Initial Feedback from PTAC Preliminary Review Team on "An Innovative Model for Primary Care Office Payment" Submitted by Jean Antonucci, MD

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Disclaimer Regarding Initial Feedback:

- Initial feedback is preliminary feedback from a Preliminary Review Team (PRT) subcommittee of the PTAC and does not represent the consensus or position of the full PTAC;
- Initial feedback is not binding on the full Committee. PTAC may reach different conclusions from that communicated from the PRT as initial feedback;
- Provision of initial feedback will not limit the PRT or PTAC from identifying additional weaknesses in a submitted proposal after the feedback is provided; and
- Revising a proposal to respond to the initial feedback from a PRT does not guarantee a favorable recommendation from the full PTAC to the Secretary of Health and Human Services (HHS).

Summary of PRT Assessment Relative to Criteria:

Criteria Specified by the Secretary (at 42 CFR§414.1465)	PRT Rating	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	Unanimous
5. Flexibility	Meets	Unanimous
6. Ability to be Evaluated	Does Not Meet	Majority
7. Integration and Care Coordination	Does Not Meet	Unanimous
8. Patient Choice	Does Not Meet	Unanimous
9. Patient Safety	Does Not Meet	Unanimous
10. Health Information Technology	Meets	Unanimous

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CRITERION 1. SCOPE (HIGH PRIORITY CRITERION)

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.

Does Not Meet Criterion (Majority)

Although more primary care physicians need the ability to participate in a Medicare APM, multiple models are already being tested or proposed for testing. This proposal incorporates some potentially important innovations in quality measurement, but also has many similarities to other primary care medical home payment models, and it is not clear that enough primary care physicians would find the proposed approach sufficiently superior to other models to warrant testing it separately. It would be desirable to find a way to further develop and test this approach as an option within other primary care models or ACOs, rather than as a completely separate model.

Strengths:

- The proposed payment model for primary care practices is significantly different than the payment models that have been previously tested by CMMI and that are being tested in the CMS Comprehensive Primary Care Plus (CPC+) model.
- The structure of the payment model is specifically designed to be less complex and more administratively feasible for solo and very small primary care practices.
- The proposed payment method uses a completely different approach to risk stratification of payments and quality measurement than any other CMS payment model and any other PFPM proposal that PTAC has previously recommended.

Weaknesses:

- The stratified monthly payment in the proposed payment model is similar to the payment structure in the PFPM for primary care submitted by the AAFP that PTAC previously recommended for testing. Although the monthly payment in the proposed model is simpler than the payments in the AAFP model, and the methods of accountability for quality and spending are different, it is not clear that these differences would lead to sufficiently different or better results to warrant creating a separate model.
- Because of the innovative nature of the quality measurement approach, additional development work would be needed in order to implement this with a large number of practices.
- It is not clear how many primary care practices would be interested in participating in this model or how many would prefer it over other approaches. No letters of support were included, and no public comments (positive or negative) were received. The applicant indicates that she has identified over two dozen interested physicians/practices that care for at least 5,000 Medicare beneficiaries, which would be equivalent to the smallest number of beneficiaries permitted to participate in the Medicare Shared Savings Program as an ACO.

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CRITERION 2. QUALITY AND COST (HIGH PRIORITY)

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.

Does Not Meet Criterion (Unanimous)

Based on available data, the proposed payment amounts would represent almost a tripling of Medicare payments for participating practices compared to what they would receive under the current system. The only justification provided for this is to increase earnings for primary care physicians, rather than to cover costs of explicitly identified additional services for patients. The applicant indicates that the practice could benefit financially from the payment model, such as through reductions in administrative costs, even if the payment amounts from Medicare were set on a budget-neutral basis.

There is mixed evidence as to how much savings can be achieved by changing or increasing payments to primary care practices. It is possible that some practices could achieve sufficient savings to offset the significantly higher payments that are proposed if they are caring for patients who are at a high risk of hospitalizations and if they use the additional funds to provide effective care management services for those patients, but the model would not be restricted to practices with such patients, nor would there be any requirement that participating practices use evidence-based approaches for reducing avoidable hospitalizations or other expensive services.

If the change in payment method or amount encourages more primary care physicians to enter or remain in practice in rural and underserved areas, the improved access to care could generate additional savings for patients living in those communities. However, the proposed limits on practice panel size have the potential for reducing access to primary care services in the short run, which could increase Medicare spending.

The flexibility provided in the payment model and the focus on improving performance on patient-centered quality measures would enable and encourage physicians to deliver more responsive, higher-quality care. However, experience with practice capitation payment systems indicates that some practices could be less responsive to patients who need to be seen by the physician, and nothing in the payment model is explicitly designed to prevent that. Although the payment model includes a significant penalty for a practice that fails to meet quality targets, and that penalty is greater than what the practice could experience under MIPS or other CMS primary care models, the large increase in monthly payments would mean the practice would still be receiving significantly more revenue that it would under the current system even if it failed to receive the 15% withhold, which could reduce the incentive to deliver high-quality care.

The proposal's focus on patient-reported outcomes using the How's Your Health tool is innovative and is very desirable in many ways, including reducing administrative burden on physicians for collecting and reporting multiple quality measures and ensuring attention to the issues that matter to patients. Although patient-reported measures have many advantages over process measures and claims-based measures, they can also create burden for patients and the potential for disparities in care due to low response rates for patients with limited health literacy, language barriers, and lack of computer/internet access. Moreover, the How's Your Health tool and risk adjustment through the What Matters Index have not been tested or validated for performance evaluation or payment, and the impacts on patient access and measure reliability from tying the results to payment would need to be

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carefully assessed. In order to use the results of the How's Your Health Tool as part of a performance-based payment, a standardized sampling frame and mode of administration would be needed in order to insure consistency and comparability of results and to avoid the possibility of manipulation of results, and this would be very different than the proposed method of data collection for use in quality improvement and patient care.

Strengths:

- The practice would have more flexibility and more resources to deliver more and different services to patients.
- The proposed quality and risk stratification tool is more directly tied to patient characteristics and issues that a primary care practice can directly address than typical diagnosis-based risk tools and outcome measures.
- The proposed quality/risk stratification system is being actively used by the applicant and by some other practices to improve the quality of care they deliver.
- The patient surveys identify barriers to adherence and social determinants of health so that practices will be aware of these and can try to address them.

Weaknesses:

- Because the monthly payment would incorporate payments that would otherwise be made for minor procedures and office-based tests, it is possible that some practices could send patients to specialists or urgent care centers for these services rather than performing them directly, which would increase Medicare spending.
- Using a completely different quality metric for practices participating in this model will make it difficult for patients and CMS to determine whether the quality of care is better than in non-participating practices.
- It is not clear what level of quality the participants will be expected to achieve.
- The proposed payment amounts would represent an approximately 150-200% increase in Medicare spending for a practice with the mix of patient characteristics and visit frequencies described in the proposal. This would represent approximately $150,000 for a practice with 300 Medicare patients. Based on average emergency department (ED) visit and hospitalization rates for the Medicare population, the participating practices would need to completely eliminate ED visits or reduce the total number of hospitalizations by approximately 20% in order to offset the higher payments to the practice.

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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

Does Not Meet Criterion (Unanimous)

The proposed payment methodology would provide better support for primary care practices that want to deliver higher-quality, more efficient care for Medicare beneficiaries. However, it could also enable primary care practices to deliver lower-quality, less efficient care. The quality component of the methodology is significantly different from the methodology used in any other Medicare payment program, and it would be challenging for CMS to ensure that the quality of care for beneficiaries was being maintained or improved.

Strengths:

- The practice would receive a risk-stratified monthly payment that would replace virtually all of the practice's fee-for-service revenues and provide complete flexibility as to how services should be delivered to patients.
- Higher payments would be paid for patients whose characteristics would be expected to increase the amount of time and resources the practice would need to spend in caring for the patients; this would discourage cherry-picking of patients.
- There would also be greater opportunities to reduce spending on the patients receiving higher payments, since the risk stratification tool has also been shown to have equivalent ability to predict utilization and spending as claims-based risk adjustment systems.
- The payment system would be relatively simple for practices and payers to implement.
- A significant portion (15%) of the practice's revenues would be at risk based on quality performance.

Weaknesses:

- It would be possible for a practice to reduce access for patients and to reduce the number of services it delivered with no immediate/short-run impact on the practice's revenues.
- The proposal does not define whether patients could continue to receive primary care services from other practices, or whether any adjustment to the proposed payments would be made if they did.
- The proposed payment amounts are almost triple current payment levels based on Medicare spending for a practice with the mix of patient characteristics and visit frequencies described in the proposal. There are no data provided showing that the proposed amounts are needed to cover specific costs required to deliver high-quality care.
- The penalty for any shortfall in quality would be complete loss of the withhold, rather than a more graduated penalty based on relative levels of performance, which could increase the resistance to setting high goals for quality.
- Specific criteria for awarding the withhold have not been defined.

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CRITERION 4. VALUE OVER VOLUME

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

Meets Criterion (Unanimous)

The payments to the practice would no longer be based on the number or type of services delivered, but would instead be based on the number of patients managed, the level of need for those patients, and the practice's performance on quality and utilization.

The proposed cap on patient panel size would discourage the practice from taking on an excessive number of patients without being able to adequately serve them. Although the risk-adjusted payment and the cap on panel size would encourage the practice to take on higher-need patients, it could discourage the practice from accepting healthier patients who need good preventive care. The applicant has suggested that modifications to the cap could be made to ensure that all types of patients could access services.

Strengths:

- The payment to the practice would no longer be tied to the number or types of services it delivers.
- Practices would be paid more for patients with characteristics that typically indicate a need for more proactive or intensive services.
- A significant portion (15%) of the practice's revenues would be at risk based on quality performance.

Weaknesses:

- The lack of a direct connection between payments and services could lead to stinting on aspects of care that would not be readily detectable through the proposed quality measures.
- The high payments per patient and the proposed cap on panel size could discourage the practice from accepting healthier patients.

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CRITERION 5. FLEXIBILITY

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

Meets Criterion (Unanimous)

A participating practice would have substantially greater resources to deliver services and greater flexibility regarding the types of services it could deliver to patients than under the current payment system. Even more resources would be available for higher-need patients.

Strengths:

- The primary care practice would have complete flexibility as to which services it would deliver using the revenues from monthly per-patient payments.
- The practice would receive a higher payment for patients with higher-need/risk characteristics, giving it the flexibility to deliver additional services to those patients.
- The proposed payments are much higher than what the practice currently receives, which could enable the delivery of many more or different services to patients.

Weaknesses:

- The practice's flexibility would be limited to the services that it could deliver itself; there would be no changes in payment for any services delivered by other providers.
- There is no assurance in the model that higher payments would be used to deliver more or different services to patients, rather than simply increasing physicians' income for the same services as they are delivering today.

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CRITERION 6. ABILITY TO BE EVALUATED

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

Does Not Meet Criterion (Majority)

The majority of the PRT members felt that because the proposed model would use a completely different method of assessing quality than in the rest of the Medicare program, and because there would be no direct way of tracking how the practice's services to patients had changed, it would be very difficult to assess whether the quality of care had been maintained or improved.

A minority view was that more innovative payment models will inherently be more difficult to evaluate, and since it would be feasible to evaluate the model's impact on standard measures of utilization and spending, the proposal can at least minimally meet this criterion.

Strengths:

- Because most aspects of utilization and spending occur outside of the primary care practice, it would be straightforward to calculate utilization and spending per patient for patients assigned to the practices in the model, and then to compare that to utilization and spending for patients attributed to non-participating practices.

Weaknesses:

- Because the practices would be using a different tool for measuring quality, it would be difficult to assess the differences in quality between participating and non-participating practices. If participating practices were required to report standard MIPS quality measures as well as the patient-reported measures in order to facilitate evaluation, it would increase their administrative burden rather than reduce it.
- Because risk stratification is based on a tool that would only be used by practices participating in the model, it would be difficult to separately measure differences in utilization and spending for patients in each of the risk tiers.
- It would be difficult to evaluate the extent to which favorable impacts on cost and quality resulted because (1) the practice began using the HYH tool and was more effectively able to identify patient problems, or (2) because of the different services that could be provided due to the increased payments and greater flexibility.
- Because payments would no longer be based on service-specific claims, it would be difficult to determine what services are actually being delivered unless practices agree to submit encounter forms for services.
- Depending on how many practices would participate and where they were located, it could be difficult to find comparison practices that are not participating in CPC+ or other payment models.

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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.

Does Not Meet Criterion (Unanimous)

Although the proposed model would give the primary care practice more flexibility to carry out care coordination activities, there are no specific mechanisms defined for assuring that it would do so.

Strengths:

- The payment model would provide more resources and flexibility to a primary care practice to enable it to carry out care coordination activities for its patients.
- Use of the How's Your Health survey would help the practice identify patients who do not feel their care is being effectively coordinated and to measure whether the practice's services had resulted in improved coordination from the patient's perspective.

Weaknesses:

- The proposal does not establish any specific standards or goals related to care coordination.
- While the proposed payment model would provide more resources and flexibility to the primary care practice to support care coordination activities, it does not directly affect the willingness or ability of other providers to support coordinated services.

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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.

Does Not Meet Criterion (Unanimous)

The payment model would enable primary care practices to deliver services in different ways based on their patients' needs. Depending on the types of changes a practice makes, the changes could be beneficial to patients or harmful to patients. The proposal does not describe how patients would be informed about the differences between the proposed payment model and the current payment system and what information and assurances the patient would receive about the types of services and the quality of the care they would receive. Consequently, it is impossible to say for sure that the model would *improve* the patient's choices.

If the payment model encourages more physicians to enter or remain in primary care, patients would have more choices about where to receive their primary care in the long run. However, the proposed limit on practice panel size could potentially reduce access to primary care in underserved areas in the short run.

Strengths:

- The payment model could encourage more physicians to enter or remain in primary care, thereby increasing the number of primary care physicians that patients have to choose from, particularly in rural areas.
- The use of the How's Your Health survey and What Matters Index would create a direct way for patients to notify the practice of their needs and would encourage practices to respond to individual needs.

Weaknesses:

- The proposal does not define or set standards for the information that would need to be provided to patients to enable them to make an informed choice about whether to enroll in a practice that is being paid in this way.
- The higher payments per patient and the proposed limits on practice size could reduce access to primary care in the short run.

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CRITERION 9. PATIENT SAFETY

Aim to maintain or improve standards of patient safety.

Does Not Meet Criterion (Unanimous)

There is no assurance that individual patients would receive the care they need. The practice would be paid the same amount regardless of how many services were provided, as long as an annual assessment was conducted, and there is no requirement that every patient would complete the How's Your Health survey, so it is possible that the practice could receive its full payment for every patient even if a subset of patients is receiving poor-quality care.

Strengths:

- The How's Your Health survey and the What Matters Index would help practices identify patients with potential medication safety issues and other safety issues.

Weaknesses:

- There is no requirement that the How's Your Health survey be completed by all patients.
- The highest-risk patients may be the least able or willing to complete an online survey.
- Because the practice's revenues would not depend at all on the number of face-to-face visits with the patient, a practice could be paid even though it failed to see patients who needed visits.

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CRITERION 10. HEALTH INFORMATION TECHNOLOGY

Encourage use of health information technology to inform care

Meets Criterion (Unanimous)

The model is premised on the use of an online system for patient-reported outcomes and analysis of practice performance.

Strengths:

- Patients in participating practices would be encouraged or required to complete an on-line survey tool assessing health-related issues and satisfaction with the practice's services.

Weaknesses:

- The proposal says that at least "50% of qualifying participants are expected to use CEHRT" (Certified Electronic Health Records Technology), but there is no mechanism for assuring that.

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