Initial Feedback of the Preliminary Review Team of the Physician-Focused Payment Model Technical Advisory Committee (PTAC) on the "Medical Neighborhood Alternative Payment Model"

February 21, 2019

A. Evaluation of Proposal Against Criteria

Criterion 1. Scope (High Priority Criterion). The proposal aims to either directly address an issue in payment policy that broadens and expands the CMS APM portfolio or include APM Entities whose opportunities to participate in APMs have been limited.

(Rating) PRT Qualitative Rating: Meets Criterion

This model is responsive to the need for a flexible and broad model that encompasses various types of specialists. The submitters have intentionally attempted to design a model that is inclusive of practices with different employment structures, and specialties that engage in various ways with primary care. However, there are critical aspects of the model that have not been sufficiently elucidated in the proposal, such as necessary practice infrastructure, payment methodology, overall clinical program and care coordination design and quality outcomes measurement. More detail on these is needed to enable the PRT to assess the extent to which the model is likely to achieve the broad and important intent of the proposal to engage specialists in value based care delivery.

Criterion 2. Quality and Cost (High Priority Criterion). The proposal is anticipated to (1) improve health care quality at no additional cost, (2) maintain health care quality while decreasing cost, or (3) both improve health care quality and decrease cost.

(Rating) PRT Qualitative Rating: Does Not Meet Criterion

The proposal's requirement that participating practices meet quality standards, such as NCQA's Patient-Centered Specialty Practice designation, encourages specialists to strengthen collaborative efforts to drive higher quality outcomes while lowering costs. The requirement that participating practices attain certain quality thresholds in order to be eligible for the Performance-Based Incentive Payment (PBIP) also illustrates the importance of quality in this proposal. Similarly, cost is clearly important for successful participation in this model, with a focus on what the submitter describes as the "total cost of care as it relates to the specialist."

Nonetheless, the PRT had the following significant concerns, mainly related to the need for more detail on certain aspects of the model.

- Limited detail on actual quality measures that would be used, and how performance on those measures would be used to calculate the PBIP.
- Will the sample size for subspecialty practices or for conditions which might be in lower volume in certain settings be enough to support valid and reliable quality measures for benchmarking?
- Proposed model is unclear as to the process for alerting and assisting participating practices that are underperforming on quality; need more clarity for the process including time lag, etc.
- Approach to benchmarking is unclear, such as what charges are included in the historical benchmarking.

Criterion 3. Payment Methodology (High Priority Criterion). **Pay APM Entities with a payment methodology to achieve the goals of the PFPM Criteria. Addresses in detail through this methodology how Medicare, and other payers if applicable, pay APM Entities, how the payment methodology differs from current payment methodologies, and why the PFPM cannot be tested under current payment methodologies.**

(Rating) PRT Qualitative Rating: Does Not Meet Criterion

The payment model is responsive to the challenge of compensating specialists for engaging in time-consuming care coordination with primary care providers, and potentially averting unnecessary patient visits. In the submitted responses, the proposal discusses the ability of any provider in a variety of specialties and settings to qualify for this PFPM. However, the PRT finds that several aspects of the payment methodology lack important detail, particularly how such a payment methodology is significantly different from a potentially expanded version of the CMS Comprehensive Primary Care Plus (CPC+) initiative (in other words, is this really just CPC+ for specialists?).

- Similarities to CPC+ were highlighted but it is not clear whether a similar payment structure would be employed as well as details around those payments:
  - When would payments be initiated and what would the trigger mechanism be?
  - What is the process for claims adjudication?
  - Is there a potential for recoupment, and if so would this be handled through clawbacks?
  - How would beneficiary copays be handled or waived for certain non face-to-face communications?
- Similarly, the payment model did not sufficiently define when providers are paid, how attribution occurs, and how patients exit the model.

Criterion 4. Value over Volume. **The proposal is anticipated to provide incentives to practitioners to deliver high-quality health care.**

(Rating) PRT Qualitative Rating: Does Not Meet Criterion

The PRT recognizes the intended value proposition of the model and its effort to incentivize better care coordination between primary care providers and specialists, and potentially avert unnecessary specialty care. Nonetheless, while the value intent is clear, it was not as evident that this model would unambiguously reduce volume.

- It seems plausible that some volume-based behaviors, such as specialists who may keep patients under their oversight for longer durations than necessary, would not be mitigated in this model.
- The general lack of detail described in Criterion 3 above, and the limited visibility into the flow of funds and the initiation and termination of model enrollment made it challenging to understand how volume is controlled.
- Furthermore, it is unclear how this model accounts for redistribution in care. For example, there may be scenarios in which one would actually want to see specialist spending increase, which could be disincentivized in the model. Similarly, if specialist spending declines because more care is being shouldered by the primary care physician, that would be a different volume change than a simple reduction in unnecessary specialist care; it is not clear how the model accounts for these two scenarios.

Criterion 5. Flexibility. **Provide the flexibility needed for practitioners to deliver high-quality health care.**

(Rating) PRT Qualitative Rating: Meets Criterion

The PRT appreciates the proposed model's stated emphasis on flexibility and inclusiveness, allowing it to be applicable to practices regardless of size, type, geography, and other characteristics. One caveat is that the extent to which CPC+ forms a foundation for this model may complicate participation in places that are not in current CPC+ geographies.

Criterion 6. Ability to be Evaluated. **Have evaluable goals for quality of care, cost, and any other goals of the PFPM.**

(Rating) PRT Qualitative Rating: Does Not Meet Criterion

The PRT appreciated the submitter's recognition of how the current CPC+ evaluation framework could be applied to the proposed model. Nonetheless, the PRT felt that

insufficient detail was provided as to how the CPC+ evaluation approach would be tailored to the proposed model. Specifically the PRT had the following questions:

- How are practices outside of CPC+ handled in the evaluation?
- What is the minimum volume of eligible patients per practice that merits evaluation? There is mention of 100 patients as a threshold – what is eligibility for being counted toward this cutoff?
- What goals and domains of the evaluation are most important for this model?
- How would this model's evaluation approach respond to the limitations of the CPC+ model evaluation? Concerns about variability in impact in CPC+, for example, and precision in findings may be more pronounced in the proposed model given the likely smaller number of patients and patient-months per practice.

Criterion 7. Integration and Care Coordination. **Encourage greater integration and care coordination among practitioners and across settings where multiple practitioners or settings are relevant to delivering care to the population treated under the PFPM.**

(Rating) PRT Qualitative Rating: Does Not Meet Criterion

The PRT notes the spirit of the medical neighborhood concept and its focus on integration as the basis for this PFPM. However, a number of concerns on this point give the PRT pause:

- How do providers on separate electronic systems or even similar systems which do not communicate facilitate the necessary coordination to jointly participate in the model?
- What are the minimum essential practice requirements for appropriate care coordination?
- The provider interactions could aggregate to a significant time burden, and if requirements for what constitutes a sufficient "e-consult" are not articulated, could create significant variation in how these interactions occur in the model.
- The proposed model potentially positions patients as the role responsible for managing care coordination
- How are staff involved in assisting with the flow of information and coordination across providers and practices?

Criterion 8. Patient Choice. **Encourage greater attention to the health of the population served while also supporting the unique needs and preference of individual patients.**

(Rating) PRT Qualitative Rating: Does Not Meet Criterion

The model's expansiveness allows for tailoring of the primary care-specialty interaction to reflect the specific needs and preferences of individual patients.

Nonetheless, there are potentially "behind-the-scenes" influences of this model that a patient may be unaware of, and which may limit patient choice.

- Patients may not be aware they are being "assigned" for ongoing care to a specialist, which may lead to prolonged care
- Process for disenrollment is unclear
- Potentially may disadvantage patients being referred from non-CPC+ participating primary care practices.

Criterion 9. Patient Safety. How well does the proposal aim to maintain or improve standards of patient safety?

(Rating) PRT Qualitative Rating: Does Not Meet Criterion

Taking the view that safety is appropriateness, this model aims to incentivize better interaction across providers to facilitate appropriateness of care and therefore aspires to improve patient safety. Nonetheless, the PRT is concerned that patient safety may be compromised.

- May incentivize practices to take on patients who have high HCC scores but are not as high-risk or intensive to treat, such as those with less severe conditions or fewer time intensive barriers to care
- What is appropriateness of care for an e-consult? How is appropriateness defined for the monthly oversight that the CCF accounts for?

Criterion 10. Health Information Technology. Encourage use of health information technology to inform care.

(Rating) PRT Qualitative Rating: Does Not Meet Criterion

Health information technology is an essential part of this model, facilitating the interactions and information exchange across providers that is the foundation of the proposed model. However, the PRT is concerned that the health information technology requirements may be too demanding for practices, thereby reducing the flexibility and inclusiveness that were touted as strengths of the proposed model.

- Many of the processes described in the model are often conducted via paper means, and thus could limit participation if practices were required to adopt electronic mechanisms.
- Interoperability challenges are not sufficiently addressed.