used by CMS for measuring resource use
- *Basis for Proposal*: EGM software currently used by CMS, as well as establishing a consortium of professional organizations that have followed and supported development of the augmented software components
- *Description*: Grouper processes claims data using clinical specifications for each episode that have been reviewed by ACS' members and affiliates, including trigger codes and relevant services. Financial risk is attributed to providers based on their individual role in providing care to the patient. The model incorporates a rigorous quality measurement framework and will adjust payments based upon the quality of care delivered, creating a minimum floor for receiving share saving and higher shared saving for those who demonstrate superior quality. Unlike existing CMS models, however, this model does not require a hospitalization, allowing inclusion of procedures performed in the outpatient setting as well as episodes for acute and chronic conditions cared for by medical specialties. Given that this model is built upon existing software that is familiar to CMS, implementation could begin in stages as early as January 2018.
- View the full submission here

COPD and Asthma Monitoring Project (CAMP)

Sponsor: Pulmonary Medicine, Infectious Disease and Critical Care Consultants Medical Group Inc. of Sacramento, California (PMA)

Submission Date: December 6, 2016

Comments Due: January 5, 2017; extended to January 12, 2017

Voting Update: April 11, 2017, model **not** recommended for limited-scale testing

Brief Summary:

- *Overview*: Payment model for the acute and chronic management of high risk Medicare beneficiaries with chronic obstructive pulmonary disease (COPD), asthma, and other chronic lung diseases through remote interactive monitoring, including novel data presentation formats, computerized decision support, and smart alarms
- *Basis for Proposal*: Presents three studies from three different countries offering support that remote management (i.e. telemonitoring) reduces ED visits and hospitalizations for participating COPD patients
- *Description*: Employ smart phone applications ("apps") and operate a continuous and interactive remote monitoring center supported by specially-trained providers who will track member input into the app and engage program participants via voice phone, secure text messaging, email and video conferencing
    - Patients will be provided with daily prompts and tools to monitor their disease state from home, including color-coded alerts, an alarm clock, and a "panic" button; digital flow meters and software; a training period for using these tools; and education courses
    - Patients will then transmit data from the Peak Flow Meter device and perform manual entry of the diary data points via their smartphones or electronic "dongles" that can be used to transmit data via a wall socket
    - Patient's electronic medical record (EMR) will contain a database of interventions taken, with reports transmitted to the patient's primary care provider (PCP) in real-time
    - Monthly, quarterly, and annual reports will be made available to each participant and their PCP, and all individual data will be consolidated for population-based review and reporting
- View the full submission here

Project Sonar (PS)

Sponsor: Illinois Gastroenterology Group (IGG) and SonarMD, LLC

Submission Date: December 21, 2016

Comments Due: January 20, 2017

Voting Update: April 11, 2017, model recommended for limited-scale testing

Brief Summary:

- *Overview*: Intensive Medical Home (IMH) care management program to improve the management of patients with chronic disease, using evidence based medicine coordinated with proactive patient engagement
- *Basis for Proposal*: Deployed in 2013 by IGG, a 50-person physician practice that is the largest single-specialty, non-academic, Gastroenterology practice in Illinois, for use in 50 patients with Crohn's Disease (CD), a chronic condition in the family of Inflammatory Bowel Disease (IBD). IBD disorders are high cost (due to hospitalizations for complications and use of biologic medications) and high risk (loss of intestine, infections, development of cancers and extra-intestinal manifestations) with a frequency that has been increasing in recent decades. CD specifically is also associated with a high variability in outcome and cost. After partnering with Blue Cross Blue Shield of Illinois (BCBSIL), IGG created its first specialty-based IMH. BCBSIL attributed 303 patients with CD to IGG of which 185 were enrolled. The IMH went live on December 1, 2014.
- *Description*: Team-based approach deploying Clinical Decision Support (CDS) tools to guide healthcare professionals on optimal care, appropriate use of anti-tumor necrosis factor (TNF) and other biologic medications, and incorporation of Nurse Care Managers (NCMs) as the focal point in the team to engage with and manage the patient, and to intervene before patients realize they need care
    - Evidence Based Guidelines: direct the course of care. These are embedded into the electronic medical records (EMR) system through use of CDS tools
    - Patient Engagement "Hovering Tools": create a "sonar system" to ping them in their usual environment on a periodic basis
        - All patients are risk assessed using a set of 26 biopsychosocial measures and given a Sonar Score
        - All patients are enrolled in a web-based communication platform; if not web- or smartphone enabled, they are engaged by phone calls from the NCMs; and every patient is proactively 'touched' at least once a month; more frequently as needed
- Clinical and financial data analysis: the care pathway is continually refined through the development of care management algorithms
    - Practice receives one year of historical claims data on attributed patients and quarterly medical and pharmacy claims data going forward
- Payment: practice receives a supplemental per member per month (PMPM) payment to

cover the infrastructure for participating
    - In addition to FFS payment
    - Varies on an annual basis
- *Results of Basis for Proposal*:
    - Net decrease in cost of 9.87% even with an 8.97% increase in infusible biologics and Net of PMPM payments to the practices
    - A 57.14% decline in inpatient costs driven by an equivalent decline in admissions/complications
- View the full submission here

The Comprehensive Colonoscopy Advanced APM for Colorectal Cancer Screening, Diagnosis and Surveillance

Sponsor: Digestive Health Network, Inc.

Submission Date: December 29, 2016

Comments Due: January 25, 2017

Brief Summary:

- *Overview*: Outpatient, prospective, dual-risk episode-based model with retrospective reconciliation for colorectal cancer screening, diagnosis, or surveillance. The episode includes colonoscopy, anesthesia, moderate sedation, pathology, radiology, capsule endoscopy, evaluation and management services, emergency room visit, and facility costs during a 1-year episode framework.
- *Basis for Proposal*: Prevalence, severity, and historical context of colorectal cancer and current screening and surveillance procedures. Variations of the model have been implemented in several states under direct contracts with self-funded employer and Taft-Hartley trusts, with good success.
- *Description*: Outpatient, prospective episode-based model with retrospective reconciliation
    - Financial risk is attributed to teams of providers based on their individual role in providing care to the patient and will adjust payments based on the quality of care delivered
    - Rigorous quality measurement framework
    - One co-pay for the entire episode of care
- View the full submission here