

Physician-Focused Payment Model Technical Advisory Committee

Preliminary Review Team Report to the Physician-Focused Payment Model Technical Advisory Committee (PTAC)

Robert Berenson, MD (Lead Reviewer)

Tim Ferris, MD, MPH

Len M. Nichols, PhD

November 17, 2017

In accordance with the Physician-Focused Payment Model Technical Advisory Committee's (PTAC's) proposal review process, proposals for Physician-Focused Payment Models (PFPMs) that contain the information requested by PTAC's Proposal Submission Instructions will be assigned to a Preliminary Review Team (PRT). The PRT will draft a report containing findings regarding the proposal for discussion by the full PTAC. This PRT report is preparatory work for the full PTAC and is not binding on the PTAC. This report is provided by the PRT to the full Committee for the proposal identified below.

A. Proposal Information

1. **Proposal Name:** Annual Wellness Visit Billing at Rural Health Clinics
2. **Submitting Organization or Individual:** Mercy Accountable Care Organization
3. **Submitter's Abstract:** "Mercy Accountable Care Organization and our member rural health clinics have identified issues in rural health clinic reimbursement structure which make it difficult to make the significant progress in preventative care seen in other clinics. This proposal addresses two changes to Medicare Annual Wellness Visit reimbursement policies which we believe could significantly increase preventative care utilization by rural beneficiaries.

Challenges: Rural health clinics (RHCs) are not able to receive reimbursement for the Annual Wellness Visit (AWV) in conjunction with another service provided on the same day. The visit falls under the all-inclusive rate regardless of the number of services performed. This makes completing an AWV challenging. Clinics are left with the option to provide a service that will not be reimbursed or to ask patients to return on another day to complete the AWV.

The second challenge RHCs experience when implementing AWVs is the requirement that a patient be seen by an RHC practitioner, which includes physician, nurse practitioner, physician assistant, certified nurse midwife, clinical psychologist, or certified social worker. Rural health clinics are not allowed to have registered nurses (or

other licensed staff who are not practitioners) provide the AWW without a face-to-face practitioner visit, even under direct supervision of a physician. When properly supervised by a physician, and within state licensure, registered nurses are allowed to provide this care in other primary care settings.

Payment Model Solution: Mercy Accountable Care Organization’s payment model proposes a two pronged solution to improve preventative care through increased Annual Wellness Visit utilization in rural health clinics. First, we propose that RHCs be reimbursed the all-inclusive rate (AIR) for an AWW when performed in conjunction with a secondary medical visit. Thus, receiving two AIR payments for the services completed the same day. This is the case for Initial Preventive Physical Examinations in RHCs and for AWWs in provider-based clinics. Second, we propose that licensed professionals, under the direct supervision of a physician, be allowed to complete the AWW. This will make the important preventative services included in an AWW more feasible, without reducing the time physicians and mid-level providers have available to work with patients whose appointments require their skill and knowledge. Together these changes will facilitate an important culture shift toward making preventative services readily available in rural communities.”

B. Summary of the PRT Review

The *Annual Wellness Visit Billing at Rural Health Clinics* proposal (available on the PTAC [website](#)) was received by PTAC on August 14, 2017. The PRT conducted its work between October 20, 2017 and November 14, 2017. A summary of the PRT’s findings are provided in the table below.

PRT Rating of Proposal by Secretarial Criteria

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

C. PRT Process

The PRT reviewed the Mercy ACO Annual Wellness Visit proposal as well as additional, relevant information from other sources on key aspects of the proposed model.

The PRT's summary of the proposal and description of the additional, relevant information on key aspects of the proposed model reviewed by the PRT are described below and on the PTAC website.

1. Proposal Summary

Mercy ACO proposes changes to the Medicare Annual Wellness Visit (AWV) reimbursement policies for Rural Health Clinics (RHCs). Current Medicare policy considers the AWV as a routine service that is not separately payable under the RHC All-Inclusive Rate (AIR). In addition, in order to be reimbursed for the Annual Wellness Visit, a physician or non-physician practitioner must see the patient.

Under current law and regulation, RHCs are paid per date of service, regardless of the number of services provided or number of physician or non-physician practitioners seen, with a few exceptions as noted below. To calculate actual payments, the Medicare Administrative Contractor (MAC) with jurisdiction in the RHC's geography calculates and All-Inclusive Rate (AIR) by dividing total reported RHC costs by the total number of visits. This rate is paid unless it exceeds the upper payment limit, set by Medicare and updated annually to account for medical inflation. The upper payment limit AIR for 2017, for reference, is \$82.30.

In addition to the single payment rate of the AIR, an RHC may receive a second AIR payment for a select few enumerated services when they occur on the same date as an earlier qualifying RHC encounter:

- An Initial Physical and Preventive Exam (IPPE) performed on the same date as other qualified RHC services,
- A mental health visit the same date as a medical visit (or vice versa), and
- An emergency medical situation that is entirely unrelated to the earlier qualifying encounter on the same date.

RHCs receive separate payment for Transitional Care Management (TCM), Chronic Care Management (CCM), Advance Care Planning (ACP), and influenza and pneumonia vaccination services.

Mercy ACO proposes a national model to provide a second AIR payment to RHCs for the AWV. Mercy ACO also seeks an exception to allow mid-level providers to perform this service, which otherwise requires practitioner supervision. Mercy ACO is proposing that Medicare policy for RHCs regarding the AWV be changed to mirror physician office and

provider-based AWV reimbursement policies. Specifically, Mercy ACO proposes that 1) an Annual Wellness Visit can be reimbursed to RHCs on the same day as another Medicare reimbursable service; and 2) registered nurses are allowed to conduct the Annual Wellness Visits under provider supervision. Mercy ACO postulates that these changes will increase the number of patients receiving the AWV and will improve visit efficiency for providers and patients, reducing the number of unnecessary additional visits beneficiaries would need to make. The goal of the model is to make providing AWVs financially feasible for RHCs and their patients, thereby reducing eventual total cost of care. Participants include all Medicare beneficiaries receiving primary care services at RHCs, who are eligible for Medicare Annual Wellness Visits.

2. Additional Information Reviewed by the PRT

a) Environmental Scan and Literature Review

ASPE, through its contractor, conducted an environmental scan related to this proposal. Documents comprising the environmental scan were primarily identified using Google and PubMed search engines. Key words guiding the environmental scan and literature review were directly identified from the Letter of Intent (LOI). The key word and combination of key words were utilized to identify documents and material regarding the submitting organization, the proposed model in the LOI, features of the proposed model in the LOI or subject matter identified in the LOI. Key terms used included: Mercy ACO; Medicare Shared Savings Program (MSSP); Medicare; Annual Wellness Visit (AWV); Clinical Pharmacist Practitioner (CPP); Medicare Preventive Services; Affordable Care Act (ACA); Medicare beneficiaries; Personalized Prevention Plan Services (PPPS); Access to Care; Rural; Rural health, CMS, rural health clinic, preventive services, Affordable Care Act (ACA), patient, physicians, and payment.

b) Data Analyses

The PRT did not seek any data analyses.

c) Additional Information reviewed

The PRT sought additional information regarding Medicare fee-for-service payments to Rural Health Clinics under the All-Inclusive Rate (AIR) payment system. ASPE staff drafted a background paper for discussion describing the history of RHCs, the calculation of the All Inclusive Rate, and the origins of the few enumerated services that remain separately paid to RHCs outside the AIR.

d) Public Comments

The PRT did not receive any public comment letters on the proposal.

D. Evaluation of Proposal Against Criteria

Criterion 1. Scope of Proposed PFPM (High Priority Criterion). Aim to either directly address an issue in payment policy that broadens and expands the CMS APM portfolio or include APM Entities whose opportunities to participate in APMs have been limited.

PRT Qualitative Rating: Not applicable

Not applicable; see commentary under Criterion 3.

Criterion 2. Quality and Cost (High Priority Criterion). Are anticipated to improve health care quality at no additional cost, maintain health care quality while decreasing cost, or both improve health care quality and decrease cost.

PRT Qualitative Rating: Not applicable

Not applicable; see commentary under Criterion 3.

Criterion 3. Payment Methodology (High Priority Criterion). Pay APM Entities with a payment methodology designed to achieve the goals of the PFPM criteria. Addresses in detail through this methodology how Medicare and other payers, if applicable, pay APM Entities, how the payment methodology differs from current payment methodologies, and why the Physician-Focused Payment Model cannot be tested under current payment methodologies.

PRT Qualitative Rating: Not applicable

The PRT considers this proposal a recommendation for changing existing payment policy for RHCs, rather than an Alternative Payment Model (APM). The PRT finds that the proposal merely seeks modifications in existing rules that govern the current payment model for rural health clinics and as such does not represent a physician payment model that PTAC should deliberate over. Two of the PRT members point out that the proposed rule modifications do not include accountability for either quality or spending associated with the rule changes, and as such the proposal does not meet what they consider hallmark expectations for PFPMs.

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

PRT Qualitative Rating: Not applicable

Not applicable; see commentary under Criterion 3.

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

PRT Qualitative Rating: Not applicable

Not applicable; see commentary under Criterion 3.

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

PRT Qualitative Rating: Not applicable

Not applicable; see commentary under Criterion 3.

Criterion 7. Integration and Care Coordination. Encourage greater integration and care coordination among practitioners and across settings where multiple practitioners or settings are relevant to delivering care to the population treated under the PFPM.

PRT Qualitative Rating: Not applicable

Not applicable; see commentary under Criterion 3.

Criterion 8. Patient Choice. Encourage greater attention to the health of the population served while also supporting the unique needs and preferences of individual patients.

PRT Qualitative Rating: Not applicable

Not applicable; see commentary under Criterion 3.

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

PRT Qualitative Rating: Not applicable

Not applicable; see commentary under Criterion 3.

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

PRT Qualitative Rating: Not applicable

Not applicable; see commentary under Criterion 3.

E. PRT Comments

The PRT unanimously and unequivocally did not consider the proposal to represent an alternative, physician payment model that PTAC should be reviewing, but rather rules

changes within a well-established payment methodology. The Secretary may wish to consider the merits of the proposal as part of CMS's ongoing supervision of rural health clinics.

The PRT had a lengthy discussion before arriving at its recommendation, concluding that it lacked the expertise or standing to consider modifications to an existing payment methodology, such that any recommendations it would make regarding this proposal could have unintended consequences. At the same time, so that the public and future submitters more clearly understand the scope of PTAC's work, the PRT suggests that the PTAC develop criteria that distinguish proposals that meet tests of meriting review as alternative physician payment models and those that seek modifications in established payment methodologies, such as the all-inclusive rate approach for rural health clinics.

END OF DOCUMENT