

# Physician-Focused Payment Model Technical Advisory Committee

## Preliminary Review Team Report to the Physician-Focused Payment Model Technical Advisory Committee on the *The “Medical Neighborhood” Advanced Alternative Payment Model (AAPM) (Revised Version)*

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Physician-focused payment model (PFPM) proposals submitted to the Physician-Focused Payment Model Technical Advisory Committee (PTAC) in accordance with PTAC’s proposal submission instructions are assigned to a preliminary review team (PRT). Each PRT prepares a report of its findings on the proposal for discussion by the full PTAC. The report is not binding on PTAC; PTAC may reach different conclusions from those contained in the report. Each report and related materials are available on the PTAC section of the Office of the Assistant Secretary for Planning and Evaluation (ASPE) [website](#).

### A. Proposal Information

- 1. Proposal Name:** The “Medical Neighborhood” Advanced Alternative Payment Model (AAPM) (Revised Version)
- 2. Submitting Organization or Individual:** American College of Physicians (ACP); National Committee for Quality Assurance (NCQA)
- 3. Submitter’s Abstract:**

The Medical Neighborhood Model (MNM) is a five-year, multi-payer pilot that seeks to improve coordination between specialty practices and primary care practices who refer patients to them and provide advanced support to their patients. The model addresses two key problems:

- A dearth of specialty Advanced Alternative Payment Models (APMs). The MNM can apply to a broad range of specialties with a sufficient number of high value electronically specified clinical quality measures.

- Poor primary care practice and specialist referral coordination, which is a significant contributor to poor quality care, inefficient resource allocation, and unnecessary costs. The MNM holds clinicians accountable for outcomes, patient experience and efficient resource utilization. It builds on the Patient-Centered Specialty Practice (PCSP) concept, which is promoted by the Medicare Access & CHIP Reauthorization Act (MACRA) statute and accompanying regulations with full automatic credit in the Merit-Based Incentive Payment System's (MIPS) Improvement Activities Category. PCSPs meet rigorous criteria that promote high-quality coordination with referring primary care practices guided by Care Coordination Agreements. PCSP standards emphasize enhanced access to timely, patient-focused care, shared decision making, continuous improvement, and use of Certified Electronic Health Record Technology (CEHRT). All of these features improve primary care and specialty coordination, close gaps in care, and lead to better outcomes.

**Quality:** The MNM features a core set of cross-cutting measures and a menu of high-value specialty-specific electronic clinical quality measures. It uses electronic reporting exclusively to minimize burden and leverage the rich clinical data in electronic health records, specialty-specific registries, and other electronic sources. Measures focus on high-priority domains such as utilization, behavioral health, patient-reported outcomes, patient experience, and care coordination (where applicable). The model also features two claims-based readmission measures and a subset of CAHPS®1 patient experience survey questions (see Appendix 1).

**Payment:** All MNM practices receive a monthly per beneficiary per month (PBPM) care coordination fee to support enhanced care coordination and care delivery innovations. All model participants are also subject to a retrospective positive or negative payment adjustment based on how actual spending compares with a financial benchmark (adjusted for performance on quality and utilization metrics). The MNM would feature two distinct tracks. Track 1 practices would bill traditional Medicare as usual, while Track 2 practices would receive reduced Medicare payments in exchange for prospective quarterly payments based on projected spending.

**Scalability:** The MNM pilot will compare referrals from Comprehensive Primary Care Plus and Primary Care First primary care practices to specialists in MACRA-approved PCSPs versus [*sic*] non-PCSPs. It has the capacity to include any specialty that has enough high-value electronic clinical quality measures and ideally, a dedicated Qualified Clinical Data Registry (QCDR). Currently Cardiology, Neurology, and Infectious Disease meet these qualifications and we [ACP-NCQA] have provided sample quality measures for these specialties. If the pilot is successful, the model can be expanded to include referrals from patient-centered medical homes (PCMHs), additional specialties, and additional payers.

## B. Summary of the PRT Review

The ACP NCQA 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 submitter—which was submitted to PTAC and found to have met the Committee’s administrative requirements on November 20, 2018. The PRT conducted its review of the revised version of the proposal between March 20, 2020 and July 24, 2020. The PRT’s findings are summarized in the table below.

### PRT Rating of Proposal by Secretarial Criteria

Criteria Specified by the Secretary (at 42 CFR §414.1465)	PRT Rating	Unanimous or Majority Conclusion
1. Scope (High Priority)	Meets Criterion	Unanimous
2. Quality and Cost (High Priority)	Meets Criterion	Unanimous
3. Payment Methodology (High Priority)	Meets Criterion	Unanimous
4. Value over Volume	Meets Criterion	Unanimous
5. Flexibility	Meets Criterion	Unanimous
6. Ability to Be Evaluated	Meets Criterion	Unanimous
7. Integration and Care Coordination	Meets Criterion	Unanimous
8. Patient Choice	Meets Criterion	Unanimous
9. Patient Safety	Meets Criterion	Unanimous
10. Health Information Technology	Meets Criterion	Unanimous

## C. Information Reviewed by the PRT

### 1. Proposal and Additional Information Provided by the Submitter

The PRT reviewed the ACP NCQA proposal, including additional information provided by the submitter in response to written questions, and it held a one-hour teleconference call with the submitter during which the submitter responded to additional PRT questions. In addition, three public comment letters were received in response to the proposal.

The PRT’s summary of the proposal and evaluation of the proposal compared to the Secretary’s criteria for physician-focused payment models (PFPMs) are below.

#### ***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 the Center for Medicare & Medicaid Innovation’s (CMMI) Comprehensive Primary Care Plus (CPC+) model and the Primary Care First (PCF) model slated to begin in 2021. The model incorporates Patient-Centered Specialty Practices (PCSP) standards and guidelines developed and maintained by NCQA. The submitter proposes that the Medical

Neighborhood Model (MNM) be piloted in a subset of CPC+ regions (and PCF regions once initiated) with specialties that have enough high-value electronic clinical quality measures (eQMs) that can be used to implement and monitor the MNM; the submitter proposes 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 submit annual documentation. While this process involves high standards and many physician practices achieve this certification, PCSP recognition is proprietary and is not open source. MNM practices will be assessed on quality and utilization measures and 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 receive regular fee-for-service (FFS) payments, while Track 2 practices receive a reduced rate of FFS payments of 75 percent in exchange for prospective quarterly payments based on projected spending. The MNM payment model has three components:

1. Care Coordination Fee (CCF): All participants will receive a per beneficiary CCF to support care delivery investments, as well as a potential performance-based payment based on spending relative to a benchmark and adjusted for quality and utilization metrics.
2. Performance-Based Payment Adjustment (PBPA): All participants will receive performance-based payments based on spending relative to a benchmark.
3. Comprehensive Specialty Care Payments (CSCPs): Participants who choose Track 2 will 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 MNM specialty practice would bear risk through PBPAs, which reflect performance relative to a benchmark based half on a practice’s own historical spending and half on regional spending. PBPAs are 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.

## **2. Literature Review and Environmental Scan**

ASPE, through its contractor, conducted a targeted environmental scan of peer-reviewed and non-peer-reviewed publications. The review included a formal search of major medical, health services research, and general academic databases; relevant grey literature, such as research reports, white papers, conference proceedings, and government documents; and websites of professional associations and societies and the Centers for Medicare & Medicaid Services (CMS) for relevant evaluation reports and program documentation. Key words guiding the environmental scan and literature review were identified from the proposal. The search may not be comprehensive and was limited to documents that met predetermined parameters, generally including a five-year look-back period, a primary focus on United States-based literature and documents, and relevancy to the proposal.

## **3. Data Analyses**

ASPE, through its contractor, used all 2017 Medicare FFS claims for eligible beneficiaries who had a usual PCP at the outset of the year to assess the distribution of specialist visits (any specialist, as well as CPC+ aligned and cardiology, neurology, and infectious disease specifically) for the eligible beneficiary population. The analysis estimated how many beneficiaries, visits, and specialist practices might be covered by the MNM, were it implemented nationwide.

## **4. Public Comments**

There were three public comments for this proposal: two comments from medical specialty societies and one comment from an independent physician.

## **5. Other Information**

The PRT also met with a family medicine physician consultant who was provided by the ASPE PTAC support contractor.

## D. Evaluation of Proposal Against Criteria

### Criterion 1. Scope (High Priority)

*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.*

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**PRT Qualitative Rating: Meets Criterion**

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#### Strengths:

- The proposal aims to provide an opportunity for more specialists to participate in APMs, especially practices that do not have an opportunity to participate in ACOs or other CMS APM initiatives.
- The proposed model potentially leverages two existing CMMI APMs (CPC+ and PCF). The submitter indicates that specialty practices would be drawn from CPC+, currently operating in 18 geographic regions, or the PCF model, which is scheduled to begin in 26 regions in 2021. The submitter believes that including providers from PCF would double the number of referrals.

#### Weaknesses:

- 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 MNM may be positive for some but not all specialty practices.
- 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 is not open source. Further, PCSP recognition may be costly and time-consuming to obtain, especially for small practices (approximately 10 physicians or less).

#### Summary of Rating:

The PRT unanimously believes that the proposed PFPM meets the criterion. The proposed model will provide more opportunities for specialists to participate in APMs. Although the initial pilot would be limited to a subset of specialty practices (i.e., cardiology, neurology, and infectious disease), if fully implemented the model could be expanded to encompass additional types of specialists. The PRT notes that the model could in theory be an option for smaller or rural providers that do not have opportunities to participate in ACOs or other large health system initiatives, although the volume of patients for some of these practices may make participation infeasible or very costly.

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

*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.*

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### PRT Qualitative Rating: Meets Criterion

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#### Strengths:

- The proposal calls for the use of existing evidence-based quality measures that are captured electronically.
- Quality is also enhanced by the requirement for PCSP recognition. However, as noted above, such recognition is proprietary and practices must pay a fee to obtain the recognition in addition to meeting the standards.
- Participating specialty care practices must meet minimum quality standards to share in PBPAs.
- The submitter proposes that CMS provide regular (e.g., quarterly) performance feedback reports to model participants, including meaningful comparison/benchmark data.

#### Weaknesses:

- The proposed model has the potential to lower costs by reducing unnecessary testing and referrals and by improving care management and coordination. However, the model's increased payments may be difficult to offset through downstream savings.
- The proposal states that pre-screening can be done by non-physician staff at the specialist's office. Using non-physician staff rather than physicians for pre-screening may result in access, quality, or patient safety problems.
- Specialists may already be participating in care coordination activities under other models, including CPC+ or Accountable Care Organizations (ACOs). Almost three quarters of CPC+ primary care practices report using collaborative care agreements with specialists.<sup>1</sup> In a recent national survey, over half of multispecialty practices reported participating in a Medicare ACO (one-third of single specialty practices). Participation was reported to be nearly as high in medical homes, Medicaid ACOs, and commercial ACOs.<sup>2</sup> The large share of specialists already engaged in these arrangements would generally find they already qualify for the attractive enhanced payments offered by the

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<sup>1</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>.

<sup>2</sup> AMA 2018 Survey, p. 12. <https://www.ama-assn.org/system/files/2019-09/prp-care-delivery-payment-models-2018.pdf>.

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.

**Summary of Rating:**

The PRT unanimously believes that the proposed PFPM meets the criterion. The model will provide a framework to strengthen collaborative efforts between specialists and PCPs to achieve higher-quality outcomes. While reductions in costs would need to be assessed through evaluation, several mechanisms in the proposal could enable costs to be maintained or possibly lowered.

**Criterion 3. Payment Methodology (High Priority)**

*Pay APM Entities with a payment methodology 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.*

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**PRT Qualitative Rating: Meets Criterion**

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**Strengths:**

- The payment model aims to address the challenge of compensating specialists for engaging in time-consuming care coordination with primary care providers. Specifically, the proposal payment methodology includes a payment (CCF) to incentivize care coordination.

**Weaknesses:**

- The proposed model describes periodic handoffs between participating specialists and primary care practices/physicians participating in CPC+ (and potentially PCF later). Without proper implementation of the proposed attribution methods, these handoffs between providers and the quarterly nature of the payments under the MNM 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 with the primary care clinician resuming coordination of care for the beneficiary. However, the PRT believes that a robust attribution methodology will mitigate this issue.
- A key expectation of the model is that participating specialists would use prospective CCFs and CSCPs to invest in care coordination staff, technology, or other related practice improvements. However, CPC+ already includes care management fees, and early evaluations results have not shown cost savings. CPC+ tested an incentive up to twice as



large as CPC but failed to show any offsetting impact on claims cost in the first year.<sup>3</sup> The latest estimate for CPC is that the \$15 PBPM average fee only generated about \$9 PBPM in partially offsetting savings.<sup>4</sup> Additionally, it is not clear how CMS would monitor whether the CCFs are used properly.

- Downside risk is not incorporated into this proposal and, while not required to qualify for consideration of a PFP, the submitters state the model they are proposing qualifies as an Advanced APM where significant downside risk is required.
- Half of the PBPA benchmark would be based on regional spending. Although risk adjustment is included, such a benchmark could be difficult to define under a general formula to serve as a counterfactual spending target. There would potentially be certain specialty types (or subsets of practices within certain specialty types) that find favorable bias in their regional benchmark. Resulting selective participation could increase the savings shared with participants under the PBPA and inflate the break-even savings point to an even higher level. Participants could also selectively choose a lower minimum savings/loss rate if they find their regional benchmark to be favorable.

#### **Summary of Rating:**

The PRT unanimously believes that the proposed PFP meets the criterion. The proposed payment model will support improved coordination between specialists and PCPs while incentivizing high-value care and maintaining quality. While concerns exist about some aspects of the payment model (e.g., duplicate payments, attribution methods, etc.), the piloting of the model in a subset of specialties means there will be an opportunity to address these issues before full implementation of the model as well as before implementation with additional specialties.

#### **Criterion 4. Value over Volume**

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

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#### **PRT Qualitative Rating: Meets Criterion**

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#### **Strengths:**

- The proposed model requires pre-screening to reduce inappropriate specialist referrals and unnecessary or duplicate testing.

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<sup>3</sup> Independent Evaluation of Comprehensive Primary Care Plus (CPC+) First Annual Report April 2019. Mathematica Policy Research, pp. ES.8-9. <https://downloads.cms.gov/files/cmmt/cpcplus-first-ann-rpt.pdf>.

<sup>4</sup> CPC Fourth Annual Report, p. xviii. <https://downloads.cms.gov/files/cmmt/CPC-initiative-fourth-annual-report.pdf>.

- The 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.

**Weaknesses:**

- The proposed MNM model allows specialists to select quality measures from a bank of options, which may lead to cherry-picking of measures.

**Summary of Rating:**

The PRT unanimously believes that the proposed PFPM meets the criterion. The model will facilitate high-value referrals while also curtailing inappropriate referrals and unnecessary or incorrect diagnostic testing selection. The PRT believes that the model's success will be contingent on ensuring that the payment methodology, including attribution methods, adequately supports improved coordination between specialists and PCPs. However, as noted above, because the model will first be implemented as a smaller-scale pilot initiative, there will be an opportunity to refine the payment model prior to a larger-scale implementation.

**Criterion 5. Flexibility**

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

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**PRT Qualitative Rating: Meets Criterion**

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**Strengths:**

- The proposed model accommodates a range of specialist-patient referral relationships, including one-time consultations and ongoing collaboration with PCPs.
- The submitter suggests 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.

**Weaknesses:**

- Small practices may find obtaining PCSP recognition too costly and burdensome to participate in the proposed model.
- The volume of patients in smaller practices may be insufficient to warrant participation in small and rural practices.

**Summary of Rating:**

The PRT unanimously believes that the proposed PFPM meets the criterion. After the initial pilot, the proposed model could be applicable to practices regardless of specialty, practice type, geography, and other characteristics. However, smaller practices may find the requirement to obtain PCSP recognition burdensome.

## Criterion 6. Ability to Be Evaluated

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

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### PRT Qualitative Rating: Meets Criterion

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#### Strengths:

- Proposed evaluation data sources would include Medicare claims, eQMs (reported), and CAHPS survey data (from surveys distributed to patients by referring practices).
- The submitter recommends 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 who received care from non-MNM specialty practices (i.e., a difference-in-differences analytic design). The analysis would assess whether and how participation affects patient experience, health outcomes, resource utilization, and total cost of care.

#### Weaknesses:

- To guarantee a statistically valid sample size, the proposal requires that at least 100 patients must be attributed and trigger monthly CCFs over the course of a year. However, the proposal does not include calculations of statistical power, and it is not clear that this minimum sample size will be sufficient or attainable by all participating practices. The sample size of 100 is far lower than the minimum considered statistically stable enough for shared savings under Medicare's ACO agreements (e.g., 5,000 for the Shared Savings Program).<sup>5</sup>
- While the suggestion to identify and compare cohorts of patients with and without referrals to MNM specialists is helpful, systematic differences between the treatment and control groups could still bias estimated effects of the proposed model.

#### Summary of Rating:

The PRT unanimously believes that the proposed PFPM meets the criterion. The PRT finds that the proposal provides adequate provisions for construction of an adequate control group and evaluation of quality and cost outcomes.

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<sup>5</sup> Medicare Shared Savings Program: Shared Savings and Losses and Assignment Methodology Specifications. May 2018 Version #6 Applicable Beginning Performance Year 2018, p. 46. <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/Downloads/Shared-Savings-Losses-Assignment-Spec-V6.pdf>.

## 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.*

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**PRT Qualitative Rating: Meets Criterion**

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### Strengths:

- The proposal aims to expand integration, care coordination, and data-sharing between PCPs and select specialists (i.e., cardiology, neurology, and infectious disease) by leveraging existing medical neighborhoods created through the CPC+ or PCF models.

### Weaknesses:

- 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.

### Summary of Rating:

The PRT unanimously believes that the proposed PFPM meets the criterion. The PRT finds improving integration and care coordination is an integral goal of the program and that the model design will encourage greater coordination of care between specialists and PCPs.

## Criterion 8. Patient Choice

*Encourage greater attention to the health of the population served while also supporting the unique needs and preference of individual patients.*

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**PRT Qualitative Rating: Meets Criterion**

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### Strengths:

- The proposed model does not restrict patient choice of specialty care providers and would curtail unnecessary referrals and specialist visits.
- The submitter notes that the MNM's requirement that participating specialty practices be part of PCSP should result in greater access to specialty care, due to anticipated reduction of inappropriate referrals and priority given to urgent care.

### Weaknesses:

- The process for attribution of patients may be a challenge. However, the submitters propose that the model first be piloted in a limited number of practices, which would provide an opportunity to refine the attribution methods.

### **Summary of Rating:**

The PRT unanimously believes that the proposed PFPM meets the criterion. The MNM model could reduce inappropriate referrals and unnecessary, duplicative, or incorrect diagnostic testing or imaging, and increase access to specialty care without limiting patient choice.

### **Criterion 9. Patient Safety**

*How well does the proposal aim to maintain or improve standards of patient safety?*

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**PRT Qualitative Rating: Meets Criterion**

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#### **Strengths:**

- The proposal suggests multiple approaches to maintain patient safety, including requirements under NCQA's PCSP model and monitoring specific to the proposed MNM model (i.e., CAHPS survey on patient experience, eQMs, and administrative claims measures on quality and utilization).

#### **Weaknesses:**

- It is unclear what constitutes appropriateness of care for an e-consult and whether this definition would vary across specialties.

### **Summary of Rating:**

The PRT unanimously believes that the proposed PFPM meets the criterion. The PRT notes that participating practices would be required to meet PCSP standards that emphasize patient safety and appropriateness of care.

### **Criterion 10. Health Information Technology**

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

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**PRT Qualitative Rating: Meets Criterion**

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#### **Strengths:**

- The proposal calls for all data and measures to be captured electronically, either through administrative claims or eQMs.
- The model requires practices to use CEHRT and electronically report quality, cost, and outcomes data.
- The submitter 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.

- Challenges of interoperability may potentially be addressed or mitigated by the requirement that all clinicians and vendors use uniform electronic data exchange standards and CEHRT.

**Weaknesses:**

- While the proposal indicates use of CEHRT, some electronic medical record systems can be certified while still not performing functions that doctors need or that could actually improve coordination.
- The submitter proposes multiple subsidies to facilitate health information technology (HIT) upgrades and meeting of MNM-related requirements. Such subsidies add to the cost of the models for CMMI and make it harder to achieve net savings for the model.
- 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 model particularly challenging and expensive for smaller practices, and the proposed subsidies may not be sufficient to offset these additional costs.

**Summary of Rating:**

The PRT unanimously believes that the proposed PFPM meets the criterion. The proposed model would enhance use of certified CEHRT and increase electronic reporting of quality and outcomes data.

**E. PRT Comments**

Through its deliberations on previously submitted models, PTAC has increasingly recognized the need for an APM for specialists. The potential goals of such a model would be very important: improving access to high-quality care through better care coordination across providers, and controlling costs by reducing unnecessary specialist referrals as well as increasing timely use of services for patients needing specialist care. The PRT views the MNM as one possible approach to incentivizing better care coordination between primary care providers and specialists both to potentially avert unnecessary specialty care as well as improve care within and between specialty practices. While some specialists may currently participate in APMs in conjunction with ACOs or health system initiatives, many providers do not currently have opportunities to participate in such programs. Furthermore, the MNM 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.

As discussed in this report, the PRT finds the MNM needs further development on many aspects of both the care model and the payment model. The PRT was uncertain about the incentives and mechanisms for many practices to participate and the feasibility/cost of some of the proposed interactions. A number of logistical issues would need to be addressed or further developed to ensure successful implementation of the model, even as a pilot or test model. Key aspects to be developed further include:

- A comprehensive set of required quality measures that also accommodates the fact that the most appropriate quality measures may differ for various conditions or specialists
- Adequate implementation support for specialty practices, including obtaining NCQA PCSP recognition (or development of an alternative approach within CMS rather than being dependent on a non-governmental organization)
- Robust attribution methodology to ensure that payments are not duplicated across participating specialists and referring PCPs
- Careful evaluation to identify impacts on quality and costs

Despite the above limitations, the PRT believes that the MNM provides sufficient framework and mechanisms to justify further consideration. This assessment is made with an acknowledgment that a specialist APM may not be able to achieve the threshold of large savings preferred for model development and implementation. The identified payment and care model challenges could be addressed and logistical details could be refined during an initial pilot. While ultimately a specialist-focused APM should be available to a wide range of specialists, the three specialties proposed by the submitter were identified due to a combination of existing relevant quality measures and interest by those specialists. If refined and deemed successful through a pilot for these three specialists, the model could be considered for expansion to additional specialties.