

# Physician-Focused Payment Model Technical Advisory Committee

## Committee Members

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September 3, 2020

Alex M. Azar II, Secretary  
U.S. Department of Health and Human Services  
200 Independence Avenue, SW  
Washington, DC 20201

Dear Secretary Azar:

On behalf of the Physician-Focused Payment Model Technical Advisory Committee (PTAC), I am pleased to submit PTAC's comments and recommendation to you on a physician-focused payment model (PFPM), *Eye Care Emergency Department Avoidance (EyEDA) Model*, submitted by University of Massachusetts Medical School. These comments and recommendation are required by section 1868(c) of the Social Security Act, which directs PTAC to: 1) review PFPM models submitted to PTAC by individuals and stakeholder entities; 2) prepare comments and recommendations regarding whether such models meet criteria established by the Secretary of Health and Human Services (HHS); and 3) submit these comments and recommendations to the Secretary.

With the assistance of HHS' Office of the Assistant Secretary for Planning and Evaluation (ASPE), PTAC's members carefully reviewed the *EyEDA* proposal (submitted to PTAC and found to have met the Committee's administrative requirements on June 28, 2019); additional information on the model, which was provided by the submitter in response to questions from a PTAC Preliminary Review Team; and other information. PTAC also reviewed supplemental information on the model provided by the submitter and considered issues in payment and care delivery, as well as relevant research findings. At a public meeting of PTAC held on June 22, 2020, the Committee deliberated on the extent to which this proposal meets the criteria established by the Secretary in regulations at 42 CFR §414.1465 and whether it should be recommended.

PTAC does not recommend the *EyEDA* proposal to the Secretary for implementation as a physician-focused payment model as specified in PTAC's comments. The Committee finds that the proposal meets six of the Secretary's 10 criteria for PFPMs; the Committee found that the proposal does not meet the other four criteria, including two of the high-priority criteria (scope and payment methodology). PTAC concludes that the proposed model, which seeks to encourage treatment of selected eye-related symptoms through office visits with optometrists and ophthalmologists rather than visits to hospital emergency

departments (EDs), would help to improve quality of care for patients with those eye conditions. PTAC agrees that increasing access to appropriate urgent eye care in lower-cost settings outside the ED could enhance value and improve quality. Further, PTAC notes that the proposal is based on the submitter's experience in the Transforming Clinical Practices Initiative (TCPI), which showed promise in improving care delivery and shifting care from EDs to office-based settings appropriate for urgent visits. TCPI also demonstrated that small practices have the interest and ability to expand patient access for the proposed set of eye conditions. PTAC believes it would be beneficial to identify ways to incorporate the lessons and practice transformation experiences from TCPI into future payment models.

Despite supporting the proposal's overall objectives, PTAC has several key concerns about the *EyEDA* proposal; most notably, the proposal did not include adequately detailed specifications regarding payment, integration of care coordination, and patient safety concerns. PTAC concludes that the proposed payment model did not convincingly demonstrate its ability to achieve the proposal's desired objectives of more access to urgent eye care and appropriate utilization or diversion from costly ED visits, improved quality, and cost savings. The proposal continues to rely on visit-based fee-for-service payments with a shared savings component that needs significant refinement. PTAC believes that other payment approaches, such as bundled payments or care coordination fees, could be more effective at achieving the submitter's goals. In addition, embedding the concept within a more comprehensive payment model could also achieve care delivery objectives. A payment model more inclusive of eye care specialists, EDs, and primary care physicians could encourage greater coordination beyond the approach proposed by the submitter.

In addition, PTAC believes that as currently described, the proposed payment model may not garner sufficient participation of either providers or patients. On average, the number of potential qualifying visits that a participating provider would have with Medicare fee-for-service (FFS) beneficiaries is very low in a given month, necessitating multi-payer implementation of the proposed model. The low volume of potential visits introduces risk for providers due to random chance. The incorporation of financial risk in the form of an 8 percent discount on urgent visits could also deter providers from participating. For these reasons, PTAC believes the proposal lacks sufficient scope for implementation as a PFPM.

The members of PTAC appreciate your support of our shared goal of improving the Medicare program for both beneficiaries and the physicians who care for them. The Committee looks forward to your detailed response.

Sincerely,

//Jeffrey Bailet//

Jeffrey Bailet, MD

Chair  
Attachments

# REPORT TO THE SECRETARY OF HEALTH AND HUMAN SERVICES

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Comments and Recommendation on  
*Eye Care Emergency Department Avoidance (EyEDA) Model*

September 3, 2020

## About This Report

The Physician-Focused Payment Model Technical Advisory Committee (PTAC) was established by the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) to: 1) review physician-focused payment models (PFPMs) submitted by individuals and stakeholder entities; 2) prepare comments and recommendations regarding whether such models meet criteria established by the Secretary of Health and Human Services (HHS); and 3) submit these comments and recommendations to the Secretary. PTAC reviews submitted proposals using criteria established by the Secretary in regulations at 42 CFR §414.1465.

This report contains PTAC's comments and recommendation on the PFPM proposal *Eye Care Emergency Department Avoidance (EyEDA) Model*. This report also includes: 1) a summary of PTAC's review of the proposal; 2) a summary of the proposed model; 3) PTAC's comments on the proposed model and its recommendation to the Secretary; and 4) PTAC's evaluation of the proposed PFPM against each of the Secretary's criteria for PFPMs. The appendices to this report include a record of the voting by PTAC on this proposal, the proposal submitted by the University of Massachusetts Medical School, and additional information on the proposal submitted subsequent to the initial proposal submission.

## SUMMARY STATEMENT

PTAC does not recommend the *EyEDA* proposal to the Secretary for implementation as a physician-focused payment model as specified in PTAC's comments. The Committee finds that the proposal meets six of the Secretary's 10 criteria for PFPMs; the Committee found that the proposal does not meet the other four criteria, including two of the high-priority criteria (scope and payment methodology). PTAC concludes that the proposed model, which seeks to encourage treatment of selected eye-related symptoms through office visits with optometrists and ophthalmologists rather than visits to hospital emergency departments (EDs), would help to improve quality of care for patients with those eye conditions. PTAC agrees that increasing access to appropriate urgent eye care in lower-cost settings outside the ED could enhance value and improve quality. Further, PTAC notes that the proposal is based on the submitter's experience in the Transforming Clinical Practices Initiative (TCPI), which showed promise in improving care delivery and shifting care from EDs to office-based settings appropriate for urgent visits. TCPI also demonstrated that small practices have the interest and ability to expand patient access for the proposed set of eye conditions. PTAC believes it would be beneficial to identify ways to incorporate the lessons and practice transformation experiences from TCPI into future payment models.

Despite supporting the proposal's overall objectives, PTAC has several key concerns about the *EyEDA* proposal; most notably, the proposal did not include adequately detailed specifications regarding payment, integration of care coordination, and patient safety concerns. PTAC concludes that the proposed payment model did not convincingly demonstrate its ability to achieve the proposal's desired objectives of more access to urgent eye care and appropriate utilization or diversion from costly ED visits, improved quality, and cost savings. The proposal continues to rely on visit-based fee-for-service payments with a shared savings component that needs significant refinement. PTAC believes that other payment approaches, such as bundled payments or care coordination fees, could be more effective at achieving the submitter's goals. In addition, embedding the concept within a more comprehensive payment model could also achieve care delivery objectives. A payment model more inclusive of eye care specialists, EDs, and primary care physicians could encourage greater coordination beyond the approach proposed by the submitter.

In addition, PTAC believes that as currently described, the proposed payment model may not garner sufficient participation of either providers or patients. On average, the number of potential qualifying visits that a participating provider would have with Medicare fee-for-service (FFS) beneficiaries is very low in a given month, necessitating multi-payer implementation of the proposed model. The low volume of potential visits introduces risk for providers due to random chance. The incorporation of financial risk in the form of an 8 percent discount on urgent visits could also deter providers from participating. For these reasons, PTAC believes the proposal lacks sufficient scope for implementation as a PFPM.

## **PTAC REVIEW OF THE PROPOSAL**

The *EyEDA* proposal was submitted to PTAC and found to have met the Committee's administrative requirements on June 28, 2019. The proposal was first reviewed by a Preliminary Review Team (PRT) composed of three PTAC members (Paul Casale, MD, MPH; Harold D. Miller; and Kavita Patel, MD, MSHS). The PRT conducted its review of the proposal between September 4, 2019, and November 8, 2019. The proposal was also posted for public comment. The PRT's findings were documented in the PRT Report to the PTAC on the *EyEDA* proposal dated November 8, 2019. At a public meeting held on June 22, 2020, PTAC deliberated on the extent to which the proposal meets the criteria established by the Secretary in regulations at 42 CFR §414.1465 and whether it should be recommended to the Secretary for implementation. The submitter and members of the public were given an opportunity to make statements to the Committee at the public meeting. Remaining sections of this report provide a summary of the proposal, PTAC's comments and recommendation to the Secretary on the proposal, and the results of PTAC's evaluation of the proposal using the Secretary's criteria for PFPMs.

## **PROPOSAL SUMMARY**

The *EyEDA* proposal seeks to encourage treatment of certain kinds of eye-related symptoms through office visits with optometrists and ophthalmologists rather than visits to hospital emergency departments (EDs). Using a grant from the Centers for Medicare & Medicaid Services (CMS) Transforming Clinical Practices Initiative (TCPI) program, the submitter has assisted over 1,600 optometry practices across the U.S. to increase the number of patients with eye-related symptoms who make visits to the practice rather than an ED for urgent eye conditions. The submitter asserts that this approach has improved the quality of care for patients because EDs generally do not have eye care professionals or equipment on site for posterior eye exams. The submitter also asserts that the approach has reduced the cost of treating urgent eye-related conditions for both payers and patients because the payment for an office visit is much less than the payment for an ED visit. The proposed payment model is intended to sustain this approach and expand it to additional practices by providing a financial incentive to optometrists and ophthalmologists to increase the number of urgent care visits

with patients who are diagnosed with specific eye conditions. In addition, the proposed payment model is intended to qualify as an Advanced Alternative Payment Model (AAPM) under Medicare and thereby to give optometrists and ophthalmologists an opportunity to participate in an AAPM. The submitter would also like to see the proposed model implemented by all payers, not just Medicare, since there are opportunities to reduce eye-related ED visits for patients of all ages.

Eligible participants would include licensed optometrists and ophthalmologists, as well as organizations employing optometrists and ophthalmologists. All participants would be required to use certified electronic health record technology.

Urgent care visits would be defined as visits that result in a diagnosis of conjunctivitis, corneal injury, corneal injury with a foreign body, hordeolum (commonly called a stye), acute posterior vitreous detachment, eye pain, and a number of other eye conditions on a list of ICD-10 diagnosis codes included in the proposal. To develop the proposed set of diagnoses, the submitter convened an expert panel of five optometrists to review broad eye conditions that were in the purview of optometric licensure. The list provided in the proposal includes only those codes that were unanimously accepted as appropriate for outpatient management by optometrists. Only an initial visit for the condition would be considered as urgent care; follow-up visits for the same condition would not be counted as urgent care visits.

Under the proposed payment model:

- A participating physician or practice would agree to be paid 8 percent less for all urgent care visits than they would otherwise be paid under the normal fee schedule.
- If the physician or practice increased the number of such urgent care visits to a pre-specified target volume level and met quality performance thresholds, they would be eligible for a bonus payment. Based on its experience in the TCPI-funded project, the submitter believes that a combination of: (a) educating patients about the desirability of receiving urgent care from an optometry or ophthalmology practice, and (b) expanded office hours will increase the number of patients making urgent care visits to the practice instead of the ED. The proposed model does not, however, require that participating practices use any specific approach to encourage such visits.
- The bonus payment would be based on the estimated savings achieved by the payer if there were a reduction in ED visits for the same set of eye-related conditions, i.e., the physician or practice would receive shared savings based on avoided ED visits. The proposal does not specify the percentage of the savings that would be shared, but it gives examples in which the physician or practice would receive 25 percent or 50 percent of the savings.

The proposed model is intended to involve both upside and downside risk for both spending and quality:

- If the participating physician or practice does not successfully increase the number of urgent care visits, its revenues for urgent care visits will decrease by 8 percent.
- If the practice increases the number of urgent care visits but does not meet the quality thresholds, it will not be eligible for the shared savings bonus.
- If the participating physician or practice successfully increases the number of urgent care visits, the proposed model assumes that the number of ED visits for eye-related conditions will decrease. Examples provided in the proposal show that because of the higher payments associated with an ED visit, the shared savings bonus and the higher volume of payments for urgent care visits at the practice can more than offset the loss from the 8 percent reduction in payments for each visit. However, it is possible that ED volume (by payer) for the conditions might not decline, so that the decreases in practice revenue from the 8 percent discount might not be offset.

Two quality measures would be used to measure the performance of participants and make them eligible to receive shared savings bonuses:

- Patient experience would be measured with a patient survey. Participating physicians or practices would have to receive scores of three points or more on a four-point scale on each core survey question to achieve the patient experience threshold.
- Patient safety would be measured by calculating the rate of adverse events (complications) that occur within seven days of an office visit for a qualifying eye condition. Adverse events include the following events if they relate to the same ICD-10 diagnosis as the original office visit: an unscheduled ED visit, hospital admission, or observation stay; blindness or permanent visual impairment; or death. Practices with an adverse event rate that is less than or equal to the adverse event rate for visits made to EDs will be deemed to have achieved the patient safety threshold. The proposal states that the adverse event rate could be adjusted for age, gender, or other factors, but it did not specify a risk adjustment methodology.

The target level for the increase in the number of urgent care visits would be established with the following process: First, the historical volume of visits to the practice for the specified ocular conditions would be determined to establish a baseline volume for the practice. Then the target level of visits for the practice would be based on a percentage increase above the baseline volume for that practice.

At the end of a performance year, CMS would calculate the total payments made for ED visits for qualifying conditions and subtract the equivalent level of payments for ED visits in the base year. If this calculation shows that there were savings on ED visits, the payer would calculate the change in the amount the payer had paid to all participating physicians or practices for urgent care visits relative to the base year, and then that amount would be subtracted from the ED savings to determine the net savings for the payer. A fraction (e.g., 50 percent) of the net savings amount would represent the total amount of savings to be distributed to the participating physicians or practices. Each participating physician or practice would receive a share of the total savings based on the increase in urgent care visits at that practice as a percentage of the total increase in urgent care visits across all participating practices.

## **RECOMMENDATION AND COMMENTS TO THE SECRETARY**

PTAC does not recommend the *EyEDA* proposal to the Secretary for implementation as a payment model as specified in our comments below. PTAC commends the submitter for its effort to redirect treatment for urgent eye-related conditions from the emergency room to lower-cost, higher-quality settings. PTAC members' concerns with the proposal focus on the potential scope of the proposed model and the ability of proposed payment methodology to achieve the submitter's objectives.

PTAC agrees that increased access to eye care professionals and appropriate equipment as proposed by the submitter could improve quality of care for Medicare beneficiaries and enhance value by providing care at lower-cost sites outside of the ED. A large proportion of ocular-related visits to the ED often could be appropriately treated in an office-based setting. In particular, offices may be better equipped than EDs to treat some ocular problems. The ability to have extended hours and to direct people away from the ED when there is a non-emergent but urgent eye problem is appropriate, and PTAC commends the submitter on its efforts to achieve that goal. The TCPI experience showed interest and ability of many practices, including small practices, to expand their clinical services for the proposed set of eye conditions. Participating practices also demonstrated improvements in quality and reduced use of EDs for urgent eye conditions.

PTAC notes that the proposal also has the potential to capitalize on telehealth services, such as triage and virtual visits, to help guide patient care and delivery of services in the most appropriate setting. The COVID-19 experience in early 2020, which necessitated a massive shift away from office-based visits, emphasized the value of flexible payment models, virtual services, and office-based versus hospital-based visits for ocular conditions that can appropriately be treated in other settings.

PTAC members also appreciate the submitter's efforts to include optometrists and ophthalmologists in the movement toward value-based care, a group that has historically been left out of many alternative payment models (APMs).

Despite these positive aspects of the proposal, PTAC believes the proposed payment model would not achieve the care and quality objectives sought by the submitter. PTAC wonders whether other potential payment methodologies, such as bundled payments or care coordination fees, would be more effective in achieving the aims of the proposed model than the proposed discount for office-based visits with shared savings. PTAC also wonders whether this proposed model could be embedded within a broader model such as an accountable care organization (ACO) to achieve the quality and cost objectives outlined by the submitter in a way that would include more coordination with primary care physicians and other practitioners caring for the patient.

As described, the proposed payment model may not garner adequate participation of providers or patients. PTAC is concerned that the proposed model might need to include a broader population than Medicare FFS beneficiaries to achieve sufficient numbers of patients to make participation worthwhile for providers. Additionally, the proposed payment model's incorporation of financial risk in the form of an 8 percent discount on payments could deter some physicians from participating. The estimated number of qualifying encounters that participating physicians would have each month with Medicare FFS beneficiaries is low (zero to one per doctor). The low volume of potential visits introduces risk for providers due to random chance, which highlights the challenges of achieving sufficient volume to support the payment methodology and limited scope of the proposal.

PTAC is also concerned about the proposed measures to ensure patient safety. There is a potential for misdiagnosis of patients, inadequate triage, and adverse outcomes. Patients who need care in an ED may not receive it. The broad range of conditions that are included in the proposal increases the potential for this adverse outcome. During deliberation, several Committee members also suggested that the proposed seven-day period for adverse events or complications from procedures was too short, and a longer period would be more appropriate. In addition, the proposed patient safety metrics do not appear to crosswalk to what is standard for ambulatory-sensitive conditions.

While PTAC does not recommend the *EyEDA* proposal for implementation, Committee members believe it would be beneficial to identify ways to carry forward the lessons learned from TCPI. PTAC believes it is important to find a home within APMs for the practice transformations that were tested and demonstrated to be effective as part of the TCPI program. In addition, TCPI offers lessons with regard to the training of ED physicians as well as urgent care physicians in the treatment of eye conditions.

## EVALUATION OF PROPOSAL USING SECRETARY’S CRITERIA

### PTAC Rating of Proposal by Secretarial Criteria

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

#### 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.*

#### Rating: Does Not Meet Criterion

PTAC concludes that the proposed model does not meet this criterion. Though the proposal would expand the opportunity for optometrists and ophthalmologists to participate in APMs, the proposed model narrowly focuses on changing the site of treatment for one particular set of health problems, rather than taking a more holistic approach to the patient’s needs.

The proposed model is designed to encourage patients to receive treatment from optometrists for specific conditions that optometrists are qualified to treat, but other health problems may have similar symptoms, including serious emergencies. The patient will not know what problem they have until it is diagnosed, so the proposed model may encourage some patients to receive care in the wrong place.

ED visits for eye-related conditions occur primarily among those under age 65. The environmental scan indicates that visits by adults over age 65 comprised only 8 percent of all eye-related ED visits from 2006 to 2011. The submitter intends to offer the proposed *EyEDA* model to private payers and Medicaid programs. However, the focus of PTAC review is on the potential impact for Medicare. Of the 15.9 million Medicare FFS beneficiaries who saw an ophthalmologist or optometrist in 2017, only 102,680 beneficiaries were seen in the ED for one of the diagnoses groups proposed by the submitter. It is not clear if practices would be able to increase their provision of urgent care in the office if the proposed model is not implemented for more payers beyond Medicare.

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

*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.*

### Rating: Meets Criterion

PTAC concludes that the proposed model meets this criterion. In terms of quality, increased access to care in the most appropriate setting could potentially improve health care quality. Visits to the ED are often not well-connected to a patient's usual source of care, and EDs may not have the full range of specialized ocular equipment necessary to diagnose and treat urgent eye conditions. Many patients may not be aware that they can receive urgent care for eye conditions at optometrist or ophthalmologist offices, or they may not be able to get an appointment in a timely fashion, so increased accommodation for urgent care in such offices could improve quality while reducing cost.

The proposed model includes two novel quality measures designed to ensure that urgent conditions receive high-quality care in an office setting. The proposal describes the patient safety measure as being adapted from existing outcomes measures for outpatient surgeries and procedures used by CMS, but it does not state whether the measures have been validated by an independent entity for eye-related procedures.

While the proposed model includes measures of patient safety and satisfaction, the proposed measures have limitations that may not adequately ensure the highest quality care and patient safety. Patient satisfaction, while important, does not necessarily ensure that a condition was treated in the most appropriate way for long-term outcomes. The patient safety measure captures only adverse events that occur within seven days and only adverse events that are related to the same ICD-10 diagnosis code as the original office visit, rather than a more comprehensive measure that includes other sequelae of untreated eye conditions and problems that develop more than a week after a visit. In addition, the proposed measures may not be consistent with standard measures of complications used in other ambulatory-sensitive conditions.

Further, the rate of adverse events (ED use, hospitalization, blindness, or death) is unlikely to be a statistically valid measure for small practices. The median annual number of Medicare FFS ambulatory visits per provider for ED-avoidable eye conditions is 10, and overall, less than 1 percent of visits for these conditions have ED involvement.

Related to potential impact on costs, treatment of patients in an office-based setting for the proposed eye conditions rather than in an ED when appropriate would reduce costs for both payers and patients. However, some conditions do not just represent urgent needs but are emergencies that cannot be safely treated in an office setting. For example, perforated corneal ulcers are likely to require emergency surgical intervention, but other corneal ulcers are less urgent. Delays in receiving the most appropriate treatment for some emergent conditions could lead to permanent vision loss and increased health care costs.

### 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.*

#### Rating: Does Not Meet Criterion

PTAC concludes that the proposed model does not meet this criterion. The proposal includes a strong financial incentive to participating practices to increase the number of urgent care visits for eye conditions since practices would lose up to 8 percent of the revenue for current visits if they do not meet quality and spending targets. This visit-based payment approach may assure payers that there will be an increase in such outpatient urgent visits. However, it would penalize practices whose patients already come to them for most urgent care needs. The practice may be unable to appropriately increase such visits in order to meet the target, which is based on an increase from baseline levels of urgent care visits at that specific practice, or offset the loss of 8 percent of revenue for the targeted diagnoses. In addition, the variability in visits for a small practice could cause a practice to have a low or high baseline rate based purely on random variation, thereby resulting in an inappropriately low or high target level.

The payment reductions and target levels are based on qualifying patient visits that are assigned one of a large number of diagnosis codes, including diagnoses that could be assigned for both urgent and non-urgent symptoms. The proposal does not require any mechanism to document the nature of the presenting symptom or to identify the reason the visit should be deemed urgent. Since there would be both financial incentives and disincentives to assign the designated diagnoses to a visit, some patients could be incorrectly classified, thereby resulting in higher spending.

The proposed care model calls for practice transformation activities and patient education to promote increased access to office-based urgent visits. However, the proposal does not provide any upfront payments or other mechanisms to support the ability of participating practices to deliver more and better urgent care, such as 24/7 telephone lines, same-day appointment scheduling, or after-hours care.

Although the quality performance thresholds to qualify for shared savings would provide a strong financial incentive to deliver high-quality urgent care, PTAC notes some limitations in the proposal's approach to determining shared savings payments for participating practices. The proposal requires calculating a shared savings pool based on the reduction in ED visits for these conditions. However, if only a subset of optometry and ophthalmology practices in a community are participating in the proposed model, and if only a subset of a payer's patients have a relationship with participating optometry and ophthalmology practices, only a portion of any change in ED visits would be attributable to the actions of the participating practices. The proposal does not specify how this attribution would be addressed in making the savings calculation, or how adjustments would be made when the number of eligible patients in the service area changes between the baseline and performance periods. The submitter suggested the adverse event rate could be risk-adjusted, but the proposal does not include a risk adjustment approach. Previous experiences with APMs with shared savings approaches show that calculations become complicated when a new practice forms or merges because a baseline or comparable practice is difficult to identify for the calculation of an accurate benchmark.

#### Criterion 4. Value over Volume

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

#### **Rating: Meets Criterion**

PTAC concludes that the proposed model meets this criterion. The proposal creates an incentive for optometry and ophthalmology practices to encourage patients to come to their office for urgent care needs, which would likely decrease ED visits for eye-related conditions. The proposal also includes a measure indicating whether the ocular problem was resolved and also tracks satisfaction and adverse events.

One limitation is the fact that the small size of many practices will make statistically appropriate assessment of adverse event rates problematic. Payments for urgent care services and targets are still tied to office visits with the physician. The proposed model also incentivizes practices to increase the number of office-based visits in order to offset payment cuts and meet visit targets, even if more visits are not needed.

## Criterion 5. Flexibility

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

### Rating: Meets Criterion

PTAC concludes that the proposed model meets this criterion. The proposal would reward optometrists and ophthalmologists for changes in their care delivery processes in order to better respond to patients with urgent eye conditions, without dictating how the practices should do this.

Though the proposal would provide flexibility for practitioners, it does not fundamentally alter the Medicare FFS structure of payment for eye visits. In addition, the 8 percent reduction in visit payments and an uncertain shared savings payment could make it more difficult for practices to provide services that do not qualify for fees.

## Criterion 6. Ability to Be Evaluated

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

### Rating: Meets Criterion

PTAC concludes that the proposed model meets this criterion. The proposal's primary performance measure (the increase in the number of office visits for qualifying conditions) is quantifiable and could be compared with other providers. The information is systematically collected through claims across providers and over time. The proposal uses standard ICD-10 coding to identify urgent visits, so the same definitions of eligible visits could be used for non-participating providers. The adverse event metric could also be determined from claims for participating providers and compared with non-participating providers.

The evaluation of the proposed model could be challenging in several ways. To compare patient experience and satisfaction between participating providers and non-participants, patient survey data would have to be collected from a comparison group of patients who see non-participating providers. The difficulties in determining which ED visits should be associated with participating providers for purposes of calculating shared savings would also make it difficult to evaluate whether changes in ED visits were different between participating and nonparticipating providers.

## Criterion 7. Integration and Care Coordination

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

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

PTAC concludes that the proposed model does not meet this criterion. Though the submitter noted that eye care specialists informally make referrals among themselves and to other providers to ensure appropriate care, participating providers would be encouraged to see patients for urgent care needs even if they are not the most appropriate provider to treat the condition. In addition, the proposed model does not include formal methods for integration with primary care physicians or other providers who may be initiating treatment or treating a patient.

This proposed model was developed through TCPI in the context of an academic “hub and spoke” setting, with an interdisciplinary approach of ED physicians, optometrists and ophthalmologists, urgent care physicians, and others. This integrated approach may be difficult to scale to other practices that do not have existing robust systems of referral and triage. A broader payment model that supports and facilitates these triage and referral systems across settings may be more appropriate to achieve the care delivery objectives.

## 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.*

### **Rating: Meets Criterion**

PTAC concludes that the proposed model meets this criterion. The proposed model would make it easier for patients to receive appropriate treatment for urgent eye conditions outside of a hospital ED. The TCPI experience demonstrates that office-based providers can expand urgent care availability and that patients appreciate the expanded choices for sites of care.

It is possible that a beneficiary might not realize that they have the right to seek care in another setting (such as an ED) even if their optometrist or ophthalmologist presents them with access in the office setting.

## Criterion 9. Patient Safety

*Aim to maintain or improve standards of patient safety.*

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

PTAC concludes that the proposed model does not meet this criterion. PTAC is concerned that the proposed diagnosis codes cover a broad range of eye conditions, some of which are much more clinically serious (e.g., corneal ulcers) than others (e.g., conjunctivitis). Moreover, patients do not know their diagnosis when they seek care for an eye condition, only their symptoms. The same symptoms—such as eye pain, impairment of visual field, or redness—can result from conditions across a wide range of clinical severity, not all of which are appropriate for care by an optometrist or in an office setting.

Patients who need care in an ED may not receive care in that setting, which could harm patient safety. The broad range of conditions that are included in the proposal increases the potential for this adverse outcome. Although the quality measures would help to ensure that adverse events do not occur frequently, they would not preclude them from occurring in individual cases. In addition, one PTAC member noted that the quality measures proposed are not consistent with measures of adverse events used for other ambulatory-sensitive conditions.

## Criterion 10. Health Information Technology

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

### **Rating: Meets Criterion**

PTAC concludes that the proposed model meets this criterion. The TCPI project, on which the proposal is based, led providers to use electronic health records more extensively. If implemented well, the proposal could encourage providers to use technology to a greater extent to inform care. There is potential for providers to incorporate telehealth services to expand access and achieve the proposal's objectives.

While the proposed model does not explicitly require or encourage enhanced use of health information technology, it is likely that providers participating in the proposed model would find enhanced use of health information technology to be beneficial in order to triage patients and increase access.

## APPENDIX 1. COMMITTEE MEMBERS AND TERMS

**Jeffrey Bailet, MD, Chair**

**Grace Terrell, MD, MMM, Vice Chair**

Term Expires October 2020

**Grace Terrell, MD, MMM**

*Eventus WholeHealth*

Concord, NC

Term Expires October 2021

**Jeffrey Bailet, MD**

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## APPENDIX 2. PFPM CRITERIA ESTABLISHED BY THE SECRETARY

### PFPM CRITERIA ESTABLISHED BY THE SECRETARY

1. **Scope.** 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.
2. **Quality and Cost.** 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.
3. **Payment Methodology.** 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 Physician-Focused Payment Model cannot be tested under current payment methodologies.
4. **Value over Volume.** Provide incentives to practitioners to deliver high-quality health care.
5. **Flexibility.** Provide the flexibility needed for practitioners to deliver high-quality health care.
6. **Ability to Be Evaluated.** Have evaluable goals for quality of care, cost, and any other goals of the PFPM.
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.
8. **Patient Choice.** Encourage greater attention to the health of the population served while also supporting the unique needs and preferences of individual patients.
9. **Patient Safety.** Aim to maintain or improve standards of patient safety.
10. **Health Information Technology.** Encourage use of health information technology to inform care.

**APPENDIX 3. DISTRIBUTION OF MEMBER VOTES ON EXTENT TO WHICH PROPOSAL MEETS CRITERIA<sup>1</sup>**

Criteria Specified by the Secretary (at 42 CFR §414.1465)	Not Applicable	Does Not Meet Criterion		Meets Criterion		Priority Consideration		Rating
	*	1	2	3	4	5	6	
1. Scope (High Priority)	0	1	6	1	0	0	0	Does Not Meet Criterion
2. Quality and Cost (High Priority)	0	0	0	7	1	0	0	Meets Criterion
3. Payment Methodology (High Priority)	0	4	4	0	0	0	0	Does Not Meet Criterion
4. Value over Volume	0	0	1	6	1	0	0	Meets Criterion
5. Flexibility	0	0	0	6	2	0	0	Meets Criterion
6. Ability to Be Evaluated	0	0	1	7	0	0	0	Meets Criterion
7. Integration and Care Coordination	0	3	2	3	0	0	0	Does Not Meet Criterion
8. Patient Choice	0	0	0	6	2	0	0	Meets Criterion
9. Patient Safety	0	2	5	0	1	0	0	Does Not Meet Criterion
10. Health Information Technology	0	0	1	5	2	0	0	Meets Criterion

\* Indicates a vote that was not in any of the other categories for this criterion

<sup>1</sup>Criteria designated as “high priority” are those PTAC believes are of greatest importance in the overall review of the payment model proposal.

## APPENDIX 4. DISTRIBUTION OF MEMBER VOTES ON OVERALL RECOMMENDATION

### Recommendation Vote: Part 1 of 2<sup>1</sup>

Not Recommended for Implementation as a PFPM	Recommended	Referred for Other Attention by HHS	Result
7	0	1	Not Recommended for Implementation as a PFPM

### Recommendation Vote: Part 2 of 2 (if applicable)

Proposal substantially meets Secretary's criteria for PFPMs. PTAC recommends implementing proposal as a payment model.	PTAC recommends further developing and implementing the proposal as a payment model as specified in PTAC comments.	PTAC recommends testing the proposal as specified in PTAC comments to inform payment model development.	PTAC recommends implementing the proposal as part of an existing or planned CMMI model.	Result
N/A	N/A	N/A	N/A	N/A

**Final recommendation to Secretary: PTAC does not recommend this model for implementation as a PFPM.**

<sup>1</sup> In 2018, PTAC adopted new voting categories, used first at its December 2018 public meeting. First, PTAC votes on the three categories listed above as Part 1 of 2. PTAC must achieve a two-thirds majority for one of these categories. If a two-thirds majority votes to not recommend the proposal for implementation as a PFPM or to refer the proposal for other attention by HHS, that category is the Committee's final recommendation to the Secretary. If the two-thirds majority votes to recommend the proposal, the Committee proceeds to Part 2 of 2 to determine the final, overall recommendation for the Secretary. The second vote uses the four subcategories listed above. A two-thirds majority must be achieved for one of these four categories.