

Physician-Focused Payment Model Technical Advisory Committee

Preliminary Review Team Findings on

Advanced Primary Care: A Foundational Alternative Payment Model (APC-APM) for Delivering Patient-Centered, Longitudinal, and Coordinated Care

Submitted by the American Academy of Family Physicians (AAFP)

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December 19, 2017

Presentation Overview

- Preliminary Review Team (PRT) Composition and Role
- Proposal Overview
- Summary of the PRT Review
- Key Issues Identified by the PRT
- PRT Evaluation Using the Secretary's Criteria

Preliminary Review Team Composition and Role

- The PTAC Chair/Vice Chair assigns two to three PTAC members, including at least one physician, to each complete proposal to serve as the PRT. One PRT member is tapped to serve as the Lead Reviewer.
- The PRT identifies additional information needed from the submitter and determines to what extent any additional resources and/or analyses are needed for the review. ASPE staff and contractors support the PRT in obtaining these additional materials.
- After reviewing the proposal, additional materials gathered, and public comments received, the PRT prepares a report of its findings to the full PTAC. The report is posted to the PTAC website at least three weeks prior to public deliberation by the full Committee.
- The PRT report is not binding on PTAC; PTAC may reach different conclusions from those contained in the PRT report.

Proposal Overview

- **Eligible Participants** – Physicians with a primary specialty designation of family medicine, general practice, geriatric medicine, pediatric medicine, or internal medicine
- **APM Entity** – The primary care practice would likely serve as the APM Entity.
- **Payment** – 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. The APM Entity could select from two options:
 - a) A payment that includes only office-based E/M services, or
 - b) A payment that includes all E/M services regardless of site of service.
 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.
 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 amounts a payer pays for the PBPM and incentive payments would 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.

Proposal Overview (continued)

- **Quality** – 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 would result in the APM Entity having to repay all or part of the incentive payments.

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
 5. Comprehensiveness and coordination
- **Attribution** – Patient choice is the primary method of determining which patients the primary care practice will receive payment and be accountable for.
 - **Risk Adjustment** – The submitter noted its desire to work with CMS to identify and test more comprehensive risk-adjustment approaches.
 - **Health Information Technology** – At least 50% of the APM Entity’s participants will use Certified Electronic Health Record Technology (CEHRT).

Summary of the PRT Review

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

Key Issues Identified by the PRT

- The PRT grappled with how to evaluate a model that shares so many commonalities with Comprehensive Primary Care Plus (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.
 - Another strength is the flexible monthly payment for E/M services.
- The PRT observes key concerns with the model including:
 - Making patient choice the primary method of attribution,
 - The use of two PBPMs, and
 - The use of two levels of payments for E/M services.

Criterion 1. Scope (High Priority)

Criterion Description

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 Conclusion

Meets criterion

Unanimous or Majority Conclusion

Unanimous

- The proposed model would enable more primary care practices to participate in an APM.
 - Under CPC+, providers outside of the regions where CMS has identified payer partners do not have an opportunity to participate. The proposed model would not require multi-payer involvement.
- 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. The proposed model would:
 - Completely replace E/M services with a flexible monthly payment,
 - Increase total payments to the primary care practice significantly beyond what is typically generated under current fee-for-service payments, and
 - Enable patients to explicitly choose which practice would be accountable for managing their care.
- It was not clear whether small and rural practices or other practices with small numbers of beneficiaries could feasibly participate.

Criterion 2. Quality and Cost (High Priority)

Criterion Description

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 Conclusion

Meets criterion

Unanimous or Majority Conclusion

Majority

- The majority finds that the focus on the five key areas to guide delivery transformation, the increase in resources directed at primary care, and changes in provider incentives could reasonably be anticipated to improve quality while reducing total health care spending.
- However, the PRT has concerns that the proposed model would increase payments for primary care practices without sufficient 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.
- The PRT is also somewhat uncertain about what improvements in quality could be expected under this proposed model. Proposed measures seem inadequate to provide assurance of quality improvement. In addition, a participant could select measures around one discrete condition; patients who do not qualify for the measures might not receive improved care.
- 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.

Criterion 3. Payment Methodology (High Priority)

Criterion Description

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.

PRT Conclusion

Meets criterion

Unanimous or Majority Conclusion

Majority

- The majority finds that the payment methodology is designed to achieve the goals of the PFPM criteria, and the PRT does not believe that the way the proposal’s novel features would affect primary care practices has been tested.
- The PRT feels there are several aspects of the payment methodology which could be problematic:
 - The combination of patient election and claims-based attribution proposed is overly complex and could lead to selection bias.
 - If a practice underperforms, it would have to pay some or all of the incentive back. This puts the government in the position of performing collections on money already paid out and puts participants with weak balance sheets at significant financial risk.
 - The PRT is not convinced that multiple PBPMs or that the two different levels of monthly payments for different subsets of E/M services are needed.

Criterion 4. Value over Volume

Criterion Description

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

PRT Conclusion

Meets criterion

Unanimous or Majority Conclusion

Unanimous

- 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.
- 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.
- 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, but it could also expose patients to "cherry picking."

Criterion 5. Flexibility

Criterion Description

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

PRT Conclusion

Meets criterion

Unanimous or Majority Conclusion

Unanimous

- 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.
- 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

Criterion Description

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

PRT Conclusion

Does not meet criterion

Unanimous or Majority Conclusion

Unanimous

- Some of the submitter's stated goals are evaluable, but 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.
 - 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.
 - Depending on how broadly the proposed model is made available and 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

Criterion Description

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 Conclusion

Does not meet criterion

Unanimous or Majority Conclusion

Unanimous

- 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.
- There are no requirements or measures of care coordination for individual patients.
- The submitter did not provide any indication as to how providers outside of the primary care practice, such as consulting specialists, would have greater ability to spend time in communication and coordination with the primary care practice.

Criterion 8. Patient Choice

Criterion Description

Encourage greater attention to the health of the population served while also supporting the unique needs and preferences of individual patients.

PRT Conclusion

Meets criterion

Unanimous or Majority Conclusion

Unanimous

- Under the model, patient choice is the primary method of determining which patients the primary care practice will receive payment and be accountable for.
 - However, attention must be paid to avoid unintended worsening of disparities and precluding patients with low literacy levels or low levels of self-activation.
- 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.

Criterion 9. Patient Safety

Criterion Description

Aim to maintain or improve standards of patient safety.

PRT Conclusion

Meets criterion

Unanimous or Majority Conclusion

Unanimous

- 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.
- Because payments would be risk-adjusted, practices that have more patients with multiple health problems would receive more resources to support these types of outreach and response services.
- 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.

Criterion 10. Health Information Technology

Criterion Description

Encourage use of health information technology to inform care.

PRT Conclusion

Meets criterion

Unanimous or Majority Conclusion

Unanimous

- The proposed model requires that at least 50% of the APM Entity's participants use CEHRT, consistent with the requirements for an Advanced APM.

Physician-Focused Payment Model Technical Advisory Committee

Preliminary Review Team Findings on:

**LUGPA APM for Initial Therapy of Newly Diagnosed Patients
with Organ-Confined Prostate Cancer**

Submitted by Large Urology Group Practice Association (LUGPA)

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December 19, 2017

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Model Overview

- Eligible patients: Medicare patients who are diagnosed with localized prostate cancer after a biopsy
- Active Surveillance (AS) Episode length: 12 months, with subsequent 12 month episodes possible
- Model provides a \$75 monthly care management fee during AS episodes (\$900 total) and a performance-based shared savings/losses payment

Payment Overview (Provider Payments and Incentives)

Care Management Fee

- \$75 monthly care management fee supports enhanced services that are part of AS, such as patient education, tracking lab results consistently, tracking patient compliance, social services, reviewing the care plan, etc.
- Fee could be allocated to urologists, PAs/NPs, or other providers according to their role in AS.

Performance-based Payment

- Retrospectively compares actual initial episode total spending for Medicare Parts A and B against a target amount; shared savings or losses based on quality performance and capped.
- Episodes for patients with localized prostate cancer are classified into 12 subcategories.
 - Benchmark is blend of practice and provider type/regional (AMCs, hospitals, and offices within Census Division) spending in 3-year historical period; relative weights of practice and region shift over time.
 - Benchmarks created for each subcategory, all AS and all AI categories, and one composite benchmark.
 - Composite benchmark includes historical practice and regional AS utilization, applicable weight for practice/region experience in performance year, and benchmark prices for AS and AI episodes.

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3. Payment Methodology (High Priority)	Meets Criterion	Majority
4. Value over Volume	Meet Criterion	Unanimous
5. Flexibility	Meets Criterion	Unanimous
6. Ability to be Evaluated	Meets Criterion	Unanimous
7. Integration and Care Coordination	Does Not Meet Criterion	Unanimous
8. Patient Choice	Meets Criterion	Unanimous
9. Patient Safety	Meets Criterion	Unanimous
10. Health Information Technology	Does Not Meet Criterion	Unanimous

Criterion 1. Scope (High Priority). 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 Conclusion: Proposal Does Not Meet the Criterion

Strength:

- Participation in the Oncology Care Model (OCM) is low for patients with organ-confined prostate cancer and their providers. The proposal creates new opportunities to participate in an APM for a *limited* number of providers and patients.

Concerns:

- Urology practices are changing behaviors and increasingly using AS for appropriate patients even without revisions to Medicare payment policy.
- Current opportunities in the Medicare PFS could support AS, including the chronic care management fee or CPT codes for additional services.

Criterion 2. Quality and Cost (High Priority). 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 Conclusion: Proposal Meets the Criterion

Strengths:

- The model would strengthen physician incentives to pursue AS, which is associated with lower costs compared to AI.
- The model encourages greater patient education and shared decision making, which could enhance patient satisfaction.

Concerns:

- The proposed quality measure of time on AS establishes a low bar for performance.
- Proposed auditing actions to ensure quality could impose large burdens for CMS and providers.

Criterion 3. Payment Methodology (High Priority). 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.

PRT Conclusion: Proposal Meets the Criterion

Strength:

- The model includes a care management fee to support upfront costs to incentivize treatment changes toward AS as well as a performance-based incentive to reduce costs below historical norms.

Concerns:

- The inclusion of a performance-based payment seems to be a very complex way to incentive AS relative to AI.
- Though the performance-based payments reflect total cost of care during the episode, the model does not provide sufficient detail on how integration with other providers will be achieved, who may be important components of care management for patients with comorbidities.
- Comparison with historical personal and regional benchmarks means the model is not affected by evolving trend toward AS.
- Heavy weights on the practice-based component may make savings easy to obtain; e.g., almost anyone who was overusing AI before could gain financially from following recommended clinical guidelines.
- The power of historically-based benchmarks to incentivize degrades over time as practice patterns trend toward the optimal clinical level.

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

PRT Conclusion: Proposal Meets the Criterion

Strength:

- Current reimbursement policies incentivize urologists to deliver a high volume of services to patients with localized prostate cancer; this model would shift incentives away from volume.

Concern:

- The standard of care is already shifting toward AS, reducing the net value of financial incentives in the model.

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

PRT Conclusion: Proposal Meets the Criterion

Strengths:

- The care management fee provides financial support to deliver enhanced services necessary in AS.
- It also provides flexibility for APM entities to design and tailor AS activities to fit patient populations, practice structure and culture, and local resources.

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

PRT Conclusion: Proposal Meets the Criterion

Strengths:

- The details of the model and required calculations are clearly described in the proposal.
- The quality measures and performance targets are clearly specified to facilitate evaluation and most are based on validated, accepted measures of quality.

Concerns:

- With the shift toward AS, finding control groups (required for a proper evaluation) using appropriate standards of care would require some work but is feasible.
- The time on active surveillance metric is a new measure developed for this PFPM and does not have the same validation as other proposed quality measures.

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 Conclusion: Proposal Does Not Meet the Criterion

Strength:

- The care management fee will support coordinated urological care for patients with localized prostate cancer during the AS episode.

Concerns:

- The shared savings component focuses on total cost of care, but the model does not provide sufficient detail on integration with other primary care providers and specialists to manage comprehensive care for the patients.
- The model does not require care coordination or integration with other specialties or provide a plan for allocating the care management fee or gains or losses from total cost of care.

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 Conclusion: Proposal Meets the Criterion

Strengths:

- Current reimbursements may limit patient choice by encouraging providers to pursue AI, even if the patient may prefer AS or watchful waiting.
- The shared decision making measure would encourage providers to educate patients about treatment options for localized prostate cancer and would likely increase patient comfort with AS versus AI.
- The model would support the needs and preferences of individual patients and facilitate patient choice in their treatment.

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

PRT Conclusion: Proposal Meets the Criterion

Strength:

- Increased AS could avoid potentially unpleasant side effects of surgery, radiation, or hormone therapies that are part of AI.

Concerns:

- The proposed actions to address patient safety could place a large reporting burden on providers and a large enforcement burden on CMS.
- Corrective action/contact CMS for help in the event of fear/belief about inappropriate assignment to AS puts a large burden on the patient and CMS to ensure patient safety.

PRT Conclusion: Proposal Does Not Meet the Criterion

Strength:

- The tracking of lab results and other AS activities during the episode would implicitly require health information technology (HIT).

Concerns:

- The model does not encourage new efforts to improve information flow to inform care and instead relies on the existing state of the world of HIT.
- The model does not explicitly address how providers might use HIT to achieve quality and performance goals.

Key Issues Identified by the PRT

The PRT supports the proposal's goal of greater use of AS vs AI for appropriate patients. However, several major issues needed to be addressed:

- 1. Evolving Standard of Care.** If the standard of care is moving as fast toward AS as some think it is, then creating financial incentives of this type risks being redundant at best. If financial incentives are necessary, a change in the Physician Fee Schedule for AS would be a lot simpler and likely to be more effective than the current proposal.
- 2. Historical Practice Performance as Benchmark.** The model does not adequately account for the evolving shift toward AS as the standard of care. A more rigorous reference pricing model using control groups that are implementing current standard of care (i.e., higher AS usage rates) to develop spending targets or benchmarks could be used to judge performance on total cost of care.

Physician-Focused Payment Model Technical Advisory Committee

Preliminary Review Team Findings on:

**A Single Bundled Payment for Comprehensive Low-Risk Maternity and Newborn
Care Provided by Independent Midwife-Led Birth Center Practices that Are
Clinically Integrated with Physician and Hospital Services**

Submitted by Minnesota Birth Center

Rhonda M. Medows, MD (Lead Reviewer)
Len M. Nichols, PhD
Grace Terrell, MD, MMM

December 19, 2017

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Model Overview

- Bundled payment for maternity and newborn care for low-risk pregnancies.
- Payment covers from initiation of prenatal care through the “perinatal episode,” defined as nine months of pregnancy plus eight weeks postpartum for mother, and newborn care for first 24 hours of life.
- “Low risk” definition: “largely based on the absence of high-risk factors;” proposal specifies 35 “Exclusionary Risk Criteria.”
- Certified nurse midwives (CNMs) are primary providers to patients; proposal states, “our model is most accurately described as a ‘Provider Focused Payment Model’ with integral physician involvement.”
- Proposed bundle to include all professional and facility fees during labor and birth, which the proposal refers to as the BirthBundle®. CPT codes and services in the BirthBundle® specified in the proposal and include mother professional fees, newborn professional fees, prenatal lab tests, and facility fees. Prenatal education, doulas, and lactation support services also included.
- Proposal is for care of cohorts of 250–300 low-risk pregnant mothers per year via five-member, CNM teams collaborating with consulting obstetric, pediatric, and neonatal physicians. CNM teams have hospital privileges, for when more than birth center level of care is required. In-hospital physician services also available 24/7.

Payment Overview (Provider Payments and Incentives)

- Beyond calling for the concept of bundled payment, payment methodology not further described in the proposal; e.g.,
 - “We would appreciate PTAC assistance in further design of the payment methodology for this PFPM. This would include help in determining the appropriate amount of the bundled payment as well as the timing of its distribution. In addition, we would like to explore the possibility of having providers take on additional risk beyond the single bundled payment.”
 - “Providers should not have to carry the costs of care for many months after performing the service. A solution would be an upfront partial payment at 20 weeks gestation followed by a final retrospective bundled payment shortly after completion of the episode. . . . It would be very helpful to have PTAC assistance in addressing these questions.”

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Criterion 1. Scope (High Priority). 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 Conclusion: Does Not Meet Criterion

Strength: Worthy concept for insurers that cover large number of deliveries and newborns.

Weaknesses:

- Not as applicable to Medicare because of very low volume of Medicare-covered pregnancies overall and high unlikelihood of low-risk Medicare pregnancies:
 - Only 22,086 Medicare-covered births nationwide in 2016—74% identified as having one or more co-occurring chronic conditions.
 - Women of childbearing age eligible for Medicare only through the presence of a disability, End-Stage Renal Disease, or other serious disease.
- Low number of low-risk Medicare births prevent fair assumption of risk-based payment, quality measurement, and ability to evaluate model.
- Eligibility Problem: The proposal includes coverage of newborn care for the first 24 hours of life. However, Medicare does not provide newborn eligibility. After delivery, items and services furnished to the infant are not covered and reimbursed by Medicare based on mother's eligibility.

The PRT could not find that the proposed model would likely directly address an issue in payment policy that broadens and expands the CMS APM portfolio.

Criterion 2. Quality and Cost (High Priority). 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 Conclusion: Does Not Meet Criterion

Strength:

- Proposal states accreditation by the Commission for Accreditation of Birth Centers (CABC) should be mandatory for participation in bundled perinatal payments.

Weaknesses:

- Absence of comprehensive quality measures a risk to improving or maintaining quality:
 - The proposal discussed only cesarean section (C-section) rates, and did not identify other measures of health care quality.
 - However, the American Association of Birth Centers (AABC) identified multiple quality measures for maternity care; e.g., number of prenatal visits, cesarean birth rate, elective delivery before 39 weeks, preterm birth and low birth weight rates, breastfeeding initiation and continuation, neonatal intensive care unit (NICU) admissions, readmissions, perineal integrity, and completion of the 6-week postpartum visit as measures of perinatal quality.
- With respect to controlling costs, proposal states that cost savings expected to be realized “through a lower-intervention model of maternity care that is highly coordinated and leverages the use of a birth center, a lower-cost facility.” The PRT did not view a cost differential resulting from change in the site-of-care by itself as a payment model change.

Criterion 3. Payment Methodology (High Priority). 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.

PRT Conclusion: Does Not Meet Criterion

Beyond identifying the concept of bundled payment, payment methodology not further developed; e.g., proposal states:

“We would appreciate PTAC assistance in further design of the payment methodology for this PFPM. This would include help in determining the appropriate amount of the bundled payment as well as the timing of its distribution. In addition, we would like to explore the possibility of having providers take on additional risk beyond the single bundled payment. Finally, stop loss insurance or risk pools will be needed for the rare expensive outlier perinatal cases. . . .

Providers should not have to carry the costs of care for many months after performing the service. A solution would be an upfront partial payment at 20 weeks gestation followed by a final retrospective bundled payment shortly after completion of the episode. Providers could also take on additional risk by taking cost responsibility for some multiple of the agreed upon bundled price. It would be very helpful to have PTAC assistance in addressing these questions.”

Proposal also states, “A specific pregnancy insurance component could provide outlier payment adjustments if the costs for a patient or her baby exceeded a certain amount. This would reduce the financial risk to providers and facilities participating in the bundled payment program.” However, this concept is not further detailed in the proposal.

The PRT concluded that the submission does not sufficiently:

- describe a payment methodology;
- address how Medicare would “pay APM Entities, how the payment methodology differs from current payment methodologies, and why the PFPM cannot be tested under current payment methodologies.”

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

PRT Conclusion: Does Not Meet Criterion

- Proposal states overuse of C-section is the primary volume problem in perinatal care and overuse of ultrasound imaging as another major driver of perinatal care cost.
- Model proposes to address these via the financial incentives inherent in bundled payment to shift from encouraging use of technology-intensive care to encouraging use of low-technology, high-value approaches.
- Proposal states savings derived from fewer C-sections and lower facility fees for the majority of women would offset costs associated with small number of complicated births requiring hospital care.

The PRT found that (as discussed under Criterion 3. Payment Methodology), the actual payment methodology is insufficiently described; and (as discussed under Criterion 2. Quality and Cost), the model does not contain sufficient measures of health care quality. Thus, the PRT could not find that the model would provide incentives to practitioners to deliver high-quality health care.

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

PRT Conclusion: Does Not Meet Criterion

- Proposal states: “by paying a single amount for the entire perinatal episode providers will have the flexibility to be creative and to use proven high value supportive services to improve outcomes and patient satisfaction.”
- PRT agrees with this statement in principle, but as discussed in the preceding criteria, the details of this proposed model are not sufficiently developed to assume with reasonable certainty that it will provide the flexibility needed for practitioners to deliver high-quality health care.
- PRT does not believe that one can automatically assume delivery of high-quality care based solely on the use of a bundled payment.

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

PRT Conclusion: Does Not Meet Criterion

The PRT believes evaluation of this proposed model in the Medicare program would be very difficult because:

1. Medicare is not a major payer of perinatal care;
2. Only very few Medicare beneficiaries could likely be included in a model of care for low-risk beneficiaries;
3. Variation in State laws affect scope of practice and subsequently design of the model; and
4. Specific evaluable goals for quality of care are not sufficiently articulated in the proposal.

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 Conclusion: Does Not Meet Criterion

➤ Proposal's limited discussion of this issue consists of:

"This care model is based on integrated CNM-led multispecialty teams caring for cohorts of 250-300 mother/baby pairs each year. Having 4 or 5 CNM FTEs on each team maximizes continuity of care for the mothers with avoidance of burnout for the CNM providers.

Care coordination is crucial. We utilize the unique and the overlapping skills of CNMs, RNs, LPNs, perinatal educators, doulas, and administrative personnel to provide a caring and consistent care path for mothers. This works well for mothers without complications, but it also works well when complications develop.

In tragic situations when lethal fetal abnormalities are detected, many mothers choose perinatal hospice care. This involves providing clinical and emotional support for a mother and family as they await the natural birth and death of their child. Our model has provided support for families in this situation, as well as those with other complications."

➤ How the model would encourage greater integration and care coordination among practitioners and across settings is not sufficiently described; e.g.,

- composition of the CNM-led multispecialty teams and the clinical integration with physicians and hospitals are not well described;
- no measures of care coordination are proposed.

➤ The PRT does not believe one can automatically assume greater integration and care coordination among practitioners and across settings based solely on use of a bundled payment.

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 Conclusion: Meets Criterion

- Because the proposed model would offer the services of perinatal educators and doulas, along with the services of CNMs, RNs, LPNs, and physicians and choice of setting for delivery, the PRT believes that patients would have greater choice of service providers and setting of care.
- This would encourage greater attention to the choices of individual patients.

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

PRT Conclusion: Does Not Meet Criterion

1. Proposal defines “low risk” pregnancies as those without specific maternal conditions (“exclusion criteria”). No explanation given for how criteria were determined. Review of the criteria by an obstetrical consultant identified other conditions recommended as exclusionary criteria. Further, comments from the MN & WA Chapters of National Association of Certified Professional Midwives & MN Council of Certified Professional Midwives state:

“It is important to note that the risk criteria submitted is for the author’s practice. Birth centers accredited by the Commission for the Accreditation of Birth Centers (CABC) follow a different set of risk criteria as determined by the American Association of Birth Centers (AABC). This risk assessment is based on a multi-disciplinary group of Certified Professional Midwives (CPMs), CNMs, and physicians in a review of current evidence.”

2. Proposal states, “Our PFPM is designed to maximize the number of mothers and babies cared for within the bundled clinical care and payment model.” The PRT is concerned that proposed exclusionary criteria might indeed maximize the number of mothers in the model but as a side effect might not sufficiently protect beneficiaries.
3. The PRT expected to see additional patient safety standards, especially as without strong quality measures (as discussed in the PRT comments under Criterion 2. Quality and Cost) a bundled payment approach could incentivize stinting on care. Such standards could include, for example, a quality improvement process with case review to ensure appropriate care is being provided, and systematic tracking of mother and baby outcomes.

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

PRT Conclusion: Does Not Meet Criterion

Insufficient attention to this issue in proposal, entirely consisting of:

“Health information technology tools can help mothers wisely choose their preferred care model and to access care through that model. The integrative nature of our perinatal care PFPM provides an excellent foundation for the development of these tools.

Health information technology can also be applied to the vast amount of coding and billing data that is crucial for the analysis and definition of bundled payments. Our model necessarily started at a grassroots level, but other tools have been developed. These include the PROMETHEUS model of the Health Care Incentives Improvement Institute (HCI3). The combination of these complex tools with grassroots clinical bundle initiatives such as ours can assist with perinatal care improvement.”

The PRT was looking for some level of specificity about how health information technology would be used in this model.

Key Issues Identified by the PRT

- The PRT appreciated the potential for bundled payments of perinatal care to provide improvements in patient choice, quality, and costs, but concluded that the Medicare program is not the best vehicle for testing such a payment model — and by extension that PTAC is not the best vehicle for responding to such a proposal.
- The PRT notes that the submitted proposal seems to reflect this perspective as well, in its repeated references to Medicaid, including:

“The ultimate goal is to provide higher value perinatal care for a lower price for mothers covered by Medicaid. When this is achieved it will encourage bundled payment for mothers covered by commercial insurance.”
- While the PRT concluded that this proposal does not meet key criteria for Medicare PFPs, it hopes that well-developed proposals for the use of bundled payment for perinatal care can and will be considered by the federal and State Medicaid programs and commercial insurers.