

Physician-Focused Payment Model Technical Advisory Committee

Preliminary Review Team Report to the Physician-Focused Payment Model Technical Advisory Committee (PTAC) on the “Comprehensive Care Physician Payment Model”

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In accordance with the Physician-Focused Payment Model Technical Advisory Committee’s (PTAC’s) Proposal Review Process described in *Physician-Focused Payment Models: PTAC Proposal Submission Instructions* (available on the ASPE PTAC [website](#)), physician-focused payment models (PFPMs) that contain the information requested by PTAC’s Proposal Submission Instructions will be assigned to a Preliminary Review Team (PRT). The PRT will draft a report containing findings regarding the proposal for discussion by the full PTAC. This PRT report is preparatory work for the full PTAC and is not binding on PTAC. This report is provided by the PRT to the full Committee for the proposal identified below.

A. Proposal Information

1. **Proposal Name:** The Comprehensive Care Physician Payment Model (CCP-PM)
2. **Submitting Organization or Individual:** University of Chicago Medicine
3. **Submitter’s Abstract:**

“A large fraction of health care spending in the United States is concentrated in a small part of the population. Not surprisingly, these high cost patients are much more frequently hospitalized than the population as a whole. In an effort to improve outcomes and decrease health care spending for frequently hospitalized patients, we established the Comprehensive Care Physician (CCP) Program at the University of Chicago. The program seeks to defragment care for patients at increased risk of hospitalization by providing them with a physician who will care for them both in clinic and the hospital. In a CMMI-funded trial of CCP compared to standard care with different doctors in the inpatient and outpatient setting, we found CCP significantly improves patient satisfaction with care and self-rated mental health status, decreases hospitalization 15-20% and lowers annual Medicare spending care by ~\$3,000 per patient per year. Estimated savings are even larger for patients with the highest risk of hospitalization.

The Comprehensive Care Physician Payment Model (CCP-PM) is designed to increase the uptake of programs such as CCP in which patients can receive both inpatient and outpatient care from the same physician. To incentivize this behavior, the CCP-PM provides a care continuity fee for participating physicians who meet benchmarks for providing their patients with both inpatient and outpatient care. Participating clinicians who do not meet these targets are subject to a fine. To ensure that these incentives encourage CCP physicians to care for patients at increased risk of hospitalization, patients must have been hospitalized at least once in the past year to be eligible for the program, and CCP-PM panels are capped at 300 patients per physician.

In addition to the novelty of the CCP program in integrating inpatient and outpatient care under one physician, the CCP-PM is innovative in its structure. Because of the evidence that CCP-like programs may substantially reduce Medicare spending, one could imagine developing a stand-alone CCP-based ACO [accountable care organization] that incentivizes shared savings. However, since the CCP model works best for the sickest patients, challenges of risk adjustment could create perverse incentives for CCP-ACOs to avoid caring for the patients that could most benefit from CCP care or to shift high-risk patients into such an arrangement to improve profitability in another Medicare alternative payment model. To avoid this, we designed the proposed CCP-PM as a supplemental payment/fine that would be added on top of incentives created by existing Medicare payment models, including Medicare alternative payment models or the Medicare Shared Savings Program (MSSP). That this model can be added on to MSSP has the advantage of expanding access to physicians and patients who may not have had exposure to risk-based contracting in the past.

In this proposal, we describe several promising approaches to evaluate the effects of the CCP-PM on the uptake of CCP-like models, improving patient outcomes and decreasing Medicare spending. If implemented, we look forward to working with CMS to identify a preferred evaluation strategy. If the pilot is successful and CCP-PM were scaled to its potential nationally, we estimate that up to 3.8 million Medicare beneficiaries would be eligible for the program.

Assuming similar clinical outcomes, we would expect participating patients to experience improved satisfaction, mental health status and decreased utilization. Extrapolating based on the \$3,000 per patient per year savings we have found with the University of Chicago CCP program, savings at the national level could exceed \$11 billion per year.”

B. Summary of the PRT Review

The proposal was received on March 1, 2018. The PRT met between May 8, 2018, and July 20, 2018. A summary of the PRT’s findings is provided in the table below.

PRT Rating of Proposal by Secretarial Criteria

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

C. PRT Process

The PRT reviewed the CCP-PM proposal as well as additional information provided by the submitter in written responses to questions from the PRT. The submitter also participated in a phone call with the PRT. The PRT sent a document with Initial Feedback to the submitter. The proposal, questions and answers, Initial Feedback document, and call transcript are available on the ASPE PTAC [website](#).

1. Proposal Summary

The overall goal of the CCP-PM is to improve care, especially transitions between inpatient and outpatient settings, by enabling the same physician to oversee care for the patient in both settings. The submitter expects that most physicians participating in the CCP-PM will be general internal medicine physicians, hospitalists or family practitioners. The submitter also indicates that some medical subspecialists and physicians from other specialties that provide primary care (e.g., gynecology) might be appropriate candidates in some instances. All estimates in the proposal are based on the CCP experience at the University of Chicago. The submitter proposes that CCP-PM panels should be capped at 300 patients per physician and estimate that on average each panel would have 200 patients in a national program. They expect a maximum of 10 participating physicians per institution or participating practice.

Under the proposed model, care continuity fees will depend on whether a patient has been hospitalized for any cause at least once in the past 12 months. Participating physicians will receive an add-on payment of \$40 per new and renewed enrolled patient per month and \$10 per continued enrolled patient per month payable at the end of each year if they meet both of the following two criteria:

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

Therefore, payment of the CCP-PM care continuity fee is contingent on the participating physicians providing a high percentage of their patients' inpatient and outpatient internal medicine care. For clinicians participating in fee-for-service based contracts, the care continuity fee would be in addition to current Medicare bills. Participation in the CCP-PM would not directly alter any payments related to other MIPS, MSSP, or alternative payment models in which the clinician participates but would simply serve as an add-on payment to these models. Any payments would be included in the total cost of care for those participating in these other payment models. Some specific details with respect to initiating CCP-PM within these models would need to be finalized. For example, page 12 of the proposal notes that "physicians would be paid / penalized annually in alignment with their home institution's ACO or APM yearly payment cycle." Text on page nine indicates that for providers in other APMs, "the care continuity fees themselves not be at risk so that providers not be penalized twice should they fail to meet these [APM outcome] measures after making the effort to reorganize their practice to follow a CCP model."

Participating physicians will be subject to a penalty of \$10 per patient per month at the end of the year if they meet either of two penalty criteria:

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

The submitter considered but did not propose specific outcome metrics other than the two penalty criteria that would put the CCP-PM care continuity fees at risk for three reasons: the focus on high-risk patients means that standard quality metrics would need to be risk-adjusted; quality metrics are already incentivized within APMs in which the CCP-PM might be layered; and the CCP-PM is designed to function across various payment models, which might use varying quality metrics.

The submitter expects that CCP physicians would spend all or the majority of each weekday morning caring for their own patients in the hospital and spend weekday afternoons in clinic. The submitter does not expect the workflow of a participating clinician to vary dramatically with regard to overall business arrangements (private practice, employed, affiliated), but they do expect variation in the structure for off-hours coverage. For example, in some settings, CCPs might rotate with other CCPs serving as the "hospitalist," e.g., covering the inpatient service in the weekday afternoons when their colleagues are in clinic and covering for their colleagues when

they are off on the weekend. The model envisions that participating physicians would interact with specialist using similar structures to current practice but that the integration available with the CCP would reduce duplicative consultation and testing.

The submitter calculated program costs as follows. Assuming that a patient is enrolled in the CCP-PM for a full year and that the patient qualified for the maximum care continuity fee of \$40 per month (vs. \$10 per month for patients who have not been hospitalized in the past year), total CCP-PM payments would be \$480 per patient. The submitter estimates that with a typical panel size of 200 patients and under the mix of care continuity fees (assuming half of participating are hospitalized in a year), the average care continuity fee would be \$25 per month (\$300/year). Therefore, the submitter expects the likely payout per participating physician would be \$60,000 for physicians with a panel of 200 CCP-PM patients, which would only be a proportion of their total patient panel.

2. Additional Information Reviewed by the PRT

a) Literature Review and Environmental Scan

The Office of the Assistant Secretary for Planning and Evaluation (ASPE), through its contractor, conducted an abbreviated environmental scan that included a review of peer-reviewed literature as well as a search for relevant grey literature, such as research reports, white papers, conference proceedings, and government documents. The search and the identified documents were not intended to be comprehensive and were limited to documents that meet predetermined research parameters, including a five-year look back period, a primary focus on U.S.-based literature and documents, and relevance to the letter of intent. These materials are available on the ASPE PTAC [website](#).

b) Public Comments

There were no public comments submitted for this proposal.

c) Other Information

The PRT spoke with the Centers for Medicare & Medicaid Services (CMS) Innovation Center regarding the submitter's experience with a Health Care Innovation Award (HCIA). The [final HCIA Evaluation Report](#) assesses the CCP on pages 125-133. The PRT also spoke with a clinical expert (a hospitalist) to assess their perspective on the proposal. ASPE staff participated in a call with the CMS Office of the Actuary (OACT) regarding the proposal.

D. Evaluation of Proposal Against Criteria

Criterion 1. Scope (High Priority). Aim to either directly address an issue in payment policy that broadens and expands the CMS APM portfolio or include APM Entities whose opportunities to participate in APMs have been limited.

PRT Qualitative Rating:

Does Not Meet Criterion

Strengths:

- The CCP-PM addresses a common occurrence in patient care (specifically, transitions in care between inpatient and ambulatory settings) in a novel way. While fee-for-service (FFS) payment has codes and models that allow for transitional care management, the submitter argues that these codes are not sufficient for direct provision and transition of care by the same provider between inpatient care and primary care.
- The current system does not necessarily reward providers across settings for lowering the cost for Medicare patients. Some existing models provide incentives for primary care physicians, but hospitalists are not currently included in such models and may not face direct incentives to reduce future hospitalizations.
- The CCP-PM is in the form of an APM supplement that enables additional focus on beneficiaries at high risk for future hospitalization.
- The model provides room to innovate because it does not have many structural requirements.

Weaknesses:

- Existing programs through CMS and CMMI, such as accountable care organizations (ACOs) and Bundled Payment for Care Improvement (BPCI), could enable physicians to establish similar processes for bridging care between inpatient and ambulatory settings.
- The feasibility of the CCP-PM both within and beyond academic settings may be limited.
 - While some hospitalists in academic settings may be enthusiastic about participating, other hospitalists may not be interested, so it may be challenging for some academic settings to sustain a program of sufficient size.
 - The program may be even more of a stretch for hospitalists who are not employed by community-based hospitals and primary care physicians in private practices serving those patients.
 - The strongest business case is for initiation within a hospital. Otherwise, structural issues arise for financial feasibility, as some mechanism is needed for stand-alone primary care practices to initiate a program with a hospital and follow their patients into that hospital.

- Hospitals or community practices that initiate a program may still need to overcome potential barriers for patient enrollment (a comment which was cited by evaluators of the HCIA program as well). Some community-based physicians will not want to relinquish patients to CCP-PM. While the CCP-PM is appropriately targeted to high-risk patients and has provisions against cherry-picking low-risk patients, high-risk patients may have established relationships with certain physicians that they do not want to drop.

Summary of Rating: This proposal highlights an important clinical need that is broad in scope: that of clinical transitions from inpatient to outpatient settings. The alignment between the clinical need and the payment mechanism need further development, however. Thus, the PRT finds that the proposal meets the scope criterion in some ways but is also lacking in others. Significant concerns remain about the ability to enroll patients and ensure that a minimum threshold of both patients and providers could be met. The fact that the model could work well for some providers in some settings is not considered sufficient justification by the full PRT to recommend implementing the model broadly.

Criterion 2. Quality and Cost (High Priority). Are anticipated to improve health care quality at no additional cost, maintain health care quality while decreasing cost, or both improve health care quality and decrease cost.

PRT Qualitative Rating:	Does Not Meet Criterion
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Strengths:

- The proposal directly quantifies the target for savings at an estimated \$3,000 per patient per year. Based on estimates of scaling up nationally, total savings would exceed \$10 billion.
- Estimates from the HCIA final evaluation and the proposal come from a randomized trial, supporting strength of the evidence.
- The model does not compete with other mechanisms being developed. For example, the CCP-PM does not compete with ACO models for assignment, and there are not challenges associated with pulling out high-cost beneficiaries.

Weaknesses:

- The proposal provides unpublished statistics that are different from the HCIA final evaluation. The HCIA evaluation finds non-significant increases in total spending and emergency department visits and a non-significant decrease in admissions.
 - Differences between the proposal and the HCIA evaluation could be due to slow patient recruitment for the trial. The HCIA evaluation indicates: “Only in the last two quarters of the HCIA funding period did the accumulated number of patients reach the goal of 1,167 per study arm, and the funded study period ended soon afterward. It is possible that with a longer

intervention period, additional impact would have been achieved (although we saw no evidence that longer tenure in the program achieved greater improvement in health care utilization or Medicare spending).”

- In total, the feasibility as well as the reality of the savings projected in the proposal are not clear.
- The proposal discusses quality within a “structure, process, outcome” framework but does not provide specific measures or benchmarks other than thresholds for the percentage of inpatient and outpatient care provided by participating physicians. For example, the proposal (on page eight of the proposal) maintains that the empaneling of physicians who structure their care to be delivered in both the clinic and hospital is a measure of structural quality, but quality measures for tracking or comparison to peers are not proposed. Evaluation would require specific benchmarks.
- The patient empanelment is not well defined. Therefore, there is a risk of patient selection and unintended consequences.

Summary of Rating: The PRT does not believe the quality and cost criterion is met. While the CCP-PM is intended to improve quality and reduce cost, the savings indicated in the proposal are not supported by published evidence. The PRT agrees that improved care transitions would improve quality of care, but more specific quality metrics are needed.

Criterion 3. Payment Methodology (High Priority). 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.

PRT Qualitative Rating:	Does Not Meet Criterion
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Strengths:

- The proposal lays out a clear payment mechanism, and it is easy to understand what the spending for CCP-PM might be. The continuity fee is different for new or renewed patients versus continued patients, and the fee is contingent on the participating physician providing a high percentage of their patients’ inpatient and outpatient internal medicine care.
- The payment mechanism, which is articulated as either a stand-alone payment (e.g., to a practice) or as a supplement in existing models such as ACOs, could work particularly well in ACOs. The likely advantage of basing the CCP-PM in a hospital setting was discussed above, and the payment mechanism would facilitate implementation of the CCP-PM beyond academic medical centers as a supplemental payment in community hospital-based ACOs.

- The penalty criteria apply even if only one is not met (e.g. a penalty is applied if only one or two penalty criteria are met)

Weaknesses:

- While the payment could be a supplement for hospital-based ACOs, the current payment methodology for ACOs already includes incentives to better coordinate care across settings. Therefore, the CCP-PM might simply end up increasing payments to hospital-based ACOs for something they are already supposed to be doing.
- The payment model lacks financial risk, which results in a weak linkage between payment methodology and intended outcomes (reduced total expenditures and improved health outcomes for the patient).
- The financial risk in the model may be insufficient to generate savings unless there is some downside risk aside from meeting the penalty criteria. Only a \$10 penalty per patient per month (e.g., \$24,000 total per year for a panel of 200 patients) is at risk in a stand-alone model. Providers who lose money may simply leave the program.
- The role of some services such as telehealth in calculating the penalty has not been clarified or standardized.
- The cash flow diagram (on page 14 of the proposal) raises some feasibility issues, as it is not clear that CMS has a mechanism for making the payments as drawn. Physicians affiliated with institutions have different financial arrangements than other physicians who are not similarly employed or affiliated, including independent practices. The diagram tries to get at the attribution of patients that may not work well in mixed arrangements in which different physicians see the same patient, rather than using an approach such as a convener model (e.g., as with BPCI or a model where a third party takes risk and deals with Medicare reimbursement).
- The CCP may have an experience similar to other models being tried in the sense that the model may improve quality but does not have sufficient mechanisms to result in measurable reductions in spending. The existing literature does not provide strong evidence that improving continuity of care reduces spending or results in savings sufficient to cover the fees or cost of the program.
- Since ACOs and other models are already trying to increase continuity, it is not clear that model would not simply create an extra payment for a pattern of care that is already being delivered within ACOs.

Summary of Rating: The PRT feels the payment methodology criterion is not met. Although the proposal lays out a payment mechanism, with specific criteria for fee payment as well as financial penalty, the level of risk and risk mechanisms are insufficient. To the extent that the model is embedded in an organization such as an ACO, the additional payments might be unnecessary if the providers are adhering to the incentives inherent in the ACO payment structure.

Criterion 4. Value over Volume. Provide incentives to practitioners to deliver high-quality health care.

PRT Qualitative Rating:

Meets Criterion

Strengths:

- Under the proposed model, the payment is not dependent on volume of care.
- The unpublished results cited in the proposal show that the CCP-PM improved patient satisfaction and reduced costs for high-risk patients at the University of Chicago, yielding value to beneficiaries as well as to the overall system.

Weaknesses:

- The results cited in the proposal were not documented in the HCIA evaluation.
- The presence of CCP-PM may not be sufficient to drive behavior change to attain value over volume in other settings. Community-based office settings might have barriers or lack enthusiasm for the scheduling and logistical changes needed to attain the value-based care envisioned under CCP-PM. Therefore, the proposed model as written might not be sufficient to drive care to be different in other settings.
- Selection of patients in other settings might be different from the patients enrolled in the University of Chicago’s HCIA award. Patient enrollment under the HCIA award proceeded slowly, and the extra efforts to recruit patients might mean that the patients enrolled in an ongoing program could be different (though the value over volume could improve or decline). For example, patients with significant language barriers or those that might require additional intensive coordination for social services may cause the enrolled population to differ from those enrolled in the HCIA award.

Summary of Rating: Despite the weaknesses noted, the intent of the CCP-PM as well as the experience of the University of Chicago with their CCP program show promise for achieving value over volume, particularly for the important problem of poor transitions in care and a lack of continuity as patients transition through clinical settings.

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

PRT Qualitative Rating:

Meets Criterion

Strengths:

- The CCP-PM appears to be flexible for many types of practitioners, including specialists.
- The flexibility in arrangements and limited number of specific requirements means

that providers can tailor care to patients as they deem most appropriate without trying to implement certain model of care.

Weaknesses:

- No evidence is available indicating that specialists would be willing to participate as a CCP-PM provider.
- The experience to date does not include an independent community-based provider who has tried to implement a model like CCP without a willing hospital partner.

Summary of Rating: The PRT finds that the flexibility criterion is met. The CCP-PM is offers optionality for numerous types of practitioners, from primary care to specialty care. Additionally, by allowing for practitioners to move between inpatient and outpatient settings, there is significant potential for high-value care, particularly patient-centered care.

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

PRT Qualitative Rating:	Meets Criterion
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Strengths:

- The randomized controlled trial conducted for the HCIA evaluation already provided a strong design and important lessons, including some of the challenges of patient enrollment. Qualitative analysis also provided important insights.
- Patient costs and the penalty criteria can be measured for evaluation.
- Model overlaps with ACOs could facilitate evaluation, as the approach does not have challenges such as carve-out provisions.
- The proposal suggests some novel evaluation mechanisms (e.g., changes to billing volumes, qualitative practice structures, etc.) that are potentially applicable to other CMMI programs.

Weaknesses:

- The lack of definition of measures for some components (structure, process and outcome measures) means their evaluation is not clearly defined. Lack of objective criteria for empanelment is particularly problematic.
- Although the proposal advocates for wider testing in additional sites, other trends such as decreased patient participation due to increased Medicare Advantage enrollment could complicate such evaluation.
- The PRT would like to have better understood why the unpublished results in the proposal differ from the HCIA evaluation results.

Summary of Rating: The PRT feels that the CCP-PM model could be evaluated. In particular, both the prior experience of the submitter and certain measures such as rates of rehospitalization and costs constitute evaluable goals.

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.

PRT Qualitative Rating:

Does Not Meet

Strengths:

- This model clearly addresses the issue of care coordination during the peri-hospitalization period by having the same clinician manage the patient’s care in both the inpatient and outpatient settings.
- The CCP-PM could work particularly well in an integrated system that facilitates having the same physician for inpatient and ambulatory care.

Weaknesses:

- The model as described focuses on hospital care and primary care. The proposal did not provide a clear understanding of the role of and interactions with specialists other than the expectation for coordination with specialists, which was noted in subsequent communication with the submitter.
- There does not appear to be a mechanism in the model for making sure the patient is getting the right care (e.g., that certain conditions that would be monitored in a primary care setting are followed). The model does not clarify broadly how patient standards pertaining to basic screening and preventive care will be met.
- Some ACO metrics that would be useful for assessing integration and care coordinate are not incorporated, which could be problematic for a stand-alone primary care practice, even if working in conjunction with a hospital.
- The PRT has some concern that this model is returning to an approach used previously (i.e., a community doctor follows patient into hospital) that became problematic for care when an office-based physician spent less time inside the hospital, etc.
- Some patients may also not want to leave their existing primary care physician in order to participate.
- Furthermore, the model may only be delaying an inevitable handoff for a patient who is no longer at risk for hospitalization.

Summary of Rating: The PRT does not feel that the CCP-PM has sufficient provisions to ensure greater care coordination and integration. While having the same physician follow the patient between inpatient and outpatient settings inherently improves integration and

care coordination during the immediate period following hospital discharge, the model does not entail mechanisms to ensure that care is appropriate and complete over the long run. Patients may find that the person who is best positioned to coordinate care immediately following hospital discharge is not the best person to coordinate specialty care or provide preventive services over a longer follow-up period.

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.

PRT Qualitative Rating:

Meets Criterion

Strengths:

- By concentrating on an important gap in clinical care, the proposed model reflects an opportunity to close such gaps and offer patient-centered care.
- Qualitative findings from the HCIA award reinforce the high degree of patient satisfaction and enthusiasm for the proposed model.
- For the randomized control trial, patients had choice to enroll, and the proposal described a robust enrollment (empanelment) process. A situation of prospective enrollment in the CCP-PM would also enable choice and be preferred, as retrospective attribution of patients to the model does not make sense.
- The empanelment process may be most efficient if the program is implemented within a system such as an ACO.

Weaknesses:

- Despite the advantages of prospective enrollment, efficient ways to ensure sufficient and appropriate patient empanelment are not known. Enrollment in the randomized control trial was slower than expected, and the investigators had to implement additional recruitment efforts. Appropriate patient enrollment is important for the payment methodology to be able to achieve reductions in the total cost of care while ensuring quality care.
- It may be important to address any barriers to empanelment (limited language proficiency, health literacy, etc.) to ensure that patients understand the fact that a single provider or provider group will be seeing them in both ambulatory and inpatient settings, which may be different from what they are used to. Patient choice to go to other providers must be respected, but continuation of visits to all existing providers could reduce ability to achieve program savings.
- The model does not include specific provisions beyond the penalty payment to reduce the likelihood of selection in enrollment by patients who are less seriously ill but willing to change their providers. Such “favorable” selection could mean that only relatively lower-risk rather than higher-risk patients may be willing to enroll. Since the penalty payment pertains to the average experience for a potentially large

group of patients, the model does not have a patient-specific mechanism to discourage enrollment of relatively low-risk patients.

- The proposal does not seem to include sufficient mechanisms to avoid unintended consequences such as perverse gaming (e.g., hospitalization of a patient to be able to re-enroll the patient with a higher payment). In response to questions, the submitter indicated that such a mechanism inherently exists within ACOs (because any gain in revenue from care continuity fees would be significantly outweighed by reductions in or eligibility for shared savings), but other non-ACO settings would not necessarily embody such a provision. The submitters indicated that physicians would be unlikely to know their ratios for the penalty in real time and therefore unlikely to game the system. They also noted that the relationships fostered by CCP would reduce the likelihood of gaming; however, the lack of a specific mechanism means that gaming could occur.

Summary of Rating: While the PRT identified some concerns, a majority of the PRT felt that the CCP-PM is oriented toward patient choice and that patient choice is not inherently blocked by any component of the model. It would be important that any implementation of the CCP-PM should have clear provisions to ensure patient choice to decline participation if the patient prefers to stay with existing providers.

Criterion 9. Patient Safety. Aim to maintain or improve standards of patient safety.

PRT Qualitative Rating:	Meets Criterion
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Strengths:

- The PRT recognizes that patient safety can be increased by consolidating a patient's care under a single physician or group of physicians during a period of transition following hospital discharge.
- Patient safety is particularly likely to be improved for hospitalized beneficiaries who do not already have strong relationships with a primary care provider, as follow-up care after discharge is likely to be improved.

Weaknesses:

- The lack of monitoring of specific outcomes means that the model's effect on patient safety may not be known.
- Concerns about patient safety may be particularly pertinent for standard aspects of primary care involving prevention or monitoring of other disease conditions beyond the particular disease that caused a hospitalization that triggered enrollment in the CCP-PM. It may be difficult to assess whether or not the patient is getting the right care since quality transitional care following discharge may differ from aspects of ongoing primary or general medical care. As noted in other points, appropriate

safeguards may be more feasible within organizations such as ACOs than in stand-alone practices.

- Unintended consequences or potentially perverse incentives to rehospitalize patients mentioned above also may threaten to reduce rather than improve patient safety.

Summary of Rating: The PRT finds that the patient safety criterion is met. A model that consolidates a patient’s care under a single physician or group of physicians during a period of transition following hospital discharge is inherently likely to ensure patient safety.

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

PRT Qualitative Rating:	Meets Criterion
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Strengths:

- Large integrated systems including academic medical centers are likely to have health information technology that will facilitate model implementation and provision of high-quality and high-value care.
- Such systems will also be able to capitalize on emerging technologies (e.g., telehealth) to support better innovation of coordination of care processes within models like CCP.

Weaknesses:

- Lack of similar health information technologies for providers outside of integrated systems or academic medical centers could compromise communication and coordination of care. Many patients and providers, especially in some geographic areas, currently experience frustration when attempting to transfer information across different providers; e.g., the lack of interoperability and limitation of health exchange efforts.

Summary of Rating: The PRT finds that the HIT criterion is met. As with all health system innovation and alternative payment models, health information technology can play an important role for programs like CCP. The CCP-PM will work most efficiently and will be most likely to be used in health systems or provider groups with efficient HIT.

E. PRT Comments

The PRT considers the clinical needs of the particular population of patients served in this proposal to be not well-addressed under current payment models. The distinction between inpatient and outpatient care is blurred for a small fraction of highly complex and frail

patients, precisely the group of patients for whom this model is designed to improve care. The CCP-PM represents the culmination of a great deal of work to improve patient care by a set of dedicated clinicians. Participating clinicians and patients have been supportive and the submitter noted an abstract recently presented that underscores the potential for savings. The clinical workflows that were developed, particularly those that allowed for inpatient hospitalists to follow patients into the outpatient clinic setting and vice versa, are highly customized which is a strength but also poses challenges for broader replication.

Therefore, a decision to recommend the CCP-PM for broader implementation is complicated by several considerations. The proposal focuses on creating a viable payment model that provides sufficient assurance for ensuring high-quality clinical care will be replicated simply by implementing the suggested payment model. The PRT was concerned that the financial model might not necessarily lead to the exemplary clinical model developed by the submitters and that the proposal lacked sufficient methods for assuring improved patient outcomes. In addition, the PRT found it difficult to determine whether the financial model would be applicable more broadly. In other words, are the workflows and career paths included in the clinical model likely to be adopted? Are there other approaches to addressing this important set of clinical challenges? Furthermore, the PRT had concerns that the utilization and cost outcomes presented in the proposal are not consistent with the HCIA evaluation.

Despite the important gap in clinical care this proposal attempts to fill, it nonetheless raises some important questions. The PRT thinks that the interest of hospitalists themselves in this model would be informative for considering future versions of CCP-PM. Since the CCP could be viewed as an attempt to mitigate the discontinuities that developed when primary care physicians stopped following their hospitalized patients, the clinical model could be viewed as simply delaying an inevitable transition back to primary care for a small at-risk population. It seems important to better understand if and how the potential advantages of this model justify a change back to an approach (having the same physician be both inpatient and outpatient) that used to be widespread.

The success and enthusiasm of the submitter as well as of other hospitalists (including a clinical expert outside of the system who participated in a conference call with the PRT) mean that the model likely has benefits, at least in selected settings. However, the questions raised in this review against the Secretary's criteria were substantial. Therefore, despite the important clinical need and the success of the submitters in addressing that need, the PRT thought the payment model as proposed did not appear to meet a majority of the Secretary's criteria.

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