

# Physician-Focused Payment Model Technical Advisory Committee

## Committee Members

Jeffrey Bailet, MD, *Chair*

Elizabeth Mitchell, *Vice  
Chair*

Robert Berenson, MD

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Harold D. Miller

Len M. Nichols, PhD

Kavita Patel, MD, MSHS

Bruce Steinwald, MBA

Grace Terrell, MD, MMM

May 7, 2018

Alex M. Azar II, Secretary  
U.S. Department of Health and Human Services  
200 Independence Avenue, SW  
Washington, DC 20201

Dear Secretary Azar:

On behalf of the Physician-Focused Payment Model Technical Advisory Committee (PTAC), I am pleased to submit PTAC's comments and recommendation to you on a physician-focused payment model (PFPM), *Intensive Care Management in Skilled Nursing Facility Alternative Payment Model (ICM SNF APM)*, submitted by Avera Health. These comments and recommendation are required by section 1868(c) of the Social Security Act which directs PTAC to (1) review PFPM models submitted to PTAC by individuals and stakeholder entities, (2) prepare comments and recommendations regarding whether such models meet criteria established by the Secretary of Health and Human Services (HHS), and (3) submit these comments and recommendations to the Secretary.

With the assistance of HHS' Office of the Assistant Secretary for Planning and Evaluation (ASPE), PTAC's members carefully reviewed Avera Health's proposed model (submitted to PTAC on September 7, 2017), additional information on the model provided by the submitter in response to questions from a PTAC Preliminary Review Team and PTAC as a whole, and public comments on the proposal. At a public meeting of PTAC held on March 27, 2018, the Committee deliberated on the extent to which this proposal meets the criteria established by the Secretary in regulations at 42 CFR § 414.1465 and whether it should be recommended.

PTAC recommends the *ICM SNF APM* proposal to the Secretary for implementation. The Committee finds that the proposal meets all 10 of the Secretary's criteria and that the proposal deserves priority consideration based on the scope criterion. Members believe that patients residing in skilled nursing facilities (SNFs) and nursing facilities (NFs) could greatly

benefit from the model which encourages better care for these residents through 24/7 access via telehealth to a geriatrician-led care team providing care management and real-time response to a patient's change in health status. In addition, there are currently no alternative payment models focused on geriatricians. However, PTAC identifies several issues that will need to be resolved as part of the implementation process, including determining the feasibility of the model for smaller population and practice sizes, whether to implement both of the proposed payment paths, refining performance measurement, and developing risk adjusters specific to patients in SNFs/NFs. In addition, the Committee finds that, for this and other proposals, the CMS Innovation Center will need to resolve areas of overlap with Accountable Care Organizations.

The members of PTAC appreciate your support of our shared goal of improving the Medicare program for both beneficiaries and the physicians who care for them. The Committee looks forward to your detailed response posted on the CMS website, and would be happy to assist you or your staff as you develop your response. If you need additional information, please have your staff contact me at [Jeff.Bailet@blueshieldca.com](mailto:Jeff.Bailet@blueshieldca.com).

Sincerely,

A handwritten signature in black ink, appearing to read "Jeffrey Bailet", written over a thin horizontal line.

Jeffrey Bailet, MD  
Chair

Attachments

# Physician-Focused Payment Model Technical Advisory Committee

## REPORT TO THE SECRETARY OF HEALTH AND HUMAN SERVICES

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Comments and Recommendation on

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

May 7, 2018

## About This Report

The Physician-Focused Payment Model Technical Advisory Committee (PTAC) was established by the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) to (1) review physician-focused payment models (PFPMs) submitted by individuals and stakeholder entities, (2) prepare comments and recommendations regarding whether such models meet criteria established by the Secretary of Health and Human Services (HHS), and (3) submit these comments and recommendations to the Secretary. PTAC reviews submitted proposals using criteria established by the Secretary in regulations at 42 CFR § 414.1465.

This report contains PTAC's comments and recommendation on a PFPM proposal, *Intensive Care Management in Skilled Nursing Facility Alternative Payment Model (ICM SNF APM)*, submitted by Avera Health. This report also includes (1) a summary of PTAC's review of the proposal (2) a summary of the proposed model, (3) PTAC's comments on the proposed model and its recommendation to the Secretary, and (4) PTAC's evaluation of the proposed PFPM against each of the Secretary's criteria for PFPMs. The appendices to this report include a record of the voting by PTAC on this proposal, the proposal submitted by Avera Health, and additional information on the proposal submitted by Avera Health subsequent to the initial proposal submission.

## **SUMMARY STATEMENT**

PTAC recommends the *ICM SNF APM* proposal to the Secretary for implementation. The Committee finds that the proposal meets all 10 of the Secretary's criteria and that the proposal deserves priority consideration based on the scope criterion. Members believe that patients residing in skilled nursing facilities (SNFs) and nursing facilities (NFs) could greatly benefit from the model which encourages better care for these residents through 24/7 access via telehealth to a geriatrician-led care team providing care management and real-time response to a patient's change in health status. In addition, there are currently no alternative payment models focused on geriatricians. However, PTAC identifies several issues that will need to be resolved as part of the implementation process, including determining the feasibility of the model for smaller population and practice sizes, whether to implement both of the proposed payment paths, refining performance measurement, and developing risk adjusters specific to patients in SNFs/NFs. In addition, the Committee finds that, for this and other proposals, the CMS Innovation Center will need to resolve areas of overlap with Accountable Care Organizations (ACOs).

## **PTAC REVIEW OF THE PROPOSAL**

Avera Health's proposal was submitted to PTAC on September 7, 2017. The proposal was first reviewed by a PTAC Preliminary Review Team (PRT) comprised of three PTAC members, two of whom are physicians. These members requested additional data and information to assist in their review. The proposal was also posted for public comment. The PRT's findings were documented in the *Preliminary Review Team Report to the Physician-Focused Payment Model Technical Advisory Committee (PTAC)* dated February 22, 2018. At a public meeting held on March 27, 2018, PTAC deliberated on the extent to which the proposal meets the criteria established by the Secretary in regulations at 42 CFR § 414.1465 and whether it should be recommended to the Secretary for implementation.<sup>1</sup> The submitter and members of the public were given an opportunity to make statements to the Committee at the public meeting. Below are a summary of the proposal, PTAC's comments and recommendation to the Secretary on the proposal, and the results of PTAC's evaluation of the proposal using the Secretary's criteria for PFPMs.

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<sup>1</sup>PTAC member Rhonda M. Medows, MD, was not in attendance.

## PROPOSAL SUMMARY

The proposal is based on a Health Care Innovation Award (HCIA) Round Two demonstration project. Under the proposed model, geriatrician-led care teams (GCTs) would partner with SNFs/NFs and supplement the facilities' on-site staff via telehealth. Beneficiaries would continue to have services provided by an attending primary care physician (PCP) and be cared for by the facility staff. However, the beneficiary (as well as the facility staff) would additionally have access to the GCT via telehealth. The overall goals of the model are to reduce avoidable emergency department (ED) visits and hospitalizations and to lower costs.

The geriatric physician/practice would be the Alternative Payment Model (APM) Entity. 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. Criteria for participation in the model include articulating strategies for the following: PCP care coordination and assessment of satisfaction; facility engagement and measurement of staff satisfaction; assessment of beneficiary satisfaction; use of appropriate Health Information Technology (HIT) to coordinate care between the GCT and facility staff, including telemedicine access; facility staff coaching and mentorship; provision of didactic continuing education credits targeted at identifying knowledge and skill gaps; and use of data to drive continuous quality improvement. The submitter also notes that implementation of the model must be facility-wide, rather than for a subset of patients.

Under the proposed model, the GCT would render geriatric care management activities such as monitoring beneficiaries' care, risk stratification of the patient population, development of care plans for high-risk patients, medication reconciliation and management, evidence-based disease management, behavioral health support, advance care planning, and transitional care support. The GCT would also provide timely access to care such as 24/7 access via telehealth to a physician or advanced practice provider on the GCT and real-time response to a patient's change in health status. In order to accomplish these activities, the GCT would be expected to have the capability to provide HIPAA-compliant, real-time, two-way audio/visual assessment of the patient, virtual access to health records at the facility, and risk stratification and population health tools. The GCT would work in close collaboration with the PCP and facility staff, as the PCP would retain ultimate oversight and management of a patient's care.

To support the GCT's activities, the submitter proposes two possible payment designs: (1) a "performance-based payment" model that the submitter considers simpler and preferred (the "simpler" model) and (2) a shared savings model intended to qualify as an Advanced APM. The submitter does not expect the Centers for Medicare & Medicaid Services (CMS) to implement both. Under both payment model options, the APM Entity would receive a one-time payment

of \$252 for each new beneficiary admission to a partnering SNF/NF and a per beneficiary per month (PBPM) payment of \$55; beneficiaries would not share in these costs. Also, under both options, the APM Entity would decide whether and how to share payments with the facilities.

Under the first option, an APM Entity that failed to meet performance standards would receive reduced one-time and PBPM payment amounts in the following year. Performance would be determined using 11 measures of clinical quality, health outcomes, and indicators of health care cost management that are used for Nursing Home Compare and the SNF Value-Based Purchasing Program. Performance would not impact payments in the first two years of implementation.

Under the second option, the APM Entity would be eligible for shared savings/at risk for shared losses and the shared savings/losses would be adjusted based on whether performance standards were met (using the same 11 measures under the first option); adjustments to shared savings/losses based on performance would not occur in the first two years of implementation. To calculate shared savings/losses, 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) plus 30-days post-discharge would be compared against Hierarchical Condition Category (HCC) risk-adjusted target amounts based on historical spending. The reconciliation would occur annually. Beneficiaries attributed to other programs (e.g., ACOs) would be excluded from these calculations. Shared savings would be limited to 10 percent of the target amount, and repayments would be limited to the one-time and PBPM payments. The submitter noted on a call with the PRT that, under this option, they believed APM Entities would have greater flexibility regarding the standards of services they would need to meet because of the greater accountability for outcomes and spending.

Under both options, in addition to the 11 quality measures tied directly to payment, the APM Entity must monitor an additional 13 measures included in Nursing Home Compare. Failure to meet the performance standard on more than five of these measures would result in discontinued participation in the program.

## **RECOMMENDATION AND COMMENTS TO THE SECRETARY**

PTAC finds that the proposal meets all 10 of the Secretary's criteria and that the proposal deserves priority consideration based on the scope criterion. The Committee recommends the *ICM SNF APM* proposal to the Secretary for implementation. However, PTAC identifies several issues to be resolved as part of the implementation process.

PTAC believes that patients residing in SNFs/NFs could greatly benefit from the *ICM SNF APM*. Although there are existing CMS initiatives aimed at reducing avoidable ED visits and hospitalizations for SNF/NF patients, PTAC believes that there is still significant opportunity for improvement in the care of these vulnerable patient populations. There are currently no models in the CMS portfolio that are explicitly for geriatricians, and the central role of telehealth distinguishes the model from other initiatives.

The overall goals of the model are to reduce avoidable ED visits and hospitalizations and to lower costs for patients in SNFs/NFs. PTAC believes that providing beneficiaries and SNF/NF facility staff with 24/7 access to a GCT via telehealth seems likely to accomplish the model's goals. These facilities typically do not have a clinician on-site around the clock. This 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 submitter's initial internal findings from their HCIA Round 2 demonstration project supports that the proposed model could improve quality and reduce cost.

However, PTAC has several concerns and uncertainties. PTAC is uncertain about the feasibility of the model for smaller population and practice sizes, since the proposal was designed assuming that the GCT would serve a population of approximately 5,000 beneficiaries, and the submitter suggests a fairly large GCT composition. PTAC believes that the payment amounts and staffing standards may need to be modified to make the model feasible for smaller nursing facilities (e.g., 100) and physician practices (e.g., solo practitioners).

Furthermore, the submitter proposed two payment designs, a simpler "performance-based payment" model and a shared savings option. The Committee agrees that that the fundamental concepts present in both payment options, i.e., the one-time and PBPM payments with accountability for performance, are appropriate and would support the goals of the model. The submitter indicated that the shared savings model is not the preferred model but was included to address CMS's perceived preference for such models. None of the PTAC members favored implementing the shared savings model alone, but some members supported implementing both options, some opposed using shared savings for this patient population, and others suggested that the CMS Innovation Center might implement a hybrid model.

In addition, the Committee believes that various aspects of the proposed performance measurement should be refined as part of the implementation process. For example, as proposed, performance would not impact payment in the first two years of model implementation. However, PTAC believes that performance should impact payment by the

second year rather than the third year, particularly for the simpler payment option. Furthermore, under the model, an APM Entity could fail to meet the standards for ED visits and readmission measures and still not have a negative performance adjustment. The Committee believes that there should be separate accountability for quality and utilization measures so that APM Entities cannot focus on quality while neglecting utilization or vice versa. In addition, the metrics are facility-based. Members had concerns about how they would roll up to the level of the APM Entity and how meaningful benchmarks would be established. For measure denominators, members suggest using rates per 1,000 patients or something similar. PTAC also believes that documentation of patient goals of care should be a participation requirement and that monitoring to ensure that the model does not delay or prevent access to services provided at a hospital when such services are needed should occur, even if not included as performance metrics.

The Committee is also concerned that neither of the payment options proposes a way to risk adjust based on the specific types of patient characteristics that can affect hospitalization rates for SNF/NF residents. As a result, participants could be unfairly rewarded or penalized based on differences in the types of patients in the nursing facilities they support, rather than the effectiveness of the care delivered. PTAC believes that developing risk adjusters specific to these patient populations should be part of the implementation process.

Finally, the Committee finds that, for this and other proposals, the CMS Innovation Center will need to resolve areas of overlap with ACOs.

## EVALUATION OF PROPOSAL USING SECRETARY’S CRITERIA

### PTAC Rating of Proposal by Secretarial Criteria

Criteria Specified by the Secretary (at 42 CFR §414.1465)	Rating
1. Scope (High Priority) <sup>1</sup>	Meets Criterion and Deserves Priority Consideration
2. Quality and Cost (High Priority)	Meets Criterion
3. Payment Methodology (High Priority)	Meets Criterion
4. Value over Volume	Meets Criterion
5. Flexibility	Meets Criterion
6. Ability to be Evaluated	Meets Criterion
7. Integration and Care Coordination	Meets Criterion

<sup>1</sup>Criteria designated as “high priority” are those PTAC believes are of greatest importance in the overall review of the payment model proposal.

8. Patient Choice	Meets Criterion
9. Patient Safety	Meets Criterion
10. Health Information Technology	Meets Criterion

### 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.*

**Rating: Meets Criterion and Deserves Priority Consideration**

PTAC concludes that the proposed model meets this criterion and deserves priority consideration. Although there are existing CMS initiatives aimed at reducing avoidable ED visits and hospitalizations for SNF/NF patients, PTAC believes that there is still significant opportunity for improvement in the care of these vulnerable patient populations. The central role of telehealth also distinguishes the model from other initiatives. Furthermore, there are currently no models in the CMS portfolio that are explicitly for geriatricians (although, members believe that internists or other physicians with a particular focus in the care of geriatric patients might also be appropriate).

However, the Committee is uncertain about the feasibility of the model for smaller practice and population sizes. The proposal was designed assuming that the GCT would serve a population of approximately 5,000 beneficiaries. The submitter suggests that GCTs include, in addition to the gerontologist, gerontology-trained or certified advanced practice providers, pharmacists, social workers, nurses, and behavioral health practitioners. Yet, the model would provide more opportunity for participation if it could be implemented with fewer beneficiaries and with smaller GCTs. PTAC believes that the question of the model’s feasibility for smaller practice and population sizes should be resolved as part of the implementation process. In addition, it is unclear which aspects of the model are absolute requirements necessary to achieve the model’s desired outcomes. Fewer requirements could make the model more broadly available, particularly to smaller practices.

### 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.*

**Rating: Meets Criterion**

PTAC concludes that the proposed model meets this criterion. 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. These facilities typically do not have a clinician on-site around the clock. This 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 also supports that the proposed model could improve quality and reduce cost. The submitter found that 88 percent of beneficiaries were able to stay in the SNF/NF immediately following a telemedicine encounter. In addition, using a simple pre-post design, the submitter found that the care model could reduce Medicare spending by approximately \$342 PBPM (this number does not include the HCIA Round 2 award amount). (These are the submitter's initial internal findings and a final evaluation of the project is not yet available). The submitter's demonstration project took place in facilities in Iowa, Minnesota, Nebraska, and South Dakota. 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 if the model were expanded into these high utilization areas.

Nevertheless, different SNFs/NFs may have patient populations of varying acuity. The model, particularly the simpler payment design, may incentivize GCTs to partner with facilities where they perceive the most opportunity based on patient characteristics ("cherry-picking") since the one-time and PBPM payments are not risk adjusted. However, current risk adjustment methodologies have not been developed specifically for SNF and NF patient populations. PTAC believes that developing risk adjusters specific to these patient populations should be part of the implementation process.

However, since the model creates incentives for the GCT to keep patients out of the hospital when it is avoidable, a potential challenge is ensuring that the model does not delay or prevent access to services provided at a hospital when such services are needed. PTAC members believe that monitoring by the facility and the PCP would help guard against such delays in or denial of access, since the GCT's activities are at the invitation of the facility and the PCP retains ultimate oversight of the patient's care. Nevertheless, the Committee believes that hospital access should be monitored by CMS during implementation of the model.

### 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.*

#### Rating: Meets Criterion

PTAC concludes that the proposed model meets this criterion. PTAC supports the fundamental concepts present in both payment designs included in the proposal, i.e., the one-time and PBPM payments with accountability for performance. The model directly ties payment to measures of clinical quality, health outcomes, and indicators of health care cost management; these measures are aligned with other reporting programs. Under both payment options, failure to meet performance standards could impact payments (beginning in Year 3 of implementation). Under the simpler payment option, the one-time and PBPM payments could be reduced. Under the two-sided risk option, any shared savings could be reduced. Through its HCIA Round 2 demonstration project, the submitter learned about the time and resources required to care for the SNF/NF patients with this care model; the one-time and PBPM amounts are based upon that learning. PTAC finds that the simpler payment design with less financial risk and complexity could enable greater participation, particularly from smaller practices. At the same time, the submitter indicates that the shared savings model would allow for greater flexibility in the way services could be delivered, 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).

The submitter indicated that the shared savings model is not the preferred model but was included to address CMS's perceived preference for such models. None of the PTAC members favored implementing the shared savings model alone, but some members supported implementing both options, some opposed using shared savings for this patient population, and others suggested that the CMS Innovation Center might implement a hybrid model.

In addition to determining whether to implement both of the proposed payment paths, PTAC identifies several other payment methodology issues. One of those issues is refinement of the proposed performance measurement. Under both payment options, performance would be determined using 11 measures of clinical quality, health outcomes, and indicators of health care cost management. However, performance on these measures would not impact payments in the first two years of implementation. In addition, the 11 measures include ED and readmission measures for SNF patients, but there are not measures for hospitalization of NF

patients. Furthermore, performance on measures would not negatively impact payments under either payment option unless the APM Entity fails to meet the standards on four or more measures (in the case of the shared savings option, there also needs to be savings or repayments). Therefore, an APM Entity could fail to meet the standards for ED visits and readmission measures for SNFs and still 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. This is in contrast to the simpler payment option, in which monthly payments in the subsequent year can be reduced due to poor performance. At the same time, the simpler payment option does not provide any increase in payments for good performance (e.g., if ED visits and hospitalizations are significantly reduced), limiting the flexibility to deliver additional services that could help avoid additional ED visits/admissions. Finally, the metrics are facility-based. Members had concerns about how they would roll up to level of the APM Entity and how meaningful benchmarks would be established.

PTAC finds that most of these issues could be resolved fairly easily. For example, PTAC believes that performance should impact payments by the second year, particularly for the simpler payment option. Furthermore, the Committee believes that accountability for quality and utilization measures should be separate so that APM Entities cannot focus on quality while neglecting utilization or vice versa. For measure denominators, members suggest using rates per 1,000 patients or something similar.

Another issue is that neither of the payment options proposes a way to risk adjust based on the specific types of patient characteristics that can affect hospitalization rates for SNF and NF residents. As a result, participants could be unfairly rewarded or penalized based on differences in the types of patients in the nursing facilities they support, rather than the effectiveness of the care delivered. PTAC believes that developing risk adjusters specific to these patient populations should be part of the implementation process.

In addition, under the shared savings model option, repayments are limited to the amount of the monthly payments, but shared savings can be as high as 10 percent of the total cost of care. If there is random year-to-year variation but no change in the average spending per patient, the shared savings payments could be much higher than the repayments, which would result in increased spending for Medicare.

Finally, the Committee finds that, for this and other proposals, the CMS Innovation Center will need to resolve areas of overlap with ACOs.

#### Criterion 4. Value over Volume

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

##### **Rating: Meets Criterion**

PTAC concludes that the proposed model meets this criterion. Real-time, 24/7 access to geriatric specialists in nursing facilities should promote the delivery of higher-quality health care. 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. Furthermore, unlike traditional Medicare, under the proposed model, payments are made per patient rather than per service. Therefore, the model does not incentivize service volume.

However, PTAC notes that the GCT is expected to risk stratify patients to help deliver the right amount of patient care and planning, yet the submitter indicates that there are currently no well-validated risk stratification models for the SNF and NF patient populations.

#### Criterion 5. Flexibility

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

##### **Rating: Meets Criterion**

PTAC concludes that the proposed model meets this criterion. 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. Furthermore, 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.

However, while the submitter indicated that it believes the shared savings model would allow for greater flexibility in the way services could be delivered, 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. More requirements provide less flexibility.

#### Criterion 6. Ability to be Evaluated

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

##### **Rating: Meets Criterion**

PTAC concludes that the proposed model meets this criterion. PTAC believes that the model has evaluable goals for 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.

However, the proposed metrics are facility-based, and members had concerns about how they would roll up to the level of the APM Entity and how meaningful benchmarks would be established. In addition, 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. PTAC believes that developing risk adjusters specific to these patient populations should be part of the implementation process.

### 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 PFP.*

#### Rating: Meets Criterion

PTAC concludes that the proposed model meets this criterion. Criteria for participation in the model 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 proposal indicates that the GCT would be expected to work in close collaboration with the PCP and facility staff (although delineation of roles was not prescribed), as the PCP would retain ultimate oversight and management of a beneficiary's care. The proposal also indicates that the GCT would be expected to have virtual access to health records at the facility.

PTAC notes that nothing in the proposal guarantees that integration and coordination will occur. Furthermore, while the PCP is ultimately responsible for the patient's care, 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. Additionally, 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. Nevertheless, PTAC believes that integration and care coordination are likely to occur.

## 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.*

### Rating: Meets Criterion

PTAC concludes that the proposed model meets this criterion. Currently, patients are often sent to the hospital without much choice. This model would provide patients with more options, since it 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. Furthermore, beneficiaries can opt out of GCT services.

However, the proposal does not articulate how the GCT would factor patient preferences and advance care plans into the advice given to facility staff. PTAC believes that documentation of patient goals of care should be required.

## Criterion 9. Patient Safety

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

### Rating: Meets Criterion

PTAC concludes that the proposed model meets this criterion. Because clinicians are not always on-site or immediately available, providing real-time 24/7 access to a GCT via telehealth is likely to improve patient safety, as is mentoring and training of SNF/NF staff.

However, since the model creates incentives for the GCT to keep patients out of the hospital when it is avoidable, a potential challenge is ensuring that the model does not delay or prevent access to services provided at a hospital when such services are needed. Members acknowledge that the facility and the PCP would help guard against such delays in or denial of access, since the GCT's activities are at the invitation of the facility and the PCP retains ultimate oversight of the patient's care. Nevertheless, the Committee believes that hospital access should be monitored.

## Criterion 10. Health Information Technology

*Encourage use of health information technology to inform care.*

### Rating: Meets Criterion

PTAC concludes that the proposed model meets this criterion. 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. Furthermore, 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.

## APPENDIX 1. COMMITTEE MEMBERS AND TERMS

**Jeffrey Bailet, MD, Chair**

**Elizabeth Mitchell, Vice-Chair**

Term Expires October 2018

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**Jeffrey Bailet, MD**  
*Blue Shield of California*  
San Francisco, CA

**Elizabeth Mitchell**  
*Blue Shield of California<sup>1</sup>*  
San Francisco, CA

**Robert Berenson, MD**  
*Urban Institute*  
Washington, DC

**Kavita Patel, MD, MSHS**  
*Brookings Institution*  
Washington, DC

Term Expires October 2019

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**Paul N. Casale, MD, MPH**  
*New York Quality Care*  
*New York-Presbyterian, Columbia University*  
*College of Physicians and Surgeons, Weill*  
*Cornell Medicine*  
New York, NY

**Bruce Steinwald, MBA**  
*Independent Consultant*  
Washington, DC

**Tim Ferris, MD, MPH**  
*Massachusetts General Physicians*  
*Organization*  
Boston, MA

Term Expires October 2020

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**Rhonda M. Medows, MD**  
*Providence Health & Services*  
Seattle, WA

**Len M. Nichols, PhD**  
*Center for Health Policy Research and Ethics*  
*George Mason University*  
Fairfax, VA

**Harold D. Miller**  
*Center for Healthcare Quality and Payment*  
*Reform*  
Pittsburgh, PA

**Grace Terrell, MD, MMM**  
*Envision Genomics*  
Huntsville, AL

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<sup>1</sup>Ms. Mitchell was President and CEO, Network for Regional Healthcare Improvement, when PTAC deliberated and voted on this proposal.

## APPENDIX 2. PFPM CRITERIA ESTABLISHED BY THE SECRETARY

### PFPM CRITERIA ESTABLISHED BY THE SECRETARY

- 1. Scope.** 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.
- 2. Quality and Cost.** 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.
- 3. Payment Methodology.** 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.
- 4. Value over Volume.** Provide incentives to practitioners to deliver high-quality health care.
- 5. Flexibility.** Provide the flexibility needed for practitioners to deliver high-quality health care.
- 6. Ability to be Evaluated.** Have evaluable goals for quality of care, cost, and any other goals of the PFPM.
- 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.
- 8. Patient Choice.** Encourage greater attention to the health of the population served while also supporting the unique needs and preferences of individual patients.
- 9. Patient Safety.** Aim to maintain or improve standards of patient safety.
- 10. Health Information Technology.** Encourage use of health information technology to inform care.

**APPENDIX 3. DISTRIBUTION OF MEMBER VOTES ON EXTENT TO WHICH PROPOSAL MEETS CRITERIA AND OVERALL RECOMMENDATION<sup>1</sup>**

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

Not Applicable	Do Not Recommend	Recommend for Limited-scale Testing	Recommend for Implementation	Recommend for Implementation as a High Priority	Recommendation
-	-	1	6	3	Recommend for Implementation

<sup>1</sup>PTAC member Rhonda M. Medows, MD, was not in attendance.

<sup>2</sup>Criteria designated as “high priority” are those PTAC believes are of greatest importance in the overall review of the payment model proposal.