

Physician-Focused Payment Model Technical Advisory Committee

Preliminary Review Team Report to the Physician-Focused Payment Model Technical Advisory Committee (PTAC) on the *“An Innovative Model for Primary Care Office Payment”* 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:** An Innovative Model for Primary Care Office Payment
2. **Submitting Organization or Individual:** Jean Antonucci, MD
3. **Submitter’s Abstract:**

“The foundations of primary care are access, comprehensive care, continuity of care, and care coordination. When done well, primary care improves outcomes and reduces costs. The primary care delivery system in the U.S. [United States] has neither tools nor financial support to achieve its potential. The expectations, work and business models of primary care physicians (PCPs) have expanded and changed, and frustrated the most passionate and persistent practitioners, with devastating consequence to the delivery of high quality care.

This proposal outlines a way forward driven by the work of high functioning practices. This model would fund office-based primary care, with one tool to capture both risk and quality, and is a real-world capitation model for outpatient services.

The proposed tool for risk assessment, measurement and improvement is a low-burden, Internet-based instrument that contributes to the welfare of the individual patient and to overall practice improvement. Available free-of-charge to practices from HowsYourHealth.org (HYH), it has been extensively validated.

The proposed quality measurement tool is based on the same patient-reported survey (HYH), and measures both standard metrics and the patient's view of their quality of care. HYH is based on what matters to patients, an approach which improves care and outcomes, and, as well, collects disease-centric and cost metrics.

The capitation fee would be paid monthly, based on risk assessment of patients. [The] payment structure would be straightforward, align with actuarial values, and bring primary care into parity with specialists – both a payment goal and a necessity to support primary care. Any primary care physician or independent NP [nurse practitioner] (PCP) could participate, without practice size or geographic restrictions.

This proposal is elegantly innovative and rigorously planned, and is targeted to small independent practices. This proposal meets PTAC's request for an innovative proposal targeting small independents and is a scalable pilot that remains large enough to gather relevant data. We request a limited scale testing in a pilot big enough to gather data.

This model:

- (1) Can be used in any clinical primary care setting;
- (2) Evaluates quality of care;
- (3) Evaluates cost;
- (4) Reflects the Joint Principles of the Patient-Centered Medical Home (PCMH) and the five key functions of the CPC+ [Comprehensive Primary Care Plus advanced primary care medical home model];
- (5) Attributes patients based primarily on patient choice; and
- (6) Carries the expectation that at least 50% of qualifying participants will use certified electronic health record technology (CEHRT)."

B. Summary of the PRT Review

The *An Innovative Model for Primary Care Office Payment* proposal (available on the ASPE PTAC [website](#)) was received on March 21, 2018. The PRT met between June 8, 2018, and July 27, 2018. A summary of the PRT's findings are 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	Unanimous
5. Flexibility	Meets	Unanimous
6. Ability to be Evaluated	Does Not Meet	Majority
7. Integration and Care Coordination	Does Not Meet	Unanimous
8. Patient Choice	Does Not Meet	Unanimous
9. Patient Safety	Does Not Meet	Unanimous
10. Health Information Technology	Meets	Unanimous

C. PRT Process

The PRT reviewed the *An Innovative Model for Primary Care Office Payment (IMPC-APM)* proposal and submitted a list of detailed questions to the submitter on June 19, 2018. The submitter provided written responses to the PRT's questions on July 7, 2018 and July 16, 2018. The PRT reviewed the written responses, and it held a one-hour teleconference with the submitter on July 27, 2018 in which the submitter provided additional information regarding the PRT's initial questions and also responded to additional PRT questions. The PRT subsequently sent a document with initial feedback to the submitter on July 30, 2018, and the submitter provided a written response to the initial feedback from the PRT on August 3, 2018. The proposal, questions and answers, initial feedback document, submitter's response to the initial feedback document, and call transcript are available on the ASPE PTAC [website](#).

The PRT's summary of the proposal and description of the additional, relevant information from other sources on key aspects of the proposed model reviewed by the PRT are described below and on the ASPE PTAC [website](#).

1. Proposal Summary

Under the proposed IMPC-APM, 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 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 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 appeal to have the withhold paid if a 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, the practice would be required to have the same office hours, staff and phone numbers as they 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 that are strongly associated with the use of costly hospital and emergency services (e.g., pain, emotional issues, polypharmacy, adverse medication effects, and low confidence in managing health problems).

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 less than 2-3 times per year, 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.

2. 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 CMMI, and it also has many similarities to the APC-APM that PTAC recommended for implementation at its December 2017 meeting, but it also has some important differences. 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 located in 18 regions	Practices including physicians with a primary specialty designation of family medicine, general practice, geriatric medicine, pediatric medicine, or internal medicine Would be available nationally	Any primary care practice (excluding pediatrics) Would be available 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 <ul style="list-style-type: none"> • Track 1 practices continue to bill and receive payment from Medicare FFS as usual • Track 2 practices receive: <ul style="list-style-type: none"> ➤ quarterly Comprehensive Primary Care Payments (CPCP), and 	4 Components <ul style="list-style-type: none"> • 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 	2 Components <ul style="list-style-type: none"> • 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

Dimension	CPC+	APC-APM	IMPC-APM
	<ul style="list-style-type: none"> ➤ 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 performs on patient experience, clinical quality, and utilization measures (~10% of revenue for Track 1; higher for Track 2) 	<p>services delivered by the practice</p> <ul style="list-style-type: none"> • 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 payments 	<p>meet quality targets</p>
<p>Approach to Risk Stratification of Payments</p>	<p>CMF payments are stratified into 4-5 tiers based on the CMS Hierarchical Condition Categories (CMS-HCC) risk score assigned to patients</p>	<p>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</p>	<p>PBPM payments would be stratified into 2 tiers based on the patient’s score on the “What Matters Index” (Low/ Medium Risk and High Risk)</p> <p>The How’s Your Health Tool would be used for risk stratification of performance measures</p>
<p>Accountability for Quality and Spending</p>	<p>One half of the performance-based incentive payment</p>	<p>The performance-based incentive payment would be</p>	<p>The withhold payment would be returned based on</p>

Dimension	CPC+	APC-APM	IMPC-APM
	<p>would be based on quality measures and one-half would be based on utilization of hospital services</p> <p>Quality measures include patient experience of care measures from the CAHPS Clinician and Group Patient-Centered Medical Home Survey and clinical quality using eQMs</p> <p>Practices must report at least 9 of the 14 CPC+ eQMs (all of which are MIPS 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</p>	<p>retained or recouped based on the practice's performance on measures of both quality and cost, similar to CPC+</p> <p>However, fewer measures and a different mix of quality measures would be used than CPC+</p> <p>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</p>	<p>the practice's performance on patient-reported measures from the "How's Your Health" survey instrument.</p> <p>Measures would include outcomes, access to care, and utilization of hospital services.</p> <p>The exact measures and standards of performance are not specified in the proposal.</p>

3. 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. Key words guiding the environmental scan and literature review were directly identified from the Letter of Intent (LOI) and Proposal. The search and the identified documents were not intended to be comprehensive and were limited to documents that met predetermined research parameters, including a five-year look back period, a primary focus on U.S.-based literature and documents, and relevancy to the letter of intent. These materials are available on the ASPE PTAC [website](#).

b) Data Analyses

In light of the similarities between the IMPC-APM proposal and the APC-APM proposal that PTAC reviewed in 2017, the PRT determined that the materials that had been prepared to assist in the review of the APC-APM proposal were sufficient for its review of the IMPC-APM. Those materials are available on the ASPE PTAC [website](#).

c) Public Comments

There were no public comments submitted for this 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 proposed payment model for primary care practices is significantly different than the payment models that have previously been tested by CMMI and that are currently being tested in CMMI’s Comprehensive Primary Care Plus (CPC+) model.
- The structure of the payment model is specifically designed to be less complex and more administratively feasible for solo and very small primary care practices.
- The proposed payment method uses a completely different approach to risk stratification of payments and quality measurement than any other CMS payment model and any other PFPM proposal that PTAC has previously recommended.

Weaknesses:

- The stratified monthly payment in the proposed payment model is similar to the payment structure in the 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 creating a separate model.
- Because of the innovative nature of the quality measurement approach, additional development work would be needed in order to implement this with a large number of practices.

- It is not clear how many primary care practices would be interested in participating in this model or how many would prefer it over other approaches. No letters of support were included, and no public comments (positive or negative) were received. The submitter indicates that she has identified over two dozen interested physicians/practices that care for at least 5,000 Medicare beneficiaries, which would be equivalent to the smallest number of beneficiaries permitted to participate in the Medicare Shared Savings Program as an Accountable Care Organization (ACO).

Summary of Rating:

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

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 practice would have more flexibility and more resources to deliver more and different services to patients.
- The proposed quality and risk stratification tool is more directly tied to patient characteristics and issues that a primary care practice can directly address than typical diagnosis-based risk tools and outcome measures.
- The proposed quality/risk stratification system is being actively used by the 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.

Weaknesses:

- Because the monthly payment would incorporate payments that would otherwise be made for minor procedures and office-based tests, it is possible that some

practices could send patients to specialists or urgent care centers for these services rather than performing them directly, which would increase Medicare spending.

- Using a completely different quality metric for practices participating in this model will make it difficult for patients and CMS to determine whether the quality of care is better than in non-participating practices.
- It is not clear what level of quality the participants will be expected to achieve.
- The proposed payment amounts would represent an approximately 150-200% increase in Medicare spending for a practice with the mix of patient characteristics and visit frequencies described in the proposal. This would represent approximately \$150,000 for a practice with 300 Medicare patients. Based on average emergency department (ED) visit and hospitalization rates for the Medicare population, the participating practices would need to completely eliminate ED visits or reduce the total number of hospitalizations by approximately 20% in order to offset the higher payments to the practice.

Summary of Rating:

The proposed PFFM does not meet the 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 only justification provided for this is to increase earnings for primary care physicians, rather than to cover costs of explicitly identified additional services for patients. The submitter indicates that the practice could benefit financially from the payment model, such as through reductions in administrative costs, even if the payment amounts from Medicare were set on a budget-neutral basis.

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

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

The flexibility provided in the payment model and the focus on improving performance on patient-centered quality measures would enable and encourage physicians to deliver more responsive, higher-quality care. However, experience with practice capitation payment

systems indicates that some practices could be less responsive to patients who need to be seen by the physician, and nothing in the payment model is explicitly designed to prevent that. Although the payment model includes a significant penalty for a practice that fails to meet quality targets, and that penalty is greater than what the practice could experience under MIPS or other CMS primary care models, the large increase in monthly payments would mean the practice would still be receiving significantly more revenue 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.

The proposal’s focus on patient-reported outcomes using the How’s Your Health tool is innovative and is very desirable in many ways, including reducing administrative burden on physicians for collecting and reporting multiple quality measures and ensuring attention to the issues that matter to patients. Although patient-reported measures have many advantages over process measures and claims-based measures, they can also create burden for patients and the potential for disparities in care due to low response rates for patients with limited health literacy, language barriers, and lack of computer/internet access. Moreover, the How’s Your Health tool and risk adjustment through the What Matters Index have not been tested or validated for performance evaluation or payment, and the impacts on patient access and measure reliability from tying the results to payment would need to be carefully assessed. In order to use the results of the How’s Your Health Tool as part of a performance-based payment, a standardized sampling frame and mode of administration would be needed in order to insure consistency and comparability of results and to avoid the possibility of manipulation of results, and this would be very different than the proposed method of data collection for use in quality improvement and patient care.

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**

Strengths:

- The practice would receive a risk-stratified monthly payment that would replace virtually all of the practice's fee-for-service revenues and provide complete flexibility as to how services should be delivered to patients.
- Higher payments would be paid for patients whose characteristics would be expected to increase the amount of time and resources the practice would need to spend in caring for the patients; this would discourage cherry-picking of patients.

- There would also be greater opportunities to reduce spending on the patients receiving higher payments, since the risk stratification tool has also been shown to have equivalent ability to predict utilization and spending as claims-based risk adjustment systems.
- The payment system would be relatively simple for practices and payers to implement.
- A significant portion (15%) of the practice's revenues would be at risk based on quality performance.

Weaknesses:

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

Summary of Rating:

The proposed PFFM does not meet the criterion. The proposed payment methodology would provide better support for primary care practices that want to deliver higher-quality, more efficient care for Medicare beneficiaries. However, it could also enable primary care practices to deliver lower-quality, less efficient care. The quality component of the methodology is significantly different from the methodology used in any other Medicare payment program, and it would be challenging for CMS to ensure that the quality of care for beneficiaries was being maintained or improved, particularly if the participating practices are not also reporting data for standard MIPS quality measures.

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

PRT Qualitative Rating:

Meets Criterion

Strengths:

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

Weaknesses:

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

Summary of Rating:

The proposed PFFM meets the criterion. The payments to the practice would no longer be based on the number or type of services delivered, but would instead be based on the number of patients managed, the level of need for those patients, and the practice’s performance on quality and rates of emergency department visits and hospital admissions.

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

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

PRT Qualitative Rating:	Meets Criterion
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Strengths:

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

Weaknesses:

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

Summary of Rating:

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

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

PRT Qualitative Rating:

Does Not Meet Criterion

Strengths:

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

Weaknesses:

- Because the practices would be using a different tool for measuring quality, it would be difficult to assess the differences in quality between participating and non-participating practices. If participating practices were required to report standard MIPS quality measures as well as the patient-reported measures in order to facilitate evaluation, it would increase their administrative burden rather than reduce it.
- Because risk stratification is based on a tool that would only be used by practices participating in the model, it would be difficult to separately measure differences in utilization and spending for patients in each of the risk tiers.
- It would be difficult to evaluate the extent to which favorable impacts on cost and quality resulted because (1) the practice began using the HYH tool and was more effectively able to identify patient problems, or (2) because of the different services that could be provided due to the increased payments and greater flexibility.
- Because payments would no longer be based on service-specific claims, it would be difficult to determine what services are actually being delivered unless practices agree to submit encounter forms for services.

- Depending on how many practices would participate and where they were located, it could be difficult to find comparison practices that are not participating in CPC+ or other payment models.

Summary of Rating:

The majority of the PRT concluded that the proposed PFPM does not meet the criterion. They felt that because the proposed model would use a completely different method of assessing quality than in the rest of the Medicare program, and because there would be no reliable way of tracking how the practice’s services to patients had changed, it would be very difficult to assess whether the quality of care had been maintained or improved.

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

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
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Strengths:

- The payment model would provide more resources and flexibility to a primary care practice to enable it to carry out care coordination activities for its patients.
- Use of the How's Your Health survey would help the practice 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.

Weaknesses:

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

Summary of Rating:

The proposed PFPM does not meet the criterion. Although the proposed model would give the primary care practice more flexibility to carry out care coordination activities, there are no specific mechanisms defined for assuring that it would do so.

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:

Does Not Meet Criterion

Strengths:

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

Weaknesses:

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

Summary of Rating:

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

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

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

PRT Qualitative Rating:

Does Not Meet Criterion

Strengths:

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

Weaknesses:

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

Summary of Rating:

The proposed PFFM does not meet the criterion. There is no assurance that individual patients would receive the care they need. The practice would be paid the same amount regardless of how many services were provided, as long as an annual assessment was conducted, and there is no requirement that every patient would complete the How's Your Health survey, so it is possible that the practice could receive its full payment for every patient even if a subset of patients is receiving poor-quality care.

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

PRT Qualitative Rating:

Meets Criterion

Strengths:

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

Weaknesses:

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

Summary of Rating:

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

E. PRT Comments

At its December 2017 public meeting, PTAC unanimously 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.

The IMPC-APM payment model has some similarities to the APC-APM, but also some important differences. Similar to the APC-APM, under the IMPC-APM proposal, a primary care practice would receive a flexible monthly payment for each patient instead of fees for individual services, and the amount of the monthly payment would be higher for patients with higher levels of need. However, the payment structure is significantly simpler than the APC-APM, which could make it easier for primary care practices to implement, particularly solo and small practices similar to the submitter's practice.

Because both the APC-APM proposed by AAFP and the IMPC-APM model use monthly payments rather than payments tied to visits or services, there is the risk in both models that patients could be undertreated, so it is important to have mechanisms for accountability regarding patient access and quality of care. The IMPC-APM uses an approach to quality accountability that is completely different than the APC-APM and also completely different from any other CMS APM. Quality accountability in the proposed model would be based on patient-reported measures from the "How's Your Health" survey instrument, and risk adjustment of both payments and performance measures would be based on the "What Matters Index." The PRT believes there are many desirable aspects to this approach, including reducing administrative burden on physicians for collecting and reporting multiple quality measures and ensuring attention to the issues that matter to patients. However, while patient-reported measures have 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 and unreliable responses for patients with limited health literacy, language barriers, and lack of computer/internet access. Also, the PRT believes that in order to use the results of the How's Your Health Tool as part of a performance-based payment, a standardized sampling frame and mode of administration would be needed in order to insure consistency and comparability of results and to avoid the possibility of manipulation of results, but no method for doing this is described in the proposal.

The proposal does not include details regarding how the payments to the practice would be tied to the results of the How's Your Health tool, nor does it describe what performance standards would be used to prevent patient harm. Because of this, the PRT was unable to conclude that the proposed payment model met the priority criteria regarding Quality and Cost or Payment Methodology. However, the PRT believes that it would be very difficult, if not impossible, for the submitter or any other stakeholder to fully develop these details

other than through limited-scale testing of a new payment model, because of the many changes a practice would need to make in its approach to both patient care and quality measurement that would not be financially feasible under the Medicare Physician Fee Schedule.

In addition, because of the significant increase in the amount of payment that is proposed, the PRT was unable to conclude that Medicare spending would be maintained or decreased under the proposal. However, the PRT believes that the proposed model would still have potential advantages for patients and primary care practices even with a lower amount of payment. Although the submitter and many other stakeholders have advocated for increases in payments to primary care providers, it is not within PTAC's statutory charge to make recommendations about the appropriate compensation levels for primary care physicians or any other specialty.

There are other weaknesses in the proposal that resulted in the PRT's findings that the proposal failed to meet several other criteria. The PRT believes that these weaknesses could be resolved through revisions to the proposal, but the submitter would likely need technical assistance in order to make these changes. Also, the PRT felt it would be difficult to conduct a formal evaluation of the impacts of the proposed model for a variety of reasons (particularly because it would be difficult to assess differences in quality between participating and non-participating practices due to the use of a different tool for measuring quality), but it notes that in many cases, more innovative payment models will inherently be more difficult to evaluate.

In summary, the PRT concluded that the proposed model does not meet the majority of the Secretary's criteria and does not meet any of the high priority criteria. However, the PRT believes that this proposal has many desirable features that could support the delivery of better primary care, and it also incorporates some potentially important innovations in quality measurement that could be used in payment models for both primary care and other types of physicians, but the proposal would need a considerable amount of further development in order to be tested on a broad scale. Also, the proposal has many similarities to other primary care medical home payment models, and it is not clear to the PRT that enough primary care physicians would find the proposed approach sufficiently superior to other models to warrant creating a free-standing program to test it. Consequently, the PRT believes that it would be desirable to find a way to further develop and test this approach as an option within other primary care models or ACOs, rather than as a completely separate model.

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