

# **Initial Feedback from PTAC Preliminary Review Team on the *Comprehensive Care Physician Payment Model (CCP-PM)* Proposal Submitted by the University of Chicago Medicine**

**July 30, 2018**

**Disclaimer Regarding Initial Feedback:**

- Initial feedback is preliminary feedback from a Preliminary Review Team (PRT) subcommittee of the PTAC and does not represent the consensus or position of the full PTAC;
- Initial feedback is not binding on the full Committee. PTAC may reach different conclusions from that communicated from the PRT as initial feedback;
- Provision of initial feedback will not limit the PRT or PTAC from identifying additional weaknesses in a submitted proposal after the feedback is provided; and
- Revising a proposal to respond to the initial feedback from a PRT does not guarantee a favorable recommendation from the full PTAC to the Secretary of Health and Human Services (HHS).

**Executive Summary of Initial Feedback**

The model that has been proposed focuses on an important, clinically relevant issue – transitions post discharge as well as enhancing patient-centered care through meaningful continuity of practitioners. The payment methodology proposed for the CCP-PM unfortunately does not provide sufficient assurance that such a clinically relevant issue will result in either lower cost or better quality. Gaps in this proposal include alignment between payment and clinical quality metrics, feasibility/reality related to projected savings as well as explicit measures/processes regarding patient enrollment, etc.

**Summary of PRT Assessment Relative to Criteria:**

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

**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.

***Does Not Meet Criterion (Majority)******Strengths:***

- The CCP-PM addresses a common occurrence in patient care (specifically, transitions in care between inpatient and ambulatory settings) in a novel way. While fee-for-service (FFS) payment has codes and models that allow for transitional care management, the submitter argues that these codes are not sufficient for direct provision and transition of care by the same provider between inpatient care and primary care.
- The current system does not necessarily reward providers across settings for lowering the cost for Medicare patients. Some existing models provide incentives for primary care physicians, but hospitalists are not currently included in such models and may not face direct incentives to reduce future hospitalizations.
- The CCP-PM is in the form of an APM supplement that enables additional focus on beneficiaries at high risk for future hospitalization.
- The model provides room to innovate because it does not have many structural requirements.

***Weaknesses:***

- Existing programs through CMS and CMMI, such as ACOs and Bundled Payment for Care Improvement (BPCI), could enable physicians to establish similar processes for bridging care between inpatient and ambulatory settings.
- The feasibility of the CCP-PM both within and beyond academic settings may be limited.
  - While some hospitalists in academic settings may be enthusiastic about participating, other hospitalists may not be interested, so it may be challenging for some academic settings to sustain a program of sufficient size.
  - The program may be even more of a stretch for hospitalists who are not employed by community-based hospitals and primary care physicians in private practices serving those patients.
  - The strongest business case is for initiation within a hospital. Otherwise, structural issues arise for financial feasibility, as some mechanism is needed for stand-alone primary care practices to initiate a program with a hospital and follow their patients into that hospital.
- Hospitals or community practices that initiate a program may still need to overcome potential barriers for patient enrollment (a comment which was cited by evaluators of the HCIA program as well). Some community-based physicians will not want to relinquish patients to CCP-PM. While the CCP-PM is appropriately targeted to high-risk patients and has provisions against cherry-picking low risk patients, high-risk patients may have established relationships with certain physicians that they do not want to drop.

**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.**

*Does Not Meet Criterion (Unanimous)**Strengths:*

- The proposal directly quantifies the target for savings at an estimated \$3,000 per patient per year. Based on estimates of scaling up nationally, total savings would exceed \$10B.
- Estimates from the HCIA final evaluation and the proposal come from a randomized trial, supporting strength of the evidence.
- The model does not compete with other mechanisms being developed. For example, the CCP-PM does not compete with ACO models for assignment, and there are not challenges associated with pulling out high cost beneficiaries.

*Weaknesses:*

- The proposal provides unpublished statistics that are different from the HCIA final evaluation. The HCIA evaluation finds non-significant increases in total spending and ED visits, and a non-significant decrease in admissions.
  - Differences between the proposal and the HCIA evaluation could be due to slow patient recruitment for the trial. The HCIA evaluation indicates: “Only in the last two quarters of the HCIA funding period did the accumulated number of patients reach the goal of 1,167 per study arm, and the funded study period ended soon afterward. It is possible that with a longer intervention period, additional impact would have been achieved (although we saw no evidence that longer tenure in the program achieved greater improvement in health care utilization or Medicare spending).”
  - In total, the feasibility as well as the reality of the savings projected in the proposal is not clear.
- The proposal discusses quality within a “structure, process, outcome” framework but does not provide specific measures or benchmarks other than thresholds for the percentage of inpatient and outpatient care provided by participating physicians. For example, the proposal (p. 8) maintains that the empaneling of physicians who structure their care to be delivered in both the clinic and hospital is a measure of structural quality, but quality measures for tracking or comparison to peers are not proposed. Evaluation would require specific benchmarks.
- The patient empanelment is not well defined. Therefore, there is a risk of patient selection and unintended consequences.

**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.**

*Does Not Meet Criterion (Unanimous)*

*Strengths:*

- The proposal lays out a clear payment mechanism, and it is easy to understand what the spending for CCP-PM might be. The continuity fee is different for new/renewed versus continued patient, and the fee is contingent on the participating physician providing a high percentage of their patients' inpatient and outpatient internal medicine care.
- The payment mechanism, which is articulated as either a standalone payment (e.g., to a practice) or as a supplement in existing models such as ACOs, could work particularly well in ACOs. The likely advantage of basing the CCP-PM in a hospital setting was discussed above, and the payment mechanism would facilitate implementation of the CCP-PM beyond academic medical centers as a supplemental payment in community hospital-based ACOs.
- The penalty criteria apply even if only 1 is not met (e.g. a penalty is applied if only 1 or 2 penalty criterion are met)

*Weaknesses:*

- While the payment could be a supplement for hospital-based ACOs, the current payment methodology for ACOs already includes incentives to better coordinate care across settings. Therefore, the CCP-PM might simply end up increasing payments to hospital-based ACOs for something they are already supposed to be doing.
- The payment model lacks financial risk, which results in a weak linkage between payment methodology and intended outcomes (reduced total expenditures and improved health outcomes for the patient).
- The financial risk in the model may be insufficient to generate savings unless there is some downside risk aside from meeting the penalty criteria. Only a \$10 penalty per patient per month (e.g., \$24,000 total per year for a panel of 200 patients) is at risk in a stand-alone model. Providers who lose money may simply leave the program.
- The role of some services such as telehealth in calculating the penalty has not been clarified or standardized.
- The cash flow diagram (p. 14) raises some feasibility issues, as it is not clear that CMS has a mechanism for making the payments as drawn. Physicians affiliated with institutions have different financial arrangements than other physicians who are not similarly employed/affiliated, including independent practices. The diagram tries to get at attribution of patients that might not work well in mixed arrangements where different physicians see the same patient rather than using an approach such as a convener model (e.g., as with BPCI, or a model where a third party takes risk and deals with Medicare reimbursement).
- The CCP may have an experience similar to other models being tried in the sense that the model may improve quality but does not have sufficient mechanisms to result in

measurable reductions in spending. The existing literature does not provide strong evidence that improving continuity of care reduces spending or results in savings sufficient to cover the fees/cost of the program.

- Since ACOs and other models are already trying to increase continuity, it is not clear that model would not simply create an extra payment for a pattern of care that is already being delivered within ACOs.

#### **CRITERION 4. VALUE OVER VOLUME**

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

*Meets Criterion (Majority)*

*Strengths:*

- Under the proposed model, the payment is not dependent on volume of care.
- The unpublished results cited in the proposal show the CCP-PM improved patient satisfaction and reduced costs for high-risk patients at the University of Chicago, yielding value to beneficiaries as well as the overall system.

*Weaknesses:*

- The results cited in the proposal were not documented in the HCIA evaluation.
- The presence of CCP-PM may not be sufficient to drive behavior change to attain value over volume in other settings. Community-based office settings might have barriers or lack of enthusiasm for the scheduling and logistical changes needed to attain the value-based care envisioned under CCP-PM. Therefore, the proposed model as written might not be sufficient to drive care to be different in other settings.
- Selection of patients in other settings might be different from the patients enrolled in the University of Chicago's HCIA award. Patient enrollment under the HCIA award proceeded slowly, and the extra efforts to recruit patients might mean the patients enrolled in an ongoing program could be different (though the value over volume could improve or decline). For example, patients with significant language barriers or those that might require additional intensive coordination for social services.

#### **CRITERION 5. FLEXIBILITY**

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

*Meets Criterion (Unanimous)*

*Strengths:*

- The CCP-PM appears to be flexible for many types of practitioners, including specialists.
- The flexibility in arrangements and limited number of specific requirements means that providers can tailor care to patients as they deem most appropriate without trying to implement certain model of care.

*Weaknesses:*

- No evidence is available indicating that specialists would be willing to participate as a CCP-PM provider.

- The experience to date does not include an independent community-based provider who has tried to implement a model like CCP without a willing hospital partner.

## **CRITERION 6. ABILITY TO BE EVALUATED**

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

*Meets Criterion (Unanimous)*

### *Strengths:*

- The randomized controlled trial conducted for the HCIA evaluation already provided a strong design and important lessons, including some of the challenges of patient enrollment. Qualitative analysis also provided important insights.
- Patient costs and the penalty criteria can be measured for evaluation.
- Model overlaps with ACOs could facilitate evaluation, as the approach does not have challenges such as carve out provisions.
- The proposal suggests some novel evaluation mechanisms (e.g., changes to billing volumes, qualitative practice structures, etc.) that are potentially applicable to other CMMI programs.

### *Weaknesses:*

- The lack of definition of measures for some components (structure, process and outcome measures) means their evaluation is not clearly defined. Lack of objective criteria for empanelment is particularly problematic.
- Although the proposal advocates for wider testing in additional sites, other trends such as decreased patient participation due to increased Medicare Advantage enrollment could complicate such evaluation.
- The PRT would like to have better understood why the unpublished results in the proposal differ from the HCIA evaluation results.

## **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.**

*Does Not Meet (Majority)*

### *Strengths:*

- This model clearly addresses the issue of care coordination during the peri-hospitalization period by having the same clinician manage the patient's care in both the inpatient and outpatient settings.
- The CCP-PM could work particularly well in an integrated system that facilitates having the same physician for inpatient and ambulatory care.

### *Weaknesses:*

- The model as described focuses on hospital care and primary care. The proposal did not provide a clear understanding of the role of and interactions with specialists other than the expectation for coordination with specialists, which was noted in subsequent communication with the submitter.
- There does not appear to be a mechanism in the model for making sure the patient is getting the right care (e.g., that certain conditions that would be monitored in a primary care setting are followed). The model does not clarify broadly how patient standards pertaining to basic screening and preventive care will be met.
- Some ACO metrics that would be useful for assessing integration and care coordinate are not incorporated, which could be problematic for a stand-alone primary care practice even if working in conjunction with a hospital.
- The PRT has some concern that this model is going back to an approach used previously (i.e., a community doctor follows patient into hospital) that became problematic for care when an office-based physician spends less time inside the hospital, etc.
- Some patients may also not want to leave their existing primary care physician in order to participate.
- Furthermore, the model may only be delaying an inevitable handoff for a patient who is no longer at risk for hospitalization.

#### **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.**

##### *Meets Criterion (Majority)*

##### *Strengths:*

- For the RCT, patients had choice to enroll, and the proposal described a robust enrollment (empanelment) process. A situation of prospective enrollment in the CCP-PM would also enable choice and be preferred, as retrospective attribution of patients to the model does not make sense.
- The empanelment process may be most efficient if the program is implemented within a system such as an ACO.

##### *Weaknesses:*

- Despite the advantages of prospective enrollment, efficient ways to ensure sufficient and appropriate patient empanelment are not known. Enrollment in the RCT was slower than expected, and the investigators had to implement additional recruitment efforts. Appropriate patient enrollment is important for the payment methodology to be able to achieve reductions in the total cost of care while ensuring quality care.
- It may be important to address any barriers to empanelment (limited language proficiency, health literacy, etc.) to ensure that patients understand the fact that a single provider or provider group will be seeing them in both ambulatory and inpatient settings, which may be different from what they are used to. Patient choice to go to other providers must be respected, but continuation of visits to all existing providers could reduce ability to achieve program savings.
- The model does not include specific provisions beyond the penalty payment to reduce

the likelihood of selection in enrollment by patients who are less seriously ill but willing to change their providers, because such “favorable” selection could mean that only relatively lower rather than higher risk patients may be willing to enroll. Since the penalty payment pertains to the average experience for a potentially large group of patients, the model does not have a patient-specific mechanism to discourage enrollment of relatively low-risk patients.

- The proposal does not seem to include sufficient mechanisms to avoid unintended consequences such as perverse gaming (e.g., hospitalization of a patient to be able to re-enroll the patient with a higher payment) do not occur. In response to questions, the submitter indicated that such a mechanism inherently exists within ACOs (because any gain in revenue from care continuity fees would be significantly outweighed by reductions in or eligibility for shared savings), but other non-ACO settings would not necessarily embody such a provision. The submitters indicated that physicians would be unlikely to know their ratios for the penalty in real time and therefore unlikely to game the system, and they also noted that the relationships fostered by CCP would reduce the likelihood of gaming; however, the lack of a specific mechanism means that gaming could occur.

## **CRITERION 9. PATIENT SAFETY**

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

*Meets Criterion (Unanimous)*

### *Strengths:*

- The PRT recognizes that patient safety can be increased by consolidating a patient’s care under a single physician or group of physicians during a period of transition following hospital discharge.
- Patient safety is particularly likely to be improved for hospitalized beneficiaries who do not already have strong relationships with a primary care provider, as follow-up care after discharge is likely to be improved.

### *Weaknesses:*

- The lack of monitoring of specific outcomes means that whether patient safety is improved or worsened may not be known.
- Concerns about patient safety may be particularly pertinent for standard aspects of primary care involving prevention or monitoring of other disease conditions beyond the particular disease that caused a hospitalization that triggered enrollment in the CCP-PM. It may be difficult to assess whether or not the patient is getting the right care since quality transitional care following discharge may differ from aspects on ongoing primary or general medical care. As noted in other points, appropriate safeguards may be more feasible within organizations such as ACOs than in stand-alone practices.
- Unintended consequences or potentially perverse incentives to rehospitalize patients mentioned above also may threaten to reduce rather than improve patient safety.



**CRITERION 10. HEALTH INFORMATION TECHNOLOGY****Encourage use of health information technology to inform care.***Meets Criterion (Unanimous)****Strengths:***

- Large integrated systems including academic medical centers are likely to have health information technology that will facilitate model implementation and provision of high quality and high value care.
- Such systems will also be able to capitalize on emerging technologies (e.g., telehealth) to support better coordination of care innovation of processes within models like CCP.

***Weaknesses:***

- Lack of similar health information technologies for providers outside of integrated systems or academic medical centers could compromise communication and coordination of care. Many patients and providers, especially in some geographic areas, currently experience frustration when attempting to transfer information across different providers; e.g., the lack of interoperability and limitation of health exchange efforts.