Preliminary Review Team Report to the Physician-Focused Payment Model Technical Advisory Committee on the *Eye Care Emergency Department Avoidance (EyEDA) Model*

Paul N. Casale, MD, MPH (Lead Reviewer)
Harold D. Miller
Kavita Patel, MD, MSHS

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Physician-focused payment model (PFPM) proposals submitted to the Physician-Focused Payment Model Technical Advisory Committee (PTAC) in accordance with PTAC's proposal submission instructions are assigned to a preliminary review team (PRT). Each PRT prepares a report of its findings on the proposal for discussion by the full PTAC. The report is not binding on PTAC; PTAC may reach different conclusions from those contained in the report. Each report and related materials are available on the PTAC section of the Office of the Assistant Secretary for Planning and Evaluation (ASPE) website.

A. Proposal Information

1. **Proposal Name:** Eye Care Emergency Department Avoidance (EyEDA) Model
2. **Submitting Organization or Individual:** University of Massachusetts Medical School
3. **Submitter's Abstract:**

   "The Physician-Focused Payment Model (PFPM), Eye Care Emergency Department Avoidance (EyEDA), which is proposed by the University of Massachusetts, is designed to provide a pathway to participate in an Alternative Payment Model (APM) for eligible eye care professionals. This model aims to reduce the unnecessary utilization of emergency departments (EDs) for emergency department-avoidable (ED-avoidable) eye conditions, to provide better care for individuals, better health for populations, and lower costs to the healthcare system.

   Through the Transforming Clinical Practices Initiative (TCPI), a program funded by the Centers for Medicare and Medicaid Services (CMS), our organization provided technical assistance to over 1,600 optometry practices across the nation, supporting

improvements in clinical processes and practice operations to improve outcomes and reduce costs. During our work with these providers, we identified opportunities to improve clinical quality and patients' experience of care, reduce costs to payers and patients, and provide optometrists and ophthalmologists with the opportunity to emphasize value over volume, all critical elements of an Advanced Alternative Payment Model (AAPM).

Our work with the practices has demonstrated an appreciable increase in appropriate care pathway utilization at scale. While the model will be open to all licensed eye care professionals, it is most likely to be adopted by optometrists who are more numerous than ophthalmologists and whose practices are widely distributed in cities, towns and rural areas.

This eye care-focused AAPM is designed to incentivize reduction of Emergency Department (ED) utilization for ED-avoidable eye conditions. It utilizes a payment methodology based on existing fee-for-service (FFS) rates for ED-avoidable eye conditions. A discount will be applied to the eye care professionals' current FFS rates, creating inherent downside financial risk that will be offset by a shared savings opportunity if a participating eye care professional meets performance requirements. Both the discounted FFS rates and the anticipated shared savings will provide financial incentives for eye care professionals to expand urgent care access for patients with immediate clinical needs. The APM will incorporate a "quality gate" that will require participating eye care professionals to report on and meet minimum thresholds on selected quality measures to participate in shared savings payments through the APM.

Data from the Nationwide Emergency Department Sample (NEDS) from the Healthcare Cost and Utilization Project (HCUP) databases from 2012 through 2016 demonstrate that on average more than 1.8 million people seek care in an emergency room each year for conditions that are within the scope of practice of outpatient Optometry. These visits generated $1.9 billion in charges across all payers in 2012 and increased to $3.1 billion in charges in 2016.

The proposed APM's overarching aims include: improvement of quality, access and patient convenience related to care for ED-avoidable eye conditions; increased clinical efficiency (e.g. reducing unnecessary or inappropriate services); decreased total cost of care for patients with urgent, ED-avoidable eye conditions; improved patient experience of care (e.g., reduced medical complications, reduced time in ED, and reduced out of pocket expense)."

B. Summary of the PRT Review

The University of Massachusetts Medical School (*UMass*) proposal was received by PTAC on June 28, 2019. The PRT conducted its review of the proposal between September 4, 2019 and November 8, 2019. The PRT's findings are summarized 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 Criterion	Majority
2. Quality and Cost (High Priority)	Meets Criterion	Unanimous
3. Payment Methodology (High Priority)	Does Not Meet Criterion	Unanimous
4. Value over Volume	Meets Criterion	Unanimous
5. Flexibility	Meets Criterion	Majority
6. Ability to Be Evaluated	Meets Criterion	Majority
7. Integration and Care Coordination	Does Not Meet Criterion	Unanimous
8. Patient Choice	Meets Criterion	Unanimous
9. Patient Safety	Does Not Meet Criterion	Unanimous
10. Health Information Technology	Meets Criterion	Unanimous

C. Information Reviewed by the PRT

1. Proposal and Additional Information Provided by the Submitter

The PRT reviewed the *UMass* proposal, as well as additional information provided by the submitter in response to written questions. The submitter also participated in a phone call with the PRT to clarify additional points on October 30, 2019.

Proposal Summary

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

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

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

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

Under the proposed payment model:

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

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

- If the participating physician or practice does not successfully increase the number of urgent care visits, its revenues for urgent care visits will decrease by eight percent.
- If the practice increases the number of urgent care visits but does not meet the quality thresholds, it will not be eligible for the shared savings bonus.

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

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

- Patient experience would be measured with a patient survey. Participating physicians or practices would have to receive scores of three points or more on a 4-point scale on each core survey question to achieve the patient experience threshold.

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

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

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

2. **Literature Review and Environmental Scan**

   ASPE, through its contractor, conducted a targeted environmental scan of peer-reviewed and non-peer-reviewed publications. The review included a formal search of major medical, health services research, and general academic databases; relevant grey literature, such as research reports, white papers, conference proceedings, and government documents; and websites of professional associations and societies, and CMS for relevant evaluation reports and program documentation. Key words guiding the environmental scan and literature review were identified from the proposal. The search may not be comprehensive and was limited to documents that met predetermined parameters, generally including a five year look-back period, a primary focus on United States-based literature and documents, and relevancy to the proposal.

3. **Data Analyses**

   The PRT sought additional information regarding the *UMass* proposal. ASPE, through its contractor, produced data tables on this issue. Information from the analysis included prevalence of visits for ED-avoidable ocular diagnoses among Medicare FFS beneficiaries, hospital ED and inpatient admissions associated with those conditions, time of ED discharge (weekday versus weekend), and distribution of non-ED visits by provider type.

4. **Public Comments**

   There were seven public comments for this proposal: three comments from medical specialty societies and four comments from independent physicians.

5. **Other Information**

   No external consultations with clinical experts were conducted for this report.

D. Evaluation of Proposal Against Criteria

Criterion 1. Scope (High Priority)

The proposal aims 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:

- No alternative payment models (APMs) in the CMS portfolio specifically address eye-related conditions or focus on care delivered by eye specialists. The proposal would expand the opportunity for these providers to participate in an APM.

Weaknesses:

- The model narrowly focuses on changing the site of treatment for one particular set of health problems, rather than taking a more holistic approach to the patient's needs.
- While the model is designed to encourage patients to receive treatment from optometrists for specific conditions that optometrists are qualified to treat, other health problems may have similar symptoms, including serious emergencies. The patient will not know what problem they have until it is diagnosed, so the model may encourage some patients to receive care in the wrong place.
- ED visits for eye-related conditions occur primarily among those under age 65. The environmental scan indicates that visits by adults over age 65 comprised only eight percent of all eye-related ED visits from 2006 to 2011. The submitter intends for multiple payers to implement the proposed model. However, the focus of PTAC review is on the potential impact for Medicare. Of the 15.9 million Medicare FFS beneficiaries who saw an ophthalmologist or optometrist in 2017, only 102,680 beneficiaries were seen in the ED for one of the diagnoses groups proposed by the submitter. It is not clear if practices would be able to increase their provision of urgent care in the office if the model is not implemented for more payers beyond Medicare.

Summary of Rating:

A majority of the PRT members feel the proposed PFPM does not meet the criterion. Although the proposed model would create a new opportunity for optometrists and ophthalmologists to participate in an APM, the majority of PRT members feel the scope criterion goes beyond simply developing a model for a new type of specialist. While the specialties related to eye care have not had a specific APM for their professions, given the interdisciplinary nature of urgent and ED care, patients would benefit from eye care specialists (optometrists and ophthalmologists) participating in broader APMs that allow for engagement of whole person care (e.g., diabetic eye emergencies or corneal ulcers). Stated in another way, specialty participation in APMs is important but should broaden existing opportunities, and the particular clinical issue of urgent eye visits might be appropriate in a broader risk-based model such as an Accountable Care Organization or a Bundled Payment Model.

One PRT member believes that the scope criterion is specifically intended to encourage participation of more types of physicians in APMs, and that the proposed model would provide such an opportunity for two types of physicians that do not have other APM opportunities. In addition, specialty-specific models can help improve coordination and reduce fragmentation of care by allowing each specialty to be compensated appropriately for the specific types of conditions it is best qualified to treat.

Criterion 2. Quality and Cost (High Priority)

The proposal is anticipated to (1) improve health care quality at no additional cost, (2) maintain health care quality while decreasing cost, or (3) both improve health care quality and decrease cost.

PRT Qualitative Rating: Meets Criterion

Strengths:

- Treatment of patients in an office-based setting for the proposed eye conditions rather than in an ED when appropriate would reduce costs for both payers and patients.
- Increased access to care in the most appropriate setting could potentially improve health care quality. Visits to the ED are often not well-connected to a patient's usual source of care, and EDs may not have the full range of specialized ocular equipment necessary to diagnose and treat urgent eye conditions. Many patients may not be aware that they can receive urgent care for eye conditions at optometrist or ophthalmologist offices, or they may not be able to get an appointment in a timely fashion, so increased accommodation for urgent care in such offices could improve quality while reducing cost.
- The model includes two novel quality measures designed to ensure that urgent conditions receive high-quality care in an office setting. The proposal describes the patient safety measure as being adapted from existing outcomes measures for outpatient surgeries and procedures used by CMS, but it does not state whether the measures have been validated by an independent entity for eye-related procedures.

Weaknesses:

- While the proposed model includes measures of patient safety and satisfaction, the proposed measures have limitations that may not adequately ensure the highest quality care. Patient satisfaction, while important, does not necessarily ensure that a condition was treated in the most appropriate way for long-term outcomes. The patient safety measure captures only adverse events that occur within seven days and only adverse events that are related to the same ICD-10 diagnosis code as the original office visit, rather than a more comprehensive measure that includes other sequelae of untreated eye conditions and problems that develop more than a week after a visit.
- The rate of adverse events (ED use, hospitalization, blindness, or death) is unlikely to be a statistically valid measure for small practices. The median annual number of ambulatory visits per provider for ED-avoidable eye conditions is 10, and overall, less than one percent of visits for these conditions have ED involvement.
- Some conditions do not just represent urgent needs but are emergencies that cannot be safely treated in an office setting. For example, perforated corneal ulcers are likely to require emergency surgical intervention, but other corneal ulcers are less urgent. Delays in receiving the most appropriate treatment for some emergent conditions could lead to permanent vision loss and increased health care costs.

Summary of Rating:

On balance, the PRT unanimously feels the proposed PFPM meets the criterion. Increased access to treatment by eye care specialists in urgent care cases and new quality measures could improve quality and reduce cost.

Criterion 3. Payment Methodology (High Priority)

Pay APM Entities with a payment methodology 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.

PRT Qualitative Rating: Does Not Meet Criterion

Strengths:

- The proposed payment model would provide a strong financial incentive to participating practices to increase the number of urgent care visits for eye conditions, since practices would lose eight percent of the revenue for current visits.
- There is a direct connection between the service that the practices would be encouraged to deliver and the savings they would need to achieve, assuming that each urgent care visit to the practice would have gone to the ED otherwise.
- Even if all new urgent care visits do not represent avoided ED visits, there would still be savings for payers unless urgent care visits increased by more than eight percent without a corresponding decrease in ED visits.
- The proposed payment model would provide a strong financial incentive to deliver high-quality urgent care, since a participating practice would not qualify for shared savings if it did not meet quality performance standards specifically associated with the visits.

Weaknesses:

- The proposal reduces current payment rates by eight percent for all practices and sets a target level of urgent care visits for each practice based on an increase from baseline levels at that specific practice. Although this may assure payers that there will be an increase in such visits, it would penalize practices whose patients already come to them for most urgent care needs, since the practice may be unable to appropriately increase such visits in order to meet the target or offset the loss of eight percent of revenue for the targeted diagnoses. In addition, the variability in visits for a small practice could cause a practice to have a low or high baseline rate based purely on random variation, thereby resulting in an inappropriately low or high target level.
- The payment reductions and target levels are based on visits that are assigned one of a large number of diagnosis codes, including diagnoses that could be assigned for both urgent and non-urgent symptoms. The proposal does not require any mechanism to document the nature of the presenting symptom or to identify the reason the visit

should be deemed urgent. Since there would be both financial incentives and disincentives to assign the designated diagnoses to a visit, some patients could be incorrectly classified, thereby resulting in higher spending.

- The proposal does not provide any upfront payments or other mechanisms to support the ability of participating practices to deliver more and better urgent care, such as 24/7 telephone lines, same-day appointment scheduling, or after-hours care.
- The proposal requires calculating a shared savings pool based on the reduction in ED visits for these conditions. However, if only a subset of optometry and ophthalmology practices in a community are participating in the model, and if only a subset of a payer's patients have a relationship with participating optometry and ophthalmology practices, only a portion of any change in ED visits would be attributable to the actions of the participating practices. The proposal does not specify how this would be addressed in making the savings calculation, or how adjustments would be made when the number of eligible patients in the service area changes between the baseline and performance periods. The submitter suggested the adverse event rate could be risk-adjusted, but the proposal does not include a risk adjustment approach.
- Previous experiences with APMs with shared savings approaches show that calculations become complicated when a new practice forms or merges because a baseline or comparable practice is difficult to identify for the calculation of an accurate benchmark.

Summary of Rating:

The PRT unanimously feels that the proposed PFPM does not meet the criterion. Although the proposed payment methodology would create a financial incentive to increase the number of urgent care visits in physician offices, the PRT believes that problems in the way the visits are defined, the targets are set, and the savings are calculated could harm some practices and patients and potentially lead to other unintended consequences.

The PRT concludes that many of the problematic aspects of the payment methodology resulted from the desire by the submitter to meet CMS requirements for an Advanced APM in order to qualify for the five percent bonus and exclusion from the Merit-Based Incentive Payment System (MIPS) under the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA). For example, the proposed eight percent cut in fees for urgent care visits is apparently intended to meet the CMS requirement that at least eight percent of a practice's revenues be at risk. However, since urgent care visits would presumably represent only a portion of the practice's revenues, it does not appear that the model would meet the current criteria.

During discussions with the PRT, the submitter acknowledged that there were problematic aspects of the payment methodology, but said that the methodology was the only way it could find to support an approach to improving urgent care for patients in a way that it felt was highly desirable while also meeting the risk-sharing requirements for an Advanced APM.

Criterion 4. Value over Volume

The proposal is anticipated to provide incentives to practitioners to deliver high-quality health care.

PRT Qualitative Rating: Meets Criterion

Strengths:

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

Weaknesses:

- The small size of many practices will make statistically appropriate assessment of adverse event rates problematic.
- Payments for urgent care services and targets are still tied to office visits with the physician, so practices would not have the ability to address urgent needs through phone calls, emails, or non-physician staff.
- The model forces practices to increase the number of office-based visits in order to offset payment cuts and meet visit targets, even if more visits are not needed.

Summary of Rating:

The PRT unanimously feels that the proposed PFPM meets the criterion. The project that led to development of the proposal demonstrated that there are opportunities to deliver care in an appropriate but less costly setting.

Criterion 5. Flexibility

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

PRT Qualitative Rating: Meets Criterion

Strengths:

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

Weaknesses:

- The proposal does not fundamentally alter the FFS structure of payment for eye visits. Providers would be paid only for visits with physicians, not for phone calls or emails with patients even if those services could resolve the patient's needs, and not care management or other education activities that could help patients avoid developing eye

problems. In addition, the eight percent reduction in visit payments and an uncertain shared savings payment could make it more difficult for practices to provide services that do not qualify for fees.

Summary of Rating:

The majority of the PRT feels that the proposed PFPM meets the criterion. The underlying intent of the proposal is to reward practitioners for changing the way they deliver care in order to avoid unnecessary ED visits.

One PRT member feels that the practices would have little or no flexibility to deliver care in ways other than traditional billable office visits.

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

Strengths:

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

Weaknesses:

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

Summary of Rating:

A majority of the PRT members feel that the proposed PFPM meets the criterion. While the lack of patient attribution complicates evaluation substantially, overall metrics could be assessed over time and across different providers.

Criterion 7. Integration and Care Coordination

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

PRT Qualitative Rating: Does Not Meet Criterion

Strengths:

- The submitter reported that eye care specialists informally make referrals among themselves and to other providers to ensure appropriate care.

Weaknesses:

- Participating providers would be encouraged to see patients for urgent care needs even if they are not the most appropriate provider to treat the condition.
- There are no formal methods for integration with primary care physicians or other providers who may be initiating treatment or treating a patient.

Summary of Rating:

The PRT unanimously feels that the proposed PFPM does not meet the criterion. It is problematic that participating providers would be rewarded for having urgent care visits with patients with no requirement or mechanism to ensure that the patient is seeing the most appropriate provider and that care is being coordinated with other providers.

Criterion 8. Patient Choice

Encourage greater attention to the health of the population served while also supporting the unique needs and preference of individual patients.

PRT Qualitative Rating: Meets Criterion

Strengths:

- The proposed model would make it easier for patients to receive appropriate treatment for urgent eye conditions outside of a hospital ED.

Weaknesses:

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

Summary of Rating:

The PRT unanimously feels that the proposed PFPM meets the criterion. The submitter's experience with the TCPI project indicates that office-based providers can and will expand urgent care availability and that patients appreciate the expanded choices for care location.

Criterion 9. Patient Safety

How well does the proposal aim to maintain or improve standards of patient safety?

PRT Qualitative Rating: Does Not Meet Criterion

Strengths:

- The proposed measurement of adverse event rates and patient satisfaction scores would help to ensure that eye problems are being addressed appropriately during urgent care visits.

Weaknesses:

- The proposed diagnosis codes cover a broad range of eye conditions, some of which are much more clinically serious (e.g., corneal ulcers) than others (e.g., conjunctivitis). Moreover, patients do not know their diagnosis when they seek care for an eye condition, only their symptoms. The same symptoms—such as eye pain, impairment of visual field, or redness—can result from conditions across a wide range of clinical severity, not all of which are appropriate for care by an optometrist or in an office setting.
- Patients who need care in an ED may not receive it, which could harm patient safety. The broad range of conditions that are included in the proposal increases the potential for this adverse outcome. Although the quality measures would help to ensure that adverse events do not occur frequently, they would not preclude them from occurring in individual cases.

Summary of Rating:

The PRT unanimously feels that the proposed PFPM does not meet the criterion. The financial incentives to treat more patients in the office-based setting to meet the targets could compromise patient safety.

Criterion 10. Health Information Technology

Encourage use of health information technology to inform care.

PRT Qualitative Rating: Meets Criterion

Strengths:

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

Weaknesses:

- The proposed model does not explicitly require or encourage enhanced use of health information technology.

Summary of Rating:

The PRT unanimously feels that the proposed PFPM meets the criterion. It is likely that providers participating in the model would find enhanced use of health information technology to be beneficial, despite lack of specific provisions to encourage its use.

E. PRT Comments

ED visits for eye-related conditions that could be treated in an office setting constitute an opportunity to improve the quality of care and lower cost. Many patients experiencing urgent eye conditions do not currently seek care in an optometrist's office or even an ophthalmology office, when that care could be equal or better to what they would receive in a hospital ED. The submitter's TCPI project demonstrated that optometrists can be convinced to modify office practices to better accommodate patients with urgent care needs, and that patients can be educated to know that some urgent care needs can be addressed in this way.

Although the proposed payment model would likely encourage this change in care by participating practices, the proposed payment model has a number of problems that would likely discourage practices from participating in the model and that could harm practices and/or patients that do participate in the model. In particular, the eight percent reduction in fees for urgent care visits may discourage participation and cause problematic financial losses for practices that cannot successfully meet targets for increased number of visits. Payment is still based on office visits, with no flexibility in payment to support different approaches to services, and the fact that payment reductions and visit targets are tied to specific diagnosis codes could result in undesirable incentives to code incorrectly. The methodology for determining shared savings and attributing it to participating providers is not clearly defined, and it would likely be very difficult to change the methodology in ways that would make it sufficiently accurate to encourage participation by either payers or providers. The proposed model does not require or encourage care coordination with primary care providers or other specialists. Incentives to reach the target and replace lost revenue could mean that patient safety could be compromised, and it would be difficult to measure quality accurately in small practices.

The PRT believes that many of the problems with the payment model arise due to challenges that the submitter faces in trying to craft a model to meet the requirements that CMS has established for an Advanced APM. The PRT believes that the care delivery goal the submitter is trying to achieve is desirable (avoiding ED visits for eye conditions that could be appropriately handled in an office setting), but that the components added to meet the Advanced APM requirements regarding risk sharing make the overall model problematic. The PRT believes that a simpler payment model could support the care changes while avoiding the problems with the proposed approach, and that a simpler payment model could be more desirable for physicians even though it does not qualify as an Advanced APM under the current rules.