

Preliminary Review Team Findings on

Eye Care Emergency Department Avoidance (EyEDA) Model

Submitted by the University of Massachusetts Medical School (UMass)

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Presentation Overview

- Preliminary Review Team (PRT) Composition and Role
- Proposal Overview
- Summary of the PRT Review
- Key Issues Identified by the PRT
- PRT Evaluation Using the Secretary's Criteria

Preliminary Review Team Composition and Role

- The PTAC Chair/Vice Chair assigns two to three PTAC members, including at least one physician, to each complete proposal to serve as the PRT. One PRT member is tapped to serve as the Lead Reviewer.
- The PRT identifies additional information needed from the submitter and determines to what extent any additional resources and/or analyses are needed for the review. Assistant Secretary for Planning and Evaluation (ASPE) staff and contractors support the PRT in obtaining these additional materials.
- The PRT determines, at its discretion, whether to provide initial feedback on a proposal.
- After reviewing the proposal, additional materials gathered, and public comments received, the PRT prepares a report of its findings to the full PTAC. The report is posted to the PTAC website at least three weeks prior to public deliberation by the full Committee.
- The PRT report is not binding on PTAC; PTAC may reach different conclusions from those contained in the PRT report.

Proposal Overview

Background: The EyEDA proposal is based on a Transforming Clinical Practices Initiative (TCPI) award assisting over 1,600 optometry practices across the U.S. to increase the number of patients with eye-related symptoms who make visits to a practice rather than an emergency department (ED) for urgent eye conditions.

- The submitter asserts this approach improved the quality of care for patients and 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.

Goals: The EyEDA proposal seeks to encourage treatment of selected eye-related symptoms through office visits with optometrists and ophthalmologists rather than visits to hospital EDs.

Alternative Payment Model (APM) Entity: Licensed optometrists and ophthalmologists, as well as organizations employing optometrists and ophthalmologists.

Proposal Overview – Continued

Core Elements of the Program:

- Financial risk in the form of an eight percent reduction for all urgent care visits (identified by ICD-10 diagnoses codes) relative to payments under the normal Medicare physician fee schedule.
- Shared savings payment at the conclusion of the performance year based on:
 - The participating provider or practice’s number of qualifying urgent office visits relative to a target level; and
 - The reduction in ED visits in area hospitals for the same diagnoses relative to a base year/period.
- Performance on two quality measures (patient experience and patient safety) as a quality threshold to participate in the model and to receive shared savings payments.

Proposal Overview – Continued

Payment Model: Proposed Conditions and Approach

- The eight percent reduction for initial office visits will be for specified ICD-10 codes in the following categories of “ED avoidable” conditions: conjunctivitis, corneal injury, corneal injury with a foreign body, hordeolum (stye), acute posterior vitreous detachment, eye pain, and other eye conditions.
- The submitter believes that the number of patients making urgent care visits to the practice instead of the ED will increase through:
 - Educating patients about the desirability of receiving urgent eye care from optometry or ophthalmology practices; and
 - Expanding office hours.
- The proposed model does not, however, require that participating practices use any specific approach to encourage such visits.

Proposal Overview – Continued

Payment Model: Shared Savings and Quality

- In order to receive shared savings bonus payments, providers must meet minimum thresholds on two quality measures:
 - Patient experience, assessed through a patient survey
 - Patient safety: the seven-day adverse event rate for the same ICD-10 diagnoses. Adverse events include unscheduled ED visits, hospital admission, or observation stays; blindness or permanent visual impairment; or death.
- The target number of visits for each participating practice or provider would be developed based on historical volume of visits for these conditions, increased by some percentage.
- Participating practices or providers could receive shared savings payments if there were a reduction in ED visits for the proposed urgent eye-related conditions. The proposal does not specify the percentage of the savings that would be shared or the method for identifying the service area.
- Each participating physician or practice would receive a share of the savings for distribution 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.

Proposal Overview – Continued

TCPI Experience:

- The TCPI program provided technical assistance to over 1,600 optometry practices nationwide.
- From October 2017 through May 2019, optometrists enrolled in TCPI reported more than 330,000 visits to the ED were avoided through same day office-based appointments and after-hours triage.
 - These reports were based on ICD-9 codes for office visits rather than tracking of changes in ED visit rates.
- Feedback from TCPI provider participants indicates many TCPI-enrolled optometrists would participate in EyEDA.

Summary of the PRT Review

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

Key Issues Identified by the PRT

- 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 fee-for-service based on office visits, with no flexibility in payment to support different approaches to services.
- Payment reductions and visit targets tied to specific diagnosis codes could result in undesirable incentives to code incorrectly.
- The model does not attribute patients to practices. The methodology for determining shared savings and attributing the savings to participating providers is not clearly defined.
- The proposed model does not require or encourage care coordination with primary care providers or other specialists.
- 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 Centers for Medicare & Medicaid Services (CMS) has established for an Advanced APM.

Criterion 1. Scope (High Priority)

Criterion Description

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 Conclusion

Does Not Meet Criterion

Unanimous or Majority Conclusion

Majority

- No alternative payment models (APMs) in the CMS portfolio specifically address eye-related conditions or focus on care delivered by eye specialists.
- Specialty participation in APMs is important but should broaden existing opportunities. 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.
- 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.
- ED visits for eye-related conditions occur primarily among those under age 65. 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.

Criterion 2. Quality and Cost (High Priority)

Criterion Description

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 Conclusion

Meets Criterion

Unanimous or Majority Conclusion

Unanimous

- 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.
- The model includes two quality measures designed to ensure that urgent conditions receive high-quality care in an office setting.
- However, the proposed measures have limitations that may not adequately ensure the highest quality care:
 - Patient satisfaction 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.
 - The rate of adverse events is unlikely to be a statistically valid measure for small practices.
- Some conditions may not represent urgent needs but instead are emergencies that cannot be safely treated in an office setting.

Criterion 3. Payment Methodology (High Priority)

Criterion Description

Pay APM Entities with a payment methodology designed to achieve the goals of the PFPM criteria. Addresses in detail through this methodology how Medicare and other payers, if applicable, pay APM Entities, how the payment methodology differs from current payment methodologies, and why the PFPM cannot be tested under current payment methodologies.

PRT Conclusion

Does Not Meet Criterion

Unanimous or Majority Conclusion

Unanimous

- The proposed payment model would provide a strong financial incentive to increase the number of urgent care visits for eye conditions.
- However, the approach to setting performance targets raises concerns:
 - It would penalize practices whose patients already come to them for urgent care needs.
 - Small practices could have a low or high baseline rate based on random variation.
- 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.
- The shared savings calculation is based on a reduction in ED visits without attributing the reduction to participating practices. The proposal does not specify how adjustments would be made when eligible patients in the service area change over time.
- The proposal does not provide any upfront payments to support the ability of participating practices to deliver more and better urgent care.

Criterion 4. Value over Volume

Criterion Description

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

PRT Conclusion

Meets Criterion

Unanimous or Majority Conclusion

Unanimous

- 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.
- However, 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.

Criterion 5. Flexibility

Criterion Description

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

PRT Conclusion

Meets Criterion

Unanimous or Majority Conclusion

Majority

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

Criterion 6. Ability to Be Evaluated

Criterion Description

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

PRT Conclusion

Meets Criterion

Unanimous or Majority Conclusion

Majority

- The proposal's primary performance measure 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.
- 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 lack of attribution of patients or ED visits avoided to participating providers could make it difficult to evaluate whether changes in ED visits were different between participating and non-participating providers.

Criterion 7. Integration and Care Coordination

Criterion Description

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 Conclusion

Does Not Meet Criterion

Unanimous or Majority Conclusion

Unanimous

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

Criterion 8. Patient Choice

Criterion Description

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

PRT Conclusion

Meets Criterion

Unanimous or Majority Conclusion

Unanimous

- The proposed model would make it easier for patients to receive appropriate treatment for urgent eye conditions outside of a hospital ED.
- It is possible that a beneficiary might not realize that they have the right to seek care in another setting (such as an ED) even if their optometrist or ophthalmologist presents them with access in the office setting.

Criterion 9. Patient Safety

Criterion Description

Aim to maintain or improve standards of patient safety.

PRT Conclusion

Does Not Meet Criterion

Unanimous or Majority Conclusion

Unanimous

- 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.
- However, the proposed diagnosis codes cover a broad range of eye conditions, some of which are much more clinically serious than others.
 - 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.
 - As a result, patients who need care in an ED may not receive it, which could harm patient safety.

Criterion 10. Health Information Technology

Criterion Description

Encourage use of health information technology to inform care.

PRT Conclusion

Meets Criterion

Unanimous or Majority Conclusion

Unanimous

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

Preliminary Review Team Findings on

Patient-Centered Asthma Care Payment (PCACP) Model

Submitted by the American College of Allergy, Asthma & Immunology (ACAAI)

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June 22, 2020

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Proposal Overview

Background: Asthma affects 26.5 million people in the U.S., including 3.5 million Medicare beneficiaries. The submitter estimates that Medicare spends about \$454 million on asthma-related emergency department (ED) visits and \$1.1 billion on asthma-related hospital admissions. When correctly diagnosed and managed, asthma does not have to be a life-threatening and costly disease.

Goals: The ACAAI PCACP proposal intends to give physicians specializing in asthma care (primarily allergists and immunologists) the resources and flexibility they need to better diagnose and manage patients with asthma. The proposal seeks to save costs and improve quality by avoiding unnecessary hospitalizations and ED visits through better diagnosis and management of patients with asthma.

Alternative Payment Model (APM) Entity: An Asthma Care Team (ACT) consisting of an asthma specialist such as an allergist or immunologist, primary care providers, and other providers as needed.

Proposal Overview – Continued

Core Elements of the Program:

- Three categories for varying care levels needed for treatment stage, disease severity, and therapy efficacy:
 1. Diagnosis and initial treatment for patients with poorly controlled asthma;
 2. Continued care for patients with difficult-to-control asthma; and
 3. Continued care for patients with well-controlled asthma.
- Beneficiary eligibility and payment amounts for participating ACTs differ for each category.
- The PCACP excludes asthma patients with certain comorbidities such as COPD and lung cancer. Additionally, participating asthma patients are excluded from all performance assessment measures if they fail to stop smoking, obtain prescribed medications, or attend scheduled appointments.
- Performance on service utilization/spending and quality is assessed relative to other participating ACTs, with adjustments to PCACP payments based on performance.
- ACTs must meet minimum quality standards to receive bundled payments in Categories 1 and 2.

Category 1: Diagnosis and initial treatment for patients with poorly controlled asthma

- **Eligibility:** New patients with asthma symptoms without a diagnosis in the last year, or those with poorly controlled asthma or treatments that are not consistent with current guidelines, are enrolled by the physician at the initial visit.
- **Payment:** Bundled monthly payments for up to three months, replacing some fee-for-service (FFS) billing for evaluation and monitoring (E&M) codes, for asthma-related clinical services and selected tests.
 - Payment stratified into up to five levels based on patient risk.
 - Initial adjustment of $\pm 5\%$ of PCACP payment based on performance, increasing to $\pm 9\%$ over time.
- **Performance Measures:**
 - *Care quality:* percent of patients with improved asthma symptoms, improved spirometry measures, reduced ED or urgent care visits, and ratings of practice access.
 - *Service use & spending:* average number of months to diagnosis and the price-standardized average total per patient spending on allergy testing, asthma medications, urgent and ED visits for asthma symptoms, and asthma-related hospitalizations.

Category 2: Continued care for patients with difficult-to-control asthma

- **Eligibility:** Beneficiaries are patients who do not have well-controlled asthma after medication trials, or those taking certain medications, with recent severe symptoms or hospitalizations, or significant comorbidities.
- **Payment:** Bundled monthly payment, replacing some FFS billing for E&M codes for asthma-related clinical services and selected tests.
 - Payment stratified into four levels based on patient risk.
 - Initial adjustment of $\pm 5\%$ of PCACP payment based on performance, increasing to $\pm 9\%$ over time (same as Category 1).
- **Performance Measures:**
 - Care quality: percent of patients with improved asthma control, with decreased control, and ratings of practice access.
 - Service utilization and spending: assessed using price standardized measure as in Category 1.

Category 3: Continued care for patients with well-controlled asthma

- **Eligibility:** Patients with well-controlled asthma who were previously enrolled in Categories 1 or 2.
- **Payment:** Monthly supplemental payment that covers non-face-to-face visits and communication between physicians.
- **Performance Measures:**
 - *Care quality:* percent of patients with decreased asthma control; percent of patients rating access to physician practice as very good or excellent.
 - *Service utilization and spending:* assessed using price-standardized average total per patient spending on allergy testing, asthma medications, urgent and ED visits for asthma symptoms, and asthma-related hospitalizations (same measure and exclusions as Categories 1 and 2).

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

Key Issues Identified by the PRT

- The proposed model lacks sufficient scope for implementation as a stand-alone APM.
- With three separate phases and up to five payment levels within each phase, the proposed model is highly complex.
- The program includes the potential to maximize bundled payments through patient selection rather than a simpler payment approach that applies to all patients with asthma.
- The proposal falls short in its approach to care coordination.
 - Proposed model does not address core factors (e.g., social determinants, transport, copayments, etc.) beyond education and evidence-based practice that are likely to reduce excess utilization.

Key Issues Identified by the PRT (continued)

- The proposal does not identify how the Medicare FFS payment system causes failures in diagnosing and managing Medicare patients with asthma and has a significant focus on the need for increased fee schedules rates.
- Proposal may overstate the possibility for savings citing a 50% reduction in ED visits and hospitalization.
- Inclusion of some but not all tests increases complexity and could further reduce the potential for savings.
- Allocation of the payment from the specialist to the PCP in the 2nd phase (Continued care for patients with difficult-to-control asthma) is not specified and instead is left to the providers to work out.

Criterion 1. Scope (High Priority)

Criterion Description

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 Conclusion

Does Not Meet Criterion

Unanimous or Majority Conclusion

Unanimous

- No APMs in the Centers for Medicare & Medicaid Services (CMS) portfolio specifically address asthma, a chronic condition with high prevalence and treatment costs in the general population.
- However, the exclusion of certain cohorts of asthma patients from the model could reduce the potential number of Medicare patients who might participate.
- Patients with asthma and their associated providers can participate in existing APMs such as Accountable Care Organizations (ACOs) or Comprehensive Primary Care Plus (CPC+) in areas where these models are available. Expansion of such models could enable a broader approach to patient health and directly incorporate allergists, immunologists, or pulmonologists.

Criterion 2. Quality and Cost (High Priority)

Criterion Description

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 Conclusion

Does Not Meet Criterion

Unanimous or Majority Conclusion

Unanimous

- The proposal recognizes the need to facilitate physician engagement and emphasizes shared decision-making between patients and providers.
- However, the potential Medicare savings could be overstated by assuming that effects of improved asthma care among FFS beneficiaries who are likely to be complicated by a wide variety of comorbidities would mirror utilization, spending, and savings reported for the wider asthma population.
 - Furthermore, the projected savings created by a projected 50% reduction in utilization, even if this occurs, fall far short of the \$10 billion goal that CMMI established for payment model innovations.
- The model does not contain provisions to address social determinants related to asthma control, such as smoking cessation, the patient's environment, transportation, or access to services and medications.
- The model does not address how care or payment would be coordinated between primary care providers and participating specialists, nor how that care might look different than it does today and what in this model makes those changes likely to occur.

Criterion 3. Payment Methodology (High Priority)

Criterion Description

Pay APM Entities with a payment methodology designed to achieve the goals of the PFPM criteria. Addresses in detail through this methodology how Medicare and other payers, if applicable, pay APM Entities, how the payment methodology differs from current payment methodologies, and why the PFPM cannot be tested under current payment methodologies.

PRT Conclusion

Does Not Meet Criterion

Unanimous or Majority Conclusion

Unanimous

- The proposed model is highly complex, with multiple tracks assigned by provider assessment within the three main categories. This complexity could make it difficult for providers to participate and payers to administer.
- The proposed payment models are based on a monthly risk model, yet the participating provider has discretion to determine which patients are included each month.
- Recent improvements in the Medicare Physician Fee Schedule are intended to support the types of care the PCACP proposal adopts.
- The proposal does not identify how the Medicare FFS payment system causes failures in diagnosing and managing Medicare patients with asthma and has a significant focus on the need for increased fee schedules rates.

Criterion 4. Value over Volume

Criterion Description

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

PRT Conclusion

Does Not Meet Criterion

Unanimous or Majority Conclusion

Unanimous

- The proposed model provides a payment amount to enable providers to tailor services to patient need.
- The monthly framework and the ability to ***potentially*** enroll patients who will be financially beneficial for the provider reduces accountability for providers.
- The mechanics of the proposal seem insufficient to drive more value than what is currently standard of care and available in today's FFS environment.
- The proposed model does not clearly address major known drivers of improved health among Medicare patients such as social determinants of health in the approach to improving outcomes for asthma patients.

Criterion 5. Flexibility

Criterion Description

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

PRT Conclusion

Meets Criterion

Unanimous or Majority Conclusion

Unanimous

- The proposed payment model would give participating providers additional flexibility to provide a broader range of services that could be beneficial in diagnosing and controlling asthma.
- However, it is unclear how the patient's primary care provider and asthma care specialists would work together flexibly for the benefit of the patient.

Criterion 6. Ability to Be Evaluated

Criterion Description

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

PRT Conclusion

Does Not Meet Criterion

Unanimous or Majority Conclusion

Unanimous

- The proposed model recognizes the importance of evaluation and notes the types of data that would be available for model participants.
- However, the complexity of the proposed model with up to five payment levels within each phase of potentially one month intervals could make it difficult to evaluate.
- It will be hard to determine whether or not the proposed model saves money given the proposal does not have a present benchmark for comparison patients.
- Proposed evaluation comparison is to performance by other ACTs rather than all asthma care providers.
 - This approach lacks an absolute benchmark as well as an historical perspective on improvements in asthma care.

Criterion 7. Integration and Care Coordination

Criterion Description

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 Conclusion

Does Not Meet Criterion

Unanimous or Majority Conclusion

Unanimous

- The model emphasizes co-management with primary care yet does not specify how care would be coordinated between primary care physicians and asthma specialists beyond what happens today and how this is incentivized.
- The model does not elaborate on care management outside the office, other than occasional contact by a respiratory therapist. Some practices, such as phone calls to coordinate with other providers, are expected under current standards of care.
- The proposal also does not address how care coordination might evolve over the course of the model, such as when a patient moves from a “difficult-to-control” to a “well-controlled” asthma patient.
- Without clear guidelines the negotiation of the distribution of PCACP payments between providers in each circumstance could be burdensome for providers in practice and may hinder coordination.
- The model does not identify specific innovations in care delivery or approaches to improve care for patients with asthma that will be included beyond tools already available in FFS Medicare.

Criterion 8. Patient Choice

Criterion Description

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

PRT Conclusion

Meets Criterion

Unanimous or Majority Conclusion

Unanimous

- The proposal notes that the PCACP enhances patient choice by providing an additional care option and desirable services for patients.
- On the other hand, patients would be required to commit to receiving all asthma services from the ACT during the month covered by the payment, which could limit patient choice.

Criterion 9. Patient Safety

Criterion Description

Aim to maintain or improve standards of patient safety.

PRT Conclusion

Meets Criterion

Unanimous or Majority Conclusion

Unanimous

- The submitters expect that PCACP would promote early and accurate diagnosis, encourage timely development of care plans, educate patients, and facilitate identification of asthma exacerbations before they can become severe.
- The proposal also notes that the proposed minimum quality standards would protect patients from undertreatment.
- The emphasis on provider-patient conversations and shared decision-making is a strong element of the proposed model.

Criterion 10. Health Information Technology

Criterion Description

Encourage use of health information technology to inform care.

PRT Conclusion

Meets Criterion

Unanimous or Majority Conclusion

Unanimous

- The proposal indicates that regular electronic communication between asthma specialists and primary care physicians (PCPs) will be required.
- The payments in the proposed model could be used to support outreach and remote monitoring through technology to help manage asthma and patient compliance.