Preliminary Review Team (PRT) Review of the Medical Neighborhood Advanced Alternative Payment Model (MNM, Resubmitted)— submitted by ACP and NCQA

Questions for the Submitter – April 2, 2020

Scope

1. The model proposes a five-year pilot in which practices participating in Comprehensive Primary Care Plus (CPC+) or Primary Care First (PCF) would implement the model (p. 2). Does the submitter (subsequently referred to as ACP/NCQA) have any information indicating that practices participating in CPC+ or PCF will be able to implement the model without compromising their participation in or the evaluation of these CMMI models? Alternatively, does the MNM involve redundancy due to model overlap?

    ACP/NCQA Response: The eligible participants for the Medical Neighborhood Model are exclusively specialty clinicians. As such, we do not anticipate redundancies for MNM participants since they are not themselves eligible to participate in primary care models like CPC+ or PCF. However, primary care clinicians participating in CPC+ that partner with specialists participating in the MNM would likely be able to make use of care coordination activities required for CPC+. For example, per the "Comprehensiveness and Coordination" Function requirements in CPC+, participants must "Enact collaborative care agreements with at least two groups of specialists identified based on analysis of CMS/other payer reports," and to "Ensure coordinated referral management, especially for high-frequency referral specialists and/or high-cost specialty care." We see these activities as supportive of and complementary to the MNM framework since CPC+ participants would be performing these exact same activities with specialists who are enrolled in the MNM. Importantly, no additional activities are required on the part of the CPC+ participant. Furthermore, unlike many other specialists with whom the CPC+ participant communicates, MNM specialists are specifically paid care coordination fees to provide more robust coordination and team-based care across clinical settings.

2. The proposal (p. 6) suggests piloting the model in three specialties: cardiology, infectious disease, and neurology; page 6 also indicates that 3,027 clinicians in 532 sites are enrolled in NCQA's PSCP program. Does the submitter have information indicating that a sufficient number of PCSP-recognized specialist practices in the three specialties in areas with CPC+ or PCF will participate? Can the submitter expand a bit on whether there has already been an expression of interest in these specialties in particular?

    ACP/NCQA Response: The American Academy of Neurology (AAN), a specialty society composed of more than 36,000 neurologists and clinical neuroscience professionals, submitted a letter of support to PTAC to express their interest in facilitating and encouraging neurologists to participate in the model. The letter specifically notes that it is a "great opportunity" for neurologists, particularly given dearth of substantive APM options for many specialties like neurology. We have had discussions with the American College of Rheumatology as well – their leadership believes this represents a strong opportunity for their clinicians. The American Medical Association (AMA) also submitted

a letter sharing its strong support for the model, noting the scalability and flexibility of the model to accommodate a variety of different specialties.

We provided below a list of states where CPC+ and PCF is active along with our current PCSP representation in each:

State	CMS Pilot	No of PCSP Clinicians
Colorado	CPC+, PCF	231
Florida	PCF	140
Kentucky	CPC+	117
Louisiana	CPC+, PCF	54
Maine	PCF	395
Massachusetts	PCF	46
Michigan	CPC+, PCF	9
Missouri	CPC+, PCF	20
Nebraska	CPC+, PCF	8
New Hampshire	PCF	14
New Jersey	CPC+, PCF	65
New York	CPC+, PCF	194
Ohio	CPC+, PCF	64
Oregon	CPC+, PCF	136
Pennsylvania	CPC+, PCF	511
Tennessee	CPC+, PCF	20
Virginia	PCF	21

3. Relatedly, will the specialty practices perceive enough benefits to justify participation rather than just maintaining their current practice? If so, what aspects of the model make it attractive for specialists to participate?

    ACP/NCQA Response: The Medical Neighborhood Model is designed to be a specialty-focused alterative payment model that would financially compensate specialty care practices for meeting certain advanced practice requirements including enhanced coordination with primary care practice partners. In addition to the model specific payments including a guaranteed care coordination fee and potential to earn an incentive-based payment adjustment for coming in below their benchmark, they would also potentially be eligible for other benefits, including but not limited to waivers from certain compliance or regulatory policies and being eligible for the Advanced APM bonus.

4. Does ACP/NCQA have any information indicating that primary care practices will have a sufficient volume of referrals to these specialties to support this model?

ACP/NCQA Response: There are currently 2,851 practices enrolled in the Medicare Comprehensive Primary Care Plus Model.[1] In 2018, 14,810 participating clinicians served approximately 15 million patients, of which over two million were Medicare beneficiaries[2]. We believe this is more than a sufficient number of referrals to start with as it already exceeds covered lives in other current Medicare Advanced APMs. Primary Care First has not yet announced its first round of model participants but this is expected to significantly expand the pool of participating clinicians and practices, and therefore aligned patients.

5. ACP/NCQA indicates (p. 16) that a pilot of five years is needed to allow for downstream care outcomes and savings to be fully realized and as well as to align with Comprehensive Primary Care Plus and Primary Care First. The PRT would appreciate a better understanding of the length of time needed to determine feasibility of implementing the model versus evaluating the model.

ACP/NCQA Response: The five-year period does not refer to feasibility; rather, it refers to the amount of time recommended before program evaluations can reveal the full spectrum of benefits achieved through PCSP implementation. The evidence on NCQA Patient-Centered Medical Home Recognition suggests it takes from nine months to more than a year to complete the clinical transformation and up to five years of transformation, fully supported with financial incentives, to meaningfully improve quality and efficiency and to capture savings based on those efficiencies.

Participating Practice Qualifying Criteria

6. The MNM builds on the NCQA's Patient-Centered Specialty Practice recognition program. Since CMS historically is not inclined to use external or propriety recognition programs, what standards for participation would be most important to be replicated by CMS?

ACP/NCQA Response: PCSP categorizes the various functional capacities of clinical transformation into seven different concepts:

i. Team-Based Care and Practice Organization;
ii. Initial Referral Management;
iii. Knowing and Managing Your Patients;
iv. Patient-Centered Access and Continuity;
v. Plan and Manage Care; and
vi. Performance Measurement and Quality Improvement.

"Core" and "Elective" criteria are distributed across each of the concepts, ensuring a minimum set of capabilities while giving practices flexibility to focus on activities that mean the most to their to their patient population and are feasible to accomplish, with consideration of practice and community resources. This is a compelling feature of the PCSP model and a key reason why both Congress and CMS approved of the program. However, true clinical transformation is more than the sum of its parts. It is more than

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[1] https://innovation.cms.gov/innovation-models/comprehensive-primary-care-plus

[2] https://innovation.cms.gov/files/reports/cpcplus-2018-review.pdf

individual operational changes – it requires integration of these changes across every level of the organization. For example, effective care coordination and transitions require that clinicians share, track, and follow up on information related to patient referrals. Doing so requires that clinicians set standards for data collection to identify patients in need of closely managed care; establish referral tracking processes and infrastructure; clearly define care team roles and responsibilities for data sharing and follow up; and to constantly monitor performance to identify and close any persistent gaps in coordination. These activities are necessarily integrated and interlocking, demonstrating the need for each in order to achieve the larger goal of robust care coordination. We therefore believe that replicating individual standards for participation would fail to achieve the goals of the model. Again, NCQA PCSP has both legislative and regulatory approval; the MACRA legislation and subsequent regulations indicate that PCSP is the only specialty practice program currently approved for use in QPP.

Payment

7. The PRT would like to better understand how the Care Coordination Fee (CCF) is calculated. The proposal describes an average CCF of $37 (p.12). How did ACP/NCQA arrive at this figure?

    ACP/NCQA Response: The CCF is based on the work of obtaining and reviewing data or relevant information, outlining suggestions for long-term handling of the problem, and completing literature review in response to issues raised during communication. The $37 is the median payment amount of the three online digital evaluation and management service codes (99421-99423). The work of the online digital evaluation and management is closely related to the triaging work described as performed on every referral sent to the specialty practice, wherein the physician:

    - Reviews the initial patient inquiry, medical history, documents sent by the patient and/or obtained by clinical staff;
    - Checks online data registries or information exchanges;
    - Assesses medical condition described in the patient query;
    - Formulates and sends physician's response (e.g., a diagnosis and treatment plan, and/or request for additional information);
    - Reviews test results and other reports;
    - Emails prescriptions;
    - Conducts follow-up communication; and
    - Provides necessary care coordination, telephonic, or electronic communication assistance.

8. A key expectation of the model is that participating specialists would use prospective CCFs and comprehensive specialty care payments (CSCPs) to invest in care coordination staff, technology, or other related practice improvements (p. 5). Under the proposed model, how would CMS monitor whether these funds are used properly?

    ACP/NCQA Response: As a precondition of participating in the model, practices are required to meet advanced clinical delivery standards. Moreover, CMS would monitor

the appropriateness of funds as they do for other, similar models, including CPC+.[3] Such models include tactics such as: a preliminary program integrity screening, audits on an ad hoc basis, monitoring referral patterns, cost, utilization, quality, and program integrity data, quarterly red flag reports, and quarterly attestations from participating practices that they are using funds for these purposes under threat of legal and financial implications. Any practices that are found not to be meeting the full terms of their participation agreements will be subject to a corrective action plan and face possible termination from the program. Importantly, these policies closely adhere to those that CMS has approved for other programs in the past.

9. Page 7 of the proposal reviews costs that would be incurred per practice or clinician for PCSC recognition as well as Electronic Clinical Quality Measure reporting via registry. The proposal notes that "costs vary by vendor but are modest" and gives an example that ACP's Genesis Registry costs $299 - $699 per clinician per year. The proposal further indicates that "to promote robust participation, both NCQA and ACP will discount these fees 30% for pilot participants." The PRT would like to know whether ACP/NCQA perceives another way to approach this issue (e.g., whether other entities could provide such services to avoid a conflict from receipt of discounted payments per participating provider).

ACP/NCQA Response: Per the regulatory language for the Quality Payment Program, the only approved specialty practice recognition or certification program at this point is NCQA PCSP. The fees for the program are nominal and are used to cover the cost of practice monitoring, tracking, and evaluation; under the MNM, these oversight activities would be critical for ensuring adherence to quality standards. Additionally, the upside potential for participation significantly exceeds any costs incurred for recognition and registry fees.

Health Information Technology including Certified EHR Technology, qualified registries, and qualified clinical data registries are increasingly pervasive in medical practices across the country. According to Health IT.gov, as of 2017, 86% of office-based physicians had adopted an EHR, the vast majority of which was Certified EHR Technology.[4] The type of specialty practices that would consider our model are likely to be sophisticated and are even more likely to already have a health information technology infrastructure in place. Therefore, we do not anticipate the cost of these technologies to be a burden to practices interested in participating in our model, regardless of discounts. Moreover, electronic reporting of performance data is also commonly required of other Advanced APMs such as the Medicare Shared Savings Program, which requires reporting through the Web Interface Portal.

10. The PRT would appreciate more clarification about the calculation of the performance-based payment adjustment (PBPA). Which services and patients are included in the historical benchmark for the calculation? Would quality performance affect the PBPA over time?

ACP/NCQA Response: In this proposal historical benchmarks would be based on cognitive services that are not procedure related. Procedure related services would still

[3] https://innovation.cms.gov/files/x/cpcplus-rfa.pdf
[4] https://dashboard.healthit.gov/quickstats/quickstats.php

be coded and paid under the traditional fee for service arrangement. CMS would use the national Medicare FFS Physician and Outpatient claims with service dates during the look back period. Most visits should be in the Physician file, with the exception of claims submitted by Critical Access Hospitals (CAHs), which are found in the Outpatient file. From all Physician and Outpatient claims, CMS identifies those that are cognitive services visits as listed below. The services in this proposal include but are not limited to:

- Office/outpatient visit evaluation and management (E&M) 99201–99205 99211–99215
- Home care 99324–99328 99334–99337 99339–99345 99347–99350
- Welcome to Medicare and Annual Wellness visits G0402, G0438, G0439
- Advance care planning 99497
- Collaborative care model 99492, 99493, 99494
- Cognition and functional assessment for patient with cognitive impairment 99483
- Transitional care management services 99495, 99496
- Prolonged non-face-to-face evaluation and management services 99358
- CCM services 99490
- Complex CCM services 99487
- Care management services for behavioral health conditions 99484

Under our proposal, this following methodology for how quality performance would affect a practice's PBPA would remain consistent over all the years of a practice's participation agreement. Participants must first meet minimum quality standards to share in any PBPA. They will then receive an increasing proportion relevant to their score on quality and utilization metrics. To ensure transparent, predictable performance thresholds and alignment with MIPS, utilization and quality metrics will be based on national averages from benchmarks based on electronic submission of quality measures for the most recent performance year for which data are available (most likely two years before the relevant performance year). The floor for all utilization and cost measures will be set at the national average (the 50th percentile). For every percentile increase of quality and utilization performance above this, practices will retain an additional 1%, up to 100%. Utilization and quality will be weighted equally; for example, a practice that scores in the 80th percentile on utilization and the 60th percentile on quality will earn 70% of its PBPA. All utilization and quality measures will be weighted equally within the utilization and quality components of the score. Accordingly, the two hospital readmission measures will each be worth half the utilization component while the two core measures, three specialty specific measures and CAHPS measure will each compose one sixth of the quality component. See Appendix I for a visual representation of how quality performance will impact a practice's PBPA.

Delivery Model

11. While the proposal specifies the payments to be made to help make referrals more efficient, it does not provide or describe specific provisions or steps that specialty practices should

undertake to improve care coordination or management. Please provide additional detail regarding which services qualify as “care management” under the model.

ACP/NCQA Response:
Below is a summary of care management expectations inherent in the MNM model:

- ***Care Coordination Agreements:*** Specialty care practices in the MNM will engage in a Care Coordination Agreement with the participating referring primary care practices. With this, they agree to follow standardized guidelines and protocols and use standardized templates with consistent criteria for all referrals. This helps to ensure all referrals are appropriate, consistent, and thorough. Research shows that currently, specialty care clinicians do not have the necessary information for the referral by the time of the referral appointment 60-70% of the time.
- ***Triaging Referral Requests:*** Every referral request received by the MNM specialty practice is reviewed to ensure to: (1) appropriateness (i.e. that the referral is to the correct specialty type and medically necessary); (2) ensure all relevant patient information has been received. If not, they would communicate with the requesting primary care practice to resolve the issue.
- ***Referral Response:*** Under the MNM, the specialty practice would “close the loop” on every referral request. Currently about 50% of referral requests are never completed. These might include continued monitoring by the PCP along with clinical advice and instructions, referral to another specialty clinician, or scheduling a specialty visit (based on urgency of the patient’s condition).
- ***Visit report:*** If an appointment is scheduled, specialists would send a timely, comprehensive report back to the PCP, including if a patient no shows or cancels. Referral reports would provide a detailed summary of information gleaned from the visit including any procedures or test results, recommend next steps, and initiate scheduling of any necessary follow up appointments with the PCP or specialty clinician.
- ***Individualized care plan:*** If ongoing co-management is appropriate, the specialty clinician, PCP, and patient/family would all agree on a long-term care plan that would include a clear division of management responsibilities, communication expectations, including method and frequency of contact, and clearly defined care goals that take into account patient needs and preferences. The care plan would also include a clear definition of what it would mean for the patient to be “stable” and how often this should be reassessed.
- ***Transitions of Care:*** Stability of a patient’s condition will be clearly defined and consistently reevaluated according to the terms of the patient’s individualized care plan. Once a patient is deemed stable, he/she would be “graduated” back to primary care for management of that condition. The MNM specialty care practice will develop a standardized mechanism with their primary care practices for this transition back to primary care for management of the referred condition and will ensure adequate information sharing and support for the patient and, as needed, for the primary care clinician during this transition. This improves the specialty-primary relationship and ensures patients are being treated in the most effective and efficient setting, saving costs and

freeing up specialty care clinicians' schedules to see more urgent cases sooner. Currently, outside of the MNM and the care coordination agreement, the role of specialty care is rarely discussed, and many patients end up in long-term specialty care for follow-up of conditions that could be managed by their primary care clinicians. This is unnecessarily expensive and contributes to our current backlog of specialty care.

Additionally, NCQA PCSP requires that practices implement specific care management activities and provide evidence of implementation to NCQA in order to achieve recognition. Each of the activities listed below are "Core" (rather than "Elective"), so each is mandatory. Any practice recognized as NCQA PCSP has already demonstrated evidence of their specialists or care teams:

i. Notifying the primary care or referring clinician that they have received and accepted the referral
ii. Requesting and tracking receipt of pertinent demographic and clinical data not initially received from the primary care or referring clinician
iii. Monitoring that the outgoing response to primary care and referring clinicians includes complete information, including but not limited to: answers to clinical questions in the referral; procedures, test results, and any hospitalizations; a recommended plan of care; and whether any follow up is needed
iv. Establishing a plan to communicate with the primary care clinician about routine updates or changes in the status of co-managed patients
v. Coordinating with the primary care clinician to ensure that co-managed patients receive timely preventive care
vi. For patients identified as needing a higher level of care, collaborating with the patient/family/caregiver to develop and update a specialist's care plan that includes patient's goals, potential barriers and self-care ability
vii. Informing the primary care clinician and referring clinician about referrals to secondary specialists
viii. Systematically managing diagnostic tests, including lab and imaging by: tracking tests until results are available, flagging and following up on overdue results; flagging abnormal diagnostic results; and notifying patients/families/caregivers about normal and abnormal diagnostic test results

12. The proposal (p. 5) notes that patients will be unattributed if they do not have a relevant in-person or non-face-to-face service billed during a given quarter, or if the assigned specialist is "downgraded in the Care Coordination Agreement to a less active role." The PRT would appreciate clarification of which parties have to agree regarding the Care Coordination Agreement or downgrading of a specialist. Would CMS be notified if a specialist is downgraded and, if so, how?

ACP/NCQA Response: Yes, CMS would be notified of specialty clinician status changes that would impact PMPM payments under the model. This would most ideally occur within a web portal similar to the one that CMS currently uses to engage with CPC+ patients. Importantly, all parties including the patient, specialty care clinician, and primary care clinician must come to joint agreement on changing the status of the specialty care clinician's level of involvement for managing the referred condition. In

many cases, the specialty care clinician may remain involved in the patient's overall care by co-managing the referred condition along with the primary care clinician. In other cases, it may be appropriate for the patient to fully transition back to the PCP for management of the referred condition.

13. Model participants must have "specified and systematic methods" to identify patients who have experienced acute incidents and to exchange clinical information with other providers (p. 7). Please provide more information on how ACP/NCQA envisions the existence and use of these methods (e.g., as part of PCSP recognition?). Would CMS need to implement their own method of verifying and tracking?

    ACP/NCQA Response: However, PCSP standards are routinely monitored and tracked by NCQA as part of the annual recognition process. Each year at the annual reporting date, each entity attests that it continues to meet PCSP criteria and submits key data and documentation across the seven PCSP concept areas. This process sustains Recognition and is designed to foster continuous improvement, highlighting how the practice strengthens its transformation and, as a result, patient care. NCQA audits a sample of practices, either by specific criteria or at random, to validate evidence, procedures, attestations and other responses. NCQA also reserves the right to issue a discretionary survey to validate the appropriateness of an existing Recognition decision and to target and address issues where a practice may not continue to meet our standards. NCQA may investigate complaints as well as allegations of fraud or misconduct, and it may revoke PCSP Recognition if it identifies a significant threat to patient safety or care. Historically, NCQA audited at least 5% of recognized practices on an annual basis. NCQA is currently evaluating operational capacity for auditing and can provide more detailed statistics on monthly oversight protocols in the near future.

    Absent NCQA oversight, CMS may implement similar monitoring activities. In such a scenario – consistent with CPC+ monitoring protocols – the following additional monitoring tactics could be deployed for the MNM as well: (1) Annual submission of program integrity data; (2) Quarterly attestations of care delivery achievements; (3) Quarterly "flag reports;" (4) Bi-annual submissions of revenue and expense data; (5) Annual review of cost, utilization, patient experience and quality data; and (6) Audits on an ad hoc basis, as necessary.

14. Prior to being seen by a specialist, the proposal indicates (p. 8) that the referral explanation and supporting documentation are reviewed to ensure documentation availability and appropriateness of referral. Who does ACP/NCQA envision performing this review (e.g., the specialist or other practice staff)?

    ACP/NCQA Response: The referral request would be reviewed by specialty practice staff, likely someone in an administrative or care coordination role under the direction or supervision of the specialty care clinician.

15. The proposal notes (p. 9) that "we would also encourage CMS to facilitate higher participation in the model by expanding the CPC+ Web Interface to accommodate relevant subspecialty measures and provide an additional cost-effective option for practices to report data and receive performance feedback." Does ACP/NCQA have any information on the benefits or

challenges of CPC+ practices currently using this interface as well as the practicality or burden of expanding the reporting to include subspecialty measures?

> **ACP/NCQA Response:** We do not currently have any information on the benefits or challenges of CPC+ practices currently using this interface as well as the practicality or burden of expanding the reporting to include subspecialty measures.

PHYSICIAN-FOCUSED PAYMENT MODEL TECHNICAL ADVISORY COMMITTEE (PTAC)

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PRELIMINARY REVIEW TEAM (PRT)

CONFERENCE CALL WITH THE AMERICAN COLLEGE OF PHYSICIANS (ACP) AND THE NATIONAL COMMITTEE FOR QUALITY ASSURANCE (NCQA) SUBMITTERS ON THE REVISED VERSION OF THEIR PROPOSAL

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MONDAY, JUNE 29, 2020

2:00 p.m.

PRESENT:

JEFFREY BAILET, MD, PTAC Committee Member
ANGELO SINOPOLI, MD, PTAC Committee Member

SALLY STEARNS, PhD, Office of the Assistant Secretary for Planning and Evaluation (ASPE)
STELLA (STACE) MANDL, ASPE
AUDREY MCDOWELL, ASPE

KAREN SWIETEK, PhD, NORC at the University of Chicago (NORC)
KELLY DEVERS, PhD, NORC
AMY AMERSON, NORC

SHARI ERICKSON, American College of Physicians (ACP)
SUZANNE JOY, ACP
BRIAN OUTLAND, ACP

MICHAEL BARR, MD, MBA, MACP, FRCP, National Committee for Quality Assurance (NCQA)
JOE CASTIGLIONE, NCQA

ALLEGRA CHILSTROM, Neal R. Gross & Co. (NRGCO) Transcription

1 P-R-O-C-E-E-D-I-N-G-S

2 2:04 p.m.

3 DR. STEARNS: Jeff, do you want to get

4 started?

5 CHAIR BAILET: Sure, thanks, Sally,

6 and thanks to the folks from the Medical

7 Neighborhood team for your proposal. I look

8 forward to today's discussion.

9 So, I'm Jeff Bailet, I happen to chair

10 the PTAC, but on this call I'm playing a role as

11 a member of the Preliminary Review Team. A

12 little bit about my background. I'm an ENT

13 physician by training. I've come out of the

14 medical group space, I ran a large multi-

15 specialty group practice in Wisconsin with

16 Aurora, then joined Blue Shield of California in

17 2017. And now I am leading Altais, which is a

18 physician services organization that just hit its

19 one-year anniversary. So, it's great to be on

20 the call with you today.

21 DR. SINOPOLI: This is Angelo

22 Sinopoli. I'm a pulmonary critical care

1 physician and presently the Chief Clinical
2 Officer for Prisma Health, which is a large
3 integrated delivery system in South Carolina. I
4 also am on PTAC and just a member of this PRT
5 Committee.
6 CHAIR BAILET: So, it would be great
7 if you guys and gals, whoever's on the call from
8 the Medical Neighborhood team, could introduce
9 yourselves?
10 DR. BARR: Sure, this is Michael Barr.
11 Shari, you want to start?
12 MS. ERICKSON: No, Michael, you go.
13 DR. BARR: Okay. Hi, this is Michael
14 Barr, I'm the Executive Vice President for
15 Quality Measurement and Research at NCQA, and
16 I've been the leader of the NCQA team.
17 Do all the folks from NCQA want to
18 introduce yourselves? I can't tell who's on the
19 phone actually.
20 MR. CASTIGLIONE: Sure. Okay. This
21 is Joe Castiglione, I have been a point person
22 for NCQA on this proposal.

1 DR. BARR: And, Joe, do you know if
2 Paul's going to be able to join us? I know he's
3 managing another conference.
4 MR. CASTIGLIONE: I did think he was
5 going to join us, yes, but it doesn't sound like
6 he's on just yet.
7 DR. BARR: Okay, so it might just be
8 you and me from NCQA? Over to you, Shari.
9 MS. ERICKSON: Thanks, Michael. This
10 is Shari Erickson, Vice President for
11 Governmental Affairs and Medical Practice at ACP,
12 and I guess the leader of our team over here at
13 ACP.
14 I'll hand it over to Brian and then
15 Suzanne to introduce themselves.
16 MR. OUTLAND: Yes, I'm Brian Outland,
17 Director of Regulatory Affairs at ACP and I've
18 worked on some of the information in the model
19 around payment issues and other things.
20 MS. JOY: Hi, My name is Suzanne Joy.
21 I'm also on the Regulatory Affairs Team for ACP.
22 I do a lot with value-based payment policy and I

1 was also a key contributor to the proposal. And
2 I'm very much looking forward to discussing it
3 today, so thank you all for the opportunity and
4 taking the time.
5 MS. ERICKSON: And, Sarah, are you on
6 as well? Brian or Suzanne, do you know if Sarah
7 is going to be able to join us? I wasn't sure.
8 MS. JOY: I haven't heard from her but
9 I can shoot her a text.
10 MS. ERICKSON: Okay, great, and she's
11 actually with one of the staff members here at
12 ACP who works with our Performance Measurement
13 Committee.
14 So, she was very involved working with
15 Suzanne and Brian and all of us on the
16 performance measurement aspect of the model. So,
17 if she's able to join, she could speak more to
18 that.
19 CHAIR BAILET: So, that's great, I'm
20 glad all of you guys and gals could join us
21 today. I think it would be best -- Kavita Patel,
22 Dr. Patel, she's the lead of our proposal review

1 team and she's going to be a couple minutes late.
2 I'll let her introduce herself, she's a
3 practicing family practice physician who's
4 working on an unexpected issue this morning but
5 she should be joining us pretty soon. It might
6 be helpful --
7 DR. STEARNS: Jeff, I just want to
8 note for a second, I'm actually checking an email
9 I got from her a little more closely and she does
10 just want you and Angelo to go ahead.
11 CHAIR BAILET: And we are. If she can
12 join, great. In the meantime, we'll take it. I
13 think there's six questions and there's some sub-
14 questions within there. But we do have a
15 framework for today's call and I think, perhaps,
16 since we're missing a teammate, it may be just
17 best to work through the questions.
18 Do you guys have those handy?
19 MS. ERICKSON: Yes, we do. These are
20 the ones I believe were posted in the invite on
21 Friday or Thursday of last week, correct?
22 CHAIR BAILET: Correct.

1 MS. ERICKSON: We do have those.
2 CHAIR BAILET: So, maybe we'll just
3 start? We'll turn it over to you and you guys
4 can designate whoever from your team you want to
5 address these and we'll see how far we go here.
6 MS. ERICKSON: Michael, do you want to
7 jump in on the first one related to the specialty
8 practice recognition? I'm happy to jump in as
9 well.
10 DR. BARR: Sure, I can start and turn
11 it over to you guys. So, the first question
12 addresses the PCSP[1] program, which is an NCQA
13 program, and the concern about the potential
14 burden associated with that. We understand that
15 and certainly took that into consideration.
16 I also want to point out, though, that
17 the PCSP is the only MIPS[2]-endorsed specialty
18 practice recognition program, so it's already
19 been recognized. And we do not exclude others
20 that could be developed in the future.
21 But it is the only one that is
22 currently connected to the QPP[3] and MIPS. And

1 there's a lot of overlap with the CPC+[4] program,
2 it overlaps with PCMH[5] criteria, which in and of
3 itself has 2,800 participating practices.
4 So, there's some model in the past for
5 some overlap with PCMH, and of course, the PCSP
6 program, one of the attractive parts of that is
7 it sort of models PCMH but from the specialty
8 side.
9 And we think the best benefits,
10 speaking to the overall model, is when you have
11 well-organized primary care associated with well-
12 organized specialty care and collaborating around
13 how to take care of people.
14 And that's where we think the gains
15 here are to be had. We also think that an
16 attestation just to say we are practicing in a
17 certain way is not sufficient to really
18 demonstrate that a practice is performing in that
19 particular way.
20 So, some of the upside benefits from

1 Patient-Centered Specialty Practice
2 Merit-based Incentive Payment System
3 Comprehensive Primary Care Plus
4 Quality Payment Program
5 Patient-Centered Medical Home

1 going through a recognition program such as the
2 PCSP, and again, not exclusively but the only one
3 to date that's out there, should generate some of
4 the benefits that we expect from this model.
5 Let me turn it over the ACP folks so
6 they can add their statement or additional
7 comments.
8 Shari?
9 MS. ERICKSON: Sure, I'll say a couple
10 words and then Brian or Suzanne may want to jump
11 in as well.
12 I would say that reducing burden is a
13 top priority of ACP but at the same time, we want
14 to ensure, again, as Michael was saying, that the
15 practices that would be participating in this
16 model really are doing the things they need to be
17 doing to be successful, for the model to be
18 successful.
19 And another thing I'll add is related
20 to ACP's perspective in response to this is that
21 we really don't endorse any one program over
22 another.

1 As Michael indicated, PCSP is really
2 the only MIPS-endorsed specialty practice
3 recognition program to date so it makes sense as
4 a good starting point here, not that there
5 couldn't be others that could come about.
6 And just to also re-emphasize, as
7 Michael indicated, the overlap I think in the
8 criteria between this and CPC+, which we have
9 been quite supportive of from an ACP perspective
10 as it's rolled out and has been underway.
11 I'll stop there and see if Brian or
12 Suzanne would like to add anything to that
13 response?
14 MR. OUTLAND: This is Brian. I have
15 nothing additional to add to that.
16 CHAIR BAILET: I'm sorry, go ahead.
17 No, please.
18 MS. JOY: This is Suzanne, and in
19 addition to what Michael and Shari said, to get
20 at some of the later points of the question, too,
21 as far as the sample size which we definitely
22 appreciate those concerns.

1 And I think we had a lot of
2 conversations internally and, as I'm sure
3 everyone on this call can appreciate, kind of a
4 trade-off between having the rigorous criteria to
5 make sure practices really are striving for an
6 advanced level of criteria of care delivery
7 versus getting enough practices in the model.
8 And we feel both are important and as Michael
9 said, CPC+ is meant to be the root referral, and
10 they have 2,800 practices.
11 And we think that's pretty large and
12 there's also the Primary Care First model coming
13 online and obviously, we can't predict how many
14 practices are going to participate in that.
15 But ACP has been working closely with
16 CMS behind closed doors to try and help that
17 model get the word out and hopefully be a
18 success.
19 And that would only expand the
20 beneficiary pool, as would the fact that this
21 model, similar to CPC+, is a multi-payer model.
22 So, we're hoping that a bunch of

1 private payers, if this comes online, would be
2 interested as well.
3 So, for those three prongs we're
4 expecting that beneficiary population to be more
5 than sizeable.
6 And then in addition to the financial
7 criteria the model offers in terms of payments,
8 we also list in our proposal a number of other
9 criteria, including some waivers that we think
10 CMS would probably extend to this model, similar
11 to what they have done with other models.
12 And then, just in general, and Shari,
13 Brian, or Michael, feel free to speak to this
14 more, but I think we've been hearing from our
15 members that, especially given COVID, this fee-
16 for-service system being broken really has just
17 come to the forefront more than even before,
18 which I know we've already had conversations
19 where that was kind of at the top.
20 So, we think that might even generate
21 more interest in joining a model like this that
22 offers some more predictable payments. We think

1 it's a really important time to be having these
2 discussions.
3 So, I'll stop there and invite others
4 to add on as well.
5 DR. BARR: This is Michael. The only
6 other thing I neglected to mention, and just to
7 make sure the review team is aware, the PCSP
8 program that is run by NCQA really came out of a
9 policy position paper that the American College
10 of Physicians developed. And, actually, just a
11 bit of my history, I used to be at American
12 College of Physicians before coming to NCQA.
13 And so this is a physician-oriented or
14 physician-generated concept, and the recognition
15 programs are developed to help identify those
16 practices that should merit the additional
17 payment or recognition for what they're doing.
18 So, this just continues to build on
19 what was started by the medical societies,
20 recognizing we want to keep it as burden-free as
21 possible.
22 CHAIR BAILET: So, this is Jeff. And

1 don't hesitate to jump in here, we are trying I
2 think the point of one, and it might lead through
3 in some of the other questions, we're trying to
4 understand mechanically how you implement this in
5 the native environment, which as you know is not
6 just compartmentalized.
7 It's multi-payer, some of the
8 physicians are participating in certain programs,
9 some are not, they've got partners who raise
10 their hand, other partners -- and that's just
11 sort of the background context in which a model
12 like this would be implemented.
13 And the purpose of what we want to
14 really have a feel for, how would you go about
15 implementing this?
16 So, this is just my interpretation and
17 I'm going to stop, Angelo, in a minute and let
18 you jump in. So, you've got to have a CPC+ or a
19 Primary Care First backbone, that's my
20 understanding of this model.
21 And let me just test that assumption,
22 is that correct?

1 MS. ERICKSON: Yes, Brian, do you want
2 to jump in and speak to that? I think you'll be
3 able to walk through this the best.
4 MR. OUTLAND: Yes, so we looked at the
5 CPC+ under Primary Care First, and so it would be
6 based off of the primary care CPC+ program and
7 multi-payer within those areas.
8 So, while some of the similar concerns
9 were when CPC+ came out, who would be involved
10 and they have multiple different players within
11 the area.
12 So, by already capitalizing on that
13 with the specialties, it would allow them to be
14 able to build off of what is already out there.
15 So, that was one of the reasons that
16 we wanted to pair within the same areas that CPC+
17 and Primary Care First would be.
18 Because it would make it easier for
19 them who are already referring out their patients
20 to specialists, to be able to find the
21 specialists that are within a program that they
22 know is making sure that they're getting the best

1 care for their patients and would be able to say
2 whether or not this is the appropriate person to
3 refer to, or send them back and be able to get
4 the most appropriate care for their patients in
5 the right area.
6 So, that was one of the reasons we did
7 want to pair with the CPC+ and Primary Care First
8 model area.
9 CHAIR BAILET: Okay, that's helpful.
10 Angelo, did you have a follow-on question for the
11 first section here?
12 DR. SINOPOLI: Well, for the first
13 section I guess my biggest question is what is
14 going to motivate the specialists to want to
15 participate in this, particularly if they are
16 already in the PCSP program or other alternative
17 payment models like ACOs?
18 What do you think's really going to
19 attract a specialist to participate in this?
20 DR. BARR: Well, this is Michael.
21 For existing PCSP practices, which by
22 the way, back to Brian's comments, I think one of

1 the ideas is to pilot this in an area with CPC+
2 PCF and existing PCSP practices to start with.
3 That was a nexus that we thought could
4 be a good place to start. Right now there aren't
5 any direct financial incentives for PCSP that
6 we're aware of, except for potentially some
7 commercial payers and, of course, the MIPS
8 program.
9 But this would be on top of that and
10 we think that practices would be interested in
11 the financial incentive to do what they're
12 already doing and prove that they're doing it
13 well.
14 Suzanne, Shari, Brian, I'm not sure if
15 I stated that correctly but feel free to correct
16 me.
17 MS. ERICKSON: Go ahead, Brian.
18 MR. OUTLAND: No, go ahead, Shari.
19 MS. ERICKSON: I was just going to add
20 a couple of things I think are important.
21 One of the things that came up,
22 specialists aren't really -- as Michael

1 mentioned, there are not a lot of robust, if any,
2 programs out there that are directly
3 incentivizing or rewarding those patients that
4 are specialty practices in terms of financial
5 incentives.
6 And specialists within the MSSP aren't
7 really guaranteed any sort of shared savings
8 payments, and because of that, and I know Suzanne
9 can speak a lot more to this because she really
10 knows the ACO programs inside and out, there's
11 been more limited involvement from some of the
12 specialists and sub-specialists within the MSSP.
13 And so it would help to capture some
14 of those that are not engaged in ACOs and don't
15 really have applicable specialty-practice-focused
16 models to participate in, given that there really
17 are very limited to no models out there for them.
18 And I'll stop there for a moment.
19 There's more I could say but I want to see if
20 Suzanne or Brian, I know you wanted to say
21 something else as well.
22 So, Brian, why don't you go and then,

1 Suzanne, if you want to layer on as well?
2 MR. OUTLAND: Well, why doesn't
3 Suzanne layer onto what you've already said and
4 then I can come after that?
5 MS. JOY: Yes, I mean I think Shari
6 put it very well.
7 As everyone on this call knows,
8 specialists can participate in ACOs but they're
9 not guaranteed any of those shared savings
10 payments.
11 So, the MedPAC report that just came
12 out said that they're having difficulty engaging
13 specialists for that precise reason.
14 There's just not the financial
15 incentive to do that and so that's kind of why we
16 created this model in the first place, to fill
17 the void for the current gap in the specialty-
18 practice-focused models.
19 And to Michael's point, they need this
20 upfront funding, doing all these advanced
21 initiatives. And providing preventative care
22 services costs money and it really helps when you

1 have prospective payments to be able to do that.
2 And we do think it'll achieve
3 downstream savings or else we wouldn't put it
4 forward, but we think those prospective payments
5 are really critical elements.
6 And as we said before, too, beyond the
7 payments themselves, there's also some waivers
8 that remove some of those administrative burdens
9 and practices in MIPS are facing.
10 As Shari mentioned, that we've been
11 fighting back against them and think is another
12 big incentive to join this model.
13 So, it's not just one but we do think
14 that -- and we talked to some specialty societies
15 including neurology, who has agreed to partner
16 with us.
17 And we think that's a really
18 productive sign that there is specialty interests
19 in this and we are on the right path. So, I'll
20 stop there.
21 MR. OUTLAND: This is Brian. I'll add
22 that we hear that many of the specialty practices

1 are overwhelmed with referrals that perhaps
2 aren't their primary target patient.
3 So, they have very, very long waiting
4 lists for patients to be seen but then when those
5 patients come, it's not the patients they
6 particularly need to see the most.
7 So, we feel like they would be willing
8 to be a part of this program because it would
9 help them get to their target patient and take
10 out those non-needed referrals that are sent to
11 them, but be able to get to the target patients
12 that really need the services of the specialists
13 the most.
14 And so it can help with their waiting
15 time and improve their overall activities within
16 the office.
17 DR. BARR: Brian, I'll just add that
18 the information also exchanged, based upon the
19 expectations of this model, should help
20 specialists be more effective and efficient in
21 that there's better referrals too.
22 They get the people they need to see

1 and the information they need to have to take
2 care of people.
3 MR. CASTIGLIONE: This is Joe.
4 CHAIR BAILET: Angelo, did you have
5 another question or did that really get to that
6 and answer your question?
7 DR. SINOPOLI: That got to my
8 question.
9 CHAIR BAILET: And I'd like to try and
10 move us along. We should probably get onto the
11 next question given the time, if that's okay with
12 you guys?
13 MS. ERICKSON: Yes, that works, thank
14 you.
15 CHAIR BAILET: Super, thanks.
16 MS. ERICKSON: This is Shari, I'll
17 jump in, unless Sarah has been able to join us,
18 with regards to the quality measures.
19 I'll pause for a second to see if
20 Sarah's jumping in.
21 DR. BARR: Go ahead, Shari.
22 MS. ERICKSON: Okay, I'm going ahead.

1 This is Shari with ACP. I hear what you're
2 saying with regards to the cherry-picking issue.
3 I think, though, what we've identified
4 within our membership, and I'm sure you all are
5 aware of this, ACP represents I think its 159,000
6 internal medicine physicians, which is inclusive
7 of primary care as well as sub-specialists.
8 Having some level of measure selection
9 really is necessary to ensure that they're
10 getting the measures that are most relevant to
11 their patient population.
12 There is variation across even,
13 obviously, the same specialties in terms of what
14 is the most relevant given whatever their unique
15 patient population looks like.
16 So, we did make sure to include,
17 though, that all the measures in our model are
18 MIPS-approved measures. Also, in addition to
19 that, we put them through a second screening that
20 I think, from our perspective at ACP, is really
21 important.
22 Our Performance Measurement Committee

1 has really gone through a robust screening of
2 measures that are relevant to internal medicine,
3 looking at those that they believe are the most
4 valid according to scientific process.
5 And Sarah would be able to speak more
6 in depth to that process, but that being said,
7 we're open to discussing with you all or CMS
8 considering a smaller set of measures if that
9 would make sense.
10 From our perspective, it really is
11 just important to have some level of selection
12 and then also that we're comfortable, from ACP's
13 perspective, that they really are measures that
14 are meaningful and valid for participating
15 physicians in the model.
16 And I guess the other thing is that
17 you would want to be sure that the measures are
18 broadly applicable to practices in different
19 geographic regions.
20 Again, I mentioned the patient
21 population. So, you would have some ability
22 there but if we want to talk about narrowing it

1 down a little bit, that's something I think we
2 would be open to.
3 DR. BARR: Shari, it's Michael, I just
4 want to add a couple quick things.
5 First, from a pilot perspective, going
6 at particular specialties and those particular
7 measures that fall into the subset that Shari has
8 described in terms of the ACP review with CMS
9 coming up with a smaller set of measures.
10 And then also coupling those with well
11 recommended cross-cutting measures so there would
12 be some comparability across specialties.
13 But within the specialties the
14 measures would be fairly uniform and focused.
15 CHAIR BAILET: That's helpful.
16 Angelo, I didn't have any other follow-on
17 questions for the second, Number 2, here.
18 Did you? Angelo, we can't hear you.
19 DR. SINOPOLI: I was on mute. No,
20 that answered my questions for Number 2.
21 CHAIR BAILET: Thank you.
22 MS. ERICKSON: I think we may have

1 talked a little bit about 3 when we were talking
2 earlier about ACOs. I'm just re-reading it now.
3 So, yes, I think we covered quite a
4 bit of that. The challenges that specialties,
5 that the ACOs have had in terms of engaging
6 specialty clinicians and guaranteeing those
7 shared savings.
8 So, this model, I think as Suzanne was
9 mentioning, is ideally a scalable specialty model
10 that could build off the success of some existing
11 models, like CPC+ and whenever Primary Care First
12 is to be rolled out officially.
13 We're hoping it will capture those
14 practices that may not be participating in those
15 ACO models or other models, given they don't have
16 too many other opportunities out there.
17 So, I think those are some of the main
18 points to answer that but there may be others.
19 Michael or Suzanne or Brian, if you all have any
20 other thoughts that we want to touch on that we
21 did not hit on in our earlier discussion?
22 DR. BARR: I think you captured it

1 well, Shari. Over to anybody at ACP or Angelo,
2 if there's any comments?
3 DR. SINOPOLI: This is Angelo.
4 So, if you've got a specialty practice
5 that's part of a robust network and they have a
6 set of quality measures, a care model design, a
7 care management program that they're
8 participating with robustly, and you add this on
9 as another model within their practice, have you
10 had any discussion about the possibility of that
11 being more administrative burden or interfering
12 with the model they're presently practicing with?
13 Or do you not think it's burdensome
14 enough to be an issue?
15 DR. BARR: This is Michael. I'm
16 sorry, Shari, were you going to jump in?
17 MS. ERICKSON: No, go ahead, I'll jump
18 in after.
19 DR. BARR: I think that's an
20 interesting scenario. I'm not sure, I think the
21 target that we are looking for at this practice
22 probably aren't as advanced as the ones you

1 described.

2 For those who are advanced, I think

3 the idea would be that hopefully the

4 documentation for this practice is their

5 demonstration that they are a PCSP and eligible

6 for this additional payment.

7 If they're already as advanced,

8 hopefully it would not be as burdensome as you

9 might otherwise think.

10 Typically, it's the practices that

11 have to build up some of those capabilities where

12 it's not burden, it's what they should be doing.

13 So, we try and alleviate the burden of

14 going through a recognition program while still

15 maintaining the changes being made are relevant

16 and important.

17 So, the practice that already has

18 those hopefully shouldn't have too much trouble

19 going through the recognition process.

20 The practices that don't, that's the

21 work we want them to do. Let me pause here and

22 I'll let my colleagues jump in.

1 MS. ERICKSON: This is Shari.
2 I think the other piece, which I think
3 we did raise earlier is the importance of the
4 patient screening process that would be a part of
5 this.
6 I think it would help alleviate some
7 burdens on practices now that are, again, like
8 Brian mentioned, having long wait lists and
9 patients coming in that it's not the most
10 appropriate place for them to be getting their
11 care for whatever their condition is.
12 So, hopefully that would help better
13 facilitate care coordination, make it more
14 streamlined for both the practice and the patient
15 so that then you really are alleviating burden.
16 Even if the practice may be involved
17 in some other activities, this would really work
18 I think, ideally, hand in hand with some of those
19 aspects.
20 And also, I would anticipate, and
21 obviously not knowing every measure that they may
22 be involved in, but there should be overlap in

1 those measures.

2 They are MIPS-approved measures so if

3 they are engaging in these other activities, this

4 may give them a means to use a more streamlined

5 set of measures that would be applicable across

6 multiple programs including this one.

7 DR. SINOPOLI: Thank you.

8 CHAIR BAILET: So, this is Jeff. This

9 is an assumption -- love your reaction -- I'm

10 thinking that the physicians, the specialists,

11 they're going to form these connections with the

12 primary care referral base irrespective, I

13 believe, of one particular model or another.

14 So, they're going to make these

15 connections with their staff and the staff of the

16 primary care physicians to make sure that when

17 they get a referral that is high-quality, first

18 and foremost, it's appropriate, and that the

19 information supporting that referral is present

20 to maximize the visit.

21 Irrespective of what payment model

22 they're in, that's best practice. And so my

1 assumption is a model like this that's deployed,
2 once those connections are made, it's going to
3 cross over into their other books of business
4 beyond the population, the Medicare fee-for-
5 service population that this model is attempting
6 to address.
7 That's my assumption. How does that
8 resonate with you?
9 MS. ERICKSON: This is Shari. I think
10 that's a pretty fair assumption and the intent is
11 for this to be a multi-payer model, working
12 ideally with the starting point being with those
13 practices, the primary care practices, they'd be
14 working with, or those that are in CPC+ or
15 Primary Care First, which are multi-payer models.
16 So I do think it would translate, ideally.
17 And, again, I think if I'm
18 understanding what you're saying correctly, that
19 gets I think at the point we were making earlier
20 about this providing an overall streamlining to
21 the practice and greater care coordination as
22 those relationships are formed and grow so that
23 the practice is really, both primary care as well
24 as the specialist practices, see the most

1 appropriate patient population.
2 I don't know if others want to add to
3 that or have any other different reactions?
4 DR. BARR: This is Michael, that
5 sounds right.
6 My only question was whether, and ACP,
7 you should answer this, you're experienced in
8 talking to your specialty colleagues about
9 whether those agreements and relationships with
10 primary care are generally in place now or
11 whether there are still some challenges, and
12 that's I think what we're trying to address.
13 But I agree with you that once they're
14 in place, if they're not now, it'll be
15 generalized.
16 But Shari, I think one of the reasons
17 for the whole program and policy that you
18 proposed that those sorts of foundational
19 elements of good care are not always there, not
20 because people don't want to do them but because
21 it's challenging, right?
22 MS. ERICKSON: Yes, that's absolutely
23 right. That is.
24 And Brian and Suzanne, they can speak

1 to that more but yes, that's the challenge we
2 hear, honestly both from the primary care members
3 we have as well as the sub-specialists.
4 Lots of frustrations in terms of
5 trying to establish the most appropriate
6 relationships that work really well for them and
7 for the patient.
8 So, it is definitely a gap area that
9 needs to be filled, independent quite frankly, I
10 guess, of the payment.
11 But if we can do it in a way that
12 really incentivizes it and supports it through
13 payment and ensuring that the practices are doing
14 all the right things through the mechanisms of
15 recognition and the criteria that CPC+ use, et
16 cetera, I think that really helps build the right
17 foundation for doing it over the longer term.
18 CHAIR BAILET: Well, thank you for
19 that, and the reason I'm testing that is because
20 I do think that's potentially one of the more
21 powerful elements of this model.
22 It allows a reset and it gives

1 physicians, specialists, and primary care
2 physicians a framework to adjust their practice
3 styles to create more value beyond just Medicare
4 obviously.
5 Because it would be tremendously
6 burdensome if this was really only applicable to
7 one payer class and then they had to do something
8 different for other payers. That would be -- as
9 good as this could be, it would be incredibly
10 burdensome to the practices. So, this is really
11 an adoption of practice style, irrespective of
12 the payer associated with the patients that is
13 going to occur.
14 That's how I see this playing through
15 if it's where it is intended.
16 DR. BARR: Yes, absolutely. This is
17 Michael again from NCQA.
18 In fact, for the recognition programs,
19 we're very specific in terms of the criteria that
20 they have to apply to the population being
21 served, not a particular narrower demographic.
22 So, it would foster what you're

1 suggesting in terms of distributing the
2 functionality of the features and the better care
3 across the broader population, and be consistent
4 across the population.
5 CHAIR BAILET: And you're getting that
6 feedback from your specialty colleagues?
7 DR. BARR: I'll ask ACP to respond to
8 that. But for the PCSP program, I think the
9 specialists that come through do find this very
10 beneficial.
11 But over to you, Shari.
12 MS. ERICKSON: Actually, I think Brian
13 or Suzanne can probably answer it more in depth,
14 but my answer would be yes, in a nutshell.
15 I'll still see, Brian or Suzanne,
16 given the discussions we've had with neurology
17 and others, your response on that?
18 Suzanne; Go ahead, Brian, please.
19 MR. OUTLAND: Go ahead, Suzanne.
20 MS. JOY: I was just going to say --
21 this is Suzanne Joy -- that we have a county of
22 societies and we've been working on some efforts

1 that are definitely related to this model, and
2 also getting that feedback on this model.
3 And what Michael raised earlier is
4 spot on, specialty practices want to do this.
5 They want to engage with primary care practices,
6 but you need additional staff, you need
7 additional resources, you need technology.
8 And none of that is free. We've also
9 obviously all know about the kind of
10 consolidation that's happening and just the
11 struggle for particularly independent and
12 specialty practices -- single specialty
13 practices, to stay afloat.
14 And so I think there is a hunger and
15 an appetite to do these kinds of innovations,
16 particularly that I think really innovative piece
17 about screening. All of the patients who are
18 coming in to see if that initial appointment
19 really is in the best interest of their care and
20 their pocketbook.
21 But it's not something that's deployed
22 across the board by any means at this point and

1 that's why we included the case studies in our
2 proposal, which I think provide a really small
3 but really important kind of glimpse into how
4 successful this could be and the fact that it's
5 not being implemented on a larger scale.
6 And that's something that I think
7 isn't there that we do want to see. There's an
8 appetite but there's not the means to make it
9 happen, and again, that's where that kind of
10 progressiveness comes in.
11 CHAIR BAILET: Okay, thank you.
12 MR. OUTLAND: This is Brian Outland.
13 I just want to add just a little bit. Because of
14 the feedback we were getting from the specialty
15 groups is really why we created the model to look
16 the way it does look.
17 Because we didn't want it to hit just
18 one aspect of their business like Medicare and
19 Medicaid, but to be able to touch all of the
20 different aspects of their business so that it
21 could be something that was scalable across the
22 entire model and different specialties and

1 different types of pairs and all, to make it easy
2 that way, so that perhaps all of them in the
3 future could use some of the same types of
4 measures and things within one type of a program.
5 Rather than having to do something
6 different for a lot of different programs.
7 CHAIR BAILET: Okay, I'm good on that.
8 Angelo, are you ready to move to the next
9 question?
10 DR. SINOPOLI: I am.
11 CHAIR BAILET: All right.
12 MS. ERICKSON: I think the next
13 question is Number 4, which we had discussed
14 quite a bit.
15 It's also related to ACOs and how it
16 would avoid duplicate shared savings payments on
17 the same beneficiary.
18 So, as we talked about earlier, the
19 specialists aren't guaranteed shared savings and
20 we're looking to engage the gap, I guess, of
21 those that may not have been engaged in those
22 efforts before.

1 CMS does allow CPC+ to overlap with
2 MSSP so we wouldn't want to rule out if they
3 couldn't but we think the model would incentivize
4 and reward them in different ways that could
5 really help them actually result in savings.
6 So, it may help them be more effective
7 overall in achieving savings. They really are
8 quite different approaches.
9 I don't know, Suzanne, since you're
10 really an ACO guru, if there are things you want
11 to add to that? Of course Brian or Michael, or,
12 of course, anybody else?
13 MS. JOY: I think you more or less
14 covered it for sure. I think you did a great
15 job.
16 I don't have anything to add but I
17 will just say, too, that I think we'll be solid
18 ACOs too. What we've also seen with this model
19 is that practices need time to realize those
20 savings.
21 I just kind of wanted to put that plug
22 in, I guess. You don't flip a light switch

1 overnight and then all of the sudden have $100 in
2 your pocket from your patient being healthier.
3 But if you do better care over the
4 course of years, they're going to have less
5 hospital admissions.
6 And so that's kind of where we see
7 this model going but, yes, I think to Shari's
8 point, our model just aims to capture both the
9 specialty practices that have so far not been
10 engaged and ACOs.
11 But certainly we use different
12 incentives and that's why CMS allows overlap with
13 CPC+ and MSSP, and they do that with different
14 types of models.
15 So, I think that would apply in this
16 case too, as Shari pointed out.
17 DR. BARR: This is Michael.
18 I just want to let folks know that
19 I'll need to leave somewhere around 2:47 p.m. to
20 get ready for a webinar I'm doing at 3:00 p.m. so
21 I apologize if I drop off during the
22 conversation.

1 CHAIR BAILET: That's okay, Michael,
2 and thank you for jumping on the call today and
3 helping the PRT understand a little better your
4 proposal. So, thanks for your time.
5 So, I guess what I'm hearing from the
6 group is that the mechanics of handing -- hand-
7 offs and transferring of information and I would
8 call it traffic control, if you will, air traffic
9 control.
10 As you think about how this model is
11 going to be implemented, that's not something you
12 guys are concerned about?
13 Or you think that's not going to
14 create additional challenges as it relates to
15 implementing?
16 That's what I'm hearing you say
17 before?
18 MS. ERICKSON: Yes. I think that's
19 correct.
20 I think, just reiterating one of the
21 things Suzanne mentioned, CMS has allowed
22 differing types of models with different

1 mechanisms for incentives and structures to
2 overlap when appropriate.
3 And I think this falls into that
4 category. These practices would be working with
5 the CPC practices, some of whom do participate in
6 MSSP as well.
7 And I think it actually would overall
8 help the ACO if part of that program is able to
9 be more successful, because it would provide that
10 traffic control, as you mentioned. It's in the
11 model.
12 So, I think it's a mechanism within --
13 it can be, although these specialty practices
14 actually, largely, many of them are not in MSSP
15 or if they are, they're not seeing shared
16 savings.
17 So, I think the chance of a duplicate
18 payment is quite frankly slim.
19 (Simultaneous speaking.)
20 CHAIR BAILET: Go ahead, I'm sorry.
21 MS. ERICKSON: I just wanted to add,
22 too, that this is a two-sided model so, yes, you

1 can achieve savings but that's only if you earn
2 it.
3 You have to work for it and you're
4 held accountable for losses as well, so there is
5 a risk element there. So, I think that in and of
6 itself prevents it from being a windfall
7 situation, is the concern.
8 And we also created a mechanism
9 because of concerns like that, that the
10 specialist will have to be actively engaging with
11 the patient over the course of each quarter.
12 It wouldn't just be you see the
13 patient once a year and get 12 months of
14 payments.
15 And so we put some real thought behind
16 that and we put some mechanisms in place to
17 counteract those concerns as well, which I
18 thought was worth mentioning.
19 CHAIR BAILET: Thank you for that.
20 Was there another comment before we move to the
21 next question?
22 DR. BARR: This is Michael. This

1 will be my last comment before I have to split.
2 I think to the earlier part of your
3 question, if understood correctly, I think there
4 are also opportunities to help specialists put
5 into place some of the best practices based upon
6 existing practice or educational types of
7 opportunities.
8 So, hopefully it'll expedite that
9 learning curve where they don't have those
10 systems in place already.
11 CHAIR BAILET: All right. We've got
12 about a little less than 15 minutes. We've got
13 two additional questions in this document.
14 Are you good, Angelo, with 4? Can we
15 move to 5?
16 DR. SINOPOLI: Yes.
17 CHAIR BAILET: Okay.
18 MS. ERICKSON: Thanks.
19 I'll introduce the question, but
20 actually, I'm going to defer I think largely over
21 to Suzanne and Brian to answer this, rather than
22 try and layer on my thoughts, in the interest of

1 time.

2 I want to be sure that we incorporate

3 what they want to say about it as well. So, this

4 is related to the performance-based payment

5 adjustment benchmark and some questions you had

6 about that.

7 So, I don't know, Brian or Suzanne, do

8 you want to jump in and start on that one?

9 MS. JOY: I'm happy to. Brian sort of

10 covered the first one. Yes, so I'm going to kind

11 of skip over the pieces about the beneficiary

12 population concerns because I think we did talk

13 about it earlier.

14 But with any model, there's always

15 going to be pros and cons and I think you raised

16 a really valid concern about any benchmark-based

17 model. I think it's just kind of inherent to a

18 model design. We did think that benchmark was

19 important with the specialty care model just

20 because services can be so variant, especially

21 with specialty care patients, that we really felt

22 like a benchmark was the best way to normalize

1 it, so to speak, over a larger period of time.
2 I'll also say that, again, MedPAC has
3 raised the concern with some sort of tinkering,
4 with some sort of benchmarks, but they themselves
5 say it's a thought but they don't have a lot of
6 evidence to prove it's actually a problem.
7 So, I can speak to the level of
8 effort, and again, the measure of burden of -- in
9 addition to participating in the model --
10 tinkering with it as some sort of way as
11 artificially inflating the benchmark or anything.
12 The likelihood is in all honesty just pretty low.
13 And then in addition to that, we have mechanisms
14 in place for oversight protections built into our
15 model to ensure just that, that patient safety is
16 preserved and program integrity.
17 And I know NCQA has their own set of
18 criteria as part of the patient specialty
19 program.
20 So, just some of the ones that we
21 mention in our proposal are flag reports, the
22 quality and claims data is closely monitored, and

1 then they're also subject to audits.
2 So, I think there's quite a few pieces
3 in place to prevent those kinds of concerns from
4 arising, and of course, it would be closely
5 monitored.
6 And then I did mention earlier the
7 stopgap measure we've built into our formula
8 payments where you get cut off if you don't see a
9 patient in three months.
10 So, I think, again, that's an
11 important element and I'll defer to Brian on
12 anything else.
13 MR. OUTLAND: So, this is Brian. I
14 think Suzanne covered it.
15 We did look at this extensively, but
16 we could get the best possible payment for them,
17 and benchmarking turned out to be, as we looked,
18 in our opinion, the best way to do it.
19 So that it is equitable for them
20 across the board, not just a one-time snapshot
21 here for this month and that month.
22 But to look back over a period of time

1 to get a nice benchmark for them so that they are
2 checking the types of patients that they see
3 across the continuum of their population.
4 CHAIR BAILET: That's helpful.
5 Angelo, did you have a follow-on question for 5?
6 DR. SINOPOLI: Not for 5, no.
7 CHAIR BAILET: Let's get to the last
8 one and see where we end up here.
9 MS. ERICKSON: Sure, this is Shari.
10 I'll kick it off and then see if Brian or Suzanne
11 or Joe I know is still on from NCQA, so he may
12 wish to jump in.
13 But you mention, obviously, the
14 challenges with achieving shared savings and
15 Medicare, and I know this came up earlier
16 actually.
17 I think we discussed the challenges
18 with that given that you need time to achieve
19 shared savings.
20 I do think one thing, and Suzanne and
21 Brian may wish to speak to this more, but our
22 model includes a patient screening process that's

1 not an element of CPC+ and we believe that it
2 would result in savings because you would ensure
3 that you're getting the right patients to the
4 right place.
5 And we aren't having patients go to
6 the specialists who don't need to be there.
7 And so I think the importance of
8 opening the lines of communication between the
9 specialist and primary care practices and more
10 scrutinizing about when to refer patients to
11 specialists and when the patients get referred
12 back to the PC, the primary care, for ongoing
13 follow-up.
14 We believe that will result in system-
15 wide savings. There are studies, I think one
16 found that 8 percent of referrals to sub-
17 specialty care are inappropriate, Suzanne may
18 have more data on that, either medically
19 unnecessary or the wrong specialty time.
20 And others have found that under half
21 of all specialty care, appointments are routine
22 follow-up appointments, at least some of which

1 can be delivered in primary care settings with no
2 negative impact on outcomes.
3 So, when specialists provide routine
4 primary care services, it may not be the place
5 for that to happen.
6 So, it's really a bidirectional type
7 of issue to ensure the right care is happening in
8 the right place, and the most effective and
9 efficient place for that care to be taking place.
10 I'll just stop there because there may
11 be things -- I know that Suzanne or Brian or,
12 Joe, if you want to jump in and add anything to
13 that as well?
14 MR. CASTIGLIONE: I don't personally
15 have anything to add to that, no. Shari, I think
16 you outlined it pretty well.
17 DR. SINOPOLI: This is Angelo, if
18 include ask a really quick question.
19 So, how would this model prevent the
20 specialist from continuing to schedule just
21 routine follow-up appointments?
22 Is that what I heard you say?

1 MS. ERICKSON: Right, and in fact,
2 actually, I'll let Brian jump in. I think Brian
3 is probably the most appropriate one to answer
4 this in terms of the screening process.
5 MR. OUTLAND: Yes. So, patients that
6 are referred from the primary care physician to
7 the specialist, they would triage the information
8 that they receive.
9 So every patient that comes in, their
10 information would be triaged, and it would be
11 determined whether or not this is the right
12 specialty, for that person to come to me, or
13 whether or not they send it right back to the
14 primary care physician and say, this is the wrong
15 person. You sent them to the wrong patient, and
16 you should send them to a different type of
17 specialist because I don't handle this or handle
18 that.
19 And then for patients that are
20 actually accepted into the model, those patients
21 would receive their follow-up hearing things
22 through them.

1 But there's a period of time where
2 they would, every three months or so, be
3 assessed, and the primary care physician would be
4 able to say, well I think that the care this
5 person is receiving is good.
6 And they would collaborate with the
7 specialist and they would come to an agreement
8 based on the articles of agreement that they
9 would have signed in the beginning to determine
10 whether or not that patient would continue with
11 the specialist, or if it can now be handed back
12 off to the primary care physician.
13 So, they wouldn't just continually
14 keep that patient forever and ever and ever
15 without collaborating back with the primary care
16 physician as to appropriate times that they are
17 handed back off for the best care of the patient.
18 DR. SINOPOLI: Mm-hmm.
19 MS. ERICKSON: Right, and that's an
20 aspect of establishing those upfront in part of
21 the process for participating in the model for
22 the specialty practices.

1 CHAIR BAILET: Angelo, did you have a
2 follow-on question for that?
3 DR. SINOPOLI: No. That's good.
4 (Simultaneous speaking.)
5 MS. JOY: Sorry, I just wanted to add
6 that I also think, again, that claims screening
7 comes in there.
8 Certainly if one practice is standing
9 out, we hope this won't be the case and we don't
10 think it will, but in the event that there is a
11 specialty practice that seems to be doing that
12 and their pattern triggers an alert in the claims
13 monitoring, they would be looked into.
14 So, I think, again, there are some of
15 those mechanisms we have to get into gear there.
16 And I also just wanted to add onto Shari's point
17 earlier that in addition to the savings from more
18 effective referrals, and there's just so much
19 money lost in terms of tests not being set and
20 repeated.
21 And so there's simple stuff like that
22 that you can achieve savings, but as Brian

1 pointed out, services would occur more in the
2 primary care setting.
3 The specialty practice is actually
4 giving up in a way, like easy, kind of one-off
5 appointments, through that screening process.
6 So, we actually think that in and of
7 itself is going to be a pretty big revenue loss
8 for them.
9 But that's what taking better care in
10 the additional payments of their existing
11 population is sufficed to offset.
12 So, it's not more or less patients,
13 it's more appropriate patients.
14 And then I just also wanted to point
15 to the fact that we are targeting specialty
16 patient populations, those are inherently more
17 complex and thicker and more expensive, if we're
18 going to be blunt about it.
19 So, targeting those patient
20 populations has the potential for even more
21 savings perhaps than CPC+ already has.
22 And then again, just kind of plugging,

1 yes, the preliminary results of CPC+, maybe they
2 haven't achieved savings but these types of
3 models take a few years to generate savings, just
4 like MSSP, which turned a point, and now, since
5 then, it has achieved savings.
6 So, we might not quite be there yet,
7 it's still a new model.
8 CHAIR BAILET: That's helpful. Just
9 real quickly. You have neurology, cardiology,
10 and infectious disease.
11 Was there specific underlying reasons
12 why those were the specialties that were
13 originally served up as the astronauts for this
14 proposal?
15 Or are there real concrete reasons why
16 those are selected?
17 MS. ERICKSON: Others may wish to add
18 more, but one of the reasons was because of ACP's
19 support for the measures that are relevant to
20 those specialties.
21 So, I mentioned earlier how important
22 it is to us to have measures that we view as

1 clinically relevant and valid, and that also were
2 MIPS measures.
3 And so when you take a close look at
4 that, we need to be a little bit selective in our
5 initial thought process around this to be sure
6 that we, as ACP, would be very comfortable that
7 the measures that would be involved in the work
8 would be ones that we were comfortable with.
9 Also, it had to do with -- Suzanne and
10 Brian may wish to speak more to this, but those
11 that are really interested in engaging this
12 effort, because obviously this is not an easy
13 endeavor to jump in and try to work together on
14 something like this.
15 So, that is another factor I think
16 that played into this. Suzanne or Brian, do you
17 want to add more to that?
18 MR. OUTLAND: This is Brian.
19 Everything you just said, but also there are some
20 specialties that didn't have the measures that
21 ACP was very, very supportive of, or perhaps even
22 enough measures for us to be able to look at.

1 But they did still express interest in
2 the model and it's not that they're just left off
3 the list, that they can't be a part of it, but we
4 just started with leave because it was a better
5 shift to start with than look at expanding as we
6 continue to move forward.
7 CHAIR BAILET: That's great, thank
8 you. And we are at time, I know Michael's
9 already dropped off.
10 I just want to personally thank on
11 behalf of the PRT, Joe, Shari, Brian, and Suzanne
12 for your help.
13 Your comments today were really
14 valuable in our ability to evaluate this model
15 and we really applaud you for the thoughtful work
16 that's gone into this and your developing of this
17 model and creating a framework for specialists
18 and primary care physicians to work way more
19 closely together, coordinate care, and then get
20 recognized for their efforts.
21 So, again, I applaud you for putting
22 this together and I look forward to being able to

1 deliberate with a full Committee here hopefully
2 at the next meeting in September.
3 So, thank you for that. Angelo, did
4 you have any closing comments?
5 DR. SINOPOLI: I would just echo that.
6 The comments and discussion today were very
7 valuable in explaining some of the questions we
8 had.
9 And again, I applaud you in trying to
10 figure out a mechanism to get specialists more
11 involved in the care of these patients.
12 So, thank you.
13 MS. ERICKSON: This is Shari. I just
14 want to say thanks on our behalf as well. I
15 really appreciate your in-depth review of my
16 submission and the follow-up sets of questions.
17 It's helpful for us as well to think
18 through and obviously clarify all of these
19 points.
20 So, it's important for us to try to
21 think through, as you mentioned, ways that we can
22 engage with our sub-specialists and have them

1 have opportunities to participate.
2 I think just one quick thing, I
3 mentioned what Suzanne said earlier about they're
4 getting more and more hungry for this, given even
5 the impact, even as they're facing the challenges
6 right now with regards to COVID, that an
7 opportunity like this is something I think
8 they're really hungry for so we appreciate your
9 full consideration of it.
10 CHAIR BAILET: You bet. All right,
11 folks, have a good holiday coming up and we'll be
12 in touch. We appreciate all your help today.
13 Thank you.
14 (Whereupon, the above-entitled matter
15 went off the record at 3:01 p.m.)

C E R T I F I C A T E

This is to certify that the foregoing transcript

In the matter of: Conference Call with
ACP and NCQA Submitters

Before: PTAC

Date: 06-29-20

Place: teleconference

was duly recorded and accurately transcribed under my direction; further, that said transcript is a true and accurate record of the proceedings.

Court Reporter