

Physician-Focused Payment Model Technical Advisory Committee

Preliminary Review Team Report to the Physician-Focused Payment Model Technical Advisory Committee (PTAC)

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In accordance with the Physician-Focused Payment Model Technical Advisory Committee's (PTAC's) *Processes for Reviewing and Evaluating Proposed Physician-Focused Payment Models and Making Recommendations to the Secretary of the Department of Health and Human Services*, proposals for Physician-Focused Payment Models (PFPMs) that contain the information requested by PTAC's Request for Proposals will be assigned to a Preliminary Review Team (PRT). The PRT will draft a report containing findings regarding the proposal for discussion by the full PTAC. This PRT report is preparatory work for the full PTAC and is not binding on the PTAC. This report is provided by the PRT to the full Committee for the proposal identified below.

A. Proposal Information

1. **Proposal Name:** American College of Surgeons–Brandeis Advanced Alternative Payment Model
2. **Submitting Organization or Individual:** American College of Surgeons
3. **Submitter's Abstract:**

“The ACS-Brandeis Advanced Alternative Payment Model (A-APM) is a new approach to physician-focused payment for Medicare and other payers. This model is designed to make sense to clinicians. It provides for specific and meaningful clinical contexts (episodes) that are needed to make inferences about quality and cost. Clinicians' involvement in care for each patient is identified and acknowledged in a structure of shared accountability for quality and cost outcomes. This level of precision is applied to a large majority of Medicare spending, which means that most clinicians in most specialties could practice as Qualified Participants (QPs) in an advanced APM environment.

The core model is focused on procedure episodes, but can easily be expanded to include acute and chronic conditions. QPs nested within an APM entity will go at risk for a set of episodes that represents the core of the care they provide. Each instance of a covered episode will be assigned an expected cost that reflects both a pre-determined standard

cost and the patient’s own risk factors. The difference between the observed and expected cost will represent the net saving/loss for that episode. During the risk period, responsibility for any savings or loss will be attributed to each participating QP based on the episodes he or she is involved in and on his or her specific role in that care (e.g., episodic provider). These QP based allocations are aggregated at the APM entity level. Cost reconciliation then involves integrating quality and resource use to come up with a net savings or loss for the entity.

Building on the episode framework, the ACS-Brandeis A-APM proposes a tiered quality model that creates a minimum floor for receiving shared saving and higher shared saving for those who demonstrate superior quality. Measure selection is key and will involve the medical specialties and other stakeholders to ensure clinical veracity to providers and beneficiaries. The A-APM is flexible and can fit with multiple reconciliation methods currently in use by CMS.”

B. Summary of the PRT Review

| Criteria Specified by the Secretary (at 42 CFR §414.1465) | PRT Conclusion | Unanimous or Majority Conclusion |
|---|-------------------------|----------------------------------|
| 1. Scope of Proposed PFPM (High Priority) | Meets criterion | Unanimous |
| 2. Quality and Cost (High Priority) | Does not meet criterion | Unanimous |
| 3. Payment Methodology (High Priority) | Meets criterion | Unanimous |
| 4. Value over Volume | Does not meet criterion | Unanimous |
| 5. Flexibility | Meets criterion | Unanimous |
| 6. Ability to be Evaluated | Meets criterion | Unanimous |
| 7. Integration and Care Coordination | Meets criterion | Unanimous |
| 8. Patient Choice | Meets criterion | Unanimous |
| 9. Patient Safety | Meets criterion | Unanimous |
| 10. Health Information Technology | Meets criterion | Unanimous |
| <p>PRT Recommendation (check one):</p> <p><input checked="" type="checkbox"/> Do not recommend proposed payment model to the Secretary;</p> <p><input type="checkbox"/> Recommend proposed payment model to the Secretary for:</p> <ul style="list-style-type: none"> <input type="checkbox"/> limited-scale testing of the proposed payment model; <input type="checkbox"/> Implementation of the proposed payment model; or <input type="checkbox"/> Implementation of the proposed payment model as a high priority. | | |

C. Information Reviewed by the PRT

1. Proposal (Proposal available at [PTAC website](#))

Proposal Overview: The proposed model identified more than one hundred candidate procedures and conditions (payment episodes) as the potential focus of the model. These procedures and conditions were diverse; including but not limited to: upper respiratory infection; appendectomy; colonoscopy; cataract surgery; acute simple, benign fibrocystic / dysplastic breast disease; other/not otherwise specified juvenile idiopathic arthritis; lung resection; coronary artery bypass grafting; open heart valve surgery; liver transplant; heart failure; and breast neoplasm (malignant). The American College of Surgeons (ACS) clarified that more than 50 of these procedure episodes are ready for implementation in 2018. These procedure (payment) episodes are defined by an updated version of an episode grouper developed for the Centers for Medicare & Medicaid Services (CMS) by Brandeis.

In the model, an organizational entity (which could consist of “single-specialty practices, multispecialty practices or convenor groups of small provider practices with or without ties to particular facilities... as long as the entity is able to perform its management and fiduciary responsibilities.”) would enter into a risk-based contract with CMS for the quality and cost of its contributions to a set of procedure or condition episodes defined in the contract. The contract would involve Medicare payments for every instance of the procedure or condition episodes defined in the contract during a performance period for which the entity’s affiliated QPs provide a service paid for by Medicare. Each entity participating in the model with CMS will identify its affiliated QPs who will participate under business agreements.

Improvements in care quality and efficiency would be brought about by financial incentives and Clinical Affinity Groups. Clinical Affinity Groups are sets of clinicians who regularly participate together in episodes of a given type. Their decisions and services are intended to influence the way in which patients are treated for a type of episode. Physicians would choose to participate by contracting with the APM entity. If they did so, they would continue to have their services paid through the Medicare Physician Fee Schedule, but they would be at financial risk based on their attributed role in providing care for the procedure/condition episodes defined in the entity’s contract with CMS. Attributed roles would be determined by clinical algorithms that retrospectively identify all clinicians who participated in the care of a patient for each type of episode and then infer each clinician’s role. Incentive payments would be made retrospectively based on the difference between the observed and expected spending for the episode. Each clinical role would be assigned a fixed proportion of the savings or loss amount. Savings or losses would be attributed to each participating QP based on the episodes he/she is involved in and on his/her specific role in that care. The APM entity will receive a share in these gains or losses based on the contract with CMS. The proposal states that “Several specific methods for determining the share may be considered.” In the case of

savings, the shared savings component of the payment would be paid to the APM entity. According to the proposal, “The APM entity would engage in gainsharing with affiliated QPs as agreed upon in their business agreements with the participant, and guided at its discretion by the team-based fiscal attribution framework.” If spending exceeded the expected amount, the difference would be paid to CMS by the entity. The entity would need to find a source of funds to make these payments, and the proposal indicates that “participating providers may also be required to contribute” and “to protect against catastrophic losses, the model will build in stop loss provisions.”

PRT Review: The ACS proposal was received by PTAC on December 13, 2016. The PRT met several times between December 22, 2016 and March 6, 2017. Two sets of questions were sent to the ACS and ACS’ responses were reviewed as adjunct information. In addition, the PRT had a telephone discussion with ACS. The ACS proposal received six letters of public support and six additional comment letters raising substantive questions which were reviewed. The PRT’s questions to ACS, ACS’ responses, a transcript of the PRT’s telephone discussion with ACS and all letters received from the public are available at [PTAC website](#) .

2. Data Analyses

This proposal does not address just one or a narrow range of clinical conditions; rather it is intended to address any of more than a hundred conditions provided for in the proposal. The proposed model also is asserted to be expandable to a larger number of conditions. As a result, the PRT did not ask for any additional data analysis to inform its evaluation of the proposal. The PRT did meet with staff from CMS to increase the PRT’s understanding of the Episode Grouper for Medicare (EGM) developed by ACS and Brandeis, as the strength of the proposal greatly depends upon CMS’ on-going use of this technology.

3. Literature Review and Environmental Scan

The submitter cited relevant literature in the proposal. The Office of the Assistant Secretary for Planning and Evaluation (ASPE), through its contractor, also conducted an abbreviated environmental scan that included a review of peer-reviewed literature as well as a search for relevant grey literature, such as research reports, white papers, conference proceedings, and government documents (results of the scan are located at [PTAC website](#)).

Documents comprising the environmental scan were primarily identified using Google and Pubmed search engines. Key words guiding the environmental scan and literature review were directly identified from ACS’ Letter of Intent (LOI). The key word and combination of key words were utilized to identify documents and material regarding the submitting organization, the proposed model in the LOI, features of the proposed model in the LOI or subject matter identified in the LOI. Key terms used included “American College of Surgeons”, “ACS”, “episode grouper for Medicare”, “EGM”,

“episode-based payment”, and “surgical.” This search produced eight documents from the grey literature and thirteen peer-reviewed articles. These documents are not intended to be comprehensive and are limited to documents that meet predetermined research parameters including a five-year look back period, a primary focus on U.S. based literature and documents, and relevancy to the LOI.

None of the documents identified through this search provided information that was sufficiently specific to the proposal to significantly affect the PRT’s evaluations of whether the proposal met the criteria for a PFPM.

D. Evaluation of Proposal Against Criteria

Criterion 1. Scope of Proposed PFPM (High Priority Criterion). The proposal aims to broaden or expand the CMS APM portfolio by either: (1) addressing an issue in payment policy in a new way, or (2) including APM Entities whose opportunities to participate in APMs have been limited.

The goal of this section of the proposal is to explain the scope of the PFPM by providing PTAC with a sense of the overall potential impact of the proposed model on physicians or other eligible professionals and beneficiary participation. Proposals should describe the scope and span of the payment model and discuss practice-level feasibility of implementing this model as well as clinical and financial risks.

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| PRT Qualitative Rating: | Meets Criterion |
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The PRT members concluded that the proposal meets the criterion because the model aims to provide a broad-scope Medicare payment approach whereby multiple types of clinicians currently not able to participate in APMs could do so through a mechanism that identifies episodes of care for both procedures and chronic conditions and for which teams of clinicians could jointly be held responsible for the cost and quality of care provided.

The PRT concluded, however, that the proposal did not deserve priority consideration because: (1) there was not sufficient information available about how the APM would function for the majority of the episodes described, (2) the physicians who have indicated interest in implementing this APM are primarily hospital-based physicians, and an episode payment model for many hospital procedures (i.e., the Bundled Payment for Care Improvement Initiative) has already been implemented by the Center for Medicare & Medicaid Innovation (CMMI), and (3) there was no indication as to whether physicians who treat other conditions or are not involved in existing CMMI models would be interested in participating in this APM.

The PRT was impressed at the proposal’s aspiration to be a national model that could provide a mechanism for participation in advanced alternative payment models for a large number of clinicians covering a broad range of services, from time-limited procedures to the ongoing management of patients with chronic conditions in varied settings, including in-patient, ambulatory, and outpatient facilities. Initial implementation is proposed to focus on 75 procedures in 10 clinical areas involving 75 separate medical specialties. Expansion into acute and chronic conditions increases the scope of the model to potentially impact \$1.5 trillion in Medicare expenditures annually, with the potential for over half of all clinicians in the country to have greater than 75% of their professional fees covered by this methodology. However, as a result of the enormous proposed scope of this proposal, the applicant did not provide the details as to how the model would impact provider payments and patient care in each of those areas. Moreover, the proposal does not provide any information to indicate that physicians in all of these areas would be interested in implementing the APM.

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.

The goal of this section of the proposal is to better understand the “value proposition” that will be addressed by the proposed PFPM. The submitter was asked to describe how the components of the value proposition will be achieved. For example, how will clinical quality, health outcomes, patient experience, and health care cost management be addressed within the model and how will performance be measured? The submitter was also asked to describe any current barriers to achieving desired value/quality goals and how they would be overcome by the payment model. Finally, the submitter was asked to identify any novel clinical quality and health outcome measures included in the proposed model. In particular, measures related to outcomes and beneficiary experience were to be noted.

PRT Qualitative Rating:

Does Not Meet Criterion

The proposed methodology asserts that cost will be lower and quality higher, but the submitter did not provide adequate information describing (1) the ways in which care delivery would change in order to improve quality and/or reduce costs and (2) the reasons those changes could not occur under current payment systems. It is asserted that by providing information on the total spending on episodes, the designation of Clinical Affinity Groups (teams of providers involved in specific types of care delivery), and giving physicians the ability to take on risk for spending relative to risk-adjusted benchmarks, physicians will be encouraged to improve team-based care processes and conserve resources. However, without a clear plan for how spending will be reduced in ways that are beneficial to patients, it is equally possible that spending could be reduced in ways that would *not* be beneficial to patients. Accountability for quality is primarily based on reporting on

processes of care rather than performance on outcomes, and there are no penalties for reductions in quality.

The submitter states that the model's quality will be assessed for each performance period using quality measures relevant to the specific covered procedures and conditions, and the submitter indicates that the current MIPS quality measures will be a starting point for quality reporting. However, the submitter states that the current MIPS reporting data sets are "unlikely to produce clinically meaningful improvement in outcomes of care when rigorously evaluated" and proposes sets of quality measures including process, outcome, and patient experience that are registry-based. For surgical care, the measures would be defined separately for five phases of surgical care and care coordination, including preoperative, perioperative, intraoperative, postoperative, and post-discharge. All clinicians would be required to report on patient-based quality measures that are not tied specifically to procedural episodes paid through the APM, and clinicians involved with a procedure would report additional quality measures specific to the procedure.

The PRT finds that the proposal does not meet the criterion because it is unclear, given the broad scope of the proposal, as to whether adequate quality benchmarks exist or could be developed for the hundreds of procedures and scores of conditions to which the methodology proposes that physicians could apply this payment model. Therefore the PRT concludes that the proposal contains insufficient information to assure that there would be adequate quality protections to offset the financial incentives for lower spending in the wide range of conditions and procedures proposed.

The proposal and the information provided in response to questions gave some examples of how spending could be reduced, but some of these examples could be pursued under the current payment system or under other CMMI APMs. Although the PRT believes there are likely opportunities to reduce avoidable spending for all of the conditions and procedures the proposal is designed to encompass, the proposal does not explain whether and how the APM will enable physicians to successfully change care in a way that will take advantage of those opportunities. No examples were provided as to how the payment model would protect patients from actions designed to generate savings by reducing necessary services or how the payment model would ensure that patients with higher needs could continue to receive adequate services.

The proposal asserts that new Episode Grouper for Medicare (EGM) software which analyzes Medicare reimbursement (claims) data and which is proposed for use in this model takes into account all spending in an episode of care for health care procedures and health conditions, including facility spending, costs of spending on nested procedural episodes, and spending arising from complications. The proposal states that the "end-goal is for participants to understand where they have excess utilization compared to the norm and to the highest performing groups," but they do not describe how physicians would control costs of services that they do not deliver directly, such as post-acute care costs, and they do

not explain whether the risk adjustment methodology adequately addresses differences in patient needs that can affect those costs.

The model is designed to enable multiple physicians to collaborate in addressing cost drivers in resource use and variation in care, but participation is optional for all members of the care team, and under the proposed methodology, less than full participation would leave Medicare at risk for the portion of spending that is attributed to physicians who are not participating in the clinical affinity group.

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

The goal of this section is to better understand the payment methodology for the proposed model, including how it differs from both existing payment methodologies and current alternative payment models. The submitter is asked to describe how the proposed PFPM will incorporate the performance results in the payment methodology and to describe the role of physicians or other eligible professionals in setting and achieving the PFPM objectives, as well as the financial risk that the entity/physicians will bear in the model. The submitter is asked to differentiate between how services will be reimbursed by Medicare versus how individual physicians or other eligible professionals might be compensated for being a part of this model. Finally, a goal of this section is to better understand any regulatory barriers at local, state, or federal levels that might affect implementation of the proposed model.

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| PRT Qualitative Rating: | Meets Criterion |
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The PRT finds that the proposal meets the criterion because the methodology is described in sufficient detail with respect to its general principles, and specific examples were provided in response to follow-up questions. However, because the same basic methodology is intended to be customized to each of a large number of conditions, procedures, and settings, additional details will need to be developed before it can be implemented for all of those conditions, procedures, and settings. Further, the model proposes to assign each clinician involved in a patient’s care one of several designated clinical roles (e.g., primary provider, principal provider, episodic provider, supporting provider, and ancillary provider). Each clinical role would be determined by an algorithm and a priori would be assigned a fixed proportion of savings amount determined by “policy.” Yet there is no information provided supporting the proportions proposed nor is any process defined for how those proportions might be adjusted over time.

The payment methodology also is dependent on CMS updating the episode definitions in the EGM episode grouper over time. The grouper is described as a “bundle of bundles” approach which permits multiple episodes of care for the same condition or procedure to be grouped and measured against normative spending targets with risk to the providers based upon costs and savings compared to risk-adjusted norms. The methodology is asserted to be applicable within other payment models such as ACOs, for most types of providers, in most settings, and for both procedures and chronic conditions, but no specific examples were provided describing how the model might be successfully implemented in such a broad range of settings. For several aspects of the model, options for implementation were described, but the proposal does not evaluate the options or recommend a specific approach, and so these options would have to be resolved before implementation could occur.

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

The goal of this section of the proposal is to better understand how the model is intended to affect practitioners’ behavior to achieve higher value care through the use of payment and other incentives. PTAC acknowledges that a variety of incentives might be used to move care towards value, including financial and nonfinancial ones; the submitter is asked to describe any unique and innovative approaches to promote the pursuit of value including nonfinancial incentives such as unique staffing arrangements, patient incentives, etc.

PRT Proposed Qualitative Rating: Does Not Meet Criterion

The proposed model could incentivize efficient provision of episodes of care where there are opportunities for greater efficiencies, but it lacks specificity with respect to how the model will enable physicians to change care delivery in order to reduce utilization and how it will ensure medical appropriateness of provided care. Quality of care is neither rewarded nor penalized unless savings occur. The proposed use of a retrospective episode grouper methodology is intended to provide information and standards for individual providers, episodes, and patients that can be grouped for a more comprehensive set of information from which providers can be held accountable for costs and quality. However, driving spending down within individual episodes does not necessarily achieve savings in total cost of care, unless accompanied by methods of controlling the number of services provided or ensuring clinical appropriateness. Although the proposal indicates that utilization of procedural episodes would be controlled through their nesting within condition-based episodes, the proposal would not restrict the procedural episodes to only be implemented inside condition-based episodes, nor is there any requirement that the physicians who would be accountable for managing utilization under condition-based episodes would actually participate in the model.

In addition, there are insufficient mechanisms in the model to ensure that savings are not achieved at the expense of quality, or to encourage or reward quality even with no change in spending, which are essential elements of a truly value-based approach.

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

The goal of this section is to better understand (1) how the proposed payment model could accommodate different types of practice settings and different patient populations, (2) the level of flexibility incorporated into the model to include novel therapies and technologies, and (3) any infrastructure changes that might be necessary for a physician or other eligible professionals to succeed in the proposed model.

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| PRT Qualitative Rating: | Meets Criterion |
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The PRT finds that the proposal meets this criterion because the proposed intervention could be used in inpatient, outpatient, and ambulatory settings for multiple procedures and chronic conditions involving multiple types of providers. Further, the model permits flexibility with respect to the number and types of physicians who could participate in clinical affinity groups.

However, the proposed model does not appear to make any provision for direct payment for innovative services that are not eligible for payment under current payment systems, so it is unclear whether and how physicians would have greater flexibility to control post-acute care costs and other types of non-physician services. Further, although it is clear how multi-specialty physician groups could participate, the proposal does not make clear how independent practices in different specialties that have overlapping but not identical service areas could effectively participate, since not all of the patients in one practice would be in the other practice and vice versa.

The submitter asserts that rural, critical access, and small group providers can participate “under the umbrella of a new corporate entity or convener group.” The nature of such entities is not spelled out with sufficient detail with respect to the logistical challenges or potential regulatory or monetary hurdles to determine how broadly such participation could occur. In order for there to be truly broad participation in the model, these issues would have to be resolved.

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

The goal of this section is to describe the extent to which the proposed model or the care changes to be supported by the model can be evaluated and what, if any, evaluations are

currently under way that identify evaluable goals for individuals or entities in the model. If there are inherent difficulties in conducting a full evaluation, the submitter is asked to identify such difficulties and how they are being addressed.

PRT Qualitative Rating:

Meets Criterion

The PRT concluded that the proposal minimally meets this criterion because an evaluation could be performed by comparing changes in spending under the EGM for participating vs. non-participating practices. However, the PRT observes that the proposal would be very complex to evaluate depending on how many different combinations of physicians participate in clinical affinity groups. The fact that not all clinicians in a clinical team are required to participate in this model creates flexibility in implementation, but it also increases the complexity of evaluation because of the potential for multiple configurations of clinical affinity groups and the potential for interactions between the variations in care delivery and variations in the clinical affinity group composition. In addition, the model depends upon the ability to identify members of the care teams accurately with respect to role (primary provider, principal provider, etc.) and their contributions across settings and the ability to report quality measures of greater specificity than is currently required by payers. These may increase complexity and thereby decrease the ability to be evaluated.

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 PPFM.

The goal of this section is to describe the full range of personnel and institutional resources that would need to be deployed to accomplish the proposed model's objectives. The submitter is asked to describe how such deployment might alter traditional relationships in the delivery system, enhance care integration, and improve care coordination for patients.

PRT Qualitative Rating:

Meets Criterion

The PRT finds that the proposal meets the criterion because the model includes an innovative way to support multiple clinicians working together as part of clinical affinity groups. However, there does not appear to be any minimum threshold for the level of integration required, nor any way to encourage or require support by, and coordination with, the physicians who are not part of the alternative payment model entity. The model aims to increase integration across specialties by identifying those clinicians who regularly participate in a given type of episode for purposes of measuring and reporting utilization and quality data. The voluntary nature of the involvement of members of the care team may result in less integration and care coordination than would be desirable or necessary to successfully reduce spending and ensure quality.

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

The goal of this section is to describe how patient choice and involvement will be integrated into the proposed PFPM. The submitter was asked to describe how differences among patient needs will be accommodated and how any current disparities in outcomes might be reduced. The submitter was asked to describe, as an example, how the demographics of the patient population and social determinants of care may be addressed.

PRT Qualitative Rating:

Meets Criterion

The PRT finds that the proposal meets the criterion because patients are not limited in which physicians and other providers they can choose for the different components of care included in episodes. The proposal stated that “we do not expect patients to be able to opt out of individual bundled care arrangements of the providers from whom they seek care;” however, in response to the PRT’s questions, the proposers indicated that patients would continue to have the right to seek care from whomever they choose. There is no requirement in this proposal for gatekeeper arrangements or narrowed networks that would limit patient choice.

The model may improve attention to individual differences in patient characteristics (including social needs, conditions, and health-related preferences) by incentivizing attention to the social determinants of health outcomes as a driver of adverse variances in cost and quality. However, it is not clear whether the risk adjustment methodology will adequately protect against participants avoiding high-need patients. If the model allows a wider range of clinicians to participate in advanced alternative payment models than what exists in the current CMS models, then expansion by demographical, clinical, or geographic diversity may be incentivized.

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

The goal of this section is to describe how patients would be protected from potential disruptions in health care delivery brought about by the changes in payment methodology and provider incentives. The submitter is asked to describe how disruptions in care transitions and care continuity will be addressed. Safety in this instance should be interpreted to be all-inclusive and not just facility-based.

PRT Qualitative Rating:**Meets Criterion**

The PRT finds that the proposal meets the criterion. Because the episode definitions are intended to include the costs of treatment for any complications, there are implicit penalties for an increase in patient safety problems. Process measures used for the quality component would also help to ensure patient safety. The model aims to address patient safety by ensuring that episode spending measures include costs resulting from excessive care, delayed or avoided care, and poor outcomes of care that occur within the timeframes defined for the episodes. However, the proposed initial quality measures are only process measures and they only provide incentives for improvement or penalties for reduced quality if there are savings to be distributed to participating Qualifying APM Participants. The submitter did not describe how disruptions in care transitions and care continuity would be addressed if all of the clinicians involved in the services prior to and after the transition were not participating.

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

The goal of this section is to understand the role of information technology in the proposed payment model. In this section the submitter is asked to describe how information technology will be utilized to accomplish the model's objectives with an emphasis on any innovations that improve outcomes, improve the consumer experience and enhance the efficiency of the care delivery process. The submitter is also asked to describe goals for better data sharing, reduced information blocking and overall improved interoperability to facilitate the goals of the payment model.

PRT Qualitative Rating:**Meets Criterion**

The PRT finds that the proposal meets the criterion because the model does not restrict current health information integration efforts and may incentivize use of technology that promotes improved care coordination and monitoring of factors affecting rates of complications. The model requires "at least 50% of eligible clinicians in each APM entity to use CEHRT for clinical documentation, communication, and patient care," similar to the requirement for advanced alternative payment models. The model requires identification of providers as either primary, principal, episodic, supporting, or ancillary; and it requires reporting of quality measures, which may require enhancements of current coding practices for claims reporting. The need for technology to identify high risk patients or technology-enhanced care innovations is not directly addressed in the proposal.

E. PRT Recommendation

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| <p>Do not recommend proposed payment model to the Secretary</p> |
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F. PRT Comments

The PRT concluded that the proposed model should not be recommended because (1) the proposal does not adequately meet the high priority criterion for demonstrating an improvement in the cost or quality of care provided and (2) it does not meet the criterion for “value over volume.” This is chiefly due to the broad scope of the proposal and the limited detail on how it would affect individual conditions and procedures. The applicant did not provide details as to how the model would impact provider payments and patient care except in examples for surgical procedures. Moreover, the proposal does not provide any information to indicate that physicians who treat the wide range of conditions encompassed by the proposal and physicians who are not participating in current CMMI bundled/episode payment models would be interested in implementing the proposed APM. The PRT did agree that the proposed model’s breadth also presages considerable impact if these concerns were adequately addressed in a revised proposal.

Further, the PRT concluded that the proposal should not receive a “recommendation for limited scale testing” because it did not identify a small number of specific clinical areas, episode types, and venues that would be appropriate for limited scale testing. The PRT believes that it would be easier to address the issues identified above in a proposal that had a narrower initial focus. If such a limited model were successfully implemented, it could then later be broadened to include more clinical areas, episode types, and/or venues to generate sufficient data for a detailed statistical evaluation of the full model concept.

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