

# Physician-Focused Payment Model Technical Advisory Committee

## Preliminary Review Team Report to the Physician-Focused Payment Model Technical Advisory Committee (PTAC)

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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:** Intensive Care Management in Skilled Nursing Facility Alternative Payment Model (ICM SNF APM)
2. **Submitting Organization or Individual:** Avera Health
3. **Submitter's Abstract:**

"The elderly population living in skilled nursing homes and long term care facilities are frail, medically complex, and manage multiple chronic conditions. Due to the way health care is structured and paid for in the United States, many nursing home residents face challenges in accessing timely, quality care often causing rapid health deterioration and further complications. Potentially Avoidable Hospitalizations (PAH) are a symptom of this problem and nursing facility residents experience significantly more of these events than any other patient population. Unnecessary hospitalizations and emergency room visits are harmful, costly and represent a major opportunity to improve health outcomes and quality of life for a vulnerable population.

Avera proposes a new Physician-Focused Alternative Payment Model to align physician, nursing facility, and community care incentives to proactively and holistically care for

nursing facility residents. The goal of Intensive Care Management in Skilled Nursing Facilities Alternative Payment Model (ICM SNF APM, hereafter the "Model") is to prevent avoidable escalation of illness for residents, resulting in better quality, better patient experience, and lower costs. This is accomplished through three model drivers:

- 1) Providing timely, 24/7 access to a geriatrician-led care team through telemedicine
- 2) Delivering geriatric care management and management of care transitions
- 3) Mentoring and training long term care staff to improve early identification of resident change in health status

The Model makes available the expertise of geriatricians to a wide panel of residents and clinical teams for proactive, intensive care management using telemedicine. The model is proposed by Avera Health (Sioux Falls, South Dakota). It is based on the successful Avera eLong Term Care (Avera eLTC) program, funded by a Center for Medicare and Medicaid Innovation (CMMI) Health Care Innovation Award Round 2 (HCIA2) in 2014.

The Model aligns financial incentives to improve population outcomes, quality of care, and total cost of care. The payment has two parts: a one-time payment for new admission care and a per beneficiary per month payment (PBPM) for post-admission care. The Model payment is comprehensive for all services delivered and is impacted by participants' ability to meet performance criteria on specific quality metrics. The Model lends itself to varying levels of accountability for participants. This proposal recommends two options for consideration by PTAC, each with its own benefits, from which PTAC will choose the payment method best-fit for its definition of alternative. The first option is a Performance-Based Payment that is paid throughout the year and will be potentially adjusted in subsequent years, depending on quality performance. The second option is a Shared Savings Model that provides the same monthly payments for services delivered but also includes an annual financial reconciliation to determine if savings were generated and assess if any additional shared savings are due to the model participant or, in later years, if any repayment is due to CMS (in the case where savings were not achieved). The Performance-Based Payment is a simplified option which encourages broader participation in the program, especially among smaller practices which may not be able to weather the financial risk in a shared savings arrangement and is the preferred option. The Shared Savings Model incorporates engagement for Participants by shifting performance risk to the provider in order to potentially achieve more significant cost savings. In both cases, the payment methodology exists to support the Model's care delivery model and works to align incentives to improve patient experience and outcomes."

## B. Summary of the PRT Review

The proposal was received on September 7, 2017. The PRT met between October 18, 2017, and February 14, 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)	Meets Criterion	Unanimous
2. Quality and Cost (High Priority)	Meets Criterion	Unanimous
3. Payment Methodology (High Priority)	Meets Criterion	Unanimous
4. Value over Volume	Meets Criterion	Unanimous
5. Flexibility	Meets Criterion	Unanimous
6. Ability to be Evaluated	Meets Criterion	Unanimous
7. Integration and Care Coordination	Meets Criterion	Unanimous
8. Patient Choice	Meets Criterion	Unanimous
9. Patient Safety	Meets Criterion	Unanimous
10. Health Information Technology	Meets Criterion	Unanimous

## C. PRT Process

### 1. Proposal Summary

The PRT reviewed the *ICM SNF APM* proposal as well as additional information provided by the submitter in written responses to questions from the PRT. The submitter also participated in a phone call with the PRT. The proposal, questions and answers, and call transcript are available on the ASPE PTAC [website](#).

Under the proposed model, geriatrician-led care teams (GCTs) would partner with nursing facilities (NFs) and skilled nursing facilities (SNFs) and supplement the facilities' on-site staff via telehealth. Beneficiaries would continue to have services provided by an attending primary care physician (PCP) and be cared for by the facility staff. However, the beneficiary (as well as the facility staff) would additionally have access to the GCT via telehealth. The overall goals of the model are to reduce avoidable emergency department (ED) visits and hospitalizations and to lower costs.

The geriatric physician/practice would be the APM Entity. In addition to the geriatrician, the submitter suggests that GCTs might include gerontology-trained or certified advanced practice providers, pharmacists, social workers, nurses, and behavioral health practitioners. Criteria for participation in the model include articulating strategies for the following: PCP care coordination and assessment of satisfaction; facility engagement and measurement of staff satisfaction; assessment of beneficiary satisfaction; use of appropriate Health Information Technology (HIT) to coordinate care between the GCT

and facility staff, including telemedicine access; facility staff coaching and mentorship; provision of didactic continuing education credits targeted at identifying knowledge and skill gaps; and use of data to drive continuous quality improvement. The submitter also notes that implementation of the model must be facility-wide, rather than for a subset of patients.

Under the proposed model, the GCT would render geriatric care management activities such as monitoring beneficiaries' care, risk stratification of the patient population, development of care plans for high-risk patients, medication reconciliation and management, evidence-based disease management, behavioral health support, advance care planning, and transitional care support. The GCT would also provide timely access to care such as 24/7 access via telehealth to a physician or advanced practice provider on the GCT and real-time provider response to a patient's change in health status. In order to accomplish these activities, the GCT would be expected to have the capability to provide HIPAA-compliant, real-time, two-way audio/visual assessment of the patient, virtual access to health records at the facility, and risk stratification and population health tools. The GCT would work in close collaboration with the PCP and facility staff, as the PCP would retain ultimate oversight and management of a patient's care.

To support the GCT's activities, the submitter proposes two possible payment designs: (1) a "performance-based payment" model that the submitter considers simpler and preferred (the "simpler" model) and (2) a shared savings model intended to qualify as an Advanced APM. The submitter does not expect the Centers for Medicare & Medicaid Services (CMS) to implement both. Under both payment model options, the APM Entity would receive a one-time payment of \$252 for each new beneficiary admission to a partnering SNF/NF and a PBPM payment of \$55; beneficiaries would not share in these costs. Also, under both options, the APM Entity would decide whether and how to share payments with the facilities.

Under the first option, an APM Entity that failed to meet performance standards would receive reduced one-time and PBPM payment amounts in the following year. Performance would be determined using 11 measures of clinical quality, health outcomes, and indicators of health care cost management that are used for Nursing Home Compare and the SNF Value-Based Purchasing Program. Performance would not impact payments in the first two years of implementation.

Under the second option, the APM Entity would be eligible for shared savings/at risk for shared losses and the shared savings/losses would be adjusted based on whether performance standards were met (using the same 11 measures under the first option); adjustments to shared savings/losses based on performance would not occur in the first two years of implementation. To calculate shared savings/losses, actual Medicare Part A and B expenditures (with some exclusions) for all healthcare services received by residents during their SNF/NF stays (including services delivered in hospitals) plus 30-days post-discharge would be compared against Hierarchical Condition Category (HCC)

risk-adjusted target amounts based on historical spending. The reconciliation would occur annually. Beneficiaries attributed to other programs (e.g., ACOs) would be excluded from these calculations. Shared savings would be limited to 10 percent of the target amount, and repayments would be limited to the one-time and PBPM payments. The submitter noted on a call with the PRT that, under this option, they believed APM Entities would have greater flexibility regarding the standards of services they would need to meet because of the greater accountability for outcomes and spending.

Under both options, in addition to the 11 quality measures tied directly to payment, the APM Entity must monitor an additional 13 measures included in Nursing Home Compare. Failure to meet the performance standard on more than five of these measures would result in discontinued participation in the program.

### Payment Options

Common to Options 1 & 2	Option 1: Performance-Based Payments
<ul style="list-style-type: none"> <li>• \$252/new admit + \$55 PBPM</li> <li>• No bene cost-sharing</li> <li>• APM Entity decides whether to share with partnering facilities</li> <li>• 11 performance measures</li> <li>• APM Entity must monitor additional 13 measures. Failure to meet standards on 6+ results in discontinued participation.</li> </ul>	<ul style="list-style-type: none"> <li>• Beginning in Y3, failure to meet standards on 4+ performance measures in preceding year results in payment reductions (new admit + PBPM)</li> </ul>
	<h4 data-bbox="695 869 1068 898">Option 2: Shared Savings Model</h4> <ul style="list-style-type: none"> <li>• APM Entity would be eligible for shared savings (beginning in Y1) and at risk for shared losses (beginning in Y3). Savings limited to 10% of target amount; losses limited to new admit + PBPM amounts.</li> <li>• Actual Medicare Part A and B expenditures (with some exclusions) for all healthcare services received by residents during their SNF/NF stays (including services delivered in hospitals) + 30-days post-discharge would be compared against HCC risk-adjusted target amounts based on historical spending</li> <li>• Beginning in Y3, shared savings/losses adjusted based on performance measures. Savings reduced for failure to meet standards on 4+ performance measures; losses reduced if standards met on at least 8.</li> </ul>

## 2. Additional Information Reviewed by the PRT

### a) Literature Review and Environmental Scan

The Office of the Assistant Secretary for Planning and Evaluation (ASPE), through its contractor, conducted an abbreviated environmental scan that included a review of peer-reviewed literature as well as a search for relevant grey literature, such as research reports, white papers, conference proceedings, and government documents. The search and the identified documents were not intended to be comprehensive and were limited to documents that meet predetermined research parameters, including a five-year look back period, a primary focus on U.S.-based literature and documents, and relevancy to the letter of intent. The contractor also produced a table comparing the proposal to the CMS Initiative to Reduce Avoidable Hospitalizations among Nursing Facility Residents. In addition, ASPE staff worked with the contractor to create a short annotated bibliography on ED visits and

hospitalizations for this patient population. These materials are available on the ASPE PTAC [website](#).

**b) Data Analyses**

The PRT sought additional information regarding rates of ED visits and hospital admissions from SNFs and NFs. ASPE, through its contractor, produced data tables that are available on the ASPE PTAC [website](#).

**c) Public Comments**

The PRT reviewed 18 public comment letters on the proposal. The public comment letters are available on the ASPE PTAC [website](#).

**d) Other Information**

The PRT also obtained information from CMS' Office of the Actuary, Innovation Center, and Medicare-Medicaid Coordination Office relevant to the proposal or similar initiatives.

## **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.

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**PRT Qualitative Rating: Meets Criterion**

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**Strengths:**

- Although there are existing CMS initiatives aimed at reducing avoidable ED visits and hospitalizations for the SNF/NF patient population, the PRT believes that there is still significant opportunity for improvement in this space. Furthermore, the central role of telehealth distinguishes the model from other initiatives.
- There are currently no models in the CMS portfolio that are explicitly for geriatricians. This model would provide an opportunity for geriatricians to participate in an APM.

**Weaknesses:**

- The proposal was designed assuming that a GCT would serve a population of approximately 5,000 beneficiaries. While the submitter believes that the proposed model, specifically the simpler payment option, would allow smaller scale deployment (e.g., 100 beneficiaries), the PRT is uncertain whether it would be feasible. The model would provide more opportunity for participation if it can be implemented with fewer beneficiaries.

- The proposal offers an opportunity for geriatricians, but the PRT felt that when possible, internists or other physicians with a particular focus in the care of geriatric patients might also be appropriate.
- It was unclear which aspects of the model are absolute requirements necessary to achieve the model's desired outcomes. For example, the PRT is unclear whether the capability to provide HIPAA-compliant, real-time, two-way audio/visual assessment of the patient is critical or whether telephone communication may be more typical and sufficient. The PRT notes that fewer requirements would make the model more broadly available, particularly to smaller practices.

**Summary of Rating:**

The PRT unanimously finds that the proposal meets this criterion. While the PRT has some questions and uncertainty about the minimum population size needed to make the model feasible, overall, the PRT believes that the model provides a unique opportunity for geriatricians for aspects of the care of Medicare beneficiaries where there still is significant opportunity for improvement.

**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.

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**PRT Qualitative Rating: Meets Criterion**

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**Strengths:**

- In general, providing beneficiaries and SNF/NF facility staff with 24/7 access to a GCT via telehealth seems likely to improve quality and reduce costs by reducing avoidable ED visits and hospitalizations. These facilities typically do not have a clinician on-site around the clock. This model provides on-site staff with an additional clinical resource that they can call for assistance in assessing and responding to changes in the patient's clinical presentation, rather than immediately sending the patient to the hospital for evaluation.
- Furthermore, early evidence from the submitter's experience with their HCIA Round 2 demonstration project suggests that the proposal can improve quality and reduce cost. The submitter found that 88 percent of beneficiaries were able to stay in the SNF/NF immediately following a telemedicine encounter. In addition, using a simple pre-post design, the submitter found that the care model could reduce Medicare spending by approximately \$342 PBPM (this number does not include the HCIA Round 2 award amount). It is important to note that these are the submitter's initial internal findings and that a final evaluation of the project is not yet available.
- The submitter's HCIA Round 2 demonstration project took place in facilities in Iowa, Minnesota, Nebraska, and South Dakota. The data tables requested by the PRT indicate that there are areas in the country with much higher rates of ED visits and hospitalizations from SNFs and NFs, and therefore, potential for even greater improvement if the model were expanded into these high utilization areas.

**Weaknesses:**

- Different SNF/NF facilities may have patient populations of varying acuity. The model, particularly the simpler payment design, may incentivize GCTs to partner with facilities where they perceive the most opportunity based on patient characteristics (“cherry-picking”) since the one-time and PBPM payments are not risk adjusted.
- The model creates incentives for the GCT to keep patients out of the hospital when it is avoidable. A potential challenge is ensuring that the model does not delay or prevent access to services provided at a hospital when such services are needed.

**Summary of Rating:**

The PRT unanimously finds that the proposal meets this criterion. The PRT believes that the model will reduce avoidable ED visits and hospitalizations, improving quality and reducing costs. The submitter’s initial internal findings support this conclusion. However, the PRT notes the model may incentivize GCTs to selectively choose partners, excluding facilities whose patient populations might benefit. A means to ensure access to services provided at a hospital when such services are needed is an important detail that needs to be worked out.

**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.**

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**PRT Qualitative Rating: Meets Criterion**

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**Strengths:**

- The model directly ties payment to measures of clinical quality, health outcomes, and indicators of health care cost management; these measures are aligned with other reporting programs. Under both payment options, failure to meet performance standards could impact payments (beginning in Year 3 of implementation). Under the simpler payment option, the one-time and PBPM payments could be reduced. Under the two-sided risk option, any shared savings could be reduced.
- The simpler payment design with less financial risk and complexity could enable greater participation, particularly from smaller practices.
- The payment methodology, particularly the two-sided risk option, incentivizes the GCT to reduce avoidable ED visits and hospitalizations.
- Through its HCIA Round 2 demonstration project, the submitter learned about the time and resources required to care for the SNF/NF patient population with this care model; the one-time and PBPM amounts are based upon that learning.

**Weaknesses:**

- The applicant indicates that one or the other of the optional models should be

selected, rather than designing a single model that includes the best elements of both.

- Performance would be determined using 11 measures of clinical quality, health outcomes, and indicators of health care cost management. Performance on these measures would not impact payments in the first two years of implementation. In addition, the 11 measures include ED and readmission measures for SNF patients, but there are not measures for hospitalization of NF patients. Furthermore, performance on measures would not negatively impact payments under either payment option unless the APM Entity fails to meet the standards on four or more measures (in the case of the shared savings option, there also needs to be savings or repayments). Therefore, an APM Entity could fail to meet the standards for ED visits and readmission measures for SNFs and still not have a negative performance adjustment. Under the shared savings model, performance factors only into the shared savings/loss payments (if there are any) and does not affect the monthly payments, in contrast to the simpler payment option, in which monthly payments in the subsequent year can be reduced due to poor performance. At the same time, the simpler payment option does not provide any increase in payments for good performance (e.g., if ED visits and hospitalizations are significantly reduced), limiting the flexibility to deliver additional services that could help avoid additional ED visits/admissions.
- The submitter indicated that the shared savings model would allow for greater flexibility since there would be greater accountability than under the simpler model. However, the submitter did not make clear how the additional flexibility and shared savings could make the overall program stronger. It is also unclear why a shared savings arrangement rather than another manner of adding risk to the model was chosen.
- Under the shared savings model option, repayments are limited to the amount of the monthly payments, but shared savings can be as high as 10 percent of the total cost of care. If there is random year-to-year variation but no change in the average spending per patient, the shared savings payments could be much higher than the repayments, which would result in increased spending for Medicare. In addition, although this option was proposed in order to meet the requirements for an Advanced APM, it is not clear that the limit on downside risk would meet the current standards established by CMS.
- Neither of the options proposes a way to risk adjust rates of ED visits, hospital admissions, or spending based on the specific types of patient characteristics that can affect hospitalization rates for nursing facility residents. As a result, participants could be unfairly rewarded or penalized based on differences in the types of patients in the nursing facilities they support, rather than the effectiveness of the care delivered. The submitter indicated that patients with specific characteristics are at much higher risk of hospitalization, but those characteristics are not necessarily captured effectively by HCC scores.

**Summary of Rating:**

The PRT unanimously finds that the proposal meets this criterion. The PRT supports the fundamental concepts present in both payment designs, the one-time and PBPM payments with accountability for performance. However, rather than seeing multiple payment options, the PRT would prefer to have seen a single model that includes the best elements of both. The PRT has concerns with the mix of measures and the precise manner in which performance impacts payment. The PRT is also concerned with the application and type of risk adjustment in the model. However, the PRT believes that it would be feasible to address these issues without requiring fundamental changes in the structure of the payment model.

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

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**PRT Qualitative Rating: Meets Criterion**

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**Strengths:**

- Real time 24/7 access to geriatric specialists in nursing facilities should promote the delivery of higher-quality health care. As noted above, the model provides on-site staff with an additional clinical evaluation resource, which may diminish inappropriate hospital services, reduce medical complications from polypharmacy, and improve access to geriatric specialty care, which is currently undersupplied in the U.S. health care market.
- Unlike traditional Medicare, under the proposed model, payments are made per patient rather than per service. Therefore, the model does not incentivize service volume.

**Weaknesses:**

- The GCT is expected to risk stratify patients to help deliver the right amount of patient care and planning. However, the submitter indicates that there are currently no well-validated risk stratification models for the long-term care population.

**Summary of Rating:**

The PRT unanimously finds that the proposed model meets this criterion. The PRT believes that the model of care and payment support the delivery of high-quality health care. The development of a well-validated risk stratification model would strengthen the proposal.

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

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**PRT Qualitative Rating: Meets Criterion**

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**Strengths:**

- Partnering with GCTs would give SNFs/NFs more flexibility in how the facilities could respond when their residents have clinical problems.

- Although the proposal outlines how the care model is anticipated to work, the GCT and partnering facilities seem to have quite a degree of flexibility in how they would collaborate.
- There is flexibility in the composition of the GCT. Although the proposal offers a suggested composition, geriatricians have the freedom to add other types of practitioners based on the needs of the patient population.

**Weaknesses:**

- The submitter indicated that it believes the shared savings model would allow for greater flexibility in the way services could be delivered, since the greater accountability for outcomes could allow less strict standards for service delivery and because of the additional resources available through shared savings payments. However, it was unclear which of the standards would be relaxed under the shared savings model, and it was unclear which of the standards are necessary to achieve the model's desired outcomes. Having more requirements obviously limits flexibility.

**Summary of Rating:**

The PRT unanimously finds that the proposed model meets this criterion. The PRT believes that the model would provide GCTs and SNFs/NFs more flexibility in the delivery of high-quality care. However, the PRT was unclear about how the standards might vary between the two payment models.

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

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**PRT Qualitative Rating: Meets Criterion**

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**Strengths:**

- The PRT believes that the model has evaluable goals, reducing avoidable ED visits and hospitalizations and lowering costs. The proposal includes measures (11 tied to payment and 13 tied to model participation) that are currently in use in other reporting programs.

**Weaknesses:**

- As previously noted, different SNF/NF facilities may have patient populations with differing risk of ED visits, hospitalizations, and spending. Therefore, relevant and accurate severity adjustment would be needed for an accurate evaluation. However, current risk adjustment methodologies have not been developed specifically for nursing home patient populations, which may limit the validity of the evaluation.

**Summary of Rating:**

The PRT unanimously finds that the proposed model meets this criterion. The model has evaluable goals and includes measures that are currently in use. However, the PRT believes the lack of appropriate risk adjustment methodologies will make evaluation challenging.

**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 PFFM.

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**PRT Qualitative Rating: Meets Criterion**

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**Strengths:**

- Criteria for participation in the model include articulating strategies for PCP care coordination and assessment of satisfaction; facility engagement and measurement of staff satisfaction; use of appropriate HIT to coordinate care between the GCT and facility staff, including telemedicine access; facility staff coaching and mentorship; and provision of continuing education targeted at identifying knowledge and skill gaps.
- The proposal indicates that the GCT would be expected to work in close collaboration with the PCP and facility staff, as the PCP would retain ultimate oversight and management of a beneficiary's care. The proposal also indicates that the GCT would be expected to have virtual access to health records at the facility.

**Weaknesses:**

- While criteria for participation in the model include articulating strategies for integration and coordination, and the proposal expects close collaboration between the GCT and facility, nothing in the proposal seems to guarantee that integration and coordination occur. Furthermore, while the PCP is ultimately responsible for the patient's care, there was no explicit mention of a process or a standardized approach that would ensure that the GCT consults with the PCP or follows the PCP's guidance.
- Except for the PCP, the proposal does not specifically mention how the GCT would interact with physical and occupational therapists or other practitioners relevant to the patient's care.

**Summary of Rating:**

The PRT unanimously finds that the proposal meets this criterion. The PRT believes that integration and care coordination are expected and likely to occur. If the proposal had detailed a mechanism that guaranteed integration and care coordination would take place and that the PCP's guidance would be followed, the PRT would have found that the proposal met this criterion and deserved priority consideration.

**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.

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**PRT Qualitative Rating: Meets Criterion**

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**Strengths:**

- Currently, patients are often sent to the hospital without much choice.
- The proposal indicates that beneficiaries can opt out of GCT services.

**Weaknesses:**

- The proposal does not articulate how the GCT would factor patient preferences and advance care plans into the advice given to facility staff.

**Summary of Rating:**

The PRT unanimously finds that the proposal meets this criterion. Overall, the PRT believes the proposal is an improvement over the status quo.

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

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**PRT Qualitative Rating: Meets Criterion**

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**Strengths:**

- Because clinicians are not always on-site or immediately available, providing 24/7 access to a GCT via telehealth is likely to improve patient safety, as is mentoring and training of SNF/NF staff.

**Weaknesses:**

- The model creates incentives for the GCT to decrease avoidable hospital admissions. A potential challenge is a counter-incentive to decrease medically necessary hospital admissions, particularly under the shared savings model. The PRT believes that the proposal would be better if the one-time and PBPM payments were risk-adjusted.

**Summary of Rating:**

The PRT unanimously finds that the proposal meets this criterion. The PRT believes the model allows for timely assessment and intervention that can prevent avoidable hospitalizations. However, the PRT again notes that a means to ensure access to services provided at a hospital, when such services are needed, is an important detail that needs to be worked out.

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

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**PRT Qualitative Rating: Meets Criterion**

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**Strengths:**

- Telehealth is a central component of the proposed model. GCTs would be expected to have the capability to provide HIPAA-compliant, real-time, two-way audio/visual assessment of the patient.
- SNFs and NFs have not been included in Medicare and Medicaid EHR Incentive Programs, and they lag behind acute care settings in adoption of EHRs. Under the proposed model, since GCTs would be expected to have virtual access to health records at the facility, this could encourage further adoption of EHRs among SNFs and NFs interested in participating in the model.

**Weaknesses:**

- It is unclear which aspects of the model are absolute requirements necessary to achieve the model's desired outcomes under the different payment options. Therefore, the PRT was less certain about the degree to which the model might encourage the adoption of HIT.

**Summary of Rating:**

The PRT unanimously finds that the proposed model meets this criterion, as telehealth is a central component of the model.

**E. PRT Comments**

The PRT finds that the *ICM SNF APM* proposal meets all 10 of the Secretary's criteria. The PRT is enthusiastic to see a payment model that encourages better care for patients in nursing facilities through care coordination and access to geriatricians through real time telemedicine consultation and management, particularly as there are currently no APMs focused on geriatricians. The PRT supports the fundamental concepts present in both payment designs, namely the one-time and PBPM payments with accountability for performance.

However, rather than seeing multiple payment options, the PRT would prefer to have seen a single model that includes the best elements of both. The PRT also has concerns with the mix of measures and the precise manner in which performance impacts payment. The proposed payment model could be strengthened by addressing the asymmetry in the design with respect to shared savings, risk, and penalties. Expansion of the model to include appropriately trained internists and family physicians could broaden its reach. Although the proposal was written from the perspective of a large, well-organized geriatric practice with highly sophisticated telemedicine infrastructure, experiences, and protocols, the proposers indicate they believe the model could work in a simpler form in other practice settings. This aspect of the model should be vetted as part of implementation, as this could expand its impact for smaller and/or more rural practices.