

# Physician-Focused Payment Model Technical Advisory Committee

Preliminary Review Team Findings on

## The Comprehensive Care Physician Payment Model (CCP-PM)

Submitted by The University of Chicago Medicine

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# Presentation Overview

- Preliminary Review Team (PRT) Composition and Role
- Proposal Overview
- Summary of the PRT Review
- Key Issues Identified by the PRT
- PRT Evaluation Using the Secretary's Criteria

# Preliminary Review Team Composition and Role

- The PTAC Chair/Vice Chair assigns two to three PTAC members, including at least one physician, to each complete proposal to serve as the PRT. One PRT member is tapped to serve as the Lead Reviewer.
- The PRT identifies additional information needed from the submitter and determines to what extent any additional resources and/or analyses are needed for the review. ASPE staff and contractors support the PRT in obtaining these additional materials.
- The PRT determines, at its discretion, whether to provide initial feedback on a proposal.
- After reviewing the proposal, additional materials gathered, and public comments received, the PRT prepares a report of its findings to the full PTAC. The report is posted to the PTAC website at least three weeks prior to public deliberation by the full Committee.
- The PRT report is not binding on PTAC; PTAC may reach different conclusions from those contained in the PRT report.

# Proposal Overview

**Background** – The proposal is based on a Hospital-Setting Health Care Innovation Award (HCIA) demonstration project. There is a small subset of complex chronically ill, frequently hospitalized individuals for whom having the increased continuity of care associated with a small group of dedicated providers who sees the patient as both an inpatient and outpatient may both improve care and lower costs.

**Goals** – The CCP-PM seeks to improve care for patients at increased risk of hospitalization by providing these patients with a physician who cares for them in both the ambulatory clinic and hospital settings.

**APM Entity** – A physician or physician practice would serve as the APM entity.

- Participating physicians will be general internal medicine physicians, hospitalists or family practitioners. Some physicians from other specialties (e.g., gynecology) might be appropriate candidates in some instances.

## **Core Elements of the Program:**

1. Eligible physicians enroll a panel of CCP-PM patients and provide an increased proportion of inpatient and outpatient general medical care.
2. Eligible patients join the program by enrolling in the CCP-PM panel of a participating physician, thereby indicating their desire to have the same physician care for them in both the inpatient and outpatient setting.
3. Participating physicians receive a payment per enrolled patient per month payable annually dependent upon meeting predetermined benchmarks for the percent provision of inpatient and outpatient general care.
4. Failure to meet predetermined benchmarks for the percent provision of inpatient and outpatient general medicine care results in a financial penalty.

# Proposal Overview – Continued

**Payment** – The CCP-PM provides a care continuity fee for participating physicians who meet benchmarks for providing their patients with both inpatient and outpatient care.

- Participating clinicians who do not meet these targets are subject to a penalty.
- Payments or penalties are independent of those received under other programs (e.g., MIPS, MSSP, other APM)
- Patients must have been hospitalized at least once in the past year to be eligible for the program.
- Submitter proposes that CCP-PM panels are capped at 300 patients per physician.

## Care Continuity Fees

- \$40 per new or renewed patient per month;
- \$10 per continued enrolled patient per month;
- Payable at the end of each year if APM Entity meets both fee criteria.

## Penalty Fines

- \$10 per patient per month, payable at the end of each year if either penalty criterion occurs.

## Care Continuity Fee Criteria (Both must be met)

1. The percent provision of inpatient care for their panel of enrolled patients exceeds 50%; and
2. The provision of outpatient general medical care for their panel of enrolled patients exceeds 67%.

## Penalty Criteria (Fines apply if either is met)

1. The percent provision of inpatient care for their panel of enrolled patients falls below 25%; or
2. The percent provision of outpatient general medical care for their panel of enrolled patients falls below 33%.

# Summary of the PRT Review

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

# Key Issues Identified by the PRT

- The distinction between inpatient and outpatient care is blurred for highly complex and frail patients. The clinical needs of this population of patients are not addressed well under current payment models.
- The CCP-PM represents the culmination of considerable work to improve patient care by a group of dedicated clinicians. The clinical workflows that were developed, particularly those that allow inpatient hospitalists to follow patients into the outpatient clinic setting and vice versa, are highly customized. This customization is a strength but also poses challenges for broader replication.
- The proposal focuses on creating a viable payment model that provides sufficient assurance that high-quality clinical care will be replicated simply by implementing the suggested payment model. However, the financial model alone might not necessarily lead to the exemplary clinical model developed by the submitters. The proposal lacked sufficient methods for assuring improved patient outcomes particularly in environments where clinical services are less integrated.
- The PRT found it difficult to determine whether the financial model would be applicable more broadly.
  - Are the workflows and career paths included in the clinical model likely to be adopted?
  - Would other approaches be more effective in addressing this important set of clinical challenges?

# Key Issues Identified by the PRT– *Continued*

- The utilization and cost outcomes presented in the proposal (reduced hospitalization and spending) are not consistent with the HCIA evaluation. The HCIA evaluation found no significant change in emergency department visits, hospital admissions or cost. The proposal provided updated findings which were embargoed at the time of review, but additional issues such as feasibility of enrollment/recruitment were also raised in the evaluation.
- Payments under the model are intended to be supplementary to other APMs, but it seems providers participating in other APMs could implement aspects of the CCP independently without additional payments.
- While attempting to fill an important gap in clinical care, this proposal raises some important issues.
  - Since the CCP could be viewed as an attempt to mitigate the discontinuities that developed when primary care physicians stopped following their hospitalized patients (and vice-versa), the clinical model could be viewed as simply delaying an inevitable transition back to the patients’ long-standing primary care clinician for a small at-risk population.
  - It seems important to better understand if and how the potential advantages of this model justify a change back to an approach (having the same physician for both inpatient and outpatient care ) that used to be more common prior to the advent of hospitalists and hospital-based medical practices.
- Participating clinicians and patients have been supportive. The success and enthusiasm of the submitter as well as of other hospitalists (including a clinical expert outside of the system) mean that the model has benefits, at least in selected settings.

# Criterion 1. Scope (High Priority)

## Criterion Description

Aim 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.

## PRT Conclusion

Does not Meet Criterion

## Unanimous or Majority Conclusion

Majority

- The current system does not necessarily reward providers across settings for lowering the cost for Medicare patients. Hospital-based ACOs might have direct incentives but alternative payment models in settings which are not integrated might not provide broader payment incentives across a spectrum of care.
- The model provides room to innovate because it does not have many structural requirements.
- Existing programs through CMS and CMMI, such as accountable care organizations (ACOs) and Bundled Payment for Care Improvement (BPCI), could enable physicians to establish similar processes for bridging care between inpatient and ambulatory settings.
- The feasibility of the CCP-PM both within and beyond academic settings may be limited.
- Hospitals or community practices that initiate a program may still need to overcome potential barriers for patient enrollment. Some community-based physicians will not want to relinquish patients to CCP-PM. While the CCP-PM is appropriately targeted to high-risk patients and has provisions against enrolling low risk patients, high-risk patients may have established relationships with physicians that they do not want to drop.

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

### Criterion Description

Are anticipated to improve health care quality at no additional cost, maintain health care quality while decreasing cost, or both improve health care quality and decrease cost.

### PRT Conclusion

Does Not Meet Criterion

### Unanimous or Majority Conclusion

Unanimous

- The proposal provides unpublished estimates (\$3,000 in savings per patient per year) that are different from the HCIA final evaluation.
  - The HCIA evaluation of the randomized controlled trial found no significant change in total spending, emergency department visits or hospital admissions.
  - Differences between the proposal and the HCIA evaluation could be due to slow patient recruitment for the trial.
- Quality measures for tracking or comparison to peers are not proposed other than thresholds for the percentage of inpatient and outpatient care provided by participating physicians. The desired flexibility around quality metrics must be balanced with the need for further accountability beyond proportions of time spent.
- The patient empanelment is not well defined, so there is a risk of patient selection and subsequent unintended consequences.

# Criterion 3. Payment Methodology (High Priority)

## Criterion Description

Pay APM Entities with a payment methodology designed 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.

## PRT Conclusion

Does Not Meet Criterion

## Unanimous or Majority Conclusion

Unanimous

- The proposal lays out a clear payment mechanism, and it is easy to estimate what projected spending might be based on past admission patterns, etc.
- The payment mechanism, which may be either a stand-alone payment (e.g., to a practice) or as a supplement in existing models such as ACOs, could work well in certain settings such as hospital systems, academic medical centers, or ACOs.
- The current payment methodology for ACOs already includes incentives to better coordinate care across settings. Therefore, the CCP-PM might simply end up increasing payments to hospital-based ACOs for something that they are already supposed to be doing.
- The payment model lacks financial risk, which results in a weak linkage between payment methodology and intended outcomes (reduced total expenditures and improved health outcomes for the patient).
- CMS may not currently have mechanisms for making the payments as specified in the proposal. Physicians affiliated with institutions have different financial arrangements than other physicians who are not similarly employed or affiliated, including independent practices.
- In total, the model may improve quality but may not have sufficient mechanisms to reproducibly result in measurable reductions in spending.

# Criterion 4. Value over Volume

## Criterion Description

Provide incentives to practitioners to deliver high-quality health care.

## PRT Conclusion

Meets Criterion

## Unanimous or Majority Conclusion

Majority

- Under the proposed model, the payment is largely dependent on meeting threshold criteria but does not pose any significant financial consequences for providers who fail to fulfill the important clinical model.
- Both the HCIA evaluation and the proposal report high levels of patient satisfaction, but the utilization and cost outcomes differ in the two sources.
- The presence of CCP-PM may not be sufficient to drive behavior change to attain value over volume in other settings. Community-based office settings might have barriers or lack enthusiasm for the scheduling and logistical changes needed to attain the value-based care envisioned under CCP-PM.
- Selection of patients in other settings might be different from the patients enrolled in the University of Chicago's HCIA award. Patient enrollment under the HCIA award proceeded slowly, and the extra efforts to recruit patients might mean that the patients enrolled in an ongoing program could be different (though the value over volume could improve or decline).

# Criterion 5. Flexibility

## Criterion Description

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

## PRT Conclusion

Meets Criterion

## Unanimous or Majority Conclusion

Unanimous

- The CCP-PM appears to be flexible for many types of practitioners, including specialists.
- The flexibility in arrangements and limited number of specific requirements means that providers can tailor care to patients as they deem most appropriate without trying to implement a single one-size-fits-all care model.
- However, no evidence is available indicating that specialists would be willing to participate as a CCP-PM provider. The experience to date does not include an independent community-based provider who has tried to implement a model like CCP without a willing hospital partner. Additionally, as noted by outside clinical expertise, there may be challenges in recruiting hospitalists who are interested/willing to see patients in clinic settings. Hospitalists have little training in primary care.
- In total, the CCP-PM offers options for numerous types of practitioners, from primary care to specialty care. By allowing for practitioners to move between inpatient and outpatient settings, there is significant potential for high-value care, particularly patient-centered care.

# Criterion 6. Ability to be Evaluated

## Criterion Description

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

## PRT Conclusion

Meets Criterion

## Unanimous or Majority Conclusion

Unanimous

- The randomized controlled trial for the HCIA evaluation already provided a strong design and important lessons, including some of the challenges of patient enrollment. Qualitative analysis also provided important insights.
- Patient costs and the penalty criteria can be measured for evaluation.
- The proposal suggests some novel evaluation mechanisms (e.g., changes to billing volumes, qualitative practice structures, etc.) that are potentially applicable to other CMMI programs.
- The lack of definition of measures for some components means their evaluation is not clearly defined. Lack of objective criteria for empanelment is particularly problematic for any comparative evaluation.
- Although the proposal advocates for wider testing in other sites, trends such as increased Medicare Advantage enrollment could complicate such evaluation.
- The PRT would like to have better understood why the unpublished results in the proposal differ from the HCIA evaluation results.

# Criterion 7. Integration and Care Coordination

## Criterion Description

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.

## PRT Conclusion

Does Not Meet Criterion

## Unanimous or Majority Conclusion

Majority

- This model addresses the issue of care coordination during the peri-hospitalization period by having the same clinician manage the patient's care in both inpatient and outpatient settings.
- The CCP-PM could work particularly well in an integrated system that facilitates having the same physician for inpatient and ambulatory care.
- The proposal did not provide a clear understanding of the role of and interactions with specialists other than the expectation for coordination with specialists, which was noted in subsequent communication with the submitter.
- The model lacks a mechanism for making sure the patient is getting the right care (e.g., that certain conditions that would be monitored in a primary care setting are followed).
- Some ACO metrics that would be useful for assessing integration and care coordinate are not incorporated, which could be problematic for a stand-alone primary care practice, even if working in conjunction with a hospital.
- The model seems to return to an approach used previously (i.e., a community doctor follows patient into hospital) that became problematic for care when an office-based physician spent less time inside the hospital. Furthermore, the model may only be delaying an inevitable handoff for a patient who is no longer at risk for hospitalization.

# Criterion 8. Patient Choice

## Criterion Description

Encourage greater attention to the health of the population served while also supporting the unique needs and preferences of individual patients.

## PRT Conclusion

Meets Criterion

## Unanimous or Majority Conclusion

Majority

- By concentrating on an important gap in clinical care, the proposed model reflects an opportunity to close such gaps and offer patient-centered care.
- Qualitative findings from the HCIA award reinforce the high degree of patient satisfaction and enthusiasm for the proposed model.
- A situation of prospective enrollment in the CCP-PM would enable choice and be preferred.
- Efficient ways to ensure sufficient and appropriate patient empanelment are not known. It may be important to address any barriers to empanelment (limited language proficiency, health literacy, etc.) to ensure that patients understand that a single provider or provider group will see them.
- Since the penalty payment pertains to the average experience for a potentially large group of patients, the model does not have a patient-specific mechanism to discourage enrollment of relatively low-risk patients.
- The proposal does not seem to include sufficient mechanisms to avoid unintended consequences such as perverse gaming (e.g., hospitalization of a patient to be able to re-enroll the patient with a higher payment).

# Criterion 9. Patient Safety

## Criterion Description

Aim to maintain or improve standards of patient safety.

## PRT Conclusion

Meets Criterion

## Unanimous or Majority Conclusion

Unanimous

- Patient safety can be increased by consolidating a patient's care under a single physician or group of physicians during transitions following hospital discharge.
- Patient safety is particularly likely to be improved for hospitalized beneficiaries who do not already have strong relationships with a primary care provider, as follow-up care after discharge is likely to be improved.
- The lack of monitoring of specific outcomes means that the model's effect on patient safety may not be known.
- Concerns about patient safety may be particularly pertinent for standard aspects of primary care involving prevention or monitoring of other disease conditions beyond the particular disease that caused a hospitalization that triggered enrollment in the CCP-PM.
- Unintended consequences or potentially perverse incentives to rehospitalize patients may threaten to reduce rather than improve patient safety.

# Criterion 10. Health Information Technology

## Criterion Description

Encourage use of health information technology to inform care.

## PRT Conclusion

Meets Criterion

## Unanimous or Majority Conclusion

Unanimous

- Large integrated systems including academic medical centers are likely to have health information technology that will facilitate model implementation and provision of high-quality and high-value care.
- Such systems will also be able to capitalize on emerging technologies (e.g., telehealth) to support better innovation of coordination of care processes within models like CCP.
- Lack of similar health information technologies for providers outside of integrated systems or academic medical centers could compromise communication and coordination of care.
- Many patients and providers, especially in some geographic areas, currently experience frustration when attempting to transfer information across different providers due to the lack of interoperability and limitation of some health exchange efforts.