

PHYSICIAN–FOCUSED PAYMENT MODEL (PFPM) PROPOSAL INFORMATION REQUIREMENTS

DRAFT FOR PUBLIC COMMENT

The information described below is what the Physician-Focused Payment Model Technical Advisory Committee (PTAC) intends to use to review proposals for PFPMs submitted by stakeholders to the PTAC. The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) requires that the PTAC’s review address whether such proposed models meet the criteria established by the Secretary of the Department of Health and Human Services (HHS) for PFPMs*. Based on its findings, the PTAC shall deliver to the Secretary of HHS comments and recommendations as to whether the model should be refined, further studied, tested or implemented. Please provide as much relevant information as concisely as possible; absent, incomplete, or insufficient information may delay the PTAC’s review of a proposal.

Criterion 1 of 9. Scope of Proposed Payment Model (High Priority Criterion†): The proposal aims to either:
1) Directly address an issue in payment policy that broadens and expands the CMS APM portfolio; or
2) Include APM entities whose opportunities to participate in APMs have been limited.

The goal of this section is to explain the scope of the PFPM by providing the committee with a sense of the overall potential impact on physician and beneficiary participation along with practice feasibility. Proposals should describe the scope and span of the payment model and discuss practice level feasibility of implementing this model as well as clinical and financial risks.

The description may include information such as:

- Related to physician practices:
 - How many physician practices or numbers of physicians have expressed interest and willingness to participate in the model if it is approved
 - What types of physician practices would be able to participate in this payment model
 - How many physicians and patients could participate if the model was expanded to scale
 - How the payment model would work for physicians who are employed and for those that are independent, and what changes in compensation might be necessary for employed physicians, if applicable
 - Does this model leverage the investment of other payers in payment and delivery system reform
- Related to feasibility for physician practices:
 - Whether the costs or financial risks associated with the payment model would be feasible for small practices
- Related to patient population(s):
 - The size of the population anticipated to benefit from the model in the pilot test and if the model was expanded to scale
 - How patients will be expected to benefit and how they will be protected against unintended consequences. For example, what protections will be in place to protect against the denial of needed care, overutilization, or less than optimal patient outcomes
- Overall impacts on Medicare spending that are anticipated to be achieved

* The Secretary of HHS published proposed criteria in a Notice of Proposed Rulemaking on May 9, 2016. The PTAC will revise its information requirements in accordance with the Secretary’s final criteria when published in regulation.

† Criteria designated as “high priority” are those the PTAC believes are of greatest importance in the overall review of the payment model proposal.

- Expected spillover effects on Medicaid, SCHIP, TRICARE/VA, or private health spending, or on those beneficiaries/enrollees

Criterion 2 of 9. Promoting Quality and Value (High Priority Criterion): The proposal is anticipated to: **1) improve health care quality at no additional cost; 2) maintain health care quality while decreasing cost; or 3) both improve health care quality and decrease cost. Proposal also provides incentives to practitioners to deliver high-quality health care.**

The goal of this section is to better understand the “value proposition” that will be provided by this proposed PFFM. Please describe how the components of the value proposition will be achieved. For example, how will clinical quality, health outcomes, patient experience, and health care cost management be addressed within the model and how will performance be measured? Please describe any current barriers to achieving desired value/quality goals and how they would be overcome by the payment model. Please identify any novel clinical quality and health outcome measures that will be included in this proposed model. In particular, measures related to outcomes and beneficiary experience should be noted.

In this section please describe:

- How care delivery would be expected to improve in order to achieve savings or improve quality, including:
 - Where and by how much healthcare services or costs will be reduced, and/or
 - If quality will be improved beyond a baseline, then describe how and by how much quality will be improved; if quality will not be improved, then please describe how quality will be maintained
- What evidence supports the expected changes in cost and/or quality and the strength of the evidence
- The probability of success of this model and the nature and magnitude of barriers and risks to its success
- The metrics used to assess performance under the model including the impact of the model on total cost of care, and whether any of the metrics include patient reported outcome measures or measures of beneficiary experience of care
- The level of monitoring or auditing that will be required
- Any prior/planned statistical analyses to estimate the impact of the model on spending and quality of care

Criterion 3 of 9. Flexibility for Practitioners: Provide the flexibility needed for practitioners to deliver high-quality health care

The goal of this section is to better understand (a) how the proposed payment model could accommodate different types of practice settings and different patient populations; (b) the level of flexibility incorporated into the model to include novel therapies and technologies; and (c) any infrastructure changes that might be necessary for a physician to succeed in the proposed model.

In this section please describe:

- Information about whether the proposed model can adapt to accommodate breadth and depth of differences in clinical settings and patient subgroups. (e.g. rural physicians and/or patients, physicians in a tertiary/quaternary setting, specific subgroups of patients, etc.)
- Information about how the proposed model can adapt to account for changing technology, including new drug therapies or devices.

- Whether and how practitioners will have to adapt to operational burdens and reporting requirements required as a result of the proposed payment model
- How feasible it will be for model participants to prepare and build the infrastructure to implement the proposed model

Criterion 4 of 9. Payment Methodology (High Priority Criterion): Methodology for payment model 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 law and regulations.

The goal of this section is to better understand the payment methodology for the proposed model, including how it differs from both existing payment methodologies and current alternative payment models. Include in your description how the proposed PFPM will incorporate the performance results in the payment methodology. Please describe the role of physicians in setting and achieving the PFPM objectives, and the process by which physicians will be rewarded for successfully achieving performance goals as well as the financial risk that the entity/physicians will bear in the model. Please also differentiate between how services will be reimbursed by Medicare versus how individual physicians might be compensated for being a part of this model. Finally, a goal of this section is to better understand any regulatory barriers at local, state or federal levels that might affect execution of the proposed model.

In this section please describe:

- Payment methodology:
 - How entities would be paid under the proposed model including the amount of new payments (e.g. per beneficiary per month, shared savings payments, etc.) and the methodology for calculating such payments
 - Whether the proposed model could include other payers in addition to Medicare, and if so, whether a different payment methodology would be needed for those payers
 - How the model would enable entities to sustain the expected changes in care delivery over time
 - How the targets for success would be defined and what the penalties would be for failure
 - The methodology that will be used for risk-adjustment (if relevant)
- How the payment methodology is different from current Medicare payment methodologies/Center for Medicare and Medicaid Innovation (CMMI) models for physicians and why it cannot be tested under current payment methodologies/CMMI models
- The degree of financial risk that the entity and its physicians would bear as a consequence of this proposed model (i.e. will physicians be at financial risk for their portion of care within the framework of the model and how will this be determined)
- Barriers that make a new payment methodology necessary:
 - Any barriers in the current payment system that prevent or discourage the change in care delivery
 - Awareness of barriers that exist in state or federal laws or regulations (such as current coverage limitations in Medicare or state-specific scope of practice limitations)
 - If no barriers exist, why the proposed model is the appropriate solution
 - Whether the proposed model will have an impact if regulatory barriers (if present) are not addressed
 - Where relevant, based on the model proposed, information on how the model would address:
 - Establishing the accuracy and consistency of identification/coding of diagnoses/conditions

- Clinical appropriateness of the payment unit (e.g. procedure or other treatment for which payment would be made)
- Accurately assigning claims for payment to particular episodes of care.

Criterion 5 of 9. Evaluation Goals: Have evaluable goals for quality of care, cost, and any other goals of the Physician-Focused Payment Model.

The goal of this section is to describe the extent to which the proposed model or the care changes to be supported by the model have been evaluated and what evaluations are currently under way to identify evaluable goals for individuals or entities in the model. If there are inherent difficulties in conducting a full evaluation, please identify such difficulties and how they are being addressed.

In this section please describe:

- The ability to evaluate the impact of the PFPM on metrics that are included as part of the proposed model
- Evaluable goals at various levels (e.g. for a population, for a provider entity, for individual physicians, etc.)
- Whether any evaluations that have not been referenced in other sections exist or are under development, and whether findings from those evaluations can be shared.

Criterion 6 of 9. 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 Physician-Focused Payment Model.

The goal of this section is to describe the full range of personnel and institutional resources that would need to be deployed to accomplish the proposed model's objectives. Please describe how such deployment might alter traditional relationships in the delivery system, enhance care integration, and improve care coordination for patients.

In this section please describe:

- What types of physicians and non-physicians would likely be included in the implementation of this model in order to achieve desired outcomes
- How the model would lead to greater integration and care coordination among practitioners and across settings
- Whether the proposed model would result in changes in workforce requirements compared to more traditional arrangements

Criterion 7 of 9. Patient Choice: Encourage greater attention to the health of the population served while also supporting the unique needs and preferences of individual patients.

The goal of this section is to describe how patient choice and involvement will be integrated into the proposed PFPM. Describe how differences among patient needs will be accommodated and how any current disparities in outcomes might be reduced. For example, please share how the demographics of the patient population and social determinants of care may be addressed.

In this section please describe:

- How patient choice is preserved under the model by accommodating individual differences in patient characteristics (including social needs, etc.), conditions, and health-related preferences while furthering population health outcomes
- How the payment model would affect disparities among Medicare beneficiaries by race, ethnicity, gender, disability, and geography
- How the payment model would expand the demographic, clinical, or geographic diversity of participation in alternative payment models beyond existing CMS models (e.g. would the proposed payment model address populations which are not currently addressed in current CMMI models?)

Criterion 8 of 9. Patient Safety: How well does the proposal aim to maintain or improve standards of patient safety?

The goal of this section is to describe how patients would be protected from potential disruptions in health care delivery brought about by the changes in payment methodology and provider incentives. Please describe how disruptions in care transitions and care continuity will be addressed. Safety in this instance should be interpreted to be all-inclusive and not just facility-based.

In this section please describe:

- How the proposed model would ensure that patients were not harmed by efforts to achieve savings or to improve specific aspects of quality/outcomes
- What measures may be used to ensure the provision of necessary care and monitor for any potential stinting of care
- To what degree the proposed model will ensure the integrity of its intended benefits and what embedded monitoring and potential adjustments are under consideration, should unintended or other incongruent behaviors occur

Criterion 9 of 9. Health Information Technology: Encourage use of health information technology to inform care.

The goal of this section is to understand the role of information technology in the proposed payment model. In this section please describe how information technology will be utilized to accomplish the model's objectives with an emphasis on any innovations that improve outcomes, simplify the consumer experience and enhance the efficiency of the care delivery process. Please also describe goals for better data sharing, reduced information blocking and overall improved interoperability to facilitate the goals of the payment model.

In this section please describe:

- How patients' privacy would be protected if new providers or caregivers will have access to personal health information (PHI)
- How the model could facilitate or encourage transparency related to cost and quality of care to patients and other stakeholders
- Whether interoperability of electronic health records would be needed to guide better decision-making
- Any information technology innovations that are available to support the improved outcomes, simplify the consumer experience or efficiency of the care delivery process to be achieved by the payment model.

SUPPLEMENTAL INFORMATION:

- If the entity submitting the proposal wishes to serve as a recipient of the proposed payment, please describe the proposed governance structure for entity.
- If known, please describe any infrastructure investments that might need to be made by CMS, in addition to changes in the payment model (e.g. different mechanisms for claims processing, data flows, quality reporting, etc).

END OF DOCUMENT