

# Physician-Focused Payment Model Technical Advisory Committee

## Committee Members

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Jennifer Wiler, MD, MBA

September 3, 2020

Alex M. Azar II, Secretary  
U.S. Department of Health and Human Services  
200 Independence Avenue, SW  
Washington, DC 20201

Dear Secretary Azar:

On behalf of the Physician-Focused Payment Model Technical Advisory Committee (PTAC), I am pleased to submit PTAC's comments and recommendation to you on a physician-focused payment model (PFPM), *Patient-Centered Asthma Care Payment (PCACP): An Alternative Payment Model for Patient-Centered Asthma Care*, submitted by the American College of Allergy, Asthma & Immunology (ACAAI). These comments and recommendation are required by section 1868(c) of the Social Security Act, which directs PTAC to: 1) review PFPM models submitted to PTAC by individuals and stakeholder entities; 2) prepare comments and recommendations regarding whether such models meet criteria established by the Secretary of Health and Human Services (HHS); and 3) submit these comments and recommendations to the Secretary.

With the assistance of HHS' Office of the Assistant Secretary for Planning and Evaluation (ASPE), PTAC's members carefully reviewed: the *PCACP* proposal (submitted to PTAC and found to have met the Committee's administrative requirements on May 6, 2019); additional information on the model, which was provided by the submitter in response to questions from a PTAC Preliminary Review Team; and other information. PTAC also reviewed supplemental information on the model provided by the submitter and considered issues in payment and care delivery, as well as relevant research findings. At a public meeting of PTAC held on June 22, 2020, the Committee deliberated on the extent to which this proposal meets the criteria established by the Secretary in regulations at 42 CFR §414.1465 and whether it should be recommended.

PTAC refers ACAAI's proposal to the Secretary for other attention as specified in PTAC comments. The Committee finds that the proposal meets five of the Secretary's 10 criteria. The Committee found that the proposal does not meet the other five criteria, including two of the high priority criteria (scope and

payment methodology). Although PTAC was concerned that many aspects of the *PCACP* proposal lack sufficient development for implementation as a PFP, the Committee unanimously voted to refer the proposal for other attention because a number of proposal elements warrant further consideration and, with refinement, it offers a potentially promising approach for specialty-focused PFPs. PTAC commends the submitter's efforts to improve care for patients with asthma by developing a specialty-based alternative payment model (APM) that would expand APM participation to multiple specialties involved in caring for asthma patients, particularly since asthma patients may be commonly misdiagnosed in primary care or not currently managed efficiently across specialties. The Committee recognizes that a specialty-focused APM may be attractive to rural or smaller asthma-focused specialty practices that may not have opportunities to participate in other existing models such as accountable care organizations (ACOs) or Comprehensive Primary Care Plus (CPC+).

PTAC recognizes the underlying importance of developing, evaluating, and ultimately offering specialty practice models. The stakeholder community has demonstrated substantial engagement and interest in developing such models. By referring the *PCACP* model for other attention, the Committee is signaling that the proposed model offers a sufficient framework to merit consideration for further model development. Aspects needing more detail and refinement include mechanisms for collaboration between primary care and the Asthma Care Teams, as well as specification of the diagnoses included, beneficiary attribution, risk adjustment, attention to social determinants of health, and payment methodology.

In advocating for consideration of specialty APMs, PTAC notes that it will also be important to ascertain whether specialty APMs can attain better outcomes for beneficiaries and providers at lower costs than might be derived through modification of the Medicare Physician Fee Schedule (MPFS). PTAC believes that attention to this model, which focuses on asthma, could facilitate development of APMs for a wider range of specialties beyond asthma. Also, while PTAC recognizes the value of offering APM opportunities to smaller specialty practices, it will be necessary to determine sufficient specialty APM volumes to achieve practice transformation.

The members of PTAC appreciate your support of our shared goal of improving the Medicare program for both beneficiaries and the physicians who care for them. The Committee looks forward to your detailed response.

Sincerely,

//Jeffrey Bailet//

Jeffrey Bailet, MD

Chair

Attachments

# REPORT TO THE SECRETARY OF HEALTH AND HUMAN SERVICES

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Comments and Recommendation on  
*Patient-Centered Asthma Care Payment (PCACP):  
An Alternative Payment Model for Patient-Centered Asthma Care*

September 3, 2020

## About This Report

The Physician-Focused Payment Model Technical Advisory Committee (PTAC) was established by the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) to: 1) review physician-focused payment models (PFPMs) submitted by individuals and stakeholder entities; 2) prepare comments and recommendations regarding whether such models meet criteria established by the Secretary of Health and Human Services (HHS); and 3) submit these comments and recommendations to the Secretary. PTAC reviews submitted proposals using criteria established by the Secretary in regulations at 42 CFR §414.1465.

This report contains PTAC's comments and recommendation on the PFPM proposal *Patient-Centered Asthma Care Payment (PCACP): An Alternative Payment Model for Patient-Centered Asthma Care*. This report also includes: 1) a summary of PTAC's review of the proposal; 2) a summary of the proposed model; 3) PTAC's comments on the proposed model and its recommendation to the Secretary; and 4) PTAC's evaluation of the proposed PFPM against each of the Secretary's criteria for PFPMs. The appendices to this report include a record of the voting by PTAC on this proposal, the proposal submitted by the American College of Allergy, Asthma & Immunology (ACAAI), and additional information on the proposal submitted subsequent to the initial proposal submission.

## **SUMMARY STATEMENT**

PTAC refers ACAAI's proposal to the Secretary for other attention as specified in PTAC comments. The Committee finds that the proposal meets five of the Secretary's 10 criteria. The Committee found that the proposal does not meet the other five criteria, including two of the high-priority criteria (scope and payment methodology). Although PTAC was concerned that many aspects of the *PCACP* proposal lack sufficient development for implementation as a PFFPM, the Committee unanimously voted to refer the proposal for other attention because a number of proposal elements warrant further consideration and, with refinement, it offers a potentially promising approach for specialty-focused PFFPMs. PTAC commends the submitter's efforts to improve care for patients with asthma by developing a specialty-based alternative payment model (APM) that would expand APM participation to multiple specialties involved in caring for asthma patients, particularly since asthma patients may be commonly misdiagnosed in primary care or not currently managed efficiently across specialties. The Committee recognizes that a specialty-focused APM may be attractive to rural or smaller asthma-focused specialty practices that may not have opportunities to participate in other existing models such as accountable care organizations (ACOs) or Comprehensive Primary Care Plus (CPC+).

PTAC recognizes the underlying importance of developing, evaluating, and ultimately offering specialty practice models. The stakeholder community has demonstrated substantial engagement and interest in developing such models. By referring the *PCACP* model for other attention, the Committee is signaling that the proposed model offers a sufficient framework to merit consideration for further model development. Aspects needing more detail and refinement include mechanisms for collaboration between primary care and the Asthma Care Teams, as well as specification of the diagnoses included, beneficiary attribution, risk adjustment, attention to social determinants of health, and payment methodology.

In advocating for consideration of specialty APMs, PTAC notes that it will also be important to ascertain whether specialty APMs can attain better outcomes for beneficiaries and providers at lower costs than might be derived through modification of the Medicare Physician Fee Schedule (MPFS). PTAC believes that attention to this model, which focuses on asthma could facilitate development of APMs for a wider range of specialties beyond asthma. Also, while PTAC recognizes the value of offering APM opportunities to smaller specialty practices, it will be necessary to determine sufficient specialty APM volumes to achieve practice transformation.

## **PTAC REVIEW OF THE PROPOSAL**

*The Patient-Centered Asthma Care Payment (PCACP): An Alternative Payment Model for Patient-Centered Asthma Care* proposal was submitted to PTAC and found to have met the Committee's administrative requirements on May 6, 2019. The proposal was first reviewed by a

Preliminary Review Team (PRT) composed of three PTAC members (Angelo Sinopoli, MD; Jeffrey Bailet, MD; and Bruce Steinwald, MBA). The PRT conducted its review of the proposal between June 6, 2019, and January 20, 2020. The proposal was also posted for public comment. The PRT's findings were documented in the PRT Report to PTAC on the *PCACP* proposal, dated January 20, 2020. The submitter provided a written response to the PRT Report on February 28, 2020, addressing concerns raised by the PRT. At a public meeting held on June 22, 2020, PTAC deliberated on the extent to which the proposal meets the criteria established by the Secretary in regulations at 42 CFR §414.1465 and whether it should be recommended to the Secretary for implementation. The submitter and members of the public were given an opportunity to make statements to the Committee at the public meeting. Remaining sections of this report provide a summary of the proposal, PTAC's comments and recommendation to the Secretary on the proposal, and the results of PTAC's evaluation of the proposal using the Secretary's criteria for PFPMs.

## **PROPOSAL SUMMARY**

The ACAAI *PCACP* proposal intends to give physicians specializing in asthma care (primarily allergists, immunologists, and pulmonologists) 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 emergency department (ED) visits through better diagnosis and management of patients with asthma. The submitter believes that current Medicare payments do not fully support the additional time and services needed for patients with difficult-to-diagnose or difficult-to-treat asthma.

The submitter also notes a lack of fee schedule payments for some high-value services to manage and coordinate care and believes that copayments present a barrier to using the inter-professional consultation codes that do exist. The proposal identifies an Asthma Care Team as the APM entity, which would include the asthma specialist, primary care providers (PCPs), and other providers as needed. The Asthma Care Team could use monthly payments provided by the model to support activities such as phone and email communication between providers and with patients; patient education, particularly regarding medications and adherence; evaluation and modification of patients' living environment to identify asthma triggers; and outreach and monitoring to assess whether the asthma care plan is working. The proposed model would require participating Medicare beneficiaries to commit to receive all asthma-related services from the Asthma Care Team or other providers designated by that team.

To account for the varying levels of care necessary for patients with asthma reflecting stage of treatment, disease severity, and the efficacy of therapies, the proposal would create three categories within the APM tied to the treatment phase of patients:

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 differ for each category.<sup>1</sup> For all phases of the model, patients with the following conditions would be excluded from participating: allergic bronchopulmonary aspergillosis, chronic obstructive pulmonary disease (COPD), other restrictive lung diseases, structural lung diseases, lung cancer, and severe personality disorders. The proposal indicates that diagnosis efforts during the first three months of the model could help confirm whether the patient has any of these conditions and therefore would be excluded from the APM for subsequent months.

In the first two categories, participating physicians would receive up to five risk-stratified monthly bundled payments that would replace current evaluation and management (E&M) payments. In the third category, participating providers would receive a smaller fixed supplemental payment in addition to existing MPFS payments. Though the proposal does not specify payment amounts or indicate a process for determining the payment amounts, in response to written questions from the PRT, the submitter estimated payment amounts for each category would be based on time, resources, and services supported by the APM. The process for risk adjustment is not specified.

Under the *PCACP* model, providers would be held accountable for quality objectives and spending targets through adjustments to the *PCACP* payments. The performance of participating practices on each category's quality and spending measures would be compared to prior year risk-stratified performance of other practices participating in *PCACP*. Providers would be required to meet minimum quality standards in order to receive *PCACP* payments. The proposal indicates that the proposed standardized average total per patient spending approach avoids putting physicians at risk for changes in prices but holds them accountable for utilization. Regarding the amount of risk sharing, the proposal indicates that the maximum payment increases or decreases (for "high" or "low" performance) would initially be  $\pm 5$  percent and then would increase over time to  $\pm 9$  percent.

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<sup>1</sup> Additional details on eligibility, quality and payment provisions are provided in Tables 1 and 2 (pages 5-6) in the PRT Report available at: <https://aspe.hhs.gov/system/files/pdf/261881/PRTReportACAAI.pdf>.

## RECOMMENDATION AND COMMENTS TO THE SECRETARY

PTAC refers the *PCACP* proposal to the Secretary for other attention as specified below in the comments on each of the 10 criteria. PTAC commends the submitter on its efforts to improve care for patients with asthma. Asthma is a prevalent chronic disease across all ages that is often misdiagnosed. Poorly controlled asthma is associated with avoidable hospitalizations and ED visits, as well as higher treatment costs, particularly for asthma medications. Better care coordination could improve care and quality of life for asthma patients, as well as potentially reduce costs.

The Committee also commends the submitter for developing a specialty-based APM. The *PCACP* model focuses on allergists, immunologists, and pulmonologists, but the model intends to incorporate all physicians caring for Medicare beneficiaries with asthma. The Committee supports the submitter's interest in building a model that emphasizes team-based care. PTAC recognizes that a specialty-focused APM may be attractive to small single- or multi-specialty medical practices, especially in rural areas, that may not have an opportunity to participate in health care value-based payment reforms such as ACOs, CPC+, or other large health care system initiatives.

However, PTAC believes this proposal has weaknesses, both in the clinical care model and in the proposed payment methodology that will limit its ability to achieve the outcomes described by the submitter. By focusing on a limited number of specialties for one type of patient, the proposed model may lack sufficient scope for implementation as a stand-alone APM. The *PCACP* model would enroll Medicare beneficiaries with asthma that is either newly diagnosed or poorly controlled. The number of Medicare beneficiaries with newly diagnosed asthma is a subset of all beneficiaries with asthma because many beneficiaries with asthma are diagnosed at a younger age. The proposed model also excludes a significant share of potential enrollees because of common comorbid conditions such as COPD. The remaining Medicare fee-for-service (FFS) beneficiaries who meet eligibility criteria are likely to be dispersed across physician practices, potentially making it difficult for providers to achieve sufficient volume and financial incentives to achieve practice transformation. Further, the proposed model's quality and outcome measures exclude patients with certain behaviors such as failure to stop smoking, which are behaviors that physicians should be working with their patients to address to improve asthma-related outcomes.

Additionally, with its three separate phases and multiple payment levels within each phase, the proposed model is highly complex. This complexity could make this model difficult for providers to implement and manage. It would also be difficult to assess whether the proposed model achieves desired cost and quality outcomes. The *PCACP* model proposes a complicated approach though it is not clear how the current MPFS falls short in supporting the types of care-related activities described in the proposal.



The proposed model may also include the potential for gaming by providers to maximize bundled payments rather than facing a simpler prospective payment. Participating providers have discretion over which beneficiaries are enrolled, making determinations after a visit about who is enrolled and which *PCACP* category and associated monthly payment amount is most appropriate in a given month. The complexity of the model would make it particularly difficult to monitor implementation as a check on these potential incentives for gaming.

The proposed model also falls short in its approach to care coordination. In practice, both PCPs and asthma specialists like allergists, immunologists, and pulmonologists manage patients with asthma. The proposed model does not describe how these providers would work together or share in *PCACP* payments, nor how these relationships might change over the course of a patient's disease. In addition, the proposed model does not address coordination with other providers who may be involved in treating asthma exacerbations, such as ED physicians or hospital-based providers. The way in which specialists and PCPs would negotiate the distribution of *PCACP* payments in each circumstance is not specified, and the time involved could hinder true coordination of care.

In spite of these shortcomings of the *PCACP* model, PTAC recognizes the underlying importance of developing, evaluating, and ultimately offering specialty APMs. The stakeholder community has demonstrated substantial engagement and interest in developing such models. By referring the *PCACP* model for other attention, the Committee is signaling that the proposed model offers a sufficient framework to merit consideration. It will ultimately be necessary to determine whether it would be more beneficial to develop a specialty APM model that focuses on patients with one disease or on specific specialties, versus a broader model that could accommodate a wide range of specialties and patient conditions. However, PTAC believes that many components of the proposed *PCACP* model, such as the focus on team-based care and on improving accurate diagnosis and care coordination, provide an important basis for further model development.

## EVALUATION OF PROPOSAL USING SECRETARY’S CRITERIA

### PTAC Rating of Proposal by Secretarial Criteria

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

#### Criterion 1. Scope (High-Priority Criterion)

*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.*

#### Rating: Does Not Meet Criterion

PTAC concludes that the proposed model does not meet this criterion. The proposal does not identify how the MPFS is causing failures in diagnosing and managing Medicare patients with asthma that would justify the need for an APM. Specifically, the proposal does not clearly articulate how the existing Medicare FFS payments fail to compensate providers for the types of activities described in the proposal, such as determining appropriate tests. The proposed model also does not include specific innovations in care delivery or an approach to improving care for patients with asthma beyond tools that are already available in Medicare.

The PCACP model addresses a chronic condition with high prevalence and treatment costs in the general population that is often misdiagnosed. Although asthma prevalence is low among Medicare beneficiaries relative to younger age groups, expansion of the aging population will increase costs for Medicare. However, the number of Medicare beneficiaries with asthma (either newly diagnosed or poorly controlled) who meet the proposed inclusion and exclusion

criteria may limit the scope and impact of the proposed model. The exclusion criteria that apply to all three categories in the model could reduce the potential number of Medicare patients who might participate in the *PCACP* model. For example, COPD is a common comorbidity with asthma among older adults; the submitter estimated that 61 percent of Medicare FFS beneficiaries with asthma also have COPD as a chronic condition, and the model as proposed would exclude these beneficiaries. Expanding the *PCACP* concept to include other respiratory illnesses such as COPD would increase the number of potential Medicare beneficiaries who could participate in the model.

The proposed model could expand opportunities for physicians because no APM currently exists for allergists, immunologists or pulmonologists or specifically addresses caring for patients with asthma. The stakeholder community has demonstrated substantial engagement and interest in developing specialty APMs. Providers who are not already participating in an environment or practice with risk-based arrangements may find the proposed *PCACP* payment approach beneficial. It is possible that patients with asthma and their associated providers could participate in existing APMs such as ACOs or CPC+. While these models could enable a broad approach to patient health by incorporating a range of specialists, such collaboration is not a component of many current payment models. Also, the model may offer smaller practices, or practices in rural areas where ACOs don't exist, a chance to participate in an APM.

## Criterion 2. Quality and Cost (High-Priority Criterion)

*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.*

### Rating: Meets Criterion

PTAC concludes that the proposed model meets this criterion. The proposal recognizes that care beyond the office setting is an important component of asthma management, and the proposed model seeks to facilitate physician engagement in improved management. The proposal emphasizes shared decision-making between patients and providers. The proposed quality metrics include clinically relevant aspects of asthma control, as well as some measures of patient perspective.

With appreciation for these strengths, PTAC notes some weaknesses that may be informative for future model development. Thresholds for some of the performance measures are not clearly specified (e.g., cut-off for well-controlled versus poorly controlled). Other measures, such as the patient perception of whether they got better, are very subjective as specified and are not very well developed or validated. While the proposed model identifies the importance of social determinants of health that are related to asthma control, explicit provisions are not identified to address challenges pertaining to smoking cessation, the patient's environment, or access to services. The proposed model does not address how care or payment would be

coordinated between PCPs and participating specialists, nor how that relationship might evolve over the course of the model. The proposal does not clearly identify the factors that would lead to improved asthma control among Medicare beneficiaries to a degree that is sufficient to reduce hospitalizations.

The proposal also does not include sufficient justification for its assumption that the proposed care model would reduce utilization by 50 percent. The proposal likely overestimates the potential savings in the Medicare FFS asthma population by assuming that effects of improved asthma care would mirror utilization, spending, and savings reported for the wider asthma population. The proposal relies heavily on results from observational studies of effectiveness pertaining to younger populations; however, the validity of extrapolating these metrics to the Medicare population is not demonstrated. Medicare beneficiaries diagnosed with asthma who meet eligibility criteria are likely to be dispersed across provider practices, which may make it difficult for providers to achieve sufficient volume of participating patients to support practice transformation.

In total, PTAC believes the intent to improve quality through better diagnosis and patient management was sufficiently demonstrated and extremely important for improving care. However, there is insufficient evidence on implications for cost.

### Criterion 3. Payment Methodology (High-Priority Criterion)

*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.*

#### **Rating: Does Not Meet Criterion**

PTAC concludes that the proposed model does not meet this criterion. While the proposed model recognizes that patient service needs and costs may vary at different stages of disease diagnosis and treatment, the model is highly complex, with multiple tracks assigned by provider assessment within the three main categories. It is possible that the maturity of data and analytics today could allow assessment to address these complexities, although the proposal does not include specific mechanisms or tools.

Clinically, it is unclear when patients would enter into the model. Providers may do a full workup and diagnose a patient before offering the model to patients. The proposed payment models are based on a monthly actuarial risk model, and the participating provider has discretion to determine which patients are included in the risk model. The provider could enroll eligible patients after the provider knew whether it would be financially beneficial to the provider for them to participate.

The proposed model specifies exclusion of some patients (e.g., COPD), which limits the financial risk providers would bear. Care quality and outcome measure calculations also exclude patients who fail to change behaviors (e.g., failure to stop smoking or obtain prescribed medications). These exclusions would avoid financial penalties (reductions in payments) for providers who are not able to change these behaviors despite the importance of such behaviors to asthma management. The value of an APM could be lessened considerably if the most vulnerable patients are not included in the model or if the payment model incentives do not sufficiently encourage behavioral change.

The performance metrics in the model do not encompass some important components. While the proposal states “the model includes shared risk by physicians and holds them accountable for meeting quality and cost measures,” details of risk sharing are not provided. For example, provider payments do not appear to be directly affected if patients have a high rate of ED visits or hospital stays.

It is possible that the proposed care model could be implemented more simply through a billing code, so a bundled payment may not be necessary. Recent improvements in the MPFS are intended to support the types of care the *PCACP* proposal encourages. The proposal dismisses the potential value of new Medicare policies for inter-professional consultations implemented in January 2019 (see footnotes 7 and 20 in the proposal) without providing evidence of the failure of these policies to improve care.

Although the model proposes an Asthma Care Team (consisting of the asthma specialist, the patient’s PCP, and other professionals such as a nurse and asthma educators), the group that receives and distributes portions of the payment to other members of the care team is not identified. The monthly payment could work well in some situations such as an integrated health care system with employed physicians, but mechanisms for distributing the monthly payment across other settings are not specified. Furthermore, administering the proposed payment model in integrated health systems with affiliated physician groups that are not directly employed could be challenging.

While the submitter, in response to written questions, provided additional information about determination of payment amounts for the different components, there is still insufficient justification for the additional payment amounts beyond what the fee schedule already covers. The payment model lacked specificity regarding important elements such as patient liability/copayment for the APM payments. Furthermore, payment calculations provided by the submitter include an upward adjustment of 30 percent because of a higher assumed hourly practice cost for delivering the care. Justification for the higher hourly cost is not provided. The month-to-month approach for payments could compound unpredictability for providers, especially without a clear method for allocating the monthly payment across members of the Asthma Care Team, and limit provider accountability.

#### Criterion 4. Value over Volume

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

##### **Rating: Does Not Meet Criterion**

PTAC concludes that the proposed model does not meet this criterion. The proposal framework emphasizes value over volume, especially in terms of improved diagnosis and management across specialists. The proposed model would avoid the incentive to increase volume of services (e.g., office visits) that exists in the Medicare MPFS and FFS payment. The proposed monthly bundled payment amount for the first two categories of the model would enable providers to tailor services to patient needs, including provision of some services that are not currently reimbursed. The mechanics of the proposed model, however, may be insufficient to drive more value than is currently attained. The proposed model does not clearly address major drivers of ED visits among patients with asthma, such as social determinants of health, in the approach to improving outcomes for patients.

In total, specific provisions to ensure value over volume are not identified. For example, for the well-controlled group the proposed payment model has the potential to pay providers generously for patients who would have done well anyway. The monthly framework of the *PCACP* model and the ability to enroll patients who will be financially beneficial for the provider reduces accountability for providers. The proposed model intends to reduce volume of avoidable ED visits and hospitalizations through the provision of high-value services. However, the complex mechanics of the proposal may reduce its ability to generate more value than is possible under current payments.

#### Criterion 5. Flexibility

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

##### **Rating: Meets Criterion**

PTAC concludes that the proposed model meets this criterion. 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. As noted earlier, it is not clear which member of the Asthma Care Team receives the monthly payment, and the process for distributing the payment as well as specific provisions for interactions between PCPs and specialists are not identified. However, the model's monthly payments would enable providers to implement a variety of activities and practice changes to support asthma care management.

## Criterion 6. Ability to Be Evaluated

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

### Rating: Does Not Meet Criterion

PTAC concludes that the proposed model does not meet this criterion. 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 could make it difficult to evaluate. Given the selection by providers of patients into the model, it will be hard to identify a set of comparison patients in order to determine the effects of the proposed model on quality and costs. Furthermore, the flexibility of the payments would make it difficult to assess whether and how the model achieved the intended objectives.

## 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.*

### Rating: Does Not Meet Criterion

PTAC concludes that the proposed model does not meet this criterion. While the proposed model supports the ability of allergists and other participating providers to improve diagnosis and management of Medicare beneficiaries with asthma, the proposal lacks information about specific mechanisms. The proposed model does not specify how care would be coordinated between PCPs and specialists managing the patient's asthma, such as when and whether handoffs would occur between providers. The proposed model also focuses on physician co-management and does not elaborate on true care management outside of the office, other than occasional contact by a respiratory therapist. Some of these 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. The submitter stated that the distribution of payments between specialists and PCPs would vary based on the division of time and work between the two providers in each circumstance. This negotiation between providers in each circumstance, however, could be burdensome for providers in practice and may hinder coordination.

## 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.*

### Rating: Meets Criterion

PTAC concludes that the proposed model meets this criterion. The proposed *PCACP* model would enhance patient choice by providing an additional care option for patients. Furthermore, as noted, the proposal emphasizes shared decision-making between patients and providers. Although patients would be required to commit to receiving all asthma services from the participating provider, at least within the month within the program, the proposed model expands care and treatment options overall for Medicare patients with asthma.

## Criterion 9. Patient Safety

*Aim to maintain or improve standards of patient safety.*

### Rating: Meets Criterion

PTAC concludes that the proposed model meets this criterion. The *PCACP* model is intended to promote early and accurate diagnosis, timely development of care plans, patient education, and identification of asthma exacerbations before they become severe. The proposal includes minimum quality standards that would protect patients from undertreatment of the condition. The emphasis on provider-patient conversations and shared decision-making is a strong element of the proposed model. Any reductions in ED visits or hospitalizations achieved by the model would improve patient safety.

## Criterion 10. Health Information Technology

*Encourage use of health information technology to inform care.*

### Rating: Meets Criterion

PTAC concludes that the proposed model meets this criterion. The proposal indicates that regular electronic communication between asthma specialists and PCPs would 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.

Although the proposal does not fully address how health information technology would be used to inform care delivery, certified electronic health records would be shared, and the proposed model would require regular electronic communication between providers. Such interactions could improve asthma management and other actions such as patient adherence to medication regimens.



## **APPENDIX 1. COMMITTEE MEMBERS AND TERMS**

**Jeffrey Bailet, MD, Chair**

**Grace Terrell, MD, MMM, Vice Chair**

Term Expires October 2020

**Grace Terrell, MD, MMM**

*Eventus WholeHealth*

Concord, NC

Term Expires October 2021

**Jeffrey Bailet, MD**

*Altais*

San Francisco, CA

**Angelo Sinopoli, MD**

*Prisma Health*

Greenville, SC

**Kavita Patel, MD, MSHS**

*Johns Hopkins Health System*

Baltimore, MD

**Jennifer Wiler, MD, MBA**

*UCHealth and University of*

*Colorado School of Medicine*

Aurora, CO

Term Expires October 2022

**Paul N. Casale, MD, MPH**

*NewYork Quality Care*

*NewYork-Presbyterian, Columbia University College of  
Physicians and Surgeons, Weill Cornell Medicine*

New York, NY

**Bruce Steinwald, MBA**

*Independent Consultant*

Washington, DC

**Charles DeShazer, MD**

*Highmark Health Plan*

Pittsburgh, PA

## APPENDIX 2. PFPM CRITERIA ESTABLISHED BY THE SECRETARY

### PFPM CRITERIA ESTABLISHED BY THE SECRETARY

- 1. Scope.** 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.
- 2. Quality and Cost.** 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.
- 3. Payment Methodology.** 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.
- 4. Value over Volume.** Provide incentives to practitioners to deliver high-quality health care.
- 5. Flexibility.** Provide the flexibility needed for practitioners to deliver high-quality health care.
- 6. Ability to Be Evaluated.** Have evaluable goals for quality of care, cost, and any other goals of the PFPM.
- 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.
- 8. Patient Choice.** Encourage greater attention to the health of the population served while also supporting the unique needs and preferences of individual patients.
- 9. Patient Safety.** Aim to maintain or improve standards of patient safety.
- 10. Health Information Technology.** Encourage use of health information technology to inform care.

### APPENDIX 3. DISTRIBUTION OF MEMBER VOTES ON EXTENT TO WHICH PROPOSAL MEETS CRITERIA<sup>2</sup>

Criteria Specified by the Secretary (at 42 CFR §414.1465)	Not Applicable	Does Not Meet Criterion		Meets Criterion		Priority Consideration		Rating
	*	1	2	3	4	5	6	
1. Scope (High Priority)	0	1	4	2	1	0	0	Does Not Meet Criterion
2. Quality and Cost (High Priority)	0	1	2	5	0	0	0	Meets Criterion
3. Payment Methodology (High Priority)	0	1	5	1	1	0	0	Does Not Meet Criterion
4. Value over Volume	0	1	3	3	1	0	0	Does Not Meet Criterion
5. Flexibility	0	0	0	6	2	0	0	Meets Criterion
6. Ability to Be Evaluated	0	1	5	2	0	0	0	Does Not Meet Criterion
7. Integration and Care Coordination	0	1	4	2	0	1	0	Does Not Meet Criterion
8. Patient Choice	0	0	0	7	1	0	0	Meets Criterion
9. Patient Safety	0	0	0	4	4	0	0	Meets Criterion
10. Health Information Technology	0	0	0	6	2	0	0	Meets Criterion

\* Indicates a vote that was not in any of the other categories for this criterion.

<sup>2</sup>Criteria designated as “high priority” are those PTAC believes are of greatest importance in the overall review of the payment model proposal.

## APPENDIX 4. DISTRIBUTION OF MEMBER VOTES ON OVERALL RECOMMENDATION

### Recommendation Vote: Part 1 of 2<sup>3</sup>

Not Recommended for Implementation as a PFPM	Recommended	Referred for Other Attention by HHS	Result
0	0	8	Referred for Other Attention by HHS

### Recommendation Vote: Part 2 of 2 (if applicable)

Proposal substantially meets Secretary's criteria for PFPMs. PTAC recommends implementing proposal as a payment model.	PTAC recommends further developing and implementing the proposal as a payment model as specified in PTAC comments.	PTAC recommends testing the proposal as specified in PTAC comments to inform payment model development.	PTAC recommends implementing the proposal as part of an existing or planned CMMI model.	Result
N/A	N/A	N/A	N/A	N/A

**Final recommendation to Secretary: PTAC recommends the proposal be referred for other attention by HHS as specified in PTAC comments.**

<sup>3</sup> In 2018, PTAC adopted new voting categories, used first at its December 2018 public meeting. First, PTAC votes on the three categories listed above as Part 1 of 2. PTAC must achieve a two-thirds majority for one of these categories. If a two-thirds majority votes to not recommend the proposal for implementation as a PFPM or to refer the proposal for other attention by HHS, that category is the Committee's final recommendation to the Secretary. If the two-thirds majority votes to recommend the proposal, the Committee proceeds to Part 2 of 2 to determine the final, overall recommendation for the Secretary. The second vote uses the four subcategories listed above. A two-thirds majority must be achieved for one of these four categories.