

# Physician-Focused Payment Model Technical Advisory Committee

## Committee Members

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Jennifer Wiler, MD, MBA

November 19, 2020

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 "Medical Neighborhood" Advanced Alternative Payment Model (AAPM) (Revised Version*, subsequently called *MNM*), submitted by the American College of Physicians (ACP) and the National Committee for Quality Assurance (NCQA). 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 *MNM* proposal (submitted to PTAC and found to have met the Committee's administrative requirements on February 11, 2020); additional information on the model, which was provided by the submitters in response to questions from a PTAC Preliminary Review Team; and other information. PTAC also reviewed supplemental information on the model provided by the submitters and considered issues in payment and care delivery, as well as relevant research findings. At a public meeting of PTAC held on September 15, 2020, 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 *MNM* proposal to the Secretary for testing to inform payment model development as specified in PTAC's comments (which are reflected in this report). The Committee finds that the proposal meets all 10 of the Secretary's criteria.

The submitters propose a five-year pilot connecting primary care practices in the Comprehensive Primary Care Plus (CPC+) and Primary Care First (PCF) models to three specialties (cardiology, infectious disease, and neurology) with sufficient existing electronic clinical quality measures (eCQMs). Overall, PTAC concludes that the model addresses the important challenge of compensating specialists for engaging in care coordination with primary care providers. PTAC believes the proposed model has the potential to lower costs by reducing unnecessary testing and referrals and by improving care management and coordination. PTAC commends the model's intent to address the dearth of available alternative payment models (APMs) for specialists. The Committee also believes that the model has the potential, after further development and testing, to be extended to additional specialties. PTAC notes a number of areas where the proposal can be refined further during the model pilot. Implementation issues to be addressed in practice during the pilot phase include:

- Refining and further developing aspects of the payment methodology, including the care coordination fee and patient attribution process;
- Addressing harmonization of models, including possible overlap of payments from other models being tested by the Center for Medicare & Medicaid Innovation (CMMI);
- Establishing a comprehensive set of required quality measures for various conditions or specialists, including development of risk adjustment and benchmarking methodologies; and
- Providing adequate implementation support for specialty practices, including obtaining NCQA Patient-Centered Specialty Practices (PCSP) recognition or development of a non-proprietary alternative approach.

While these and other issues require further development, the Committee believes that the proposal of a model that builds on existing models currently being tested by CMMI provides a new and potentially productive avenue for APM proposals submitted to PTAC.

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.

Sincerely,

//Jeffrey Bailet//

Jeffrey Bailet, MD

Chair

Attachments

# REPORT TO THE SECRETARY OF HEALTH AND HUMAN SERVICES

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Comments and Recommendation on  
*The “Medical Neighborhood” Advanced Alternative Payment Model  
(AAPM) (Revised Version)*

November 19, 2020

## 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 the PFPM proposal *The "Medical Neighborhood" Advanced Alternative Payment Model (AAPM) (Revised Version)*. 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 American College of Physicians (ACP) and the National Committee for Quality Assurance (NCQA), and additional information on the proposal submitted subsequent to the initial proposal submission.

## SUMMARY STATEMENT

PTAC recommends *The “Medical Neighborhood” Advanced Alternative Payment Model (AAPM) (Revised Version, subsequently called MNM)* proposal to the Secretary for testing to inform payment model development as specified in PTAC’s comments (which are reflected in this report). The Committee finds that the proposal meets all 10 of the Secretary’s criteria.

The submitters propose a five-year pilot connecting primary care practices in the Comprehensive Primary Care Plus (CPC+) and Primary Care First (PCF) models to three specialties (cardiology, infectious disease, and neurology) with sufficient existing electronic clinical quality measures (eCQMs). Overall, PTAC concludes that the model addresses the important challenge of compensating specialists for engaging in care coordination with primary care providers. PTAC believes the proposed model has the potential to lower costs by reducing unnecessary testing and referrals and by improving care management and coordination. PTAC commends the model’s intent to address the dearth of available alternative payment models (APMs) for specialists. The Committee also believes that the model has the potential, after further development and testing, to be extended to additional specialties. PTAC notes a number of areas where the proposal can be refined further during the model pilot. Implementation issues to be addressed in practice during the pilot phase include:

- Refining and further developing aspects of the payment methodology, including the care coordination fee (CCF) and patient attribution process;
- Addressing harmonization of models, including possible overlap of payments from other models being tested by the Center for Medicare & Medicaid Innovation (CMMI);
- Establishing a comprehensive set of required quality measures for various conditions or specialists, including development of risk adjustment and benchmarking methodologies; and
- Providing adequate implementation support for specialty practices, including obtaining NCQA Patient-Centered Specialty Practices (PCSP) recognition or development of a non-proprietary alternative approach.

While these and other issues require further development, the Committee believes that the proposal of a model that builds on existing models currently being tested by CMMI provides a new and potentially productive avenue for APM proposals submitted to PTAC.

## **PTAC REVIEW OF THE PROPOSAL**

The *MNM* proposal was submitted to PTAC and found to have met the Committee's administrative requirements on February 11, 2020. This proposal is a revised version of an earlier proposal with the same title from the same submitters, which was submitted to PTAC and found to have met the Committee's administrative requirements on November 20, 2018. In February, 2020, the proposal was first reviewed by a Preliminary Review Team (PRT) composed of three PTAC members (Kavita Patel, MD, MSHS; Jeffrey Bailet, MD; and Angelo Sinopoli, MD). The PRT conducted its review of the revised version of the proposal between March 20, 2020, and July 24, 2020. The proposal was also posted for public comment. The PRT's findings were documented in the PRT Report to PTAC on the *MNM* proposal dated July 24, 2020. At a public meeting held on September 15, 2020, 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. Remaining sections of this report provide 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 submitters propose a five-year, multi-payer pilot that aims to improve care for Medicare beneficiaries with multiple chronic conditions through better coordination between specialty and primary care practices (PCPs). Such coordination can often be compromised by functional and operational barriers. The proposal builds on CMMI's CPC+ model, which was implemented in January 2017, and the PCF model, which is scheduled to begin in 2021. The model incorporates PCSP's standards and guidelines developed and maintained by NCQA. The submitters propose that the proposed *MNM* be piloted in a subset of CPC+ regions (and PCF regions once initiated) with specialties that have enough high-value eQMs that can be used to implement and monitor the proposed *MNM*; the submitters propose cardiology, infectious disease, and neurology as the three potential initial pilot specialties.

The *MNM* proposal seeks to extend care coordination and data-sharing between primary care and specialty practices by leveraging existing primary care and specialty relationships ("medical neighborhoods") created through the CPC+ and PCF models. Participating specialty practices must achieve recognition as PCSPs. Developed by NCQA, the PCSP recognition standards emphasize care management, shared decision-making, and quality improvement. To achieve recognition, specialty practices must complete specific activities in seven concept areas and

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<sup>1</sup> PTAC member Jay S. Feldstein, MD abstained. PTAC member Joshua M. Liao, MD MSc was not in attendance and recused himself from deliberation and voting on this proposal.

submit annual documentation. While stringent requirements are associated with this recognition, many physician practices achieve this certification. Importantly, PCSP recognition is proprietary and is not open source.

Participating *MNM* practices would be assessed on quality and utilization measures, and practices must meet minimum quality standards to be eligible for performance-based payments. The proposed model uses existing quality measures required of specialty practices that participate in NCQA's PCSP recognition program. Measures focus on domains that include utilization, behavioral health, patient-reported outcomes, patient experience, and care coordination.

Participating specialty practices can choose from one of two tracks: Track 1 practices would receive regular fee-for-service (FFS) payments, while Track 2 practices would receive a 75 percent reduction in FFS payments in exchange for prospective quarterly payments based on projected spending. The proposed *MNM* payment model has three components:

1. Care Coordination Fee (CCF): All participants receive a monthly per beneficiary CCF to support care delivery investments, as well as a potential performance-based payment based on spending relative to an annual benchmark and adjusted for quality and utilization metrics.
2. Performance-Based Payment Adjustment (PBPA): All participants receive performance-based payments based on spending relative to an annual benchmark.
3. Comprehensive Specialty Care Payments (CSCPs): Participants who choose Track 2 receive quarterly prospective payments based on estimates of anticipated Medicare Physician Fee Schedule (MPFS) spending.

All participating specialty practices receive a risk- and geographically-adjusted, non-visit-based per beneficiary per month (PBPM) CCF on all attributed patients. The CCF payment is risk-adjusted at the population level for each practice to account for the intensity of care management services. The proposed *MNM* specialty practices would bear risk through PBPA's, which reflect performance relative to a benchmark based half on a practice's own historical spending and half on regional spending. PBPA's would be assessed annually following a 30-day claims runoff period, then divided evenly across second, third, and fourth quarter payments for the subsequent performance year. To share in earned savings, practices in the proposed model must meet minimum standards for all quality and utilization performance measures.

Targeted beneficiaries are those with multiple chronic conditions that include the specific condition on which the proposed model focuses. To be eligible, patients must be referred by a PCP that participates in CPC+ or the forthcoming PCF model. Patient attribution to the model occurs in three steps. First, all referral requests from CPC+ or PCF participants are pre-screened

to ensure a specialty visit is appropriate. If the specialist is uncertain whether a visit is necessary, step two is an optional e-consultation to determine whether an in-person visit is appropriate. Third, a patient for whom a visit is determined to be necessary has an office visit with the specialist.

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

PTAC recommends the *MNM* proposal to the Secretary for testing to inform payment model development as specified in the comments below. Through its deliberations on previously submitted models, PTAC has increasingly recognized the need for an APM for specialists. The stated goals of the proposed model are vital: improving access to high-quality care through better care coordination across providers, controlling costs by reducing unnecessary specialist referrals, and increasing timely use of services for patients needing specialist care. While some specialists may currently participate in APMs in conjunction with accountable care organizations (ACOs) or health system initiatives, many specialists do not currently have opportunities to participate in such programs. Furthermore, the submitters, as leading innovators and representatives of physician practices, bring substantial knowledge and experience in the needs and challenges faced by all types of practices.

PTAC finds this proposal to be a thoughtful response to the potential for and challenges of creating an opportunity for specialists to participate in an APM. Overall, the Committee believes that the proposed model would likely address the important challenge of compensating specialists for engaging in care coordination with primary care providers. Such engagement can have significant implications for cost and quality. PTAC notes that the proposed model has a number of important strengths, including addressing the dearth of available APMs for specialists and requiring pre-screening of patients to reduce inappropriate specialist referrals and unnecessary or duplicate testing. Further, the submitters propose integrating the proposed *MNM* into existing Centers for Medicare & Medicaid Services (CMS) payment models (i.e., CPC+ and PCF), which is a valuable strategy for accelerating the development and adoption of future APMs and other payment strategies that complement or seek to improve upon existing models.

Despite its many strengths, the Committee finds the proposed *MNM* needs further development on several aspects of both the proposed care model and the payment methodology. PTAC is uncertain about the incentives and mechanisms for many practices to participate, as well as the feasibility and cost of some of the proposed model features. A number of substantive issues would need to be addressed or further developed to ensure successful implementation of the proposed model, even as a pilot or test model. Attention would need to be paid to harmonization with existing APMs, and aspects including risk adjustment and benchmarking would need to be carefully developed. PTAC believes that



further consideration is merited regarding which specialties are most appropriate to participate in the initial model pilot. While ultimately a specialist-focused APM should be available to a wide range of specialists, the submitters proposed the three specialties due to a combination of existing relevant quality measures and interest by those specialists. However, other specialties such as endocrinology and nephrology may benefit from enhanced efforts in care coordination, making them potentially good candidates for the pilot. The Committee also recognizes that it is important to develop a comprehensive set of required quality measures that also accommodates the fact that the most appropriate quality metrics may differ for various conditions or specialists. A particular concern is identifying appropriate quality measures for different types of specialist interactions, including acute episodic events and longitudinal engagement for patients with chronic conditions.

More broadly, Committee members stress that the proposed model pilot period should be used to refine several aspects of the payment methodology. These aspects include calculation of a care coordination fee that would appropriately reimburse for costs not currently covered while also not detracting from the potential for cost savings from the model. The Committee also notes that successful implementation of the proposed model would require developing a robust patient attribution methodology to ensure that payments are not duplicated across participating specialists and referring PCPs in the CPC+ or PCF models. Finally, Committee members acknowledge that it would be important to add implementation support for specialty practices, possibly including implementation support for obtaining NCQA PCSP recognition. Several Committee members suggest that development of an alternative certification approach within CMS would be preferable to relying on the proprietary NCQA PCSP recognition program.

Despite the above considerations, PTAC believes that the proposed five-year pilot would provide a good opportunity to address these issues, and that the *MNM* proposal provides a sufficient framework and mechanisms to justify testing as a payment model. If refined and deemed successful through a pilot for several specialties, the model could then be considered for expansion to additional specialties.

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

#### Criterion 1. Scope (High-Priority Criterion)

*The proposal aims 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 proposed *MNM* approach would provide more opportunities for specialists to participate in APMs. Although the submitters propose an initial pilot that would be limited to a subset of specialty practices, the proposed model could be expanded to encompass additional types of specialists if the initial test is successful. PTAC notes that the proposed model could facilitate participation in an APM for smaller or rural providers that do not have opportunities to participate in ACOs or other large health system initiatives. Further, the proposed model would leverage two existing CMMI APMs: the CPC+ model that is currently operating in 18 geographic regions, or the PCF model, which is scheduled to begin in 26 regions in 2021.

However, PTAC notes the volume of patients for some specialty practices may make participation infeasible or very costly. It is unclear whether the volume of referrals to many specialty practices would be large enough to secure and maintain their participation in the

proposed model. PTAC also cautions that specialty practices interested in joining the proposed *MNM* may not be able to readily join because they do not have NCQA PCSP recognition. PCSP recognition is proprietary and may be costly and time-consuming to obtain, especially for small practices. Additionally, it is unclear whether the volume of referrals to many specialty practices would be large enough to secure and maintain their participation. The business case to participate in the proposed *MNM* may be positive for some but not all specialty practices.

Further, Committee members express concern that the proposed specialties (cardiology, infectious disease, and neurology) may not be the most appropriate providers to participate in the proposed model pilot and that other specialties, including nephrology and endocrinology, should be considered. The Committee notes that the initial specialties included in the pilot may warrant further discussion, including consideration of how outcomes should be evaluated for different specialties, such as those specialties that deal with acute care versus specialties focused on care for chronic conditions.

## Criterion 2. Quality and Cost (High-Priority Criterion)

*The proposal is anticipated to (1) improve health care quality at no additional cost, (2) maintain health care quality while decreasing cost, or (3) both improve health care quality and decrease cost.*

### Rating: Meets Criterion

PTAC concludes that the proposed model meets this criterion. The proposed *MNM* would provide a framework to strengthen collaborative efforts between specialists and PCPs to achieve higher-quality outcomes. Several mechanisms in the proposal (e.g., pre-screening of referrals) could enable costs to be maintained or possibly lowered. The proposal calls for the use of existing evidence-based quality measures that are captured electronically, and participating specialty care practices must meet minimum quality standards to share in PBPAs. The submitters also propose that CMS provide regular performance feedback reports to participants, including meaningful comparison data. However, the proposed model's increased payments may be difficult to offset through downstream savings, and net effects on total costs would need to be assessed through evaluation. Further, while quality may be enhanced by the requirement for PCSP recognition, an alternative approach may be appropriate given the proprietary nature of PCSP.

The Committee also notes that eligible specialists may already participate in care coordination activities under other models, including CPC+ or ACOs. Almost three quarters of CPC+ primary care practices report using collaborative care agreements with specialists.<sup>2</sup> In a recent national

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<sup>2</sup> Independent Evaluation of Comprehensive Primary Care Plus (CPC+) First Annual Report April 2019. Mathematica Policy Research, p. ES.7. <https://downloads.cms.gov/files/cmimi/cpcplus-first-ann-rpt.pdf>.

survey, 51.6 percent of multispecialty practices and 33.3 percent of single specialty practices reported participating in a Medicare ACO.<sup>3</sup> Participation was reported to be nearly as high in medical homes, Medicaid ACOs, and commercial ACOs. The large share of specialists already engaged in these arrangements would generally find they already qualify for the attractive enhanced payments offered by the model, likely crowding out the share of model participants that would need to make real changes in care delivery to qualify and participate in the model. It is not clear that the proposed model would incentivize further quality improvements and additional care coordination activities for these practices.

Finally, although the proposal states that pre-screening can be carried out by non-physician staff at the specialist's office, the Committee notes that using non-physician staff rather than physicians for pre-screening may result in access, quality, or patient safety problems. Committee members also note that the proposal lacks specific suggestions regarding ways to improve care coordination.

### 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. The proposed payment model has the potential to support improved coordination between specialists and PCPs while incentivizing high-value care and maintaining quality. The proposed payment model aims to address the challenge of compensating specialists for engaging in time-consuming care coordination with PCPs by offering a CCF.

However, the Committee has some concerns with the proposed payment model related to patient attribution. The proposed model describes a quarterly attribution method with periodic handoffs of care coordination responsibilities between participating specialists and primary care practices participating in the CPC+ and PCF models. Without proper implementation of the proposed attribution methods, these handoffs between providers and the quarterly nature of the payments under the *MNM* proposal could result in duplicate shared savings payments for the same beneficiaries, unless explicit provisions are included to coordinate payments between the different models. For example, fees would continue to be paid for the full quarter in which a specialist stops coordinating care for a beneficiary, potentially resulting in duplicate payments

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<sup>3</sup> Policy Research Perspectives. Payment and Delivery in 2018: Participation in Medical Homes and Accountable Care Organizations on the Rise While Fee-for-Service Revenue Remains Stable. American Medical Association, p. 12. <https://www.ama-assn.org/system/files/2019-09/prp-care-delivery-payment-models-2018.pdf>.

with the primary care clinician resuming coordination of care for the beneficiary. However, PTAC believes that a robust attribution methodology would mitigate these issues. Additional issues such as risk adjustment and benchmarking are important from an actuarial standpoint, and further attention is needed to the proposed methodologies. The pilot phase, however, would provide an opportunity to refine the attribution and payment methodologies.

Finally, the Committee has concerns regarding the fact that there is no initial downside risk included in the payment methodology. However, PTAC believes that the inclusion of downside risk during pilot testing may be a barrier to participation, and the Committee expects that downside risk would be added to the model after it is further refined during piloting.

#### Criterion 4. Value over Volume

*The proposal is anticipated to provide incentives to practitioners to deliver high-quality health care.*

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

PTAC concludes that the proposed model meets this criterion. The proposed model would likely facilitate high-value referrals while also curtailing inappropriate referrals and unnecessary diagnostic testing selection by requiring pre-screening for referrals. The proposed model intends to produce cost savings while maintaining quality through reduced or duplicative diagnostic testing or imaging, emergency department (ED) visits, and unplanned hospital admissions.

PTAC believes that the proposed model's success will be contingent on ensuring that the payment methodology, including patient attribution methods, adequately supports improved coordination between specialists and PCPs. In particular, the Committee notes that the proposed model allows specialists to select quality measures from a bank of options, which may lead to "cherry-picking" of measures. Because the model would first be implemented as a smaller-scale pilot initiative, the payment model could be refined prior to larger-scale testing or implementation.

#### 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 proposed model accommodates a range of specialist-patient referral relationships, including one-time consultations and ongoing collaboration with PCPs. After the initial pilot, the proposed model could be applicable to practices regardless of specialty, practice type, geography, and other

characteristics. The submitters suggest that the proposed model could be expanded over time to any specialty with sufficient high-value eQMs and/or referrals from CPC+ or PCF practices.

However, the volume of patients in smaller practices may be insufficient to warrant participation, especially in small rural practices. Furthermore, smaller practices may find the requirement to obtain PCSP recognition burdensome, and the proposed model would benefit from an alternative to the proprietary PCSP recognition program.

## 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 proposal provides provisions for construction of a control group and evaluation of quality and cost outcomes. The submitters recommend that an independent third-party evaluator identify cohorts of patients who received a referral to an *MNM* specialist for follow-up care and compare them to a control group of patients associated with the CPC+ or PCF who received care from non-*MNM* specialty practices (i.e., a difference-in-differences analytic design). Proposed data sources would include Medicare claims, eQMs (reported), and Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey data. The analysis would assess whether and how participation affects patient experience, health outcomes, resource utilization, and total cost of care.

To guarantee a statistically valid sample size, the proposal requires that at least 100 patients be attributed over the course of a year to trigger monthly CCFs. However, the Committee notes that the proposal does not include calculations of statistical power, and it is not clear that this minimum sample size would be sufficient or attainable by all participating practices. Further, systematic differences between the treatment and control groups could still bias estimated effects of the proposed model.

## 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. Improving integration and care coordination is an integral goal of the *MNM* proposal. The proposed model design would encourage greater coordination of care between specialists and PCPs by leveraging existing medical neighborhoods created through the CPC+ or PCF models. Further, through the PCSP

recognition program, practices are required to meet standards to improve care coordination and advanced care delivery and incorporate a pre-screening process for all specialist referrals.

However, the Committee notes that the proposal does not provide or describe specific provisions or steps that specialty practices should undertake to improve care coordination or management. In response to questions from the Committee about how the proposed *MNM* would enhance specific care coordination activities beyond those that are required by the CPC+ model, the submitters noted that the proposed *MNM* incentivizes specialty practices to engage in meaningful care coordination agreements with PCPs. The submitters also noted that the requirement to pre-screen every specialist referral is intended to facilitate communication between specialists and referring PCPs.

### 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. The proposed *MNM* could reduce inappropriate referrals and unnecessary or duplicative diagnostic testing or imaging, and increase access to specialty care without limiting patient choice. Further, the requirement that participating specialty practices achieve PCSP recognition should result in greater capacity to provide access to specialty care due to reduction in inappropriate referrals.

However, as noted above, the process for the attribution of patients may pose a challenge; successful implementation of the model would require a robust attribution methodology to ensure that payments are not duplicated across participating specialists and referring PCPs. PTAC believes that further refinements to the patient attribution methodology during the pilot phase are needed.

### 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. The proposal includes multiple approaches to maintain patient safety, including requirements under NCQA's PCSP model, and monitoring specific to the proposed *MNM* (i.e., CAHPS survey on patient experience, eQMs, and administrative claims measures on quality and utilization). However, it is unclear what constitutes appropriateness of care for an e-consult and whether this definition would vary across specialties; these issues should be considered further during the pilot phase.

## 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. The proposal calls for all data and measures to be captured electronically, either through administrative claims or eQMs. The proposed model would enhance use of certified electronic health record technology (CEHRT) and increase electronic reporting of quality and outcomes data. The submitters proposes that participating practices should have multiple options for reporting and sharing data, with data entry into EHRs designed to reduce administrative burden on providers.

However, the Committee notes that even in CPC+ or PCF regions, specialty practice participation may be limited by barriers to the use of CEHRT and electronic data exchange standards. These barriers may make participation in the proposed model particularly challenging and expensive for smaller practices, and the proposed subsidies may not be sufficient to offset these additional costs.



## **APPENDIX 1. COMMITTEE MEMBERS AND TERMS**

**Jeffrey Bailet, MD, Chair**

**Grace Terrell, MD, MMM, Vice Chair**

Term Expires October 2020

**Grace Terrell, MD, MMM**

*Eventus WholeHealth*

Concord, NC

Term Expires October 2021

**Jeffrey Bailet, MD**

*Altais*

San Francisco, CA

**Kavita Patel, MD, MSHS**

*Johns Hopkins Health System*

Baltimore, MD

**Angelo Sinopoli, MD**

*Prisma Health*

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**Jennifer Wiler, MD, MBA**

*UCHealth and University of*

*Colorado School of Medicine*

Aurora, CO

Term Expires October 2022

**Paul N. Casale, MD, MPH**

*NewYork Quality Care*

*NewYork-Presbyterian, Columbia University College of*

*Physicians and Surgeons, Weill Cornell Medicine*

New York, NY

**Bruce Steinwald, MBA**

*Independent Consultant*

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Term Expires October 2023

**Jay S. Feldstein, DO**

*Philadelphia College of Osteopathic Medicine*

Philadelphia, PA

**Joshua M. Liao, MD, MSc**

*University of Washington School of  
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Seattle, WA

**Lauran Hardin, MSN, FAAN**

*National Center for Complex Health and Social Needs,*

*Camden Coalition of Healthcare Providers*

Camden, NJ

## 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 Physician-Focused Payment Model 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<sup>4 5</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)	0	0	0	1	3	3	1	Meets Criterion
2. Quality and Cost (High Priority)	0	0	0	4	4	0	0	Meets Criterion
3. Payment Methodology (High Priority)	0	0	1	3	4	0	0	Meets Criterion
4. Value over Volume	0	0	0	3	4	1	0	Meets Criterion
5. Flexibility	0	0	0	2	6	0	0	Meets Criterion
6. Ability to Be Evaluated	0	0	0	5	2	1	0	Meets Criterion
7. Integration and Care Coordination	0	0	0	2	2	3	1	Meets Criterion
8. Patient Choice	0	0	0	2	5	1	0	Meets Criterion
9. Patient Safety	0	0	0	2	5	1	0	Meets Criterion
10. Health Information Technology	0	0	0	2	4	2	0	Meets Criterion

<sup>4</sup> Criteria designated as “high priority” are those PTAC believes are of greatest importance in the overall review of the payment model proposal.

<sup>5</sup> PTAC member Jay S. Feldstein, MD abstained. PTAC member Joshua M. Liao, MD MSc was not in attendance and recused himself from deliberation and voting on this proposal.

## APPENDIX 4. DISTRIBUTION OF MEMBER VOTES ON OVERALL RECOMMENDATION<sup>6</sup>

### Recommendation Vote: Part 1 of 2<sup>7</sup>

Not Recommended for Implementation as a PFPM	Recommended	Referred for Other Attention by HHS	Result
0	8	0	Recommended

### Recommendation Vote: Part 2 of 2 (if applicable)

Proposal substantially meets Secretary's criteria for PFPMs. PTAC recommends implementing proposal as a payment model.	PTAC recommends further developing and implementing the proposal as a payment model as specified in PTAC comments.	PTAC recommends testing the proposal as specified in PTAC comments to inform payment model development.	PTAC recommends implementing the proposal as part of an existing or planned CMMI model.	Result
0	1	7	0	PTAC recommends testing the proposal as specified in PTAC comments to inform payment model development.

**Final recommendation to Secretary: PTAC recommends testing the proposal as specified in PTAC comments to inform payment model development.**

<sup>6</sup> PTAC member Jay S. Feldstein, MD abstained. PTAC member Joshua M. Liao, MD MSc was not in attendance and recused himself from deliberation and voting on this proposal.

<sup>7</sup> In 2018, PTAC adopted new voting categories, used first at its December 2018 public meeting. First, PTAC votes on the three categories listed above as Part 1 of 2. PTAC must achieve a two-thirds majority for one of these categories. If a two-thirds majority votes to not recommend the proposal for implementation as a PFPM or to refer the proposal for other attention by HHS, that category is the Committee's final recommendation to the Secretary. If the two-thirds majority votes to recommend the proposal, the Committee proceeds to Part 2 of 2 to determine the final, overall recommendation for the Secretary. The second vote uses the four subcategories listed above. A two-thirds majority must be achieved for one of these four categories.