

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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November 15, 2017

In accordance with PTAC's proposal review process, proposals for 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:** Advanced Primary Care: A Foundational Alternative Payment Model (APC-APM) for Delivering Patient-Centered, Longitudinal, and Coordinated Care
2. **Submitting Organization or Individual:** American Academy of Family Physicians (AAFP)
3. **Submitter's Abstract:**

"The Advanced Primary Care-Alternative Payment Model (APC-APM) embodies the principle that patient-centered primary care is comprehensive, continuous, coordinated, connected, and accessible from the patient's first contact with the health system. The APC-APM aims to improve clinical quality through the delivery of coordinated, longitudinal care, and uses the approach to deliver care that improves patient outcomes and reduces health care spending.

The APC-APM is envisioned as a multi-payer model that builds on concepts already tested through the Comprehensive Primary Care (CPC) and CPC Plus (CPC+) initiatives. The APC- APM would be open to almost 200,000 primary care physicians and potentially impact more than 30 million Medicare patients. Based on available evidence, additional spending on primary care is projected to be more than offset by savings elsewhere in the health care system, resulting in a net savings to the payers involved.

Each APC-APM entity will be evaluated based on reporting six measures, with one being an outcomes measure in order to align with the Medicare Access and CHIP Reauthorization Act’s (MACRA’s) Merit-based Incentive Payment System (MIPS) reporting requirements. These measures will come from the core measure sets developed by the multi-stakeholder Core Quality Measures Collaborative to ensure focus, alignment, harmonization, and the avoidance of competing quality measures among all payers. These measure sets include patient experience measures, and all but one of the core measures are also measures under the MIPS.

The APC-APM would create a new payment structure for participating primary care practices consisting of a combination of four mechanisms:

- A prospective, risk-adjusted, primary care global payment for direct patient care;
- Fee-for-service limited to services not included in the primary care global fee;
- A prospective, risk-adjusted, population-based payment; and
- Performance-based incentive payments that hold physicians appropriately accountable for quality and costs.

Other features of the model require that physician practices be:

- Fully flexible to accommodate differences in clinical settings and patient subgroups covered by primary care;
- Able to be fully evaluated for quality and cost at the model and APM entity levels;
- Reflective of the Joint Principles of the Patient-Centered Medical Home (PCMH) and the five key functions of the CPC+;
- Attribute patients based primarily on patient choice; and
- Adopt, and ultimately use, interoperable, certified health information technology, with the expectation that at least 50% of qualifying participants will use certified electronic health record technology (CEHRT).”

B. Summary of the PRT Review

The APC-APM proposal was received on April 14, 2017. The PRT met between May 5, 2017 and November 3, 2017. 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 | Unanimous |
| 2. Quality and Cost (High Priority) | Meets | Majority |
| 3. Payment Methodology (High Priority) | Meets | Majority |
| 4. Value over Volume | Meets | Unanimous |
| 5. Flexibility | Meets | Unanimous |
| 6. Ability to be Evaluated | Does Not Meet | Unanimous |

| | | |
|--------------------------------------|---------------|-----------|
| 7. Integration and Care Coordination | Does Not Meet | Unanimous |
| 8. Patient Choice | Meets | Unanimous |
| 9. Patient Safety | Meets | Unanimous |
| 10. Health Information Technology | Meets | Unanimous |

C. PRT Process

1. Proposal Summary

The PRT reviewed the APC-APM proposal as well as additional information provided by AAFP in written responses to questions from the PRT. The submitter also participated in two phone calls with the PRT. The proposal, questions and answers, and call transcripts are available on the PTAC [website](#).

Physicians with a primary specialty designation of family medicine, general practice, geriatric medicine, pediatric medicine, or internal medicine would be eligible to participate in the APC-APM. The submitter indicates that the primary care practice would likely serve as the APM Entity.

Under the proposed model, primary care practices would receive payments in four parts: (1) a risk-adjusted payment per beneficiary per month (PBPM) for evaluation and management (E/M) services delivered by the primary care practice, (2) a risk-adjusted PBPM payment for care management services delivered by the practice, (3) prospectively-awarded incentive payments that may have to be repaid based on the practice's performance, and (4) continued payment under the Medicare Physician Fee Schedule for services other than E/M services and for E/M services that are not included in the monthly payments.

The APM Entity could select from two options regarding the PBPM payment for E/M services, one that includes only office-based E/M services and one that includes all E/M services regardless of site of service (e.g., including hospital-based E/M services). The incentive payments would be paid quarterly and reconciled against actual performance annually. The APM Entity would select six quality measures, including at least one outcome measure, from the Accountable Care Organizations, Patient-Centered Medical Homes, and Primary Care Measure Set developed by the Core Quality Measure Collaborative. Failure to meet agreed upon benchmarks for performance would result in the APM Entity having to repay all or part of the incentive payments. The submitter proposes that the amounts a payer pays for the PBPM and incentive payments should be designed to ensure the total payments to primary care are equal to 12% of a payer's total health care spending on its members.

The primary method for determining which patients the practice would be accountable for would be the patients who had explicitly chosen to use the practice. However, if a

patient used services from a practice but did not designate the practice as its primary care provider, the patient could still be assigned to the practice using a claims-based attribution methodology.

Those applying to become APM Entities would need to attest that they address or have a plan to address five key areas: (1) access and continuity, (2) planned care and population health, (3) care management, (4) patient and caregiver engagement, and (5) comprehensiveness and coordination. The proposed model also requires that at least 50% of the APM's participants will use CEHRT, consistent with the requirements for an Advanced APM.

By making an APM available to more primary care practices, by increasing the total amount of payment for primary care, and by changing the incentives for primary care practices, the submitters believe implementation of the proposal will improve clinical quality, improve patient outcomes, and reduce overall health care spending. Specifically, the submitters believe the increased percentage of total spending allocated to primary care would be more than offset by decreases in specialty and hospital services.

2. Additional Information Reviewed by the PRT

a) Literature Review and Environmental Scan

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. These documents are not intended to be comprehensive and are 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 abbreviated environmental scan is available on the PTAC [website](#).

b) Data Analyses

The PRT sought additional information regarding the current magnitude and distribution of the different types of E/M payments received by primary care physicians. The Office of the Assistant Secretary for Planning and Evaluation (ASPE), through its contractor, produced data tables that are available on the PTAC [website](#).

c) Public Comments

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

d) Other Information

The PRT spoke with the Centers for Medicare & Medicaid Services (CMS) Innovation

Center regarding the proposal to understand how it differed from the CPC and CPC+ models and how implementation of the model could affect the evaluation of CPC+. The PRT also participated in a call with the CMS Office of the Actuary (OACT) regarding the proposal.

D. Evaluation of Proposal Against Criteria

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.

PRT Qualitative Rating: Meets Criterion

The PRT unanimously finds that the proposed model meets this criterion. While CMS has launched models that focus on primary care, most primary care providers in the country have not had the opportunity to participate in any of these models. CPC+ is a multi-payer model limited to specific regions. Providers outside of the regions where CMS has identified payer partners do not have an opportunity to participate, and so the proposed model would enable more primary care practices to participate in an alternative payment model. While the submitter acknowledged that multi-payer involvement would be ideal, it does not believe that practices should be precluded from participating if only Medicare payments are available.

Although the Medicare Shared Savings Program also provides opportunities for primary care practices to participate in an alternative payment model as part of an Accountable Care Organization (ACO), there is no change in the underlying payment system for primary care practices in these ACOs, and any additional resources are dependent on the award of shared savings. In contrast, the proposed payment model would replace the majority of current fee-for-service payments to primary care practices with a flexible monthly payment and provide increased resources for care management services, and it does not require practices to assume financial risk for the total spending on their patients.

Given the many similarities between CPC+ and the APC-APM, the PRT considered whether the model would be necessary if opportunities to participate in CPC+ were expanded. However, the PRT felt that several novel features of the proposed payment model would significantly broaden CMS' current portfolio of payment models with respect to primary care. In particular, unlike CPC+, the proposed model would completely replace E/M services with a flexible monthly payment, it would increase total payments to the primary care practice significantly beyond what is typically generated under current fee-for-service payments, and it would enable patients to explicitly choose which practice would be accountable for managing their care.

While any primary care practice could theoretically participate in the proposed model, it was not clear to the PRT whether small and rural practices or other practices with small numbers of Medicare beneficiaries could feasibly participate, since the revenues from the monthly payments might not be sufficient to cover the costs of additional or different staff, and the proposed performance measures would be unreliable when applied to small numbers of patients.

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.

PRT Qualitative Rating: Meets Criterion

The majority of the PRT finds that the proposed model meets this criterion. The majority agrees that, overall, the focus on the five key areas to guide delivery transformation (similar to CPC+), the increase in resources directed at primary care, and changes in provider incentives (in terms of payment and quality measure reporting) could reasonably be anticipated to improve quality while reducing total health care spending.

However, the PRT does have concerns regarding whether the model would generate savings since it proposes to increase payments for primary care practices based on a proportion of total spending without any assurance that there would be proportionate savings. It is also difficult to determine the impact of replacing only office-based E/M services with the monthly payment, as is proposed in one track. Secondary data analyses performed for the PRT showed that while only 5% of a typical practice's revenues come from other types of E/M services, a subset of practices receive as much as 40% of their revenue from other types of E/M services.

The PRT is also somewhat uncertain about what improvements in quality could be expected under this proposed model. The model diverges from CPC+, requiring fewer and a different mix of quality measures, although it does seek to align with MIPS reporting requirements. From a clinical perspective, the measures are traditional at best and do not offer an opportunity to transform health quality. In particular, the PRT is concerned that a participant could select most, if not all, measures around one discrete condition. This could mean that the patients who qualify for the measures receive improved care, but other patients do not. Similarly, because rates of hospitalizations and emergency department visits are measured at the aggregate level, hospitalizations could increase for some groups of patients while decreasing for others.

Another concern, noted above, is that while the model is intended to be open to small and rural providers, the proposal does not address what would be done if a practice did not meet the minimum thresholds needed to have stable estimates of quality measure performance.

Although a majority of members felt that the proposed model met the criterion, one member felt that the lack of clarity about the magnitude of the changes in payments to individual practices and about the performance standards the practices would be expected to meet made it impossible to determine that the proposal met this criterion.

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 Physician-Focused Payment Model cannot be tested under current payment methodologies.

PRT Qualitative Rating: Meets Criterion

The majority of the PRT finds that the proposed model meets this criterion. The majority agrees that the payment methodology is designed to achieve the goals of the PFPM criteria, particularly the mechanism for the payments, to whom the payments would be made, and how payments would be adjusted for particular conditions or populations. The submitter was also clear in articulating how the payment methodology builds on but differs from current payment methodologies (i.e., CPC+ and MIPS), and it describes how the aspects that would be different from CPC+ would work, particularly monthly payments in place of E/M services and patient attribution. The PRT acknowledges that aspects of the model that are borrowed from CPC+, such as performance-based incentive payments, are currently being tested. The PRT also notes that the Next Generation ACO model includes an option for an all-inclusive population-based payment (AIPBP) that would completely replace payments to ACO participants for E/M services and other services. However, the PRT does not believe that the way the proposal's novel features would affect primary care practices is being tested under these other payment methodologies. An initial risk adjustment system is defined, although the submitter noted its desire to work with CMS to identify and test more comprehensive risk-adjustment approaches that include factors other than diagnosis codes, such as social determinants of health.

The submitter provided detailed examples/scenarios as to how funds would potentially flow; the PRT commends this level of detail as it was helpful in understanding the different payment tracks and the application of the various payment methodologies.

The PRT felt there were several aspects of the payment methodology which could be problematic:

- Patient-initiated enrollment methodology mixed with aspects of payment methodology used in ACOs or other payment models: mixed methods for payment are inherently problematic, leading to not only implementation issues but also exposing such models to selection bias, performance bias, and other unintended consequences.

- While the PRT supports moving to a more prospective, patient-directed method of assigning patients to practices, it was concerned that the combination of patient election and claims-based attribution proposed is overly complex and could lead to selection bias.
- The PRT considers the prospective incentive payments to be a problematic structure. If a practice underperforms, then it would have to pay some or all of the incentive back. This "clawback" mechanism for incentive payments puts the government in the position of performing collections on money it already paid out (significantly increasing the administrative costs of the program) and puts participants with weak balance sheets (many private practices carry no yearly balance) at significant financial risk.
- The PRT is also not convinced that multiple PBPMs are needed or that the two different levels of monthly payments for different subsets of E/M services are needed. The PRT felt that a single PBPM and a single track would be simpler to administer and would likely provide similar opportunities.

A majority of the PRT felt that the strengths of the model outweighed these concerns.

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

PRT Qualitative Rating: Meets Criterion

The PRT unanimously finds that the proposed model meets this criterion. The model changes provider incentives in a way that would be expected to enable and encourage the delivery of high-quality primary care. The risk-adjusted monthly payment in place of fees for office visits would give practices the ability to deliver high-value patient services that are not currently billable under the physician fee schedule, while also discouraging unnecessary visits. The performance-based incentive payments would tie payments to quality and outcomes rather than to volume of services. The increase in primary care spending is also aimed at creating better value in the health care system.

However, the fact that payments are no longer directly tied to patient contacts creates the concern that patients' ability to access providers when needed may be harmed, as has happened in some areas where practice capitation models have been used. The submitter argues that the quality measures would discourage that, but the PRT has concerns regarding whether the measures are adequate for this purpose.

In addition, while using patient choice as the primary method of determining the patients for which the practice is accountable will reduce the likelihood of misattribution in comparison to current methods, it could also expose patients to "cherry picking," if practices encourage enrollment of patients who are most likely to have favorable outcomes and have low use of practice resources. The PRT believes that additional mechanisms should be included to protect against this.

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

PRT Qualitative Rating: Meets Criterion

The PRT unanimously finds that the proposed model meets this criterion. The proposed monthly payments would give practices the flexibility to deliver a wide range of services that can support higher-quality care, including responding to patients through telephone/email communication, providing patient education and self-management support using practice staff other than clinicians, etc. In response to questions from the PRT, the submitter provided examples illustrating how the model would work for both a suburban group practice and a small/rural practice. However, since the submitters propose that payment amounts be based on a percentage of total payer spending rather than practice costs, and because the risk adjustment structure is based on diagnoses rather than the full range of patient needs, it is not clear whether small practices or practices with complex patient populations would have adequate resources to address their patients' needs.

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

PRT Qualitative Rating: Does Not Meet Criterion

The PRT unanimously finds that the proposed model does not meet this criterion. While the PRT agrees that some of the submitter's stated goals are evaluable, the PRT does not believe that the proposal, in its current form, would meet the standard for evaluability as an APM. The PRT does not see how valid benchmarks could be established under the proposed model, given that patient choice is the primary method of determining which patients the primary care practice will receive payment and be accountable for.

Patient selection aside, complexities of the proposed model would also make an evaluation more difficult. The model creates two different tracks with small differences in terms of the services that are bundled into the monthly payments, so in order to evaluate these options, separate comparison groups would be needed, which could be challenging to create depending on how many practices and which types of practices choose these tracks. The PRT also notes that depending on how broadly the proposed model is made available and depending on the types of practices that choose to participate, it could be more difficult to identify appropriate comparison groups for both CPC+ and the proposed model.

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.

PRT Qualitative Rating: Does Not Meet Criterion

The PRT unanimously finds that the proposed model does not meet this criterion. The proposed model makes an assumption that coordination would inherently take place because practices would be expected to adopt the Joint Principles of the Patient-Centered Medical Home and implement the five functions that guide CPC+ care delivery transformation: (1) access and continuity, (2) planned care and population health, (3) care management, (4) patient and caregiver engagement, and (5) comprehensiveness and coordination. While comprehensiveness and coordination are included in the core functions which would be assumed by a PFPM entity in this model, there are no requirements or measures of care coordination for individual patients, nor has the submitter provided any indication as to how providers outside of the primary care practice, such as consulting specialists, would be compensated for time spent in communication and coordination with the primary care practice. The PRT believes the model would be stronger if it included such requirements, noting that patient perceptions of care coordination have been validated in the published literature (e.g., Singer et al., 2013).

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.

PRT Qualitative Rating: Meets Criterion

The PRT unanimously finds that the proposal meets this criterion. Under the model, patient choice is the primary method of determining which patients the primary care practice will receive payment and be accountable for. Further, the monthly payments as well as the increased resources directed at primary care would give the practice greater flexibility to respond to differences in patient needs than the current fee-for-service payment system does. It is worth noting that when patient choice is the primary methodology, similar to Medicare Advantage plan enrollment, attention must be paid to avoid unintended worsening of disparities and precluding patients with low literacy levels or low levels of self-activation.

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

PRT Qualitative Rating: Meets Criterion

The PRT unanimously finds that the proposal meets this criterion. The PRT believes that the flexible resources provided by this payment model could enable primary care practices to create more proactive mechanisms for early identification and rapid response to patient problems. These types of services are difficult to support using current fee-for-service payments that are based primarily on face-to-face encounters with physicians and clinicians. In addition, because payments would be risk-stratified, practices that have more patients with multiple health problems would receive more resources to support these types of outreach and response services.

However, because the monthly payments would no longer be directly tied to specific services, a primary care practice would receive the same payment whether it provided these outreach and response services or not. In contrast to the current payment system, where the practice would be paid more for seeing a patient in the office to address a new or worsened health problem, under the proposed model, the practice would receive the same payment regardless of whether it scheduled a visit with such a patient. This creates the potential risk that some practices could ignore patient problems or delay responding to them, thereby jeopardizing patient safety. As noted earlier, the proposed model only has a small number of quality measures focused on a subset of patient health problems; moreover, since the practice would be evaluated based on its average performance for all of its patients, it would still be paid even if it did not respond in a timely or appropriate way when an individual patient experienced problems.

On balance, the PRT concluded that the potential positive impacts on patient safety from the flexibility and enhanced resources in the model outweighed the potential for negative impacts, particularly in comparison to the current fee-for-service payment system. However, the PRT believes it would be desirable to strengthen the quality measurement component of the model to ensure adequate access to services for vulnerable patient populations.

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

PRT Qualitative Rating: Meets Criterion

The PRT unanimously finds that the proposal meets this criterion. The proposed model requires that at least 50% of the APM's participants use CEHRT, consistent with the requirements for an Advanced APM. Nevertheless, the PRT views the requirement as a fairly low standard.

E. PRT Comments

In its review of the proposal, the PRT often grappled with how to evaluate a model that shares so many commonalities with CPC+. However, the submitter articulates a clear need for additional opportunities for primary care physicians to participate in Advanced APMs and the proposed model includes several novel features that set it apart.

A key strength of the model is that it would enable participation in an APM by a broader range of primary care practices and not require multi-payer involvement, creating more opportunities for participation than CPC+. Another strength is the flexible monthly payment for E/M services. The PRT also supports the submitter's interest in working with CMS to develop a risk-adjustment methodology that incorporates social determinants of health.

Nevertheless, the PRT observes key weaknesses in the model, particularly regarding some of the added complexity presented in the model compared to or similar to CPC+, including: (1) making patient choice the primary method of attribution, (2) the use of two PBPMs, and (3) the use of two levels of payments for E/M services.

The PRT believes that the proposal is sufficiently different from CPC+ and other current CMS APMs and that those differences hold sufficient promise for improving patient care and reducing spending to justify testing this model in addition to CPC+. Moreover, the PRT agrees with the submitter that a strong primary care system is essential to achieving higher-quality, more affordable health care.