

# Physician-Focused Payment Model Technical Advisory Committee

## Preliminary Review Team Report to the Physician-Focused Payment Model Technical Advisory Committee on the *Patient-Centered Asthma Care Payment Proposal*

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Physician-focused payment model (PFPM) proposals submitted to the Physician-Focused Payment Model Technical Advisory Committee (PTAC) in accordance with PTAC’s proposal submission instructions are assigned to a preliminary review team (PRT). Each PRT prepares a report of its findings on the proposal for discussion by the full PTAC. The report is not binding on PTAC; PTAC may reach different conclusions from those contained in the report. Each report and related materials are available on the PTAC section of the Office of the Assistant Secretary for Planning and Evaluation (ASPE) [website](#).

### A. Proposal Information

- 1. Proposal Name:** Patient-Centered Asthma Care Payment (PCACP): An Alternative Payment Model for Patient-Centered Asthma Care
- 2. Submitting Organization or Individual:** American College of Allergy, Asthma & Immunology (ACAAI)
- 3. Submitter’s Abstract:**

“Asthma is a chronic condition common among Medicare beneficiaries.<sup>1</sup> The current model of reimbursement for asthma care delivery does not take into account the additional time or resources physicians must use to properly diagnose and manage their asthma patients. This failure of the current fee-for-service payment model limits opportunities to accurately diagnose and treat and manage complex asthma cases. As a result, patients with asthma and asthma-like symptoms may be misdiagnosed or incorrectly treated, and may experience continued symptoms or side effects of medication that could have been avoided. These inadequately managed asthma

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<sup>1</sup> Wolff JL, Starfield B, Anderson G. Prevalence, Expenditures, and Complications of Multiple Chronic Conditions in the Elderly. *Arch Intern Med.* 2002;162(20):2269–2276. doi:10.1001/archinte.162.20.2269

patients may also be hospitalized or seen in an emergency department for asthma exacerbations that could have been prevented.

The Patient-Centered Asthma Care Payment (PCACP) model is an Alternative Payment Model designed to give physicians specializing in asthma care and primary care providers (PCPs) the resources and flexibility they need to more accurately diagnose, treat and manage patients with asthma and asthma-like symptoms.

The PCACP model would replace current evaluation and management (E/M) payments with a flexible payment<sup>2</sup> designed to enable physicians to deliver a range of services to patients without the restrictions of the current fee-for-service system. In addition, practices willing to do so could accept larger bundled versions of payments, which would include funds to pay for some or all the other services that asthma patients receive. The payment model involves shared risk and is designed to encourage collaboration between the asthma specialist and the patient’s primary care provider; more appropriately compensate physicians for the care they provide to asthma patients; and hold these physicians accountable for improper diagnosis or management of asthma patients. The shared risk/bundled payment model would enable asthma specialists and PCPs to collaboratively treat patients with asthma and asthma-like symptoms and co-manage their asthma problems.”

## B. Summary of the PRT Review

The ACAAI proposal was received by PTAC on May 1, 2019. The PRT conducted its review of the proposal between June 6, 2019, and January 20, 2020. The PRT’s findings are summarized in the table below.

### PRT Rating of Proposal by Secretarial Criteria

Criteria Specified by the Secretary (at 42 CFR§414.1465)	PRT Rating	Unanimous or Majority Conclusion
1. Scope (High Priority)	Does Not Meet Criterion	Unanimous
2. Quality and Cost (High Priority)	Does Not Meet Criterion	Unanimous
3. Payment Methodology (High Priority)	Does Not Meet Criterion	Unanimous
4. Value over Volume	Does Not Meet Criterion	Unanimous
5. Flexibility	Meets Criterion	Unanimous
6. Ability to Be Evaluated	Does Not Meet Criterion	Unanimous
7. Integration and Care Coordination	Does Not Meet Criterion	Unanimous
8. Patient Choice	Meets Criterion	Unanimous
9. Patient Safety	Meets Criterion	Unanimous
10. Health Information Technology	Meets Criterion	Unanimous

<sup>2</sup> Payment varies based on patient category. Physicians would receive monthly payments for Categories 1 and 2, and add-on payments (in addition to E/M) for Category 3.

## C. Information Reviewed by the PRT

### 1. Proposal and Additional Information Provided by the Submitter

The PRT reviewed the PCACP proposal, as well as additional information provided by the submitter in response to written questions.

#### *Proposal Summary*

The ACAAI PCACP proposal intends to give physicians specializing in asthma care (primarily allergists and immunologists) the resources and flexibility they need to better diagnose and manage patients with asthma. The proposal seeks to save costs and improve quality by avoiding unnecessary hospitalizations and emergency department (ED) visits through better diagnosis and management of patients with asthma. The submitter feels that current Medicare payments do not fully support the additional time and services needed for patients with difficult-to-diagnose or difficult-to-treat asthma. The submitter also notes a lack of fee schedule payments for some high-value services to manage and coordinate care and feels that copayments present a barrier to using the interprofessional consultation codes that do exist.

The proposal identifies an Asthma Care Team as the alternative payment model (APM) entity, which would include the asthma specialist, primary care providers, and other providers as needed. The Asthma Care Team could use monthly payments provided by the model to support activities such as phone and email communication between providers and with patients; patient education, particularly regarding medications and adherence; evaluation and modification of patients' living environment to identify asthma triggers; and outreach and monitoring to assess whether the asthma care plan is working. The proposed model would require participating Medicare beneficiaries to commit to receive all asthma-related services from the Asthma Care Team or other providers designated by that team.

To account for the varying levels of care necessary for patients with asthma reflecting stage of treatment, disease severity, and the efficacy of therapies, the proposal would create three categories within the APM tied to the treatment phase of patients:

1. Diagnosis and initial treatment for patients with poorly controlled asthma;
2. Continued care for patients with difficult-to-control asthma; and
3. Continued care for patients with well-controlled asthma.

Beneficiary eligibility and payment amounts differ for each category (see Table 1).

For all phases of the model, patients with the following conditions would be excluded from participating: allergic bronchopulmonary aspergillosis, chronic obstructive pulmonary disease (COPD), other restrictive lung diseases, structural lung diseases, lung cancer, and severe personality disorders. The proposal indicates that diagnosis efforts during the first three months of the model could help confirm whether the patient has

any of these conditions and therefore would be excluded from the APM for subsequent months.

In the first two categories, participating physicians would receive risk-stratified monthly bundled payments that would replace current evaluation and management (E&M) payments. In the third category, participating providers would receive a smaller fixed supplemental payment in addition to existing Medicare Physician Fee Schedule (MPFS) payments. Though the proposal does not specify payment amounts or indicate a process for determining the payment amounts, in response to written questions from the PRT, the submitter estimated payment amounts for each category based on time, resources, and services supported by the APM. The process for risk adjustment is not specified.

**Table 1. PCACP Eligibility and Payment Model Provisions by Treatment Phase Category**

<b>Model Provisions</b>	<b>1. Diagnosis and initial treatment for patients with poorly controlled asthma</b>	<b>2. Continued care for patients with difficult-to-control asthma</b>	<b>3. Continued care for patients with well-controlled asthma</b>
Eligible Patients	<ul style="list-style-type: none"> <li>• New patients who are experiencing asthma-like symptoms and who have not been diagnosed or treated for the symptoms in the past year</li> <li>• Diagnosed asthma patients treated by a different physician practice without successful symptom control</li> <li>• Diagnosed asthma patients who received treatment from a different physician practice that successfully controlled symptoms, but that treatment is not consistent with current guidelines</li> </ul>	<ul style="list-style-type: none"> <li>• Those who do not have well-controlled asthma after completing adequate trials in a stepwise approach to using medications for asthma treatment</li> <li>• Patients using certain types or combinations of medications to achieve good control of asthma symptoms</li> <li>• Patients who have experienced severe asthma-related symptoms or hospitalizations after at least three months of good control</li> <li>• Patients who have well-controlled asthma but significant comorbidities</li> </ul>	Patients with well-controlled asthma who were previously in Categories 1 or 2
Payment Approach	<ul style="list-style-type: none"> <li>• Bundled monthly payments to cover asthma-related clinical services that replaces some Medicare fee-for-service (FFS)</li> <li>• Estimated Per Beneficiary Per Month (PBPM) payment amount: \$299</li> <li>• Bundled payment for allergy skin tests, estimated \$553</li> <li>• Category payment possible for up to three months</li> </ul>	<ul style="list-style-type: none"> <li>• Same as Category 1, with no time limit</li> <li>• Estimated \$247 PBPM</li> </ul>	Payment for non-face-to-face visits and for communication between physicians <ul style="list-style-type: none"> <li>• Supplemental payment in addition to Medicare FFS</li> <li>• Payment amount: estimated \$37 per month on average</li> </ul>
Risk Adjustment	<ul style="list-style-type: none"> <li>• Bundled monthly payment stratified into five levels of risk based on severity of symptoms and patient comorbidities</li> </ul>	Same as Category 1, but with four levels for risk adjustment	None
Services Covered by Payment	Services covered <ul style="list-style-type: none"> <li>• E&amp;M codes for asthma-related services</li> <li>• Select tests (spirometry and inhaled nitrous oxide)</li> </ul>	Same as Category 1	<ul style="list-style-type: none"> <li>• Telephone or email communications in response to patient concerns</li> <li>• Coordinating with other providers about patient's care</li> </ul>
Services Not Covered by Payment	<ul style="list-style-type: none"> <li>• Other asthma-related services, e.g., medications, hospitalizations, ED visits</li> <li>• Pulmonary function tests, exercise challenge tests, chest x-rays, other imaging studies</li> </ul>	Same as Category 1	Not specified in proposal (Medicare FFS approach means anything currently covered by Medicare FFS will continue to be covered by Medicare FFS)

Table 2 shows that under the PCACP model, providers would be held accountable for quality objectives and spending targets through adjustments to the PCACP payments. The performance of participating practices on each category's quality and spending measures would be compared to prior year risk-stratified performance of other practices participating in PCACP. Providers would be required to meet minimum quality standards in order to receive PCACP payments.

**Table 2. PCACP Performance Measures and Payment Adjustments by Treatment Phase Category**

Model Provisions	1. Diagnosis and initial treatment for patients with poorly controlled asthma	2. Continued care for patients with difficult-to-control asthma	3. Continued care for patients with well-controlled asthma
Performance Measures for Care Quality	Percent of patients with: <ul style="list-style-type: none"> <li>improved asthma-like symptoms (self-report)</li> <li>improved spirometry measures</li> <li>reduced ED or urgent care visits for asthma-like symptoms</li> <li>rating access to the physician as very good or excellent (patient survey)</li> </ul>	Percent of patients: <ul style="list-style-type: none"> <li>with improved asthma control</li> <li>with decreased asthma control</li> <li>rating access to the physician as very good or excellent</li> </ul>	Percent of patients: <ul style="list-style-type: none"> <li>with decreased asthma control</li> <li>rating access to the physician as very good or excellent</li> </ul>
Exclusions from Care Quality Performance Measures	Failure to: <ul style="list-style-type: none"> <li>stop smoking</li> <li>obtain prescription medications</li> <li>attend scheduled appointments</li> </ul> Patients without insurance coverage with affordable cost sharing for prescribed medication	Same as Category 1	Same as Category 1
Performance Measures for Service Utilization and Spending	<ul style="list-style-type: none"> <li>Average number of months before a diagnosis was assigned</li> <li>Price-standardized average total per patient spending on allergy testing, asthma-related medications, urgent care visits for asthma-like symptoms, ED visits for asthma-like symptoms, and hospitalizations for conditions potentially related to asthma</li> <li>Performance on utilization and spending assessed relative to other participating teams in the current year</li> </ul>	Price-standardized average total per patient spending as in Category 1	Same as Category 2
Performance Assessment Methodology: Quality and Use	<ul style="list-style-type: none"> <li>Performance on quality assessed relative to other participating teams in the prior year</li> <li>Performance within reasonable variation of the statistical average would be “good;”</li> <li>Performance significantly higher than average would be “high;” and</li> <li>Performance significantly lower than average would be “low.”</li> </ul>	Same as Category 1	Same as Category 1
Adjustment of Payment Based on Performance (Approach to Risk Sharing)	<ul style="list-style-type: none"> <li>Default PCACP payment amounts paid if Asthma Care Team scores “good” on all measures</li> <li>Payment increased if Team scores “high” on some measures and no “lows”</li> <li>Payment reduced if Team scores “low” on some measures</li> <li>Initial adjustment of <math>\pm 5\%</math> of PCACP payment, increasing to <math>\pm 9\%</math> over time</li> </ul>	Same as Category 1	Same as Category 1

The proposal indicates that the standardized average total per patient spending approach (described in Table 2) avoids putting physicians at risk for changes in prices but holds them accountable for utilization. Regarding the amount of risk sharing, the proposal indicates that the maximum payment increases or decreases (for “high” or “low” performance) would initially be  $\pm 5$  percent and then would increase over time to  $\pm 9$  percent.

## **2. Literature Review and Environmental Scan**

ASPE, through its contractor, conducted a targeted environmental scan of peer-reviewed and non-peer-reviewed publications. The review included a formal search of major medical, health services research, and general academic databases; relevant grey literature, such as research reports, white papers, conference proceedings, and government documents; and websites of professional associations/societies and the Centers for Medicare & Medicaid Services (CMS) for relevant evaluation reports and program documentation. Key words guiding the environmental scan and literature review were identified from the proposal. The search may not be comprehensive and was limited to documents that met predetermined parameters, generally including a five-year look-back period, a primary focus on United States-based literature and documents, and relevancy to the proposal.

## **3. Public Comments**

Public comments for this proposal were received from (1) the American Medical Association and (2) the American Academy of Allergy, Asthma & Immunology.

## **4. Other Information**

The PRT sought additional information by communicating with staff in the CMS Office of the Actuary to gain a fuller understanding of the implications of the proposed model for Medicare program spending.

## D. Evaluation of Proposal Against Criteria

### Criterion 1. Scope (High Priority)

*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.*

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#### **PRT Qualitative Rating: Does Not Meet Criterion**

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##### **Strengths:**

- The PCACP addresses a chronic condition with high prevalence and treatment costs in the general population. Prevalence is lower, however, among Medicare beneficiaries, as 7 percent of adults over age 65 have asthma.
- As noted in the proposal, no APM currently exists for allergists/immunologists or pulmonologists or specifically addresses caring for patients with asthma.

##### **Weaknesses:**

- The proposal relies heavily on statistics and evidence of effectiveness pertaining to younger populations, and the validity of extrapolation of these metrics to the Medicare population is not demonstrated.
- The exclusion criteria that apply to all three categories in the model could reduce the potential number of Medicare patients who might participate in PCACP. For example, COPD is a common comorbidity with asthma among older adults; the submitter estimated that 61 percent of Medicare FFS beneficiaries with asthma also have COPD as a chronic condition. The two conditions are often misdiagnosed.
- The proposal does not identify how the Medicare FFS payment system is causing failures in diagnosing and managing Medicare patients with asthma, thereby justifying the need for an APM. The proposal also does not clearly articulate how the existing Medicare FFS payments fail to compensate providers for the types of activities described in the proposal, such as determining appropriate tests.
- It is possible that patients with asthma and their associated providers could participate in existing APMs such as accountable care organizations (ACOs) or Comprehensive Primary Care Plus (CPC+). Such models would enable a broad approach to patient health and directly incorporate allergists, immunologists, or pulmonologists.
- The model does not include innovations in care delivery or approach to improve care for patients with asthma beyond tools already available in Medicare.

##### **Summary of Rating:**

The proposed PFFM does not meet the criterion. Though the prevalence of asthma in the general population is considerable (about 8 percent across all ages), prevalence decreases with age. Further, the number of Medicare beneficiaries with asthma (either newly diagnosed or poorly controlled) who meet the proposed inclusion and exclusion criteria is likely to limit the scope of the proposed model.



## **Criterion 2. Quality and Cost (High Priority)**

*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.*

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### **PRT Qualitative Rating: Does Not Meet Criterion**

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#### **Strengths:**

- The proposal recognizes that care beyond the office setting is an important component of asthma management, and it seeks to facilitate physician engagement in improved management.
- The proposal emphasizes shared decision-making between patients and providers.
- The proposed quality metrics include clinically relevant aspects of asthma control, as well as some measures of patient perspective.

#### **Weaknesses:**

- The proposal does not include sufficient justification for its assumption that the proposed care model would reduce utilization by 50 percent. The proposal likely overestimates the potential savings in the Medicare FFS asthma population by assuming that effects of improved asthma care would mirror utilization, spending, and savings reported for the wider asthma population.
- The proposed model does not contain explicit provisions to address social determinants that are related to asthma control, such as smoking cessation, the patient's environment, or access to services.
- Most of the studies cited in the proposal are observational studies for younger populations that may not appropriately control for the fact that if patients enroll in management programs due to an exacerbation event, their expenditures subsequently decline, regardless of management program effectiveness.
- Medicare beneficiaries diagnosed with asthma who meet eligibility criteria are likely to be dispersed across provider practices, making it difficult for providers to achieve sufficient volume of participating patients to support practice transformation and achieve quality improvements.
- The quality measures could be improved by adding objective measures of quality to complement the subjective measures that are proposed.
- Thresholds for some of the performance measures are not clearly specified (e.g., cut-off for well-controlled versus poorly controlled). Other measures, such as the patient perception of whether they got better, are very subjective.
- The proposed model does not address how care or payment would be coordinated between primary care providers and participating specialists, nor how that relationship might evolve over the course of the model.

### **Summary of Rating:**

The proposed PFPM does not meet the criterion. The proposal does not clearly identify the factors that would lead to improved asthma control among Medicare beneficiaries to a degree that is sufficient to reduce hospitalizations.

### **Criterion 3. Payment Methodology (High Priority)**

*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.*

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#### **PRT Qualitative Rating: Does Not Meet Criterion**

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#### **Strengths:**

- The proposed model recognizes that patient service needs and costs may vary at different stages of disease diagnosis and treatment.
- Providers who are not already participating in an environment or practice with risk-based arrangements may find the proposed PCACP payment approach beneficial.

#### **Weaknesses:**

- The proposed model is overly complex, with multiple tracks assigned by provider assessment within the three main categories. This complexity could make it difficult for providers to participate.
- The proposed methodology for determining payment amounts for the different components, which are described in written response to questions, adds detail and precision to the general approach described in the proposal. However, there is still insufficient justification for the additional payment amounts beyond what the fee schedule already covers. The proposal also does not demonstrate how those payments will lead to reduced ED visits.
- The payment model lacked specificity regarding important elements such as patient liability/copayment for the APM payments.
- Clinically, it is unclear when patients would enter into the model. Providers may be likely to fully work up and diagnose a patient before offering the model to patients. Alternatively, the first category acknowledges that some patients who enter the model may be determined not to have asthma.
- The proposed payment models are based on a monthly actuarial risk model, and the participating provider has discretion to determine which patients are included in the risk model. The provider could enroll eligible patients after the provider knew whether it would be financially beneficial to the provider for them to participate. The model's month-to-month approach is confusing.

- The proposed model specifies a number of exclusions for patients (e.g., COPD), which limits the financial risk providers would bear. Care quality and outcome measure calculations also exclude patients who fail to change behaviors (e.g., failure to stop smoking or obtain prescribed medications). These exclusions would avoid financial penalties (reductions in payments) for providers who are not able to change these behaviors, but they also cover some important aspects of asthma management. The value of an APM could be lessened considerably if the most vulnerable patients are not included in the model or if the payment model incentives do not encourage behavioral change.
- The performance metrics in the model do not encompass some important components. While the proposal states “the model includes shared risk by physicians and holds them accountable for meeting quality and cost measures,” details of risk sharing are not provided. For example, provider payments do not appear to be directly affected if patients have a high rate of ED visits or hospital stays.
- The proposed care model could potentially be implemented more simply through a billing code, so a bundled payment may not be necessary. Recent improvements in the MPFS are intended to support the types of care the PCACP proposal adopts. The proposal dismisses the potential value of new Medicare policies for interprofessional consultations implemented in January 2019 (see footnotes 7 and 20 in the proposal) without providing evidence of the failure of these policies to improve care.
- Although the model proposes an Asthma Care Team, consisting of the asthma specialist, the patient’s primary care physician, and other professionals such as a nurse and asthma educators, the group that receives and distributes portions of the payment to other members of the care team is not identified. The monthly payment could work well in some situations such as an integrated health care system, but mechanisms for distributing the monthly payment across settings are not specified.
- The payment calculations provided by the submitter, in response to questions, include an upward adjustment of 30 percent because of a higher assumed hourly practice cost for delivering the care. Justification for the higher hourly cost is not provided.

**Summary of Rating:**

The proposed PFPM does not meet the criterion. The PRT is concerned that the complexity of the payment methodology could make it difficult for providers to participate. The month-to-month approach for payments could compound unpredictability for providers, especially without a clear method for allocating the monthly payment across members of the Asthma Care Team, and limit provider accountability. Further, key aspects of the payment methodology, including a process for determination of payment amount, are not specified by the submitter.

## Criterion 4. Value over Volume

*The proposal is anticipated to provide incentives to practitioners to deliver high-quality health care.*

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### **PRT Qualitative Rating: Does Not Meet Criterion**

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#### **Strengths:**

- The proposed model provides a monthly bundled payment amount for the first two categories of the model to enable providers to tailor services to patient needs, including provision of some services that are not currently reimbursed.
- The proposed model would avoid the incentive to increase volume of services (e.g., office visits) that exists in Medicare FFS payment.

#### **Weaknesses:**

- Provisions to ensure value over volume are not identified. For example, for the well-controlled group, the proposed payment model has the potential to pay providers generously for patients who would have done well anyway.
- The monthly framework of the PCACP proposal and the ability to enroll patients who will be financially beneficial for the provider reduces accountability for providers.
- The framework of the proposal emphasizes value over volume, but the mechanics of the proposal seem insufficient to drive more value than what is currently available. The proposed model does not clearly address major drivers of ED visits among patients with asthma, such as social determinants of health, in the approach to improving outcomes for patients.

#### **Summary of Rating:**

The proposed PPFM does not meet the criterion. The proposed model intends to reduce volume of avoidable ED visits and hospitalizations through the provision of high-value services. However, the complex mechanics of the proposal may reduce its ability to generate more value than is possible under current payments.

## Criterion 5. Flexibility

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

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### **PRT Qualitative Rating: Meets Criterion**

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#### **Strengths:**

- The proposed payment model would give participating providers additional flexibility to provide a broader range of services that could be beneficial in diagnosing and controlling asthma.

**Weaknesses:**

- It is unclear how the patient's primary care provider and asthma care specialists would work together flexibly for the benefit of the patient. As noted earlier, it is not clear which member of the Asthma Care Team receives the monthly payment, and the process for distributing the payment is not specified.

**Summary of Rating:**

The proposed PFPM meets the criterion. The model's monthly payments would enable providers to implement a variety of activities and practice changes to support asthma care management.

**Criterion 6. Ability to Be Evaluated**

*Have evaluable goals for quality of care, cost, and any other goals of the PFPM.*

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**PRT Qualitative Rating: Does Not Meet Criterion**

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**Strengths:**

- The proposed model recognizes the importance of evaluation and notes the types of data that would be available for model participants.

**Weaknesses:**

- The complexity of the proposed model could make it difficult to evaluate.
- It will be hard to determine whether the proposed model saved money or not. Data for a set of comparison patients are not identified.

**Summary of Rating:**

The proposed PFPM does not meet the criterion. The complexity of the model and the flexibility of the payments would make it difficult to assess whether and how the model achieved objectives.

**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.*

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**PRT Qualitative Rating: Does Not Meet Criterion**

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**Strengths:**

- The proposed model supports the ability of allergists and other participating providers to manage asthma among Medicare beneficiaries.

**Weaknesses:**

- The proposed model does not specify how care would be coordinated between primary care physicians and specialists managing the patient’s asthma, such as when and whether handoffs would occur between providers.
- The proposed model focuses on physician co-management and does not elaborate true care management outside of the office, other than occasional contact by a respiratory therapist. Some of these practices, such as phone calls to coordinate with other providers, are expected under current standards of care.
- The proposal also does not address how care coordination might evolve over the course of the model, such as when a patient moves from a “difficult-to-control” to a “well-controlled” asthma patient.
- In their written responses to PRT questions, the submitter states that the distribution of payments between specialists and primary care providers would vary based on the division of time and work between the two providers in each circumstance. This negotiation between providers in each circumstance would be burdensome for providers in practice and may hinder coordination.

**Summary of Rating:**

The proposed PFPM does not meet the criterion. The proposal lacks specificity about how primary care providers, asthma specialists, and other providers will coordinate care across and outside of physician offices.

**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.*

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**PRT Qualitative Rating: Meets Criterion**

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**Strengths:**

- The proposal notes that the PCACP enhances patient choice by providing an additional care option for patients.

**Weaknesses:**

- The patients would be required to commit to receiving all asthma services from the participating provider, at least within the month within the program, which could limit patient choice.

**Summary of Rating:**

The proposed PFPM meets the criterion because it expands care and treatment options for Medicare patients with asthma.

## Criterion 9. Patient Safety

*How well does the proposal aim to maintain or improve standards of patient safety?*

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**PRT Qualitative Rating: Meets Criterion**

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### Strengths:

- The submitters expect that PCACP would promote early and accurate diagnosis, timely development of care plans, educate patients, and facilitate identification of asthma exacerbations before they can become severe.
- The proposal also notes that the proposed minimum quality standards would protect patients from undertreatment.
- The emphasis on provider-patient conversations and shared decision-making is a strong element of the proposed model.

### Weaknesses:

- None identified.

### Summary of Rating:

The proposed PFPM meets the criterion. The emphasis on shared decision-making between patients and providers is a strength of the proposal. In addition, the potential avoidance of ED visits and hospitalizations would improve patient safety.

## Criterion 10. Health Information Technology

*Encourage use of health information technology to inform care.*

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**PRT Qualitative Rating: Meets Criterion**

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### Strengths:

- The proposal indicates that regular electronic communication between asthma specialists and PCPs will be required.
- The payments in the proposed model could be used to support outreach and remote monitoring through technology to help manage asthma and patient compliance.

### Weaknesses:

- The proposed model does not fully address how health information technology could be shared and used to inform care delivery. The only technology specifically mentioned in the proposed model was certified electronic medical records.

### Summary of Rating:

The proposed PFPM meets the criterion. The proposed model would require regular electronic communication between providers. There is also a potential to incorporate technology to manage asthma and improve patient adherence to medication regimens.

## E. PRT Comments

The PRT commends the submitter on its efforts to improve care for patients with asthma. Asthma is a prevalent chronic disease across all ages, including about 7 percent of adults age 65 and older. Poorly controlled asthma is associated with avoidable hospitalizations and ED visits, as well as higher treatment costs, particularly for asthma medications. There are opportunities to improve care and quality of life for asthma patients, and reduce costs.

However, the PRT believes this proposal has weaknesses both in the clinical care model and in the proposed payment methodology that will limit its ability to achieve the outcomes described by the submitter. The proposed model lacks sufficient scope for implementation as a stand-alone APM. The PCACP would enroll Medicare beneficiaries with asthma, either newly diagnosed or poorly controlled. The number of Medicare beneficiaries newly diagnosed is a subset of all beneficiaries with asthma because many are beneficiaries with asthma are diagnosed at a younger age. The proposed model also excludes a significant share of potential enrollees because of common comorbid conditions such as COPD. The remaining Medicare FFS beneficiaries who meet eligibility criteria are likely to be dispersed across physician practices, potentially making it difficult for providers to achieve sufficient volume and financial incentives to achieve practice transformation. Further, the quality and outcome measures exclude patients with certain behaviors such as failure to stop smoking, which are behaviors that physicians should be working with their patients to address.

With its three separate phases and multiple payment levels within each phase, the proposed model is overly complex. The PRT believes this complexity could make this model difficult for providers to implement and manage. It would also be difficult to assess whether the proposed model achieved desired cost and quality outcomes. The PCACP proposes a complicated approach when it is not clear how the current Medicare fee schedule falls short in supporting the types of care-related activities described in the proposal.

The proposed model also includes the potential for gaming by providers to maximize bundled payments rather than facing a simpler prospective payment. Participating providers have discretion over which beneficiaries are enrolled, making determinations after a visit about who is enrolled and which PCACP category and associated monthly payment amount is most appropriate in a given month. The complexity of the model mentioned above would make it particularly difficult to monitor implementation as a check on these incentives for gaming.

The proposed model also falls short in its proposed approach to care coordination. In practice, both primary care physicians and asthma specialists like allergists and pulmonologists manage patients with asthma. The proposed model does not describe how these providers would work together or share in PCACP payments, nor how these relationships might change over the course of a patient's disease. In addition, the proposed model does not address coordination with other providers who may be involved in treating asthma exacerbations, such as ED physicians or hospital-based providers. The expectation that specialists and primary care providers would negotiate the distribution of PCACP payments in each circumstance is unrealistic, and the time involved could hinder true coordination of care.



Finally, the PRT felt that the proposed model does not address the core factors that are most likely to reduce excess utilization among Medicare beneficiaries with asthma, such as reducing environmental exposures to asthma triggers, smoking cessation, evaluation of the need for social supports, and ongoing patient education to improve health literacy. As a result, the proposed model is unlikely to affect spending and may not truly improve care and outcomes for Medicare beneficiaries with asthma. There may be alternative opportunities to modify existing APMs to incorporate relevant asthma-specific measures to focus more on the needs of this subpopulation. For example, in a well-functioning ACO, asthma specialists could be held accountable for the cost and quality of the care they deliver.