Physician-Focused Payment Model Technical Advisory Committee

Preliminary Review Team Findings on

Intensive Care Management in Skilled Nursing Facility Alternative Payment Model (ICM SNF APM)

Submitted by Avera Health

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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 ASPE 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

Background – The proposal is based on a Health Care Innovation Award (HCIA) Round Two demonstration project.

Goals – The overall goals of the model are to reduce avoidable emergency department (ED) visits and hospitalizations and lower costs for patients in skilled nursing facilities (SNFs) and nursing facilities (NFs).

APM Entity – A geriatric physician/practice would serve as the APM entity.

Services Supported by Payments – Geriatrician-led care teams (GCTs) would partner with SNFs/NFs and supplement the facilities' on-site staff via telehealth.

- In addition to the geriatrician, the submitter suggests that GCTs might include gerontology trained or certified advanced practice providers, pharmacists, social workers, nurses, and behavioral health practitioners.
- Beneficiaries would continue to have services provided by an attending primary care physician (PCP) and be cared for by the facility staff. The PCP would retain ultimate oversight and management of a patient's care.
- Beneficiaries (as well as the facility staff) would additionally have access to the GCT via telehealth.
- The GCT would render geriatric care management activities (e.g., monitoring beneficiaries' care, risk stratification, development of care plans, evidence-based disease management, advance care planning, etc.).
- The GCT would also provide timely access to care such as 24/7 access via telehealth to a physician or advance practice provider on the GCT and real-time provider response to a patient's change in health status.

Proposal Overview – *Continued*

Payment – The proposal contains two payment options: (1) a "performance-based payment" model that the submitter considers simpler and preferred; and (2) a shared savings model intended to qualify as an Advanced APM. The submitter does not expect CMS to implement both.

Common to Options 1 & 2

- $252/new admit + $55 PBPM
- No beneficiary cost-sharing
- APM Entity decides whether to share with partnering facilities
- 11 performance measures
- APM Entity must monitor additional 13 measures. Failure to meet standards on 6+ results in discontinued participation.

Option 1: Performance-Based Payments

- Beginning in Y3, failure to meet standards on 4+ performance measures in preceding year results in payment reductions (new admit + PBPM)

Option 2: Shared Savings Model

- APM Entity would be eligible for shared savings (beginning in Y1) and at risk for shared losses (beginning in Y3). Savings limited to 10% of target amount; losses limited to new admit + PBPM amounts.
- Actual Medicare Part A and B expenditures (with some exclusions) for all healthcare services received by residents during their SNF/NF stays (including services delivered in hospitals) + 30-days post-discharge would be compared against HCC risk-adjusted target amounts based on historical spending
- Beginning in Y3, shared savings/losses adjusted based on performance measures. Savings reduced for failure to meet standards on 4+ performance measures; losses reduced if standards met on at least 8.

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	Unanimous
3. Payment Methodology (High Priority)	Meets Criterion	Unanimous
4. Value over Volume	Meets Criterion	Unanimous
5. Flexibility	Meets Criterion	Unanimous
6. Ability to be Evaluated	Meets Criterion	Unanimous
7. Integration and Care Coordination	Meets 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

- There are existing CMS initiatives aimed at reducing avoidable ED visits and hospitalizations for the SNF/NF patient population, but there is still significant opportunity for improvement. This model would provide an explicit opportunity for geriatricians to participate in an APM.
- Providing beneficiaries and SNF/NF facility staff with 24/7 access to a GCT via telehealth seems likely to improve quality and reduce costs by reducing avoidable ED visits and hospitalizations. The model provides on-site staff with an additional clinical resource that they can call for assistance in assessing and responding to changes in the patient's clinical presentation, rather than immediately sending the patient to the hospital for evaluation.
- The PRT supports the fundamental concepts present in both payment designs, i.e., the one-time and PBPM payments with accountability for performance, and believes that its concerns with payment methodology would be feasible to address without requiring changes to these concepts.
- The proposal was designed assuming that a GCT would serve a population of approximately 5,000 beneficiaries. Although the submitter indicates that the APM could be implemented with smaller numbers of beneficiaries, which would enable it to be implemented more broadly, the PRT has some uncertainty about the feasibility of smaller scale deployment.

Key Issues Identified by the PRT – *Continued*

- The PRT would prefer to have seen a single model that includes the best elements of both payment designs.
- The submitter indicated that the shared savings model would allow for greater flexibility, since there would be greater accountability than under the simpler model, but did not make clear how the additional flexibility and shared savings could make the overall program stronger.
- Neither payment option proposes a way to risk adjust rates of ED visits, hospital admissions, or spending based on the specific types of patient characteristics that can affect hospitalization rates for SNF/NF residents.
- The model directly ties payment to measures of clinical quality, health outcomes, and indicators of health care cost management that are aligned with other reporting programs. However, the PRT has several concerns. For example, while the performance measures include ED and readmission measures for SNF patients, there are not measures for hospitalization of NF patients. In addition, performance on measures would not negatively impact payments unless the APM Entity fails to meet the standards on 4+ measures (under the shared savings option, there also needs to be savings or repayments). An APM Entity could fail to meet the standards for ED visits and readmission measures for SNFs and not have a negative performance adjustment.

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

- There are existing CMS initiatives aimed at reducing avoidable ED visits and hospitalizations for the SNF/NF patient population, but there is still significant opportunity for improvement.
- This model would provide an explicit opportunity for geriatricians to participate in an APM (the PRT felt that when possible, internists or other physicians with a particular focus in the care of geriatric patients might also be appropriate).
- The proposal was designed assuming that a GCT would serve a population of approximately 5,000 beneficiaries. Although the submitter indicates that the APM could be implemented with smaller numbers of beneficiaries, which would enable it to be implemented more broadly, the PRT has some uncertainty about the feasibility of smaller scale deployment.
- It was unclear which aspects of the model are absolute requirements necessary to achieve the model's desired outcomes. Fewer requirements would make the model more broadly available, particularly to smaller practices.

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
Unanimous

- Providing beneficiaries and SNF/NF facility staff with 24/7 access to a GCT via telehealth seems likely to improve quality and reduce costs by reducing avoidable ED visits and hospitalizations. The model provides on-site staff with an additional clinical resource that they can call for assistance in assessing and responding to changes in the patient's clinical presentation, rather than immediately sending the patient to the hospital for evaluation.
- Early evidence from the submitter's experience with their HCIA Round 2 demonstration project (in Iowa, Minnesota, Nebraska, and South Dakota) suggests that the proposal can improve quality and reduce cost. Data tables requested by the PRT indicate that there are areas in the country with much higher rates of ED visits and hospitalizations from SNFs and NFs, and therefore, potential for even greater improvement.
- The model, particularly the simpler payment design, may incentivize GCTs to partner with facilities where they perceive the most opportunity based on patient characteristics since the one-time and PBPM payments are not risk adjusted.
- A means to ensure access to services provided at a hospital when such services are needed is an important detail that needs to be worked out.

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
Unanimous

- The PRT supports the fundamental concepts present in both payment designs, i.e., the one-time and PBPM payments with accountability for performance, and believes that its concerns with payment methodology would be feasible to address without requiring changes to these concepts. (Also, the PRT would prefer to have seen a single model that includes the best elements of both payment designs).
- The payment methodology, particularly the two-sided risk option, incentivizes the GCT to reduce avoidable ED visits and hospitalizations.
- The simpler payment design with less financial risk and complexity could enable greater participation, particularly from smaller practices.
- The submitter indicated that the shared savings model would allow for greater flexibility, since there would be greater accountability than under the simpler model, but it is not clear how the additional flexibility would be used to make the overall program stronger.
- Downside risk is much lower than upside risk under the shared savings model. (Also, it is not clear that the limit on downside risk would enable the model to achieve its goal of meeting the Advanced APM standards.)
- Neither payment option proposes a way to risk adjust rates of ED visits, hospital admissions, or spending based on the specific types of patient characteristics that can affect hospitalization rates for SNF/NF residents.

Criterion 3. Payment Methodology (High Priority) – *Continued*

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
Unanimous

- The model directly ties payment to measures of clinical quality, health outcomes, and indicators of health care cost management that are aligned with other reporting programs. However, the PRT is concerned that:
  - Performance on these measures would not impact payments in Y1 or Y2.
  - The 11 measures include ED and readmission measures for SNF patients, but there are not measures for hospitalization of NF patients.
  - Performance on measures would not negatively impact payments unless the APM Entity fails to meet the standards on 4+ measures (under the shared savings option, there would only be a penalty if there were savings or repayments). An APM Entity could fail to meet the standards for ED visits and readmission measures for SNFs and not have a negative performance adjustment.
  - Under the shared savings model, performance factors only into the shared savings/loss payments (if there are any) and does not affect the monthly payments.
  - The simpler payment option does not provide any increase in payments for good performance, limiting the flexibility to deliver additional services that could help avoid additional ED visits/admissions.

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 model provides on-site staff with an additional clinical evaluation resource, which may diminish inappropriate hospital services, reduce medical complications from polypharmacy, and improve access to geriatric specialty care, which is currently undersupplied in the U.S. health care market.
- Unlike traditional Medicare, under the proposed model payments are made per patient rather than per service. Therefore, the model does not incentivize service volume.
- The GCT is expected to risk stratify patients to help deliver the right amount of patient care and planning. However, the submitter indicates that there are currently no well-validated risk stratification models for the long-term care population.

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

- Partnering with GCTs would give SNFs/NFs more flexibility in how the facilities could respond when their residents have clinical problems.
- Although the proposal outlines how the care model is anticipated to work, the GCT and partnering facilities seem to have quite a degree of flexibility in how they would collaborate.
- There is flexibility in the composition of the GCT. Although the proposal offers a suggested composition, geriatricians have the freedom to add other types of practitioners based on the needs of the patient population.
- The submitter indicated that it believes the shared savings model would allow for greater flexibility, since the greater accountability for outcomes could allow less strict standards for service delivery and because of the additional resources available through shared savings payments. However, it was unclear which of the standards would be relaxed under the shared savings model, and it was unclear which of the standards are necessary to achieve the model's desired outcomes.

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
Meets Criterion

Unanimous or Majority Conclusion
Unanimous

- The PRT believes that the model has evaluable goals, namely, reducing avoidable ED visits and hospitalizations and lowering costs. The proposal includes measures (11 tied to payment and 13 tied to model participation) that are currently in use in other reporting programs.
- Different SNF/NF facilities may have patient populations with differing risk of ED visits, hospitalizations, and spending. Therefore, relevant and accurate severity adjustment would be needed for an accurate evaluation. However, current risk adjustment methodologies have not been developed specifically for nursing home patient populations, which may limit the validity of the evaluation.

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
Meets Criterion

Unanimous or Majority Conclusion
Unanimous

- Model participation criteria include: articulating strategies for PCP care coordination and assessment of satisfaction; facility engagement and measurement of staff satisfaction; use of appropriate HIT to coordinate care between the GCT and facility staff, including telemedicine access; facility staff coaching and mentorship; and provision of continuing education targeted at identifying knowledge and skill gaps.
- The GCT would be expected to work in close collaboration with the PCP and facility staff, as the PCP would retain ultimate oversight and management of a beneficiary's care. The GCT also would be expected to have virtual access to health records at the facility.
- Nothing in the proposal seems to guarantee that integration and coordination occur, and there was no explicit mention of a process or a standardized approach that would ensure that the GCT consults with the PCP or follows the PCP's guidance.
- Except for the PCP, the proposal does not specifically mention how the GCT would interact with physical and occupational therapists or other practitioners relevant to the patient's care.

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

- Currently, patients are often sent to the hospital without much choice, and the proposed model would give patients the ability to avoid ED visits and hospitalizations when they are not needed.
- The proposal indicates that beneficiaries can opt out of GCT services.
- The proposal does not articulate how the GCT would factor patient preferences and advance care plans into the advice given to facility staff.

Criterion 9. Patient Safety

Criterion Description
Aim to maintain or improve standards of patient safety.

PRT Conclusion
Meets Criterion

Unanimous or Majority Conclusion
Unanimous

- Because clinicians are not always on-site or immediately available, providing 24/7 access to a GCT via telehealth is likely to improve patient safety, as is mentoring and training of SNF/NF staff.
- The model creates incentives for the GCT to decrease avoidable hospital admissions. A potential challenge is that the proposed model creates a counter-incentive to decrease medically necessary hospital admissions, particularly under the shared savings model. The PRT believes that the proposal would be better if the one-time and PBPM payments were risk-adjusted.

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

- Telehealth is a central component of the proposed model. GCTs would be expected to have the capability to provide HIPAA-compliant, real-time, two-way audio/visual assessment of the patient.
- SNFs and NFs have not been included in Medicare and Medicaid EHR Incentive Programs, and they lag behind acute care settings in adoption of EHRs. Under the proposed model, since GCTs would be expected to have virtual access to health records at the facility, this could encourage further adoption of EHRs among SNFs and NFs interested in participating in the model.
- It is unclear which aspects of the model are absolute requirements necessary to achieve the model's desired outcomes under the different payment options. Therefore, the PRT was less certain about the degree to which the model might encourage the adoption of HIT.