Characteristics of PFPMs Likely to Be Recommended by PTAC

In order to assist stakeholders who are considering submitting proposals for Physician-Focused Payment Models (PFPMs) and to facilitate its own deliberations, PTAC has developed the guidance below describing the kinds of payment models that are more likely to receive favorable recommendations. However, PTAC will consider all proposals on their merits, and it reserves the right to make decisions on individual proposals that differ from this guidance. It also reserves the right to modify this guidance as necessary based on experience in reviewing proposals, based on comments and recommendations offered by stakeholders, and based on the regulations governing PFPMs that are issued by the Secretary. Section 1115A authorizes the use of any Alternative Payment Model that "addresses a defined population for which there are deficits in care leading to poor clinical outcomes or potentially avoidable expenditures" and that is "expected to either (a) improve the quality of care without increasing spending, (b) reduce spending without reducing the quality of care, or (c) improve the quality of care and reduce spending."

PTAC will use the information submitted in a proposal, a submitter's responses to questions from PTAC members, analyses conducted to support the proposal review, and comments from the public to determine whether a PFPM meets the Secretary's criteria. The information needed to make this determination is defined in detail under each of the Secretary's Criteria in the Supporting Information section.

1. Goals and Focus of PFPMs

PFPM proposals may include, but are not limited to:

- Payments designed to enable individual eligible professionals[‡] or groups of eligible professionals to improve care for patients who are receiving a specific treatment or procedure. These "treatment-based payments" could focus only on services delivered on the day(s) of treatment or on services delivered during a longer episode of care.
- Payments designed to enable individual eligible professionals or groups of eligible professionals to improve care during a period of time for patients who have a specific health condition or combination of conditions. These "condition-based payments" could focus on either acute conditions or chronic conditions.
- Payments designed to enable teams of eligible professionals to deliver more coordinated, efficient care for patients who have a specific condition or are receiving a specific treatment or procedure.

[‡] As defined in MACRA and the regulations issued by HHS, an "eligible professional" is a physician, physician assistant, nurse practitioner, clinical nurse specialist, physical therapist, occupational therapist, qualified speech-language pathologist, qualified audiologist, certified registered nurse anesthetist, certified nurse-midwife, clinical social worker, clinical psychologist, or registered dietitian or nutrition professional.

- Payments designed to improve the efficiency of care and/or outcomes for patients receiving both services delivered by physicians or other eligible professionals and related services ordered by eligible professionals that are delivered by other providers.
- Payments designed to enable physicians or other eligible professionals to improve care for particular subgroups of patients (e.g., patients with a severe form of a condition, patients who have an early stage of a condition where progression can be more easily prevented, patients who need special services after treatment, or patients living in frontier or rural communities.)
- Payments designed to enable a primary care physician or a multi-specialty group of eligible professionals to improve care for most or all of the health conditions of a population of patients, or to prevent the development of health problems in a population of patients with particular risk factors.
- Revisions to the codes and fee levels for a broad range of services delivered by physicians and other eligible professionals that are designed to support delivery of a different mix of services in conjunction with accountability for measures of utilization, spending, or outcomes for a group of patients.
- Payments in which the amount of payment depends on patient outcomes, with or without changes to the units of payment for individual physicians or other eligible professionals.
- PTAC will consider PFPMs in which the amount of financial risk during an initial period of time is smaller than the amount of risk in later periods.

PTAC is not likely to recommend to the Secretary a payment model that is targeted to a single health care provider, facility, institution, or system. Parties submitting proposed PFPMs to PTAC should present information in their proposal explaining how the PFPM submitted to PTAC would be feasible for implementation by multiple health care providers, facilities, institutions, or systems, as appropriate.

2. Services Supported by a PFPM

In general, PTAC will only recommend PFPMs that directly affect the method and/or amount of payments for one or more services delivered, ordered, managed, or coordinated by one or more types of physicians or other eligible professionals.

If a proposed payment model changes the method and/or amount of payments to both eligible professionals and other types of health care providers (e.g., hospitals, home health agencies, skilled nursing facilities), PTAC will be more likely to recommend the model as a PFPM if a substantial portion of the payment supports services that are delivered or ordered by physicians or other eligible professionals.

3. How the Method of Payment Differs from the Physician Fee Schedule

Payment for Individual Services Not Billable under the Physician Fee Schedule

In general, PTAC will be unlikely to recommend a proposed PFPM if the only change it makes is to give a physician or other eligible professional the ability to bill for a single type of service that is not currently eligible for payment under the Medicare Physician Fee Schedule or to alter the fee level for a service that is currently billable, particularly if there is no change in the measures or methods of accountability that would otherwise apply under MIPS. There is already a process for proposing and making these types of changes through the regulations governing the Medicare Physician Fee Schedule.

Payments for Packages and Bundles of Services

If a proposed PFPM would create a new payment for physicians or other eligible professionals that replaces or includes the payments for two or more services that are currently paid for separately under the Physician Fee Schedule, PTAC will be more likely to recommend the proposed PFPM if the new payment replaces all or most of the eligible professional's current payments for individual services that are related to (1) a specific health condition or risk factor, or combination of conditions and risk factors; (2) a specific treatment; or (3) all of the health care needs of a population of patients (e.g., a monthly payment that covers all office visits, phone calls, emails, and office-based procedures needed by a patient, replacing separate payments for Evaluation and Management services and procedures). The new payment could allow flexibility to deliver services that are not currently billable in addition to services that are billable, and the amount of the payment could be stratified or adjusted based on characteristics of the patients, rather than based on the number or types of services delivered.

If the physician or other eligible professional would continue to be paid separately for any individual services related to a condition, risk factor, or treatment covered by the new payment, the PFPM proposal should explain why those services cannot or should not be included in the new payment. In these cases, PTAC will be more likely to recommend the PFPM if it also includes a mechanism for accountability for spending on the services that are not included in the new payment. For example, the PFPM might include a performance- based payment component using a measure of total spending on all services related to the condition, risk factor, or treatment (both the services that are included in the new payment and those that are still paid separately) or a measure of total spending on all aspects of the patient's care.

PTAC will be more likely to recommend a PFPM if it defines a process for updating the definitions of what is included and excluded in a new payment and updating the amount of the new payment as changes in technology and evidence occur over time.

4. Relationship of Eligible Professionals to Entity Receiving the Payment

PTAC recognizes that there are many different organizational structures through which physicians and other eligible professionals deliver services to patients and through which eligible professionals are paid for those services. PTAC will not limit the types of entities that can submit proposed PFPMs and it will consider proposals for PFPMs that would need to be implemented through entities other than practices or groups consisting of one or more physicians or other eligible professionals. PTAC encourages submission of proposals that could be successfully implemented by small, independent physician practices.

5. Accountability for Spending and Quality

Measures of Utilization, Spending, Quality, and/or Outcomes

PTAC will be more likely to recommend a PFPM that is focused on a condition, risk factor, or treatment if the PFPM requires the eligible professionals or the entity receiving the payment to take accountability for (1) controlling total Medicare spending on all services the patients receive that are related to the condition, risk factor, or treatment, (2) controlling total Medicare spending on all services the patients receive, or (3) improving performance on measures of spending, utilization, and/or quality that are primary drivers of total Medicare spending or of the spending related to the condition, risk factor, or treatment.

PTAC will be more likely to recommend a PFPM if it appears that the projected savings for the Medicare program are sustainable without any increases in spending by other payers.

PTAC will be more likely to recommend a PFPM that changes payment related to a treatment if the eligible professionals or the entity receiving the payment take accountability for ensuring that the treatment is appropriate for the patient.

PTAC will be more likely to recommend a PFPM that changes payment related to a health condition if the payment model defines a consistent method of identifying the condition for which payment would be made and if the eligible professionals or the entity receiving the payment take accountability for ensuring the accuracy of the diagnosis of the condition.

PTAC will be more likely to recommend a PFPM that changes payment related to a health condition if it addresses how care will be delivered to patients who have health conditions in addition to the condition on which the PFPM is focused.

PTAC will be more likely to recommend a PFPM if it includes specific mechanisms for ensuring that patients receive evidence-based services for the health condition(s) or for the delivery of the preventive or treatment service(s) that are the focus of the PFPM.

PTAC will be more likely to recommend a PFPM if the eligible professionals or the entity receiving the payment take accountability for some or all of the outcomes of the care delivered.

PTAC will be more likely to recommend a PFPM if it proposes evidence-based quality measures that are feasible to collect and use to monitor performance, or, if such quality measures are not available, if the proposal presents a compelling case for how quality would be maintained or improved and how research or periodic monitoring could be used to demonstrate positive quality outcomes.

PTAC will be more likely to recommend a PFPM if it specifically identifies potential unintended consequences and includes mechanisms for preventing or mitigating them.

If a PFPM is designed to support services that would prevent future health problems, slow the progression of disease, or achieve other outcomes that will occur over a multi-year

period, and if additional spending is needed in the short run to achieve savings in the future, PTAC will be more likely to recommend the PFPM if it (1) requires accountability for improving a current clinical measure that has been shown to have a close direct linkage to the long-term outcome, and (2) requires accountability for ensuring spending does not increase more than the amount projected to be needed to achieve the improved outcome.

Financial Risk

PTAC will be more likely to recommend a PFPM in which the eligible professionals or the entity receiving the payment accept more than nominal financial risk for achieving the desired results on the measures of spending and quality/outcomes. PTAC may recommend PFPMs that do not meet the specific requirements for financial risk or other requirements for qualification as an "Advanced Alternative Payment Model" under the regulations issued by HHS. The fact that the financial risk components or other characteristics of a PFPM lead to a recommendation by PTAC does not necessarily mean that the PFPM will be approved as an Advanced Alternative Payment Model by the Secretary.

PTAC will consider proposals for PFPMs that define financial risk in different ways, including, but not limited to:

- The amount of payment that could be lost by the eligible professionals or the entity if the desired results are not achieved;
- The increase in unreimbursed costs the eligible professionals or entity would incur if the desired results are not achieved; or
- The amount that the eligible professionals or entity would be expected to pay to the Centers for Medicare & Medicaid Services (CMS) if the desired results are not achieved.

PTAC will be more likely to recommend a PFPM in which the amount of financial risk and the way in which the risk is structured are (1) likely to be financially feasible for physicians and eligible professionals to accept, including small practices, and (2) likely to adequately encourage changes in care delivery needed to achieve the desired results on the measures of spending and quality/outcomes. This includes, but is not limited to, PFPMs that have one of the following characteristics:

- When the desired results are not achieved, the potential reduction in payments to a participating eligible professional practice is at least as great as the maximum penalty the practice would face if it were being paid under current Medicare payment systems rather than under the PFPM; or
- When the desired results are not achieved, payments to the eligible professional practice or entity could be reduced by more than any increase in payments the practice or entity received compared to the standard amounts it would have received under current Medicare payment systems; or
- Payments to the eligible professional practice or entity could be reduced by an amount sufficient to ensure there is no net increase in Medicare spending for the condition(s) or treatment(s) that are the focus of the payment model.

PTAC will be more likely to recommend a PFPM that includes a method of adjusting payments, measures, and financial risk based on the differences in the needs of patients.