Physician-Focused Payment Model Technical Advisory Committee

October 20, 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), the *Comprehensive Care Physician Payment Model (CCP-PM)*, submitted by the University of Chicago Medicine. 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 the University of Chicago Medicine's proposed model (submitted to PTAC on March 1, 2018), additional information on the model provided by the submitter in response to questions from a PTAC Preliminary Review Team, and other information. At a public meeting of PTAC held on September 7, 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 *CCP-PM* proposal to the Secretary for limited-scale testing. PTAC believes that more frail Americans with complex illness and their providers should have access to the comprehensive inpatient and ambulatory care enabled by this clinical care model. The Committee finds that the proposal meets nine of the ten Secretary's criteria; the Committee

found that the proposal did not meet the payment methodology criterion. While the department has signaled concerns regarding limited-scale testing, PTAC believes that further testing and development of this model could be done in conjunction with other models of interest to HHS. Adam Boehler, the Director of the Innovation Center at the Centers for Medicare & Medicaid Services (CMS) and Senior Advisor on Value-Based Transformation and Innovation, indicated in remarks on September 6 that the administration is working on three types of models addressed in prior PTAC reviews: chronic kidney disease, primary care redesign, and serious illness. PTAC sees substantial overlap between the *CCP-PM* care model and the models in these three areas.

Our report highlights the inherent strengths in the care model component of the *CCP-PM* and the benefits that would accrue to Medicare beneficiaries if more seriously ill hospitalized patients received this type of coordinated care. Our report also assesses some potential weaknesses of the payment methodology. Because of the clear benefit of the care model, PTAC places high importance on testing the care model in a broader range of settings (e.g., academic medical centers, community hospitals, and accountable care organizations, or ACOs). However, PTAC members had concerns about the proposed payment model, which was not tested as part of the Health Care Innovation Award from which this proposal was generated. Further testing would determine the best approach to payment.

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. If you need additional information, please have your staff contact me at Jeff.Bailet@blueshieldca.com.

Sincerely,

Jeffrey Bailet, MD
Chair

Attachments

Physician-Focused Payment Model Technical Advisory Committee

REPORT TO THE SECRETARY OF HEALTH AND HUMAN SERVICES

Comments and Recommendation on

Comprehensive Care Physician Payment Model (CCP-PM)

October 20, 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, the *Comprehensive Care Physician Payment Model (CCP-PM)*, submitted by the University of Chicago Medicine. 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 the University of Chicago Medicine, and additional information on the proposal submitted by the University of Chicago Medicine subsequent to the initial proposal submission.

SUMMARY STATEMENT

PTAC recommends the *CCP-PM* proposal to the Secretary for limited-scale testing. PTAC believes that more frail Americans with complex illness and their providers should have access to the comprehensive inpatient and ambulatory care enabled by this clinical care model. The Committee finds that the proposal meets nine of the 10 Secretary's criteria; the Committee found that the proposal did not meet the payment methodology criterion.

While the department has signaled concerns regarding limited-scale testing, PTAC believes that further testing and development of this model could be done in conjunction with other models of interest to HHS. Adam Boehler, the Director of the Innovation Center at CMS and Senior Advisor on Value-Based Transformation and Innovation, indicated in remarks on September 6 that the administration is working on three types of models addressed in prior PTAC reviews: chronic kidney disease, primary care redesign, and serious illness. PTAC sees substantial overlap between the *CCP-PM* care model and the models in these three areas.

Our report highlights the inherent strengths in the care model component of the *CCP-PM* and the benefits that would accrue to Medicare beneficiaries if more seriously ill hospitalized patients received this type of coordinated care. Our report also assesses some potential weaknesses of the payment methodology. Because of the clear benefit of the care model, PTAC places high importance on testing the care model in a broader range of settings (e.g., academic medical centers, community-based hospitals settings, and ACOs). However, PTAC members had concerns about the proposed payment model, which was not tested as part of the Health Care Innovation Award (HCIA) from which this proposal was generated. Further testing would determine the best approach to payment.

PTAC REVIEW OF THE PROPOSAL

The University of Chicago Medicine's proposal was submitted to PTAC on March 1, 2018. The proposal was first reviewed by a PTAC Preliminary Review Team (PRT) composed of three PTAC members (Kavita Patel, Paul Casale, and Tim Ferris), all of whom are physicians. These members requested additional data and information to assist in their review. The proposal was also posted for public comment. In addition, the Bipartisan Budget Act of 2018 allows for initial feedback to submitters of proposed models on the extent to which their proposal meets the Secretary's criteria and the basis for that feedback. The PRT sent an initial feedback document to the submitter on July 30, 2018. The PRT's findings for the full Committee were documented in the *Preliminary Review Team Report to the Physician-Focused Payment Model Technical Advisory Committee (PTAC) on the "Comprehensive Care Physician Payment Model"* dated August 14, 2018. At a public meeting held on September 7, 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.[1] 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.

PROPOSAL SUMMARY

The proposal is based on a Health Care Innovation Award (HCIA) Round One demonstration project. The overall goal of the *CCP-PM* is to improve care, especially transitions between inpatient and outpatient settings, by enabling the same physician to oversee care for the patient in both settings. The submitter expects that most physicians participating in the *CCP-PM* will be general internal medicine physicians, hospitalists, or family practitioners. The submitter also indicates that some medical subspecialists and physicians from other specialties that provide primary care (e.g., gynecology) might be appropriate candidates in some instances. All estimates in the proposal are based on the *CCP* experience at the University of Chicago. The submitter proposes that *CCP-PM* panels should be capped at 300 patients per physician and estimates that on average each panel would have 200 patients in a national program. They expect a maximum of 10 participating physicians per institution or participating practice.

Under the proposed model, care continuity fees will be paid to the physician or physician's group, with the amount depending on whether a patient was hospitalized for any cause at least once in the past 12 months. In addition to Medicare fee-for-service (FFS) payments, participating physicians will receive an additional payment of $40 per new and renewed enrolled patient per month and $10 per continued enrolled patient per month, payable at the end of each year if they meet both of the following two criteria:

1. The percent provision of inpatient care for their panel of enrolled patients exceeds 50%; and
2. The provision of outpatient general medical care for their panel of enrolled patients exceeds 67%.

Therefore, payment of the *CCP-PM* care continuity fee is contingent on the participating physicians providing a high percentage of their patients' inpatient and outpatient internal medicine care. For clinicians participating in FFS-based contracts, the care continuity fee would be in addition to current Medicare fees. Participation in the *CCP-PM* would not directly alter any payments related to other Merit-based Incentive Payment System (MIPS), Medicare Shared Savings Program (MSSP), or alternative payment models (APMs) in which the clinician participates but would simply serve as an add-on payment to these models. Any payments would be included in the total cost of care for those participating in these other payment models. Some specific details with respect to initiating *CCP-PM* within these models would

[1]PTAC member Elizabeth Mitchell was not in attendance.

need to be finalized. For example, page 12 of the proposal notes that "physicians would be paid/penalized annually in alignment with their home institution's ACO or APM yearly payment cycle." Text on page nine indicates that for providers in other APMs, "the care continuity fees themselves not be at risk so that providers would not be penalized twice should they fail to meet these [APM outcome] measures after making the effort to reorganize their practice to follow a *CCP* model."

Participating physicians will be subject to a penalty of $10 per patient per month at the end of the year if they meet either of two penalty criteria:

- Penalty Criterion 1: The percent provision of inpatient care for their panel of enrolled patients falls below 25%; or
- Penalty Criterion 2: The percent provision of outpatient general medical care for their panel of enrolled patients falls below 33%.

The submitter considered but did not propose specific outcome metrics other than the two penalty criteria that would put the *CCP-PM* care continuity fees at risk. The submitter has three reasons for not doing so: the focus on high-risk patients means that standard quality metrics would need to be risk-adjusted; quality metrics are already incentivized within APMs in which the *CCP-PM* might be layered; and the *CCP-PM* is designed to function across various payment models, which might use varying quality metrics.

The submitter expects that *CCP* physicians would spend all or the majority of each weekday morning caring for their own patients in the hospital and spend weekday afternoons in clinic. The submitter does not expect the workflow of a participating clinician to vary dramatically with regard to overall business arrangements (private practice, employed, affiliated), but they do expect variation in the structure for off-hours coverage. For example, in some settings, *CCP* physicians might rotate with other *CCP* physicians serving as the "hospitalist," e.g., covering the inpatient service in the weekday afternoons when their colleagues are in clinic and covering for their colleagues when they are off on the weekend. The model envisions that participating physicians would interact with specialists using similar structures to current practice but that the integration available with the *CCP* would reduce duplicative consultation and testing.

The submitter calculated program costs as follows: assuming that a patient is enrolled in the *CCP-PM* for a full year and that the patient qualified for the maximum care continuity fee of $40 per month (versus $10 per month for patients who have not been hospitalized in the past year), total *CCP-PM* payments would be $480 per patient. The submitter estimates that with a typical panel size of 200 patients and under the mix of care continuity fees (assuming half of participating are hospitalized in a year), the average care continuity fee would be $25 per month ($300/year). Therefore, the submitter expects the likely payout per participating physician would be $60,000 for physicians with a panel of 200 *CCP-PM* patients, which would only be a proportion of their total patient panel.

RECOMMENDATION AND COMMENTS TO THE SECRETARY

PTAC recommends the *CCP-PM* proposal to the Secretary for limited-scale testing. PTAC feels that more frail Americans with complex illness and their providers should have access to the comprehensive inpatient and ambulatory care enabled by this clinical care model. The proposal is about incentivizing a different style of medicine, and PTAC members agreed that this style of practice needs to be encouraged. The PTAC agreed that the clinical needs of the particular population of patients served in this proposal are not well addressed under current payment models. It is likely that for a small fraction of highly complex and frail patients, it would be better to have one physician or one group of physicians managing both inpatient and outpatient care. This is precisely the group of patients for whom this model is designed to improve care, with a focus on continuity of care. The *CCP-PM* represents the culmination of a great deal of work to improve patient care by a set of dedicated clinicians. Participating clinicians and patients have been supportive. The clinical workflows that were developed, particularly those that allow inpatient hospitalists to follow patients into the outpatient clinic setting and vice versa, are highly customized.

PTAC believes it is important to test the care model in a broader range of settings (e.g., community-based settings or ACOs) than has been done to date. The *CCP* as implemented at the University of Chicago Medicine was centered on hospitalists, but this model emphasizes the crucial role that primary care physicians can and should play in the movement toward value-based case. The attention to care transitions and care coordination embodied in the model should improve quality of care. The proposed model would be strengthened by involvement of more specific quality metrics. The submitter noted that the lack of specific quality metrics in the proposal was purposeful to enable simplicity of the model but agreed that quality metrics could be added usefully.

The *CCP* care model has already been tested with a randomized design in an academic setting under a Health Care Innovation Award. The HCIA Evaluation Final Report found that the *CCP* was successful in better meeting the needs of the high-risk population with serious illness from the perspective of both patients and physicians. The HCIA Evaluation Final Report noted that patient accrual into the model was slow, and the analysis did not find statistically significant reductions in costs or hospitalizations. However, similar models such as CareMore have been able to improve quality and reduce costs. The proposal estimated reductions in costs of $3,000 per patient per year based on unpublished analyses using patient reports of hospitalizations. The submitter is extending the analysis of *CCP* impacts on costs and hospitalizations to address differential selection by some dual-eligibles into managed care that compromised data completeness for the HCIA Evaluation Final Report. Attention to these results, once published,

could be insightful.

In contrast to the Committee's support for the care model, PTAC members had concerns about the proposed payment model. The payment model consists of a monthly fee paid to participating physicians who meet two criteria regarding care for their panel of patients; a monthly penalty is imposed if physicians are insufficiently involved in caring for the patient panel on average. The payment model was not tested as part of the HCIA evaluation. Some PTAC members thought that testing a per member per month payment to incentivize care coordination for frail patients would provide important information on how to improve care for this population, especially if payment could be tied to outcomes such as quality or cost rather than care processes. Other members questioned whether a monthly payment model as an add-on to FFS payment was needed to incentivize comprehensive physician care. These members felt that modifications to billing codes including possibly higher payment amounts for existing codes could incentivize physicians to provide comprehensive care to high-risk patients in both inpatient and outpatient settings.

In recommending the *CCP-PM* for limited-scale testing, PTAC acknowledges the HHS preference not to engage in limited-scale testing of models. However, further testing and development of this model could be done in conjunction with other models of interest to HHS. Adam Boehler, the Director of the Innovation Center at CMS and Senior Advisor on Value-Based Transformation and Innovation, indicated in remarks on September 6 that the administration is working on three types of models addressed in prior PTAC reviews: chronic kidney disease, primary care redesign, and serious illness. PTAC sees substantial overlap between the *CCP-PM* care model and the models in these three areas.

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)[1]	Meets Criterion
2. Quality and Cost (High Priority)	Meets Criterion
3. Payment Methodology (High Priority)	Does Not Meet Criterion
4. Value over Volume	Meets Criterion
5. Flexibility	Meets Criterion
6. Ability to Be Evaluated	Meets Criterion

[1]Criteria designated as "high priority" are those PTAC believes are of greatest importance in the overall review of the payment model proposal.

7. Integration and Care Coordination	Meets Criterion
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

PTAC concludes that the proposed model meets this criterion. The PTAC feels that the clinical needs of the particular population of patients served in this proposal are not well-addressed under current payment models. It is likely that for a small fraction of highly complex and frail patients, it would be better to have one physician or one group of physicians managing both inpatient and outpatient care. This is precisely the group of patients for whom this model is designed to improve care, with a focus on continuity of care. The *CCP-PM* represents the culmination of a great deal of work to improve patient care by a set of dedicated clinicians. Participating clinicians and patients have been supportive. The clinical workflows that were developed, particularly those that allowed for inpatient hospitalists to follow patients into the outpatient clinic setting and vice versa, are highly customized.

PTAC members endorsed the care model component of the *CCP*, though the lack of unanimity on this criterion reflects the extent to which members felt that a new APM is needed to bring about the care model. PTAC members shared experiences and perspectives regarding the value of the model and processes that could enable such a model.

- One member noted that while most primary care physicians rely on hospitalists to cover inpatient services, some primary care physicians never stop rounding for their patients who need high levels of continuity between inpatient and outpatient services. At some institutions, the most complex and frail patients may be assigned to those physicians to provide continuity in three domains: information, management, and relationship. However, the primary care costs for this approach are typically not covered by the standard FFS billing, so that other payment arrangements may be needed to support the care model in a broader set of environments.
- Another member noted that various organizations, ranging from Medicare managed care plans to ACOs, have developed “extensivist” models. These extensivist models, of which CareMore was provided as an example, vary in terms of financial arrangements; these models all focus on comprehensive care, especially for patients at high risk of

hospitalization, and show savings in terms of total cost of care. However, it is very difficult for physicians to provide comprehensive care if they are not part of a system that will subsidize a loss on primary care services.

In total, PTAC felt that the scope of the *CCP* is very consistent with the broad goals of PFPMs even though the financing has not yet been solved. It was noted that a new specialty called "comprehensivists" may be evolving from hospitalists, and it remains to be seen whether the financing can be handled with a series of fees and billing codes or if an alternative payment model is needed.

Data are currently lacking on the range of payment options available or potential effects for these models as well as the extent to which providers would naturally develop similar approaches on their own (including working out the finances or the fact that some settings such as rural areas might be more conducive to such a model). The scope of the model could be limited by the circumstances that led to the development of the hospitalist system. Some hospitalists may prefer not to participate in such models. While the value of improving care transitions from the hospital to community settings has been demonstrated in published literature, data are also not available to understand the challenges and outcomes of subsequent transitions that might occur for some patients (e.g., those whose risk decreases over time).

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. The attention to care transitions and care coordination embodied in the model should improve quality of care. The proposed model would be strengthened by inclusion of more specific quality metrics. The submitter noted that the lack of more specific quality metrics in the proposal was purposeful to enable simplicity of the model but agreed that quality metrics could be added. While the *CCP-PM* is intended to improve quality and reduce cost, the savings indicated in the proposal are not supported by the published HCIA Evaluation Final Report.

As documented in the HCIA Evaluation Final Report, the trial initially experienced a slow rate of patient empanelment into the *CCP*. While all trials may find that some eligible patients are reluctant to participate in a study, the slow accrual into the *CCP* may also reflect a reluctance on the part of some patients to shift the group of physicians overseeing their care. Both the HCIA evaluation and analyses by the submitter found high satisfaction with the *CCP* among patients

and providers. The HCIA evaluation did not find any differences in hospital use or Medicare payment measures and noted a possible increase in ED visits ($p<0.10$).

The submitter is conducting additional analyses using a longer time frame and additional data that were not part of the HCIA evaluation. In unpublished results provided to PTAC, the submitter maintains that analyses using patient-reported measures of hospitalization (rather than claims) show reductions in total costs from the *CCP*. The submitter also notes that the State of Illinois Medicare-Medicaid Alignment Initiative (MMAI), which began in January 2014, auto-enrolled dual-eligible beneficiaries in managed care unless they opted out. Therefore, a large fraction of dual-eligible patients enrolled in the *CCP* study (whose enrollment began in November 2012) left traditional Medicare coverage. The submitter provided data showing that relatively low utilizers in the standard care arm of the trial were more likely to leave traditional Medicare; the submitter indicated that this differential shift to managed care means that FFS claims were not available for these beneficiaries so that comparisons of Medicare costs using FFS claims data are biased. In total, the model meets the criterion of being evaluable, and the submitter is continuing further analyses to determine whether adjustments for the selection into managed care support a reduction in total costs from the *CCP*.

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: Does Not Meet Criterion

PTAC concludes that the proposed model does not meet this criterion. Although the proposal lays out a payment mechanism, with specific criteria for fee payment as well as financial penalties, the level of uncertainty regarding the changes that might result from the proposed payment model was considered too high for recommendation for implementation. The PTAC expressed almost uniform concern about why the payment model was structured as proposed and whether a per beneficiary per month (PBPM) payment model added to FFS payment for other services would be able to reproducibly result in the desired care approach and outcomes. The mechanisms may also result in unintended consequences, such as hospitalizing a patient in order to maintain a higher PBPM payment in addition to the FFS payments. Several PTAC members indicated that the comprehensive care that is so desirable might be achieved within the current FFS system by using existing or new payment codes.

The proposal focuses on creating a viable payment model that provides sufficient assurance that high-quality clinical care will be obtained simply by implementing the suggested payment

model. PTAC members expressed concern that the proposed financial model might not necessarily lead to the exemplary clinical model developed by the submitters, and the payment methodology lacked sufficient methods for assuring improved patient outcomes. In addition, the PTAC found it difficult to determine whether the financial model would be applicable for a range of settings (e.g., teaching hospitals versus community practices). It was not clear that the workflows and career paths included in the clinical model would necessarily be adopted in response to the payment model.

The proposal review identified some additional concerns. The proposed payment model lacks financial risk for provider participants, which results in a weak linkage between payment methodology and intended outcomes (reduced total expenditures and improved health outcomes for the patient). The financial risk in the model may be insufficient to generate savings unless there is some downside risk aside from meeting the penalty criteria. Only a $10 penalty per patient per month (e.g., $24,000 total per year for a panel of 200 patients) is at risk in a stand-alone model. Providers who lose money may simply leave the program.

The *CCP* may have an experience similar to other models being tried in the sense that the model may improve quality but does not have sufficient mechanisms to result in measurable reductions in spending. The existing literature does not provide strong evidence that improving continuity of care reduces spending or results in savings sufficient to cover the fees or cost of the program.

The payment mechanism, which is articulated as either a stand-alone payment (e.g., to a practice) or as a supplement in existing models such as ACOs, could work particularly well in ACOs. The payment mechanism would facilitate implementation of the *CCP-PM* beyond academic medical centers as a supplemental payment in community hospital-based ACOs. To the extent that the model is embedded in an organization such as an ACO, however, the additional payments might be unnecessary and increase costs if the providers are adhering to the incentives inherent in the ACO payment structure.

PTAC noted that demonstrations are routinely done on alternative payment models but not on improvements to the fee schedule that could increase value. Using modifications to the fee schedule to elicit improved care could be important given the challenges in finding APMs with risk adjustment that improve care and reduce total cost.

PTAC broadly agreed that the current FFS system does not enable or elicit the valuable care that could be provided under a *CCP* model. Some PTAC members thought a PBPM approach with shared risk could be explored further, though several cautioned that such an approach might not work well. Other PTAC members indicated support for efforts to encourage adoption of the *CCP* care model using other financial mechanisms ranging from modifications of the fee schedule to incorporation within other APMs such as 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. The *CCP-PM* shows substantial promise for achieving value over volume, particularly for the important problem of poor transitions in care and a lack of continuity as patients transition through clinical settings. Discussion on this issue emphasized the contribution of an "extensivist" or "comprehensivist" approach to caring for patients with multiple chronic conditions who are at high risk of hospitalization and preventable health decline that will result in high cost care unless addressed preventively.

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. The *CCP-PM* offers options for numerous types of practitioners, from primary care to specialty care. Additionally, by making it financially feasible for practitioners to provide care in both inpatient and outpatient settings, there is significant potential for high-value care, particularly patient-centered care. While PTAC found the care model to be extremely flexible, PTAC expressed a concern that the payment thresholds lack flexibility. Whether it would be better to condition payment on other outcomes (e.g., readmission rates) rather than the specified thresholds in the proposal might be considered in further tests of the model.

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. The implementation of the *CCP* as a randomized trial under a Health Care Innovation Award constitutes a high standard for evaluation. (The HCIA trial only tested the *CCP* care model; the *CCP-PM* payment model was not used during the demonstration.) Qualitative and quantitative measures including patient and provider satisfaction, rates of rehospitalization, and costs to Medicare all represent relevant evaluable goals.

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.

Rating: Meets Criterion

PTAC concludes that the proposed model meets this criterion. However, PTAC made a distinction between care coordination during the immediate period surrounding a transition between settings versus care coordination over a longer period of follow-up. Having the same physician follow the patient between inpatient and outpatient settings inherently improves integration and care coordination during the immediate period following hospital discharge. In particular, the submitter noted that *CCP-PM* focuses on tertiary prevention of keeping people out of the hospital and emphasizes coordination with specialists as needed. The model does not entail mechanisms to ensure that broader types of preventive care are appropriate and complete over the long run. Patients may find that the person who is best positioned to coordinate care immediately following hospital discharge is not the best person to coordinate specialty care unrelated to the hospitalization risk or provide preventive services over a longer follow-up period. Extending the model to additional settings and following care coordination metrics in patients over time could help ensure that integration and care coordination is maintained or improved by the model.

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. PTAC felt that the *CCP-PM* is oriented toward patient choice and that patient choice is not inherently blocked by any component of the model. The model embodies a discussion with patients who meet the eligibility criteria regarding their choice of whether to participate in the *CCP-PM*. Implementation of the *CCP-PM* should have clear provisions to ensure patient choice to decline participation if the patient prefers to stay with existing providers.

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. A model that consolidates a patient's care under a single physician or group of physicians during a period of transition

following hospital discharge is inherently likely to ensure or improve patient safety. Patient safety is particularly likely to be improved for hospitalized beneficiaries who do not already have strong relationships with a primary care provider, as follow-up care after discharge is likely to be improved. The PTAC noted that the goal of ensuring patient safety is one consideration behind the recommendation for limited-scale testing. Since the model was developed in a large academic medical center, it is important to know that patient safety is appropriately protected or improved when the model is implemented in a wider range of settings. Monitoring of specific quality measures could help ensure patient safety.

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. As with all health system innovation and APMs, health information technology can play an important role for programs like *CCP*. The *CCP-PM* will work most efficiently and will be most likely to be used in health systems or provider groups with efficient HIT.

APPENDIX 1. COMMITTEE MEMBERS AND TERMS

Jeffrey Bailet, MD, *Chair*

Term Expires October 2018

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

Robert Berenson, MD
Urban Institute
Washington, DC

Elizabeth Mitchell
Blue Shield of California
San Francisco, CA

Kavita Patel, MD, MSHS
Brookings Institution
Washington, DC

Term Expires October 2019

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

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

Bruce Steinwald, MBA
Independent Consultant
Washington, DC

Term Expires October 2020

Rhonda M. Medows, MD
Providence St. Joseph Health
Seattle, WA

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

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

Grace Terrell, MD, MMM
Envision Genomics
Huntsville, AL

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[1]

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)[2]	-	1	2	2	4	-	1	Meets Criterion
2. Quality and Cost (High Priority)	-	1	2	5	-	2	-	Meets Criterion
3. Payment Methodology (High Priority)	-	2	5	2	-	1	-	Does Not Meet Criterion
4. Value over Volume	-	-	-	6	3	1	-	Meets Criterion
5. Flexibility	-	-	1	4	3	1	1	Meets Criterion
6. Ability to be Evaluated	-	-	2	4	1	3	-	Meets Criterion
7. Integration and Care Coordination	-	1	1	5	-	3	-	Meets Criterion
8. Patient Choice	-	-	-	3	5	2	-	Meets Criterion
9. Patient Safety	-	-	1	7	1	-	1	Meets Criterion
10. Health Information Technology	-	-	-	9	1	-	-	Meets Criterion

Do Not Recommend	Recommend for Attention	Recommend for Limited-scale Testing	Recommend for Implementation	Recommend for Implementation as a High Priority	Recommendation
0	3	6	1	-	Recommend for Limited-scale Testing

[1]PTAC member Elizabeth Mitchell was not in attendance.

[2]Criteria designated as "high priority" are those PTAC believes are of greatest importance in the overall review of the payment model proposal.