Physician-Focused Payment Model Technical Advisory Committee

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October 20, 2018

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), *An Innovative Model for Primary Care Office Payment (IMPC-APM)*, submitted by Jean Antonucci, MD (Dr. Antonucci). 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 Dr. Antonucci's proposal (submitted to PTAC on March 21, 2018) and additional information on the proposed payment model that she provided in response to questions from the PTAC Preliminary Review Team and PTAC as a whole. At a public meeting of PTAC held on September 6, 2018, 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 believes there is an urgent need to preserve and strengthen primary care, and it recommends the *IMPC-APM* proposal to the Secretary for limited-scale testing. The Committee finds that the proposal meets six of the Secretary's ten criteria. Although the Committee found that the submitted proposal does not meet all of the criteria, including two of the

High-priority criteria, the Committee members believed that: 1) the key elements of the proposal were very innovative and had the potential to improve primary care quality and access, particularly in communities served by small and rural primary care practices; 2) the weaknesses and gaps in the proposal could be remedied with additional information and assistance; but 3) because of the innovative nature of the proposed approach, it would not be feasible to fully address some of the most important gaps in the proposal—particularly with respect to payment, risk stratification, quality measurement, and patient safety—without "beta testing" the proposed payment model in the field with actual physician practices. While HHS has expressed concerns about the feasibility of limited-scale testing, PTAC believes that the testing and development of this model could be cost-effectively done in conjunction with testing of other primary care models. PTAC believes that the approach to payment and quality measurement in the *IMPC-APM* model could ultimately have a significant long-term impact on helping to achieve four important goals that the Secretary has identified related to getting better value from our health care system: making patients into empowered consumers, making providers into accountable navigators of the health system, paying for outcomes, and preventing disease before it occurs or progresses.

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. If you need additional information, please have your staff contact me at Jeff.Bailet@blueshieldca.com.

Sincerely,

Jeffrey Bailet, MD
Chair

Attachments

Physician-Focused Payment Model Technical Advisory Committee

REPORT TO THE SECRETARY OF HEALTH AND HUMAN SERVICES

Comments and Recommendation on

An Innovative Model for Primary Care Office Payment Alternative Payment Model (IMPC-APM)

October 20, 2018

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 a PFPM proposal, *An Innovative Model for Primary Care Office Payment (IMPC-APM)*, submitted by Jean Antonucci, MD (Dr. Antonucci). 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 Dr. Antonucci, and additional information on the proposal submitted by Dr. Antonucci subsequent to the initial proposal submission.

SUMMARY STATEMENT

PTAC believes there is an urgent need to preserve and strengthen primary care and recommends the *An Innovative Model for Primary Care Office Payment (IMPC-APM)* proposal to the Secretary for limited-scale testing. The Committee finds that the proposal meets six of the Secretary's ten criteria. Although the Committee found that the submitted proposal does not meet all of the criteria, including two of the high-priority criteria, the Committee members believed that: 1) the key elements of the proposal were very innovative and had the potential to improve primary care quality and access, particularly in communities served by small and rural primary care practices; 2) the weaknesses and gaps in the proposal could be remedied with additional information and assistance; but 3) because of the innovative nature of the proposed approach, it would not be feasible to fill some of the most important gaps in the proposal—particularly with respect to payment, risk stratification, quality measurement, and patient safety—without "beta testing" the proposed payment model in the field with actual physician practices.

While HHS has expressed concerns about the feasibility of limited-scale testing, PTAC believes that the testing and development of this model could be cost-effectively done in conjunction with testing of other primary care models. PTAC believes that the approach to payment and quality measurement in the *IMPC-APM* model could ultimately have a significant long-term impact on helping to achieve four important goals that the Secretary has identified related to getting better value from our health care system: making patients into empowered consumers, making providers into accountable navigators of the health system, paying for outcomes, and preventing disease before it occurs or progresses.

PTAC REVIEW OF THE PROPOSAL

Dr. Antonucci's proposal was submitted to PTAC on March 21, 2018. The proposal was first reviewed by a PTAC Preliminary Review Team (PRT) composed of three PTAC members (Harold Miller, Tim Ferris, and Kavita Patel), two of whom are physicians. These members requested additional information from Dr. Antonucci to assist in their review. The proposal was also posted for public comment. In addition, the Bipartisan Budget Act of 2018 allows for initial feedback to submitters of proposed models on the extent to which their proposal meets the Secretary's criteria and the basis for that feedback. The PRT sent an initial feedback document to the submitter on July 30, 2018. The PRT's findings were documented in the *Preliminary Review Team Report to the Physician-Focused Payment Model Technical Advisory Committee (PTAC)* dated August 9, 2018. At a public meeting held on September 6, 2018, 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.[1] The submitter and members of the public were given an opportunity to make statements to the Committee at the public meeting. Below are 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

Under the proposed *IMPC-APM* model, primary care practices would receive risk-stratified monthly primary care payments in place of current fee-for-service payments, and the practices would be held accountable for quality based on the results of patient-reported survey data.

Primary care physicians (excluding pediatricians) and independent primary care nurse practitioners would be eligible to participate in the *IMPC-APM*. The primary care practice would likely serve as the APM Entity. While there are no practice size or geographic restrictions, the proposed model is designed specifically for small, independent practices.

Under the proposed model, primary care practices would be paid in the following way:

- The practice would receive a risk-stratified per beneficiary per month (PBPM) payment that would replace payments under the Medicare Physician Fee Schedule for Evaluation and Management (E/M) services and minor procedures and office-based tests. The practice would continue to receive fee for service (FFS) payments for services for which the practice incurs a significant supply cost—such as intrauterine device (IUD) insertion, vaccines, and injections of medications over a specified cost threshold.

  The submitter proposes that the PBPM payments should be $60 for low- and medium-risk patients and $90 for high-risk patients. Physicians would submit encounter forms to Medicare describing the services that are delivered, so the submitter anticipates that patients' coinsurance should remain the same.

- A performance-based payment would be created by withholding 15 percent of the PBPM payment ("the withhold") and paying the withhold to the practice only if the APM Entity meets a quality performance standard (the standard was not specified in the proposal). There would be an opportunity for the practice to appeal to have the

[1]PTAC member Elizabeth Mitchell was not in attendance, and PTAC member Robert Berenson, MD, recused himself from deliberation and voting on this proposal.

withhold paid if the practice fell just short of achieving the performance standard or if there were extenuating circumstances.

The submitter anticipates that the additional financial resources and administrative burden reduction that would be made possible by the *IMPC-APM* model will provide additional flexibility that will allow primary care practices to provide e-visits, telehealth, care coordination, infrastructure improvements, and other innovations that are not possible under the Medicare Physician Fee Schedule. The *IMPC-APM* would cap panel sizes at 1,500 patients per physician to preserve quality.

Participating practices would be required to have an annual visit with every patient, and in order to maintain access for patients, each practice would be required to have the same office hours, staff, and phone numbers as it had prior to participation in the *IMPC-APM*.

Patient attribution would primarily be through patient choice of a primary care physician or nurse practitioner in a participating practice, or by using the four-step attribution process recommended by the American Academy of Family Physicians (including claims-based attribution based on Wellness Visits, All Other E/M Visits, and Primary Care Prescription and Order Events). Additionally, the submitter stated that an informational handout could be provided to patients prior to enrollment.

The quality of care would be measured using information collected in the "How's Your Health" (HYH) survey, which would be available free of charge to participating practices at www.HowsYourHealth.org. The HYH tool gathers data by having patients complete a 15-minute online survey. This process generates a report for the physician that contains actionable information about the patient's "function, diagnosis, symptoms, health habits, preventive needs, capacity to self-manage chronic conditions, and their experiences of care." Aggregate data for the practice's patients would be compared with national benchmarks derived from data submitted by patients in other participating practices. According to the submitter, the HYH data can also "be parsed by discrete time periods, patient age, disease state, or socioeconomic factors, and can be used to determine populations at risk for [emergency room] and hospital utilization." The submitter states that HYH offers "simple reporting at no cost, low burden and high value" and that it is feasible for small practices to use. The submitter also references studies that have validated the accuracy of the patient-reported quality metrics in HYH based on comparisons with chart reviews.

For risk stratification, the *IMPC-APM* model proposes to use the "What Matters Index" (WMI) derived from HYH to assign each patient into low-, medium-, or high-risk categories based on

five factors (pain, emotional issues, polypharmacy, adverse medication effects, and low confidence in managing health problems) that are strongly associated with the use of costly hospital and emergency services.

The submitter states that the WMI risk stratification also corresponds with patients' primary care service utilization patterns—with low- and medium-risk patients typically coming in to the office 2–3 times per year or less, and high-risk patients coming in 3–5 times per year or more and also needing many calls, nurse visits, family calls, prior authorizations, etc.

Participating practices would be expected to describe how they integrated HYH into the practice in such a way as to encourage completion of the survey by as many patients as possible. The submitter indicates that it would likely not be feasible to get 100 percent of the patients to complete the HYH survey, and that a practice would need to have at least 60 to 100 surveys completed per year to get statistically valid data.

Comparison to Other APMs

The *IMPC-APM* model has some similarities to the Comprehensive Primary Care Plus (CPC+) APM that is currently being tested by the Centers for Medicare & Medicaid Services (CMS) Center for Medicare & Medicaid Innovation (CMMI, or the Innovation Center), and it also has many similarities to the *Advanced Primary Care: A Foundational Alternative Payment Model for Delivering Patient-Centered, Longitudinal, and Coordinated Care* (APC-APM) proposal that PTAC recommended for limited-scale testing at the December 2017 meeting, but it also has some important differences. The *IMPC-APM* model would be closer to providing full capitation for primary care than the CPC+ model, which provides an option for partial capitation; and it would use a very different approach to quality measurement and performance-based payment. The table below shows key similarities and differences between the CPC+ model, the APC-APM, and the *IMPC-APM*:

Dimension	CPC+	APC-APM	IMPC-APM
Payer(s)	Multi-payer	Multi-payer (but can be Medicare-only)	Would begin with Medicare (but could be expanded to other payers)
Practice Eligibility	Primary care practices must apply and be selected by CMS. Only available to practices	Practices including physicians with a primary specialty designation of family medicine, general practice, geriatric medicine,	Any primary care practice (excluding pediatrics) Would be available

Dimension	CPC+	APC-APM	IMPC-APM
	located in 18 regions	pediatric medicine, or internal medicine Would be available nationally	nationally
Patient Attribution	Based on a claims-based attribution methodology that is conducted on a quarterly basis Beneficiaries remain free to select the practitioners and services of their choice	Primary method of attribution would be patients explicitly choosing to use the practice Secondary method would be based on claims-based attribution methodology	Primary method of attribution would be patients explicitly choosing to use the practice Secondary method would be based on claims-based attribution methodology
Payment Overview	3–4 Components • Track 1 practices continue to bill and receive payment from Medicare FFS as usual • Track 2 practices receive: ➢ quarterly Comprehensive Primary Care Payments (CPCP) ➢ reduced Medicare FFS payments • Risk-adjusted Care Management Fee (CMF) for each patient that is paid on a quarterly basis to support non-visit-based services • Performance-Based Incentive Payment (PBIP) paid at the beginning of each Program Year and may be recouped by the payer based on how well the practice	4 Components • Risk-adjusted PBPM payment for E/M services delivered by the primary care practice (either for office-based E/M services or for all E/M services regardless of site of service) • Risk-adjusted PBPM payment for non-face-to-face care management services delivered by the practice • Prospectively awarded incentive payments paid at the beginning of each quarter and recouped if the practice fails to meet performance benchmarks (payments would represent approximately 8% of revenue) • Continued FFS payment for non-E/M services and for E/M services that are not included in the PBPM	2 Components • Risk-stratified PBPM payment in place of virtually all current fees (including E/M services, minor procedures, and office-based tests) • 15% of PBPM payment is withheld and forfeited if the practice fails to meet quality targets

Dimension	CPC+	APC-APM	IMPC-APM
	performs on patient experience, clinical quality, and utilization measures (~10% of revenue for Track 1; higher for Track 2)	payments	
Approach to Risk Stratification of Payments	CMF payments are stratified into 4–5 tiers based on the CMS Hierarchical Condition Categories (CMS-HCC) risk score assigned to patients	Proposes use of Minnesota Complexity Assessment Model for risk stratification but does not specify how many categories of payment would be created or how they would be defined	PBPM payments would be stratified into two tiers based on the patient's score on the WMI (Low/ Medium Risk and High Risk) The HYH Tool would be used for risk stratification of performance measures
Accountability for Quality and Spending	One-half of the performance-based incentive payment would be based on quality measures, and one-half would be based on utilization of hospital services Quality measures include patient experience of care measures from the Consumer Assessment of Healthcare Providers and Systems (CAHPS) Clinician and Group Patient-Centered Medical Home Survey and clinical quality using electronic clinical quality measures (eCQMs) Practices must report at least 9 of the 14 CPC+ eCQMs (all of which are Merit-based Incentive Payment System (MIPS)	The PBIP would be retained or recouped based on the practice's performance on measures of both quality and cost, similar to CPC+ However, fewer measures and a different mix of quality measures would be used than CPC+ The APM Entity would select 6 quality measures, including at least 1 outcome measure, from the Accountable Care Organizations, Patient-Centered Medical Homes, and Primary Care Measure Set developed by the Core Quality Measure Collaborative	The withhold payment would be returned based on the practice's performance on patient-reported measures from the HYH survey instrument. Measures would include outcomes, access to care, and utilization of hospital services. The exact measures and standards of performance are not specified in the proposal.

Dimension	CPC+	APC-APM	IMPC-APM
	measures). Practices must report on at least 2 of 3 outcomes measures, at least 2 of 4 complex care measures, and any 5 of the remaining measures		

RECOMMENDATION AND COMMENTS TO THE SECRETARY

PTAC finds that the proposal meets six of the Secretary's ten criteria. The Committee recommends the *IMPC-APM* proposal to the Secretary for limited-scale testing. However, PTAC also identifies several aspects of the proposal that will require further specificity or refinement.

At its December 2017 public meeting, PTAC agreed that there is an urgent need to preserve and strengthen primary care and that additional opportunities are needed for primary care providers to participate in APMs. At that meeting, PTAC recommended that HHS conduct limited-scale testing of the Advanced Primary Care APM (APC-APM) developed by the American Academy of Family Physicians (AAFP), and that HHS do so as a high priority.

PTAC finds that the *IMPC-APM* proposal offers a creative, innovative approach for creating broader opportunities for primary care participation, improving quality, and enhancing simplicity. The *IMPC-APM* payment model has some similarities to the APC-APM, but also some important differences. Members believe the proposal has many unique and promising elements that are designed to address, and would be desirable for, small, independent, and rural primary care practices that are not currently participating in APMs.

For example, PTAC believes that the *IMPC-APM* proposal's significantly simpler payment structure and quality reporting methodology would be easier for smaller practices to implement than the methodologies in some other primary care payment models. The Committee also believes that the *IMPC-APM* proposal's innovative approach of collecting patient-reported data through an online tool and using it for risk stratification, quality measurement and performance benchmarking, and care coordination would not only be beneficial for primary care payment models but could also potentially enable increased use of patient-reported outcomes data in other payment models.

However, PTAC also identifies several aspects of the proposal that will require further specificity or refinement. In particular:

- It will be necessary to develop a standardized sampling frame and mode of administration for collecting patient-reported quality and risk stratification data in order to ensure consistency and comparability of results for use in a payment model.
- It will be important to have a way of comparing participating practices' performance on the patient-reported measures to their prior performance levels based on existing Medicare quality measures and/or with performance of nonparticipating practices that are using existing Medicare quality measures.
- Appropriate capitation payment levels will need to be determined.
- Quality benchmarks will need to be set, as well as other aspects of the mechanism for earning back the performance-based payment withhold.
- Eligibility criteria will need to be established to determine which practices can participate in the capitation model.
- A method of determining panel size caps based on practice type or the mix of patients in the practice will be needed.

During the Public Meeting, the submitter, an individual solo practitioner who has already conducted initial "alpha-testing" of the proposed model in her own practice, indicated that she is unable to resolve these technical issues on her own. Therefore, given the significant potential that this model offers related to further strengthening primary care and patient-reported quality outcomes, PTAC believes that these issues should be resolved through limited-scale testing. While HHS has expressed concerns about the feasibility of limited-scale testing, PTAC believes that the testing and development of this model could be cost effectively done in conjunction with testing of other primary care models, e.g., as one track within a larger primary care model that is being implemented through the CMS Innovation Center, rather than as a free-standing model.

PTAC believes that the approach to payment and quality measurement in the *IMPC-APM* model could ultimately have a significant long-term impact on helping to achieve four important goals that the Secretary has identified related to getting better value from our health care system: making patients into empowered consumers, making providers into accountable navigators of the health system, paying for outcomes, and preventing disease before it occurs or progresses.

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)[1]	Meets Criterion
2. Quality and Cost (High Priority)	Does Not Meet 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: Meets Criterion

PTAC concludes that the proposed model meets this criterion. PTAC believes that the *IMPC-APM* proposal's significantly simpler payment structure and quality reporting methodology could make it easier for smaller physician practices to implement than other APMs, and thus easier for them to participate in an APM.

The proposed payment model is also significantly different than the payment models for primary care practices that have previously been tested by CMMI and that are currently being tested in CMMI's 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, particularly in rural parts of the country. Additionally, 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.

[1]Criteria designated as "high priority" are those PTAC believes are of greatest importance in the overall review of the payment model proposal.

The Committee also believes that the *IMPC-APM* proposal's innovative approach of utilizing patient-reported data collected through an online tool for risk stratification, quality measurement and performance benchmarking, and care coordination could potentially be used more broadly. The *IMPC-APM*'s proposed use of patient-reported measures from the HYH survey instrument for quality accountability, and risk adjustment of both payments and performance measures based on the WMI, is completely different from any other CMS APM. Committee members believe that this proposal's creative approach to quality measurement could help increase the use of patient-reported outcomes data in other models.

The stratified monthly payment in the proposed payment model is similar to the payment structure in the APC-APM 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 APC-APM 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 testing the *IMPC-APM* as a completely separate model. PTAC believes that *IMPC-APM* could be tested as one track within a larger primary care model, rather than as a freestanding model.

Committee members believe that the proposal has the potential for a large long-term impact, even though there may be a small number of participants in the short term.

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: Does Not Meet Criterion

PTAC concludes that the model as proposed does not meet this criterion. 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 justification provided for this significant increase in payments is to increase earnings for primary care physicians, though PTAC members noted that the payments should be used primarily to cover costs of explicitly identified additional services for patients.

There is mixed evidence regarding 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. However, the proposed *IMPC-APM* 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 for patients living in those communities could generate additional savings. 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, past 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 *IMPC-APM* 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 the MIPS or other CMS primary care models, the proposed increase in monthly payments would mean the practice would still be receiving significantly more revenue than it would receive under the current system, even if it failed to receive the 15% withhold, which could reduce the incentive to deliver high-quality care.

Committee members noted that various groups such as the Medicare Payment Advisory Committee (MedPAC) and the American Medical Group Association (AMGA) have raised concerns about the limitations of MIPS and the need for improvements in the way that quality is being measured, including a need for greater simplicity. The *IMPC-APM* proposal's focus on patient-reported outcomes using the HYH tool is innovative and is very desirable in many ways, including reducing administrative burden on physicians associated with collecting and reporting multiple quality measures and ensuring attention to the issues that matter to patients. The model's use of patient-reported outcomes as a way of doing risk assessment and risk stratification for patients with more complex care needs merits testing.

However, 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 HYH tool and risk adjustment through the WMI have not been tested or validated for accountability performance evaluation or payment. The impacts on patient access and measure reliability from tying the results to payment would need to be carefully assessed, and this could only be done by beta testing the model in the field. In order to use the results of the HYH tool as part of a performance-based payment, a standardized sampling frame and mode of administration would be needed in order

to ensure consistency and comparability of results and to avoid the possibility of manipulation of results, and this would be substantially different than the current method of data collection for use in quality improvement and patient care.

Under the proposed model, participating practices 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 submitter 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.

However, 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 could diminish the efficiency of service delivery and increase Medicare spending. Additionally, 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 nonparticipating practices. Moreover, 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.

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. PTAC finds that 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. Members noted that the quality component of the proposed payment 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, particularly if the participating practices are not also reporting data for standard MIPS quality measures.

Under the proposed *IMPC-APM* model, participating primary care practices would receive a risk-stratified monthly payment that would replace virtually all of the practice's FFS 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. Additionally, a significant portion (15%) of the practice's revenues would be at risk based on quality performance.

However, the proposed model would allow practices to receive capitation payments for patients even if the patients don't complete the full HYH survey. Risk stratification would be based on a shorter WMI, which is only 5 to 7 questions. PTAC members noted that there would be an incentive for the practice to ensure that higher-risk patients answer the WMI questions because the higher risk-adjusted capitation payment within the two-tiered structure would only be paid if the patient qualified for the high-risk category based on the WMI. During the PTAC Meeting, the submitter indicated that one potential option for ensuring a high response rate would be to require that a minimum percentage of patients participate in the How's Your Health/What Matters Index survey during the first year, with the minimum increasing in subsequent years, and a penalty in the event that there is evidence of "gaming" (i.e., practices selectively encouraging or discouraging responses from specific subsets of patients).

Another concern is that 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. Additionally, 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 15% 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 15% withhold were not defined in the proposal. An all-or-nothing approach makes annual budgeting a challenge and puts the fiscal viability of a practice at some risk.

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. Under the proposed model, the payments to the participating primary care practices 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 rates of ED visits and hospital admissions.

Participating practices would be paid more for patients with characteristics that typically indicate a need for more proactive or intensive services. Additionally, a significant portion (15%) of each participating practice's revenues would be at risk based on quality performance. However, members noted that 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 proposed cap on patient panel size would discourage participating practices 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, the combination of high payments per patient and the panel size cap could discourage participating practices from accepting healthier patients who need good preventive care. Additional analysis is needed to determine a way to adjust panel size caps based on practice type or the mix of patients in the practice.

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. Members noted that the proposed model includes a very flexible payment. 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, with even more resources available for higher-need patients.

Under the proposed model, participating primary care practices would have complete flexibility as to which services they would deliver using the revenues from the monthly per-patient payments. Participating practices 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 would be much higher than what the practice currently receives, which could enable the delivery of many more or different services to patients. However, the participating primary care 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; and 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.

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. 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 those amounts to utilization and spending for patients attributed to non-participating practices. The major challenge is that the *IMPC-APM* model would use a completely different method of assessing quality than in the rest of the Medicare program.

If participating practices were required to report standard MIPS quality measures as well as the patient-reported measures, this would facilitate comparisons with nonparticipating practices, but it would also increase administrative burden. PTAC believed it would be feasible to compare practices' performance on some of the patient-reported measures in the How's Your Health and What Matters Index with existing Medicare quality measures. However, beta testing will be needed in order to develop a standardized sampling frame and mode of administration for collecting patient-reported quality and risk stratification data in order to ensure consistency and comparability of results. Also, if participating practices continue to submit encounter forms for services, an evaluation could determine how the services provided by the participating practices have changed and how they differ from other practices.

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. PTAC believes that although the proposed model could enable participating practices to carry out care coordination activities if they wanted to, there are no specific mechanisms defined for assuring that they would do so. Additionally, 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, and the proposal does not establish any specific standards or goals related to care coordination.

PTAC members noted that use of the HYH survey would help participating practices to 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. However, the ability to assess the success of care coordination would be affected by patients' response to using the online HYH tool.

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 payment model would enable primary care practices to deliver services in different ways based on their patients' needs. If the *IMPC-APM* 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, particularly in rural areas.

If all of the primary care physicians in a practice or community choose to be in this model, it could limit patient access and options; however, this concern could be minimized if the proposal is implemented with other alternative options. For example, the submitter stated that patients could potentially be given an option of continuing to see their physician in the practice with payments made under the standard Medicare Physician Fee Schedule rather than through the proposed model. Similarly, although the proposed limit on practice panel size could potentially reduce access to primary care in underserved areas in the short run, the higher and

more flexible payments could attract more primary care providers, and additional analysis could be conducted to explore ways to adjust the panel size caps based on practice type or the mix of patients in the practice to avoid limiting access.

The use of the HYH survey and WMI data would create a direct way for patients to notify the participating primary care practices of their needs and would encourage practices to respond to individual needs. There is research positively correlating health risk assessment (HRA) survey data with patients' health outcomes.

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.

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. Committee members believe that the use of patient-reported outcomes data has the potential for enhancing patient safety, and the HYH Tool provides high-quality data that could give patients a way to be more in control of thinking about their health. However, members believe the proposed model provides inadequate protections for patients relating to access and quality assurance in order to ensure that individual patients in participating practices would receive the care they need. Committee members noted that complaints have been raised regarding "stinting," or physicians not seeing the patients in prior broad-scale tests of primary care capitation, and wondered whether the proposed model could be launched in Medicare without raising similar concerns.

PTAC also noted that the *IMPC-APM* model's proposal to change the payment approach while also changing the quality measurement approach could make it more difficult to ensure that there had not been an abrupt change in the quality of care being provided to patients under the new model. For example, because participating practices would be paid the same PBPM 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 HYH survey, it is possible that a participating practice could receive its full payment for every patient even if a subset of patients is receiving poor-quality care.

Although the HYH survey and the WMI would help practices to identify patients with potential medication safety issues and other safety issues, there is no requirement that the HYH survey be completed by all patients. Additionally, the highest-risk patients may be the least able or willing to complete an online survey. Furthermore, 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 higher-risk patients or provide adequate care for patients who needed additional visits.

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 model is premised on the use of an online system (www.HowsYourHealth.com) for collecting patient-reported outcomes and for analysis of practice performance. Patients in participating practices would be encouraged to complete an online survey tool assessing health-related issues and satisfaction with the practice's services. Although the proposal says that at least "50% of qualifying participants are expected to use CEHRT" (Certified Electronic Health Records Technology), there is no mechanism for assuring that this will occur.

APPENDIX 1. COMMITTEE MEMBERS AND TERMS

Jeffrey Bailet, MD, *Chair*

Term Expires October 2018

Jeffrey Bailet, MD
Blue Shield of California
San Francisco, CA

Robert Berenson, MD
Urban Institute
Washington, DC

Elizabeth Mitchell
Blue Shield of California
San Francisco, CA

Kavita Patel, MD, MSHS
Brookings Institution
Washington, DC

Term Expires October 2019

Paul N. Casale, MD, MPH
NewYork Quality Care
NewYork-Presbyterian, Columbia University College of Physicians and Surgeons, Weill Cornell Medicine
New York, NY

Tim Ferris, MD, MPH
Massachusetts General Physicians Organization
Boston, MA

Bruce Steinwald, MBA
Independent Consultant
Washington, DC

Term Expires October 2020

Rhonda M. Medows, MD
Providence St. Joseph Health
Seattle, WA

Harold D. Miller
Center for Healthcare Quality and Payment Reform
Pittsburgh, PA

Len M. Nichols, PhD
Center for Health Policy Research and Ethics
George Mason University
Fairfax, VA

Grace Terrell, MD, MMM
Envision Genomics
Huntsville, AL

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 PFPM 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 AND OVERALL RECOMMENDATION[1]

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)[2]	-	-	1	5	-	1	2	Meets Criterion
2. Quality and Cost (High Priority)	-	1	5	3	-	-	-	Does Not Meet Criterion
3. Payment Methodology (High Priority)	-	-	6	2	-	1	-	Does Not Meet Criterion
4. Value over Volume	-	-	1	2	5	-	1	Meets Criterion
5. Flexibility	-	-	1	2	4	1	1	Meets Criterion
6. Ability to Be Evaluated	-	-	4	4	1	-	-	Meets Criterion
7. Integration and Care Coordination	-	-	6	3	-	-	-	Does Not Meet Criterion
8. Patient Choice	-	-	2	6	-	1	-	Meets Criterion
9. Patient Safety	-	-	6	2	-	-	1	Does Not Meet Criterion
10. Health Information Technology	-	-	-	7	1	1	-	Meets Criterion

Not Applicable	Do Not Recommend	Recommend for Limited-scale Testing	Recommend for Implementation	Recommend for Implementation as a High Priority	Recommendation
-	2	6	1	-	Recommend for Limited-Scale Testing

[1]PTAC member Elizabeth Mitchell was not in attendance. PTAC member Robert Berenson, MD, recused himself from deliberation and voting on this proposal.
[2]Criteria designated as "high priority" are those PTAC believes are of greatest importance in the overall review of the payment model proposal.