Responses to Questions for Submitter
Preliminary Review Team Review of the Medical Neighborhood Model (MNM)
Submitted by ACP and NCQA
January 2019

1. **Target audience.** A stated strength of this model is its breadth and applicability to a variety of specialists, patients, and clinical needs. For the purposes of clarification we would like to better understand how the proposed PFPM might be applicable in various scenarios. We have described several scenarios through two of the possible dimensions of flexibility below, termed practice type and service requested of specialist, and ask that you indicate whether the model is applicable to all combinations of these characteristics, or just a subset?

		Service requested of specialist			
		Diagnostic or treatment planning consult only	Treatment of acute condition	Treatment of chronic condition for patient with no significant comorbidities	Treatment of chronic condition for patient with multiple conditions
Practice type	Independent (non-employed) entities	Yes	Yes	Yes	Yes
	Physicians primarily in employment-based entities	Yes	Yes	Yes	Yes

2. **Scenarios. We would appreciate a few detailed examples of how you envision this model working. Specifically, it is stated on page 17 of the proposal that the model could be adapted to "a range of specialist-patient referral relationships, from one-time consults, ongoing collaboration with primary care physicians (PCPs), and cases**

such as cancer in which the specialist provides the bulk of care" please provide a scenario for each of these three types of interactions. We would request that your examples emphasize what the participating providers (both primary and specialty providers) would do differently clinically under the MNM, how they would interact (frequency, mode of communication, what information is exchanged), and how payment would be allocated.

a. **Pre-Consultation, No Referral Needed**
    i. The PCP in a rural community sends a referral request to a Medical Neighborhood Model (MNM) endocrinologist at an AMC 3 hours away regarding a 17 year old girl with a 4-5 month history of amenorrhea and increasing weight gain, stria and slight facial hirsutism. A pregnancy test had been negative and lab values for cortisol and testosterone were markedly elevated. The PCP indicates suspected Cushing's Syndrome and the clinical question from the PCP asks what imaging should be done to expedite the referral or does the endocrinologist prefer to do the imaging at the AMC. In pre-consultation review of the information included with the referral request, the endocrinologist notes that the patient is taking a hair and nail supplement. S/he suspects the biotin in this supplement may have interfered with the lab test results, so s/he asks the PCP to check the supplement and if it contains biotin to have the patient not take the supplement for several days and repeat the labs, including the pregnancy test. The repeat labs show a strongly positive HCG pregnancy test and appropriate (not abnormal for pregnancy) cortisol and testosterone levels. This virtual option required work and attention by both the endocrinologist & PCP but it expedited appropriate care for the patient as she was then seen by OB rather than endocrinology, avoided unnecessary and harmful care, including imaging, and avoided a long travel time and time off work for her parents.
    ii. A PCP sends a referral request to a MNM radiologist to perform a biopsy of a thyroid nodule seen incidentally on carotid US in a referral 72-year-old woman. The radiologist indicates in the pre-consultation review that a formal thyroid ultrasound should be done first. The ultrasound shows a low TI-RADS score indicating a low risk of malignancy and no need for the biopsy, avoiding an unnecessary procedure and appointment.
    iii. A patient is referred to a MNM Gastroenterology (GI) group for treatment of his hemorrhoids. The GI group does not treat hemorrhoids as one of the local surgeons has an updated procedure for treating hemorrhoids. In the past, every patient who was referred to this group

was scheduled and then referred on if needed. With the MNM approach, the GI practice let the PCP know through pre-consultation review that referral to the surgeon directly was more appropriate and thus avoided an unnecessary referral appointment for the patient and reduced delay in getting the care he needed.

iv. A 32-year-old female suffers from increasingly frequent migraines despite being on medication and often goes to the emergency department for pain relief. The PCP refers her to a MNM neurologist for consideration of new medications for migraines. The neurologist reviews the referral request as part of pre-consultation and suggests a therapeutic trial with drug A before the initial neurology referral appointment. The patient improved immensely with the therapeutic trial, no longer needing the neurology appointment or a trial on the newer, more expensive medication. The MNM pre-consultation process expedited care for the patient and avoided an unnecessary appointment while saving costs.

b. **One-Time Consults:** For one-time consults, the PCP would share information with the specialist about the reason for the referral, other issues the specialist should know about (such as comorbidities or social determinants), and any other pertinent information the specialist and PCP agreed to in their Care Coordination Agreements (CCAs). Afterwards, the specialist would electronically share information on what the specialist determined or did, any follow-up the patient may need and other information agreed to in the CCA.

   i. A 67-year-old male is referred to a gastroenterologist to treat his Hepatitis C. The Hepatitis-C titers are included with the referral request information. During pre-consultation review, the gastroenterology practice requests additional labs that were not included with the referral request such as albumin level, etc. At the initial appointment, the gastroenterologist has all the lab data that is needed so s/he is able to do a fibro-scan in the office and determine the degree of fibrosis and now prior authorization for the indicated medication can be done more quickly and without duplicating the lab tests. Without the MNM approach, the gastroenterologist would have ordered the missing labs and had the patient return for a second visit for the fibro-scan.

   ii. A PCP refers a 36-year-old female with Downs Syndrome to a MNM endocrinologist for difficult-to-control hypothyroidism. The attached clinical question and summary indicate that despite increasing the dose of levothyroxine (LT4) and observed administration of the pill, the TSH level had remained elevated, indicating under replacement. The patient

was scheduled and seen for an endocrine consultation with additional testing revealing co-existing Celiac Disease, accounting for the malabsorption of the LT4. The endocrinologist sent a complete report back to the PCP suggesting a further increase in the LT4 dose in the short-term with monitoring and likely reducing the dosage as the Celiac Disease is treated and absorption improves. In addition, the endocrinologist had a phone call to discuss whether the PCP is comfortable treating the Celiac Disease or would recommend referral to a Gastrolenterology group while adjusting the LT4 dose over time if needed. This approach helps to consolidate care for a patient with additional health and social challenges and ensures the PCP is supported. It also avoids unnecessary appointments to the endocrinologist and an unnecessary secondary referral to a gastroenterologist.

c. **Ongoing Collaboration with PCP:** For ongoing collaboration, the PCP would initially share the reason for the referral, other issues the specialist should know about, and any other pertinent information the specialist and PCP agreed to in their CCA. During the collaboration, the PCP and specialty clinician would continually share information on what the specialist is doing and how that might affect what the PCP should or might do for the patient. After the collaboration, the specialist would share information on outcomes of the specialty care, any follow-up the patient may need, and other information agreed to in their CCA.
    i. A 67-year-old female is referred to a MNM endocrinologist with a calcium level 10.8, an elevated PTH of 86, and a low bone density score in the osteoporotic range by DXA. The patient is wary of surgery and wants to know if there are other options. The vitamin D level was included with the referral information and is normal at 40, so the endocrinologist is able to have a detailed shared decision making appointment with the patient and her husband. The endocrinologist confirms primary hyperparathyroidism and indicates that over 80% of primary HPT is due to a single adenoma which can be cured by a minimally invasive surgical procedure. The couple agrees to get the suggested localizing parathyroid imaging and return to discuss with the endocrinologist as part of consultative evaluation. The imaging shows a single adenoma in the right upper location. The patient and her husband are agreeable to the minimally invasive surgical procedure. The endocrinologist sends a detailed consultation report back to the PCP with recommendations for referral to surgery, follow up postop calcium and a repeat DXA in 1-2 years. The MNM endocrinologist also touches base by phone with the

PCP to see if s/he prefers the endocrinologist to refer to surgery and follow or if the PCP is comfortable, and makes him/herself available for virtual assistance if needed.

d. Specialist Provides Bulk of Care: For specialists providing the bulk of care, the PCP would share the reason for the referral, comorbidities or social determinant factors, and any other pertinent information the specialist and PCP agreed to in their CCA. While the specialist provides the bulk of care, the specialist would share back information on the specialty care, how it might cause side effects, affect comorbidities, or other issues. Over the period that the specialist provides the bulk of care, the PCP would provide primary care services not directly related to the specialty care, such as screenings and management of other chronic conditions, and inform the specialist of this care. After the specialist has provided the bulk of care for a specific episode, the specialist would share information with the PCP on the outcomes of the specialty care and any follow-up the PCP should know about or provide directly.

i. A 26-year-old male is referred to a gastroenterologist to find the cause of recurrent diarrhea and abdominal pain and see if he requires a scope. The attached referral information includes a negative celiac panel, negative stool cultures, copies of recent CBC and chemistries, and a thyroid panel. The referral is requested as a procedural consultation request. The MNM gastroenterologist performs the scope which shows severe Ulcerative Colitis. The gastroenterologists shares this information with the PCP and recommends s/he assume principal co-management. The patient is scheduled for a follow-up appointment and is sent educational material via the portal. At the appointment, the GI Registered Nurse (RN) reviews the material and the different medication options. The gastroenterologist and patient jointly agree on a medication. The RN calls to check on the patient after one week. He is tolerating the medication but his symptoms have not improved. The RN calls to check in weekly, and after three weeks the patient begins to have bleeding with his stools and is scheduled for a same day appointment. The gastroenterologist coordinates with the PCP to be sure all of the necessary immunizations and testing (such as TB testing) are complete. The GI specialty care practice continues to manage the patient's Ulcerative Colitis in part through virtual check-ins but for routine care, such as a sprained ankle from hiking, the patient continues to contact his primary care team. The patient's GI and primary care practice continue to have regular, ongoing communication.

ii. A 34-year-old male is referred to a MNM endocrinologist to help manage new onset diabetes. Metformin helped initially, but the patient's control is steadily worsening. The patient is concerned about other medication options and does not want to take insulin. The endocrinologist does a pre-consultation review of the attached information and notes that the patient's BMI is 25 and his mother has diagnosis of Rheumatoid Arthritis. He suggests that the PCP order a GAD-antibody test in advance of the referral appointment. The test results show highly elevated GAD antibodies and is shared with the endocrinologist. Given this information, the endocrinologist discusses Type 1 Diabetes at the initial appointment and immediately starts the patient on insulin therapy. The endocrinologist continues to manage the patient's Diabetes, including issuing the pump and CGM therapy, educating the patient on diabetes care, and ordering the annual TSH, lipid panel, and UMCR, the results for which are communicated with the PCP. The patient is told to call the endocrinologist with any diabetes issues but to otherwise contact his PCP team for other preventive and acute care. The patient develops a severe allergic reaction after multiple hornet stings. The PCP prescribes glucocorticoid therapy and informs the endocrinologist. The endocrinology team prescribes extra insulin while the patient undergoes the glucocorticoid therapy and provides additional suggestions over the patient portal and phone.

iii. A 56-year-old female is referred to a MNM rheumatologist for increasing bilateral hand pain and stiffness with a positive rheumatoid factor blood test. The patient has known hypothyroidism, depression, hyperlipidemia, and hypertension and the PCP requests shared care co-management. The rheumatologist confirms Rheumatoid Arthritis (RA) and discusses treatment options with the patient. The patient opts to try methotrexate therapy. The PCP obtains the required liver monitoring tests and shares the results with the rheumatologist. The patient does not respond well to the therapy and additional symptoms began to appear. In addition, the liver test results were becoming elevated. The rheumatologist discusses other options with the patient and they opt to try biological therapy. The necessary testing and immunizations were obtained in coordination with the PCP, and the infusion therapy for the biologic therapy was arranged at the rheumatology office. The rheumatologist assumed principal care co-management of the RA for the patient.

3. **Interaction with CPC+. Please describe how the proposed model interacts with the CPC+ model. Is the CPC+ model an essential part of the MNM framework?**
    a. Intersection with CPC+ is not an essential part of the MNM framework. However, we believe PCPs in CPC+ have the greatest incentive and capability to coordinate care across the MNM and ensure its success. Pilot testing this model within the CPC+ framework would create a more consistent pool of referral practices to use for program evaluation purposes. MACRA-eligible Patient-Centered Medical Homes (PCMHs) are also ideal partners for future participation in the model, and provide ample opportunity for expansion beyond CPC+ practices so the model could be expanded to regions with a high density of PCMHs such as Minnesota, the Hudson Valley region of New York, or Greater Philadelphia.

4. **Care Coordination Fee (CCF)**
    a. **The proposal refers to a "small" monthly CCF. For the purposes of assessing the potential financial impact of this model, please provide more detail on the approximate payment amount (in dollars) for the CCF.**
        i. While they would not be responsible for managing a patient's care plan and coordinating between various clinicians, the patient, and his/her family, participation in our model would require from specialty participants an elevated level of coordination with PCPs and clinical practice standards that require investing in electronic data exchanges and additional staff time managing pre-consultations, etc. Additionally, specialty practices have smaller, more fluctuating patient populations and patient mixes that vary significantly; they also tend to have a smaller Medicare penetration than primary care practices.[1,2] Therefore, MNM specialty practices would need comparable care coordination fees on a per capita basis to justify participation in the model. However, the total amount Medicare pays in CCFs would be substantially less than the total CMFs it pays for CPC+ due to smaller patient population sizes and fewer Medicare patients for specialty practices. Accordingly, we would envision that for the MNM the fees would be comparable to the care management fees (CMFs) in CPC+, which vary based on the patient's level of risk but average $15 for Track 1 and $28 in Track 2, up to $100 for patients with complex care needs in Track 2. More research into the exact expected costs required to participate in the model and specialty

[1] Physician Specialty Data Book. American Association of Medical Colleges. Link.
[2] 2017 Physician Benchmark Survey Patient Mix. American Medical Association. Link.

specific claims data is needed to calculate the exact dollar figure, but a similar methodology used to calculate the CMFs for CPC+ could be used.

b. Would the amount be more, less, or the same as the Care Management Fees that primary care practices are receiving under CPC+?

i. The amount of the CCF would depend on the expected additional costs practices would have to deploy on new technologies and staff in order to successfully participate in the model divided across the estimated number of patients that would be attributed in the model, which depends on the number of payers that participate. CCF payments would likely be slightly less than CMFs in that the scope of work is relatively less intense since CPC+ requires PCPs to serve as the overall manager of a patient's care. However, the smaller patient population size would mean the CCF would have to be slightly higher on a per capita basis to cover extra costs – such as for expanded access and care coordination – in order to justify participation. Whether the CCF would ultimately be above or below CPC+ depends on those independent calculations and is indeterminate at this time, but it would likely be comparable to CMFs with these two forces negating one another. In addition, after the initial two years, the CCF should be adjusted based on data and experience gathered in the first two years.

c. How much higher would the CCF be for Track 2 practices?

i. The difference in care management fees for Track 1 versus Track 2 practices would depend on the exact calculations of additional expenses incurred to participate in the model for the respective tracks but should be comparable to the CPC+ CMF payments in both tracks for the first two years, after which fees could be refined based on model experience.

d. Would different specialties receive different CCF amounts?

i. Different specialties would receive the same CCF for pre-consultations, tracking and ranking appointments based on priority, and satisfying CCA requirements. However, these fees would be risk-adjusted to account for the differing severity of patient populations, which may intrinsically differ across specialties.

e. Would the specialty practice only receive the CCF for a patient who was explicitly referred to that practice by a CPC+ practice?

i. The initial pilot would link to CPC+ practices to ensure consistent practice transformation and care coordination standards to allow for more consistent and reliable program evaluation of similar patient populations. However, we recognize that the enhanced coordination between MNM

specialists and PCPs could have enormous potential to help reshape care delivery at the primary care and specialist level on a larger scale. Therefore, we recognize that the MNM could later be expanded to additional primary care practices beyond CPC+ practices. MIPS-eligible PCMHs are a prominent model of primary care delivery and could be considered for a secondary expansion phase, as could various state-level and private sector primary care innovations.

Is it correct that there would be no CCF for (1) a patient referred by a non-CPC+ practice, (2) a patient who was referred by a CPC+ practice to a different specialty practice but who decided to come to the specialist practice instead, and (3) a patient who did not have an explicit referral from a CPC+ practice but who decided to seek specialty care on their own?

i. (1) Correct. Patients referred by non-CPC+ practices or other primary care practices not linked to the MNM would not incur a CCF payment.

ii. (2) Payments would be made if the specialty doctor with whom the patient has an office visit is enrolled in MNM and the referring PCP is enrolled in CPC+ and the two have a CCA in place and otherwise meet the requirements of the model.

iii. (3) Payment may be made under the model if the specialist meets the MNM criteria and the patient's PCP is part of a CPC+ practice and the two have a CCA in place and otherwise meet the conditions of the model. If the patient does NOT belong to a CPC+ participating primary care practice, payment would not be made.

f. Would the specialty practice receive the CCF for an individual patient for more than one month? What would determine how many months the practice could receive the CCF for the same patient?

i. The specialty practice is paid a CCF starting in the month in which the initial plan of care is received and continues to be paid the CCF until the patient is discharged from specialty care. Criteria for discharge could be based on the CCA, patient plan to leave the practice, or if the specialist or PCP determines the episode is complete.

g. On page 16, the proposal says that the CCF would be risk adjusted based on comorbidities, cognitive impairment, self-care ability as measured by ADLs, demographics, and social determinants of health. However, the next paragraph only mentions specifically using Hierarchical Condition Category scores, which do not include many of the aforementioned categories of information. Could you please clarify what factors will be accounted for in the risk adjustment process, and the source(s) of that information?

i. HCC scoring is the common standard currently being used by CMS to assess risk adjustment in many capacities, including CPC+. Therefore, starting with the HCC scoring as a foundation would allow this model to be piloted in a short timeframe. However, ACP, NCQA and others have been on record about the shortcomings of HCC scoring, including that it does not address social determinants of health.[3] Many factors can contribute to worse outcomes and should be accounted for in the risk adjustment process: comorbidities, cognitive impairment, self-care ability as measured by ADLs, demographics, and social determinants of health, including income, education, occupational level, as well as race and ethnicity.[4] Therefore, our model could use risk-tiering based on a foundation of HCC scoring with critical supplements to account for additional factors not currently captured, such as socioeconomic status and the total number of conditions. Ideally, specialty-focused risk screens would be developed in partnership with CMS and participating specialties. Several specialties have developed condition- or specialty-specific risk adjustment screenings, such as the American College of Cardiology's Atherosclerotic Cardiovascular Disease Risk Calculator. Collecting this data could also have the added benefit of informing future CMS efforts to improve risk scoring and better isolate the impact of complex and overlapping conditions when it comes to care coordination across settings. Minimizing administrative burden should always be a key consideration when deploying new risk adjustment screenings or data collection efforts. CMS has also made some recent efforts to improve risk scoring for Medicare Advantage plans, including accounting for dual eligible and a new risk adjustment proposal that would count a patient's total number of conditions. ACP and NCQA have each been supportive of these efforts to improve risk adjustment in the MA space and we encourage the Agency to consider applying these improvements to traditional Medicare,[5,6] including a MNM pilot in the future.

h. Would the CPC+ practice still receive the same Care Management Fee for a patient during a month in which the specialty practice was receiving the CCF?

i. Yes. A CPC+ practice would be eligible to receive the CMF while the MNM practice receives the CCF. Each practice will separately incur costs to

[3] Addressing Social Determinants to Improve Patient Care and Promote Health Equity. An ACP Position Paper.
[4] California safety-net hospitals likely to be penalized by ACA value, readmission, and meaningful-use programs. Health Affairs. Aug 2014.
[5] ACP Letter to CMS on Unplanned Hospital Readmission Measure
[6] ACP Comments on Proposed Changes to the CMS-HCC Risk Adjustment Model for Payment Year 2017

develop and maintain the infrastructure and clinical standards required for participation the model. In the future, patient relationship codes could play a valuable role in further illuminating the interaction between MNM specialty practices and their primary care partners and their respective roles in patient care and associated clinical costs. The combined efforts by CPC+ and MNM practices to independently improve clinical transformation standards coupled with the enhanced coordination between the two will magnify the cost savings that more than compensate for CCFs and CMFs.

5. **Performance-Based Incentive Payment (PBIP)**
    a. **Please describe the methods for calculating the PBIP.**
        i. Our model utilizes a benchmark-based system as opposed to CPC+ prospective, set dollar amounts because specialty models tend to have more variant and unpredictable fluctuations in spending per patient, so the risk for both CMS and participating practices is mitigated with a benchmark total spending approach. The PBIP would compare actual spending in the performance year from referrals from CPC+ practices to a practice's benchmark, which is based on spending from a lookback period. The baseline savings rate would be set at 50%, which would then be adjusted up or down based on how well the practice performs on clinical quality and utilization measures so that the MNM practice would retain an increasingly larger amount of the PBIB generated from savings based on its quality and utilization performance respective to national benchmarks. See part C for more on how this would work.
    b. **How large would the PBIP be? Would it be more, less, or the same as the PBIP that CPC+ practices are receiving? How much higher would the payment be for Track 2 practices?**
        i. Specialists tend to have a smaller patient population over which to spread risks with more fluctuations in per capita spending than primary care practices, so the PBIP for the MNM is based on a retrospective evaluation of actual spending versus expected spending, which mitigates risk for both CMS and participating practices. Because the PBIP for our model is evaluated differently than for CPC+, the comparison between the two is less relevant.
    c. **Please clarify what measures of utilization or spending the PBIP would be based on. Page 14 says the PBIP would be based on "utilization measures" but then states that success would be measured by "assessments of cost-effective**

care relative to benchmarks based on a practice's historical spending that are trended forward based on regional spending."

i. Similar to CPC+, in order to be able to share in any PBIP, participants would have to first be required to beat a pre-determined financial benchmark based on their own past spending trended forward based on regional spending. In addition, each participant must also meet a performance "floor" for a core set of quality and utilization metrics based on national percentiles. Once a participating practice is determined to meet these entry-level criteria, it would then be scored on a sliding scale basis on those same utilization and quality measures to determine what percentage of the total PBIP the practice could keep. Increasingly high percentile scores relative to national benchmarks would result in a practice keeping an increasingly high percentage of the PBIP. The exact grading system would be developed in partnership with CMS and participating specialties and could be adjusted at the start of every performance year. By way of example, CPC+ requires a floor of a 30th percentile for quality performance and 50th for utilization that maxes out at 70th percentile and 80th percentile respectively.[7] Most utilization and cost measures are designed for attribution at the facility level of analysis and therefore would not be appropriate for inclusion in this payment model. However, several measures do exist for evaluating appropriate use of testing modalities specific to the work of various subspecialists (e.g., NQF ID# 0672: "cardiac stress imaging not meeting appropriate use criteria: testing in asymptomatic patients, low-risk patients"). Once we identify the subspecialty group with whom we wish to pilot this program, we can identify cost and utilization measures that are relevant to that subspecialty area and contingent upon the recommendations of the ACP Performance Measurement Committee. It would also be important that these measures be endorsed by the National Quality Forum, recommended for use by the Measures Application Partnership and, if relevant, included within core sets of measures recommended by the Core Quality Measures Collaborative.

d. What minimum numbers of patients would be required in order to use the quality measures described in Appendix I in setting the PBIP? Would only attributed patients be included in the denominators of the measures?

[7] CPC+ Payment Methodologies. Dec. 1, 2017.

i. Each MNM participating specialty practice would be required to have a minimum of 100 attributed Medicare beneficiaries to be eligible for the MNM to ensure measure reliability and validity. In addition, individual measures would be required to meet consistent standards for reliability to be counted towards a practice's quality or utilization score. CMS has adopted a reliability standard of 0.4 for MIPS cost measures, though ACP has recommended a higher minimum reliability threshold of 0.75.[8]

6. **Comprehensive Specialty Care Payment (CSCP)**
    a. **Would the CSCP in Track 2 be based on the specialty practice's total FFS revenues, including any procedures the practice performs, or just the specialty practice's E&M payments?**
        i. The CSCP would be based on the practice's total FFS revenue, including E&M charges and procedures performed by the practice, excluding drugs, biologicals, and other elements outside of the physician's control.
    b. **Would the CSCP be paid only for the subset of patients who are attributed to the specialty practice during a particular month, or for all of the specialty practice's patients?**
        i. The CSCP would only be paid based on the patients attributed to the specialty practice under the MNM during a particular month. However, because the MNM is intended to be a multi-specialty model, the goal is to have a majority of the practice's patients attributed to the model.
    c. **Is it correct that in Track 2, you are proposing a 10% increase in the CSCP above FFS rates in addition to higher CCF payments and a higher PBIP?**
        i. In Track 2, practices forego 25% of ongoing FFS payments to receive that amount up front as a prospective payment based on predicted spending. In that track, practices would have the option to put 3% of that money at risk, which would qualify them for participation in an Advanced APM under nominal amount threshold benchmark-based standard.

7. **Interactions among providers**
    a. **Are any of the payment components intended to be split among multiple providers?**
        i. Participation in the model is defined at the practice site, which is the "bricks and mortar" location under a TIN so multiple clinicians operating at the same practice site would be participating in the model as a group

[8] ACP Letter to CMS on Unplanned Hospital Readmission Measure

and would therefore have any model-specific payments distributed to them as a group. The terms of dividing model payments would be settled between the practice and the participating clinicians.

b. **The proposal states that participating practices must notify referring clinicians that the patient was accepted and when an appointment was scheduled. How would compliance with this requirement be determined? Would the specialty practice still be paid for a patient if this communication did not occur, or would payment for each patient be contingent on this communication occurring?**
    i. For each pre-consultation, the specialist must respond electronically to the CPC+ referring clinician that one of several applicable actions was taken, including scheduling the patient for an urgent face-to-face visit, scheduling the patient for a non-urgent visit, scheduling the patient but requiring additional information or test results before the appointment date, communicating with the patient by phone or video, etc. This would be monitored and tracked through the CEHRT, QCDR, or whatever technology platform the practice elects to use for communication with referring primary care practices and CMS. As noted in our proposal, if CMS were to pilot this model, we would strongly recommend the agency expand its CPC+ online portal in part to accommodate MNM specialty partners to facilitate this monitoring of communication between the specialty and primary care practices.
c. **Would this model and associated payment ever apply to specialists referring to and coordinating with each other, or only when a PCP is involved?**
    i. Payment in the MNM would only occur when the CPC+ participating primary care practice is involved. In some cases, it may be appropriate to recommend the patient be referred to a subspecialist. This information would be communicated back to the PCP for him/her to make a referral. The MNM participant would receive credit for that communication to the PCP. The key is to maintain the PCP as the center of the MNM.

8. **Pre-consultation/e-consultation**
    a. **The proposal says that a "pre-consultation" would be "required" when a referral is received. Does a "pre-consultation" require communication with the PCP in all cases, or only if the specialist feels that an appointment is unnecessary or inappropriate? If the specialist feels an appointment is not appropriate, would an e-consultation be required? What would happen if the specialty practice attempts to conduct an e-consultation with the referring primary care practice, but the PCP is unable or unwilling to participate?**

i. For each pre-consultation, the specialist must respond electronically to the CPC+ referring PCP that one of several applicable actions was taken, including scheduling the patient for an urgent or non-urgent face-to-face visit, scheduling the patient but requiring additional information or test results before the appointment date, referring back to the PCP for referral to another specialist or subspecialist, etc. If the specialist schedules the patient visit, that will trigger the patient's participation in the model. That information will be relayed back to the PCP followed later by a summary of care once the specialty visit is complete. In the event that the specialist does not feel that an appointment is the most appropriate course of action at that time, it will automatically trigger an e-consult with the PCP to discuss and agree on an appropriate next step. If the PCP and specialty clinician do not mutually agree on an appropriate next step for the patient's course of treatment, the patient may still be seen by the MNM practice and the case would be elevated to CMS' peer-to-peer review determination process for a resolution.

b. The proposal says that an e-consultation would be "paid at the FFS rate to the specialist and PCP." To what FFS rate are you referring?

i. This was in reference to the CMS fee schedule codes for 99446 (interprofessional telephone/ Internet/ electronic health record assessment and management service), 99451 (interprofessional telephone/ Internet/ EHR assessment and management service provided by a consultative physician), and other codes within this code family.

c. If an e-consultation fee is not paid if an office visit occurs within seven days, wouldn't this penalize physicians who can see patients promptly? Wouldn't this encourage physicians to wait eight days to schedule appointments at eight days after the e-consultation in order to receive both payments?

i. E-consultation visits are not paid if the referred patient is accepted into the MNM specialty practice. Participation in the model is triggered by an office visit once a specialist has assumed responsibility for treating a patient. The e-consultation payments are intended to compensate the specialty clinicians for referrals that would not result in new, attributed patients to the model. The guidelines for use of the e-consult-visit codes do not allow an e-consult within 14 days or the next available face-to-face visit. If a patient has an e-consult and the visit is the next available appointment (within or outside of the 14 days) the e-consult would not be paid, eliminating any incentive to postpone visits.

9. **Provider participation criteria**
    a. **How critical are the three elements listed on page 13?**
        i. We believe that pre-consultation review, appointment tracking and ranking to prioritize urgent cases and CCAs are each indispensable for minimizing waste, ensuring efficient and effective referrals, and protecting patients from efforts to achieve savings. The pre-consultation review establishes the clinical appropriateness of the referral and provides an opportunity to expedite or prioritize more urgent cases. This review potentially eliminates an unnecessary patient visit altogether, generating savings for the entire system. Several national specialty/subspecialty societies have already developed referral guidelines[9,10,11] that could be utilized to inform the pre-consultation process. Referral tracking and CCAs are core features of effective coordination across settings and are mandatory activities, per the required clinical transformation standards laid out in the model.
    b. **How is provision of these three elements verified?**
        i. These elements could be initially verified through the certification process (such as NCQA PCSP) in which participants would be required to demonstrate adherence to core elements of care coordination and transferring across settings. Ongoing monitoring is explained below.
    c. **Can these be maintained via paper methods, or are other means required?**
        i. All three elements could be maintained via paper methods. However, we believe that using CEHRT or other electronic systems would be the most effective and efficient way for specialists to consult with PCPs and triage and close referral loops. CMS could facilitate electronic communication, reporting, and sharing of data between clinicians in MNM and CPC+ practices by expanding the current CPC+ interface to MNM practices.

10. **Patient eligibility**
    a. **Do you believe this payment model should always be limited to patients who have a PCP that is participating in a primary care APM such as CPC+ and who are referred to the specialty practice by that PCP?**
        i. PCPs participating in CPC+ likely have the greatest incentive and capability to coordinate with specialists participating in the MNM. Building off the CPC+ model would provide consistency for program

[9] Endocrine Society Clinical Practice Guidelines
[10] American Academy of Neurology Clinical Practice Guidelines
[11] American Academy of Family Physicians Clinical Practice Guidelines

implementation and evaluation purposes, particularly for an initial pilot. However, the model could be expanded to include MACRA-eligible PCMHs. Eventually, the model could include referrals from all PCPs provided appropriate safeguards are put in place to ensure the referring PCPs understand and agree to meet the heightened standards that come with playing a role in the model.

b. For applications of the model that are not limited to single consultations (e.g. "one-off consults"), how is eligibility evaluated on an ongoing basis?

i. Patients remain eligible for inclusion in the model throughout their relationship with an MNM specialist, which entails ongoing services over the course of a performance year. CCF payments are evaluated on a monthly basis until a patient exists from the model, and PBIPs and CSCPs are evaluated on an annual basis. See below for more detail on how patient exit from the model is handled.

c. How is patient exit from the model handled?

i. The specialty practice gets a CCF starting in the month in which it receives the initial plan of care and continues to get the CCF until the episode is complete. Criteria for discharge could be based on the inter-practice CCA, patient care plan to leave the practice, or if the specialist or PCP determines the episode is complete. For PBIPs, patient attribution to the model for a given performance year will occur if there was a specialty visit within that year.

11. Quality measures reflecting core intent of model. Please describe if and how the quality measures capture the interaction of PCPs and specialists.

a. The cross cutting measures are focused on care coordination between PCPs and specialists. In addition, the patient-reported outcomes and experience measures aim to capture coordination and care planning between the patient, PCP, specialist, and any subspecialists. ACP's Performance Measurement Committee will continue to evaluate measures for possible future inclusion in the MNM.

12. Practice spending calculations

a. The proposal states that actual practice spending will be retrospectively compared to projected spending. How will this be calculated?

i. Actual spending will be retroactively reconciled against a benchmark of projected spending based on the practice's own past spending that is trended forward based on regional spending. The baseline sharing rate

would be set at 50% but could be adjusted up or down based on performance on quality and utilization measures.

b. How would such measures account for the possibility that care may be shifted to another provider, for example if the pre-consultation results in the PCP managing an issue that would have previously received specialist intervention?

i. The pre-consult aims to achieve savings from unnecessary specialty appointments. In many cases care will be delivered in a more affordable setting, or even with patient monitoring at home. In other cases where the patient is referred to a subspecialist or more urgent care setting, this would have almost certainly occurred in addition to the specialty visit, so the lack of specialty appointment still represents a cost savings. This cost savings would be recognized in the model as a debit for the foregone cost of the visit in total cost calculations.

c. If these measures are not based on total cost of care, how are distinctions made between condition-specific spending and total cost of care?

i. Specialist costs should be calculated based on charges for visits, procedures, and other services ordered by the specialist. In other words, total cost of care as it relates to the specialist. In some cases, this may align with condition-specific spending if the patient is seeing the specialist for only one condition. In other cases, specialists may treat patients for multiple conditions. Specialty models have smaller patient populations, which makes attributing total cost of care including hospital readmissions more challenging than for CPC+. However, we do agree that reducing hospital admissions is a key savings driver and benefit of the MNM. That is why we propose to make the PBIP evaluated based on specialty-specific spending but to account for downstream savings associated with fewer hospital readmissions with an avoidable hospitalizations measure as one of the utilization measures.

13. Downside risk. Please describe more about the extent to which participating providers face downside risk.

a. In Track 2, practices forego 25% of ongoing FFS payments in order to receive that amount up front as part of a prospective payment based on predicted spending. In that track, practices would have the option to put 3% of that money at risk, which would qualify them for participation in an Advanced APM under the nominal amount threshold benchmark-based standard.

14. Participating specialty practice monitoring

a. How do monitoring, compliance, and auditing work in the model?

i. In order to initially participate in the model, practices would need to demonstrate meeting a rigorous set of clinical transformation standards. Should CMS elect to use PCSP recognition, practices would be required to submit supporting documentation to NCQA on an annual basis in order to sustain that recognition. NCQA reserves the right to audit a recognized practice during this annual check-in. NCQA audits a sample of practices, either by specific criteria or randomly. Audits may be completed by email, teleconference, webinar or other electronic means. Audits may also be completed through on-site review. Practice sites selected for audit are notified and sent instructions. The first level of review is verification of the submission to NCQA. The practice may be asked to forward copies of the source documents and explanations to substantiate the information in the submission. If audit findings indicate that information submitted by the practice is incorrect or evidence does not meet standards, the application for NCQA Recognition may be denied, credits may be reduced or additional evidence may be required. NCQA notifies the practice of audit findings and the recognition status within 30 days after conclusion of the audit. Model participants could also be subject to ongoing additional monitoring by CMS modeled after CPC+ program integrity standards. As noted in the MNM proposal, ACP members report that the level of monitoring in the CPC+ model is appropriate and ensures program integrity without causing undue burden on clinicians. Monitoring criteria may also include but would not be limited to: program integrity screenings, quarterly attestations of care delivery, quarterly "flag reports," bi-annual submissions of financial data including how practices use prospective model payments, care delivery agreements with referring PCPs, an annual external report of program performance by a third party vendor, audits on an ad hoc basis, and submission of cost, utilization, patient experience, and quality data. Practices who fail to meet any required criteria would be subject to corrective action plans and risk termination from the program if they do not address areas of deficiency or concern.

b. Would these processes entail any on-site evaluation, or be entirely virtual?

i. Audits may be completed by email, teleconference, webinar or other electronic means, or through on-site review.

c. Who is monitoring participants and assessing adherence to the items on pg. 9?

i. For PCSP standards, practices must submit evidence to NCQA or demonstrate through virtual review their ability to meet PCSP standards. Other monitoring activities could be conducted directly through CMS.

d. The proposal refers to participating specialists meeting standards "such as" the NCQA recognition program. What other standards could a practice choose to meet in order to participate in the APM other than the NCQA standards?

i. At present, NCQA's PCSP is the only specialty-designated model that qualifies for credit under the Quality Payment Program. Immediately upon CMS' development or approval of a comparable specialty practice certification program, that program would be considered eligible for the MNM and subject to its own initial and ongoing monitoring criteria.

e. What if a participating entity meets some but not all requirements? Are there payment reductions?

i. Per the MNM proposal, "acceptance to the model would be contingent on certification of proven clinical practice transformation." Therefore, we expect all entities to meet all requirements in order to achieve certification and be eligible to participate in the model. This guarantees the highest quality of care standards for the patients MNM practices serve. Performance-based payments would be subject to performance on utilization and quality metrics compared to national percentile scores.

15. Multi-payer threshold. The proposal says the MNM would be a multi-payer model. What minimum participation level would be required from other payers in a market?

a. Minimum participation from private payers would depend upon the specialties and geographies selected for the model. For example, in densely populated regions, minimum required participation could be lower because participants are more likely to have larger populations for valid measurement. However, certain subspecialties and low-density regions could encounter small numbers issues and would therefore need significant multi-payer participation in order to achieve valid measurement.

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

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THURSDAY, MARCH 7, 2019

4:00 p.m.

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PRESENT:

KAVITA PATEL, MD, MSHS Lead, PTAC Committee Member
HAROLD D. MILLER, PTAC Committee Member
SARAH SELENICH, Designated Federal Officer (DFO), Office of the Assistant Secretary for Planning and Evaluation (ASPE)
JULIA DRIESSEN, PhD, ASPE
KELLY DEVERS, PhD, NORC at the University of Chicago
KAREN SWIETEK, PhD, NORC at the University of Chicago
AMY AMERSON, NORC at the University of Chicago
SARAH DINWIDDIE, American College of Physicians (ACP)
SHARI ERICKSON, ACP
SUZANNE JOY, ACP
BRIAN OUTLAND, ACP
MICHAEL BARR, MD, MBA, MACP, FRCP, The National Committee for Quality Assurance (NCQA)
JOE CASTIGLIONE, NCQA
PAUL COTTON, NCQA
GEORGE MAY, NCQA

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

4:03 p.m.

DR. PATEL: This is Kavita Patel. I think I know a good proportion of the people on the call. To keep it short, I am the lead on the Preliminary Review Team. And I'm an internist.

And some of you may know my background, so I think Julia hopefully sent you our bios, for those of you who don't know us, so that we didn't waste time. We have a hard stop in an hour, which is now evaporating to 56 minutes.

So, Harold and I thought we would keep intros short on our side. And I'll just say, Jeff Bailet, who is the Chair of PTAC and is the third member of this Preliminary Review Team, could not be on. So, he sends his regrets, but we've gotten his feedback. Harold?

MR. MILLER: And this is Harold Miller, Center for Healthcare Quality and Payment Reform, and I'm a member of the Preliminary Review Team.

DR. PATEL: And that's the PRT. So,

I'll let Julia, I know Shari and I know Michael, I'm not sure if there's a lead from each organization on the phone, but I'll let you tell us who's on the phone in whatever fashion is appropriate.

And then, all of the ASPE team members introduce themselves. So, let's try to keep it brief, so we can get to the substance.

MS. ERICKSON: Yes. That sounds good, Kavita. Thank you. This is Shari Erickson from ACP. I'm our VP for Governmental Affairs and Medical Practice and the lead staff person from ACP.

But there are a few others from ACP on, I'll just let them briefly say who they are, and then, we'll move over to NCQA's team. So, Brian, do you want to go next?

MR. OUTLAND: Yes. I'm Brian Outland, I'm the Director of Regulatory Affairs at ACP.

MS. JOY: Hi, I'm Suzanne Joy. I'm the Senior Associate for Regulatory Affairs at ACP.

MS. DINWIDDIE: And this is Sarah

Dinwiddie. I'm the Staff Lead for the Performance Measurement Committee at ACP.

DR. BARR: Great. And this Michael Barr, Executive Vice President at NCQA. Paul? Well, Paul Cotton is the Director of Federal Affairs. And Joe?

MR. CASTIGLIONE: Hi, Joe Castiglione, Strategic Initiatives at NCQA.

DR. BARR: And that's it from NCQA. And I'm the lead from NCQA. Good to hear your voice, Kavita.

DR. PATEL: You too, Michael. All right. Julia, do you want to talk for the ASPE team and the contractors, briefly?

DR. DRIESSEN: Yes, sure. So, I'm Julia Driessen. I'm the ASPE Staff Lead for this proposal. We also will be joined by Sarah Selenich, who is ASPE staff and the DFO for the Committee. We also have a number of members from our contractor, NORC, on the line.

DR. DEVERS: Yes, hello. This is Kelly Devers, Senior Fellow, NORC. I'm joined by my

colleagues, Karen Swietek and Amy Amerson.

DR. DRIESSEN: And just to start, I believe Sarah, the DFO, will be joining us shortly, but just to give a little bit of structure to this call quickly.

So, this call is related to a relatively new part of the PTAC review process. The PTAC was given the authority to provide initial feedback, as sort of a midpoint dialogue with submitters about a year ago.

And this conversation sort of is designed to review the initial feedback, with very careful boundaries around not providing technical assistance.

So, there can be questions and comments, but the Committee is prohibited from sort of giving direction about how to revise the proposal.

So, my main job here is to stay a fly on the wall, listen in, and jump in, sort of just to curb any discussions that are verging on technical assistance. But otherwise, I'll just

be sitting back. And, Kavita, I can hand it over to you now.

DR. PATEL: Okay. Well, I guess Anne Page is not joining, to kind of review --

DR. DRIESSEN: So, I was expecting Sarah to join.

DR. PATEL: Okay. And I guess, she's not? Is that --, no?

DR. DRIESSEN: Yes. So, I'm following up with her and I'm trying to track her down.

DR. PATEL: Okay. So, there may be an interruption, because I think the natural question I would ask, if I were a submitter is, so what are implications of kind of what we're going through? And I was hoping we would have somebody to do that, but we don't.

And by the way, not only is this being recorded, this is going to be transcribed, and then available to the public. Not that that changes anything, but just informational.

So, let me do, since there's just myself and Harold from the Preliminary Review

Team, I thought it would just be useful to kind of move through what hopefully you all have had time to review, which is about five pages, maybe a little bit more, on what we're calling our initial Preliminary Review Team kind of draft, and wanted to talk about that.

I think Julia said, there's been a process that we've been enabled to do, actually, through recent budget reconciliation legislation, where we can offer this feedback. This is not something that was available when the PTAC started, just for context.

So, let me just start and say, it gave me great pride to see this proposal, because I think it's been the culmination of my experience of working not only as a clinician, but thinking about payment policy.

And so, it was extremely -- just this key fact that we put in our report, is really trying to help understand where we have to review the proposal against the criterion.

So, let me start with probably the

highest priority, and you see that our PRT team felt that you did meet the criteria. I think that is all reflected in the comments. And so, what I don't want to do is spend the time reading the comments, but maybe just to give you a little depth.

I take it very seriously and so does the rest of our PTAC Committee, particularly, I want to not speak for Harold, but Harold and myself are always thrilled to see models that can engage primary care and specialists. I think, knowing who's on the phone, that's why you put this proposal forward.

Where we felt like we just lacked the sufficient details in order to deal with some of the questions we had was really around just literally some of the basics, such as the payment methodology, risk adjustment, quality metrics. We'll go into some of that in some of the individual sections.

And then, to be fair, you all did a great job in responding to some of our questions.

However, many of the answers to the questions were slightly contingent on really heavily referencing the Comprehensive Primary Care Plus Program (CPC+).

And what we wanted to do was not just kind of make assumptions, even though probably it's fair to say myself and Harold are very familiar with it, but the entire PTAC Committee might not be and we didn't want to be the people who had determined, well, this is the part of the CPC+ that we're directly referencing.

And we felt like it would not be really reflective of all your hard work to just pick and choose. So, there were some areas that we felt like needed more.

And so, let me -- on this Criterion 1, and then, also, more broadly, we were really, and have been really, kind of encouraging of how to have more of that detail. But overall, the bulk of this model was something we were very excited to see, and felt confident that many of our PTAC Committee members will share that opinion.

So, let me stop before I -- I was going to suggest that potentially I go through some of the high priority criteria, because some of these issues are wrapped together, and then, allow for anybody from the ACP or NCQA to kind of talk through it.

MR. MILLER: I have nothing to add to what you've said so far, so why don't you just keep going?

DR. PATEL: Okay. Let me keep going, yes. So, then -- and keep in mind, these criteria, as a reminder, were not criteria of our choosing. These are the Secretary's criteria.

So, we're putting, you might say, quality and cost and payment methodology are obviously correlated. And as you can see by our feedback, we think they are as well.

So, I'm going to be doing a little bit of reading here, so that -- we wanted to understand, and when you see it said it does not meet criterion, we think that, again, the initial outset of trying to encourage, like, specialists

to really collaborate with primary care partners is exactly the right point.

But we felt like it was limited in the details that would actually let us understand how to score this proposal on this criterion particularly if the numbers of quality measures and the references were good, however, how the actual quality measures might be used and the way those performance in those measures, certain thresholds reached, et cetera, for example, could be used to calculate the PBIP were not very clear. Just a concern in general about volume in certain sub-specialties.

And I think this applies to a question that was in our initial questions that were sent in writing around, is this meant for any type of practitioner or in any type of setting? So, a little bit of this is related to that.

You gave an answer for that, but certainly, for certain clinical conditions which might be lower in volume or for certain sub-specialty types, how would there be enough volume

to support such reliability in quality measurement? I think that that's something that, certainly in the field of quality improvement, we'd say has been a limitation.

And then, how, just in terms of the spirit for which we're trying to improve clinicians' performance and quality, how will people know, in a way that can help promote continuous quality improvement, what they're doing and what would the process be for that feedback?

And perhaps the answer is, again, like in a heavy reference to the Comprehensive Primary Care Plus Program, actually kind of taking the details that might be appropriate from that program and putting that detail into an example. And then, Julia is going to cut me off when I'm going off of script here.

Benchmarking, so there's reference and we can talk about the reference in the proposal directly to historical benchmarking. But it was not clear which charges and which aspects of

attributed cost would be included in that benchmarking.

And then, let me just move to the next kind of high priority criterion, Number 3, which is the payment methodology. And this was another area we did not, so 2 and 3, felt we did not meet the criterion.

And again, you can see that we wanted to understand, how would the payment methodology be different from an expanded version, for example, of CPC+? So, as you can see, we literally wrote it, in other words, is this really just CPC+ for specialists? And that's not to be difficult or contrarian, it's to ask that question.

So, that's where we wanted to probably -- and I'm going to say that part of what is challenging in phone calls like today's is that you may offer that clarity, but then, I think, part of what we wanted our Federal Officer here for is, we can listen, obviously, but we have to respond to what's in writing. So, I'm saying

that, because that's what our process is. But certainly, we can get into a discussion.

And you can see that we had a couple of questions around episode, or at least initiation for when payments would start, what would the technical trigger be, claims adjudication, recoupment? Would there be clawbacks, such as there are in current models? How are beneficiary, obviously, Part B copays handled for some of these non-face-to-face visits?

And we felt like those types of answers would add the kinds of details that we would need in order to kind of further advance our scoring of that criterion.

And then, certainly, a big theme that's occurred in a lot of payment models is kind of how the attribution would occur and when beneficiaries, or if they could exit the model? And we know that they can, but how -- where does that actual exit happen?

Because as we kind of thought about

it, and you all did a nice job saying, this really could be for anybody, but it does take a certain degree of sense, not just re-engineering. And we thought, if you've invested that kind of infrastructure for a certain volume and you do it for everybody, what happens when people exit that model, if they do?

But let me stop there. Harold, any more comments or additions to that? And then, I'll pause as well and ask the ACP or NCQA if they have questions.

MR. MILLER: I guess, if I were to boil it down, just on the points that Kavita has already covered, there was really no disagreement about the goals that you're trying to achieve, which is to support more efficient specialty consultations and better payment support for specialty physicians and having more collaboration, et cetera.

But, I'll just speak for myself, I could not understand how what you were describing was a payment model for specialists. You were

basically sort of describing CPC+ and then, sort of saying, it'll be used for specialists.

And specialists are not PCPs. I mean, they do a variety of different things from one-time consultations to procedures to sometimes short-term management of a patient, long-term management of other patients, which is not what the vision is for primary care physicians.

And so, maybe the CPC+ model could work, but it wasn't clear how. And you, when we asked you questions, you gave us some really good examples of specialists and PCPs working together.

They were good, they probably should be used for a variety of other purposes to explain how healthcare should work. But there was nothing in them that explained how the payment model would work.

It basically said, here's what the specialist will do, but it didn't say, here's how the payment model would work. And many of the other concerns that we raised about the other

criteria really sort of flow from that, not totally, but many of the others.

As Kavita said, we had trouble separating some of these criteria, because they're all interrelated. But if we can't understand exactly, because this is a payment model committee, if we can't understand how the payment model would work and how it would really support better care for the patients, then it's really hard to evaluate any of the other things too.

DR. DRIESSEN: Excuse me, Harold, this is Julia, I'm going to jump in. Did someone just join the call?

MS. SELENICH: Hey, it's Sarah. I'm sorry that I was late joining. I was stuck in another meeting.

DR. PATEL: Sarah, it's Kavita. Why don't we let this process kind of move through, but then, make sure we save a little bit of time to talk through just how the submitters should -- what kind of options, responses, et cetera?

MS. SELENICH: Okay.

DR. PATEL: So, Shari and Michael, let me just ask, because I'm confident you have discussion questions, I can move forward with the other criteria, if you don't, but I think you've kind of heard what the real feedback was. And, certainly, I agree with Harold, the other things really do stem from some of these issues.

MS. ERICKSON: So, thanks, Kavita. This is extremely helpful and I really appreciate your team's thorough review of this and all the thoughtful questions that you've raised, both in writing and then, reiterating here on the call.

I would say that we appreciate this opportunity to discuss this with you all. And I think we have been really at work, in terms of pulling together what I think could be responses to many of these issues that were raised and we're happy to discuss some of those here.

And obviously, we can follow up in writing, in whatever way is most appropriate, we can learn about that from Sarah momentarily.

One thing I'll just mention, and again, we could go into this in a lot more specificity here, but part of the reason why we did specifically construct this model, and you all are probably aware of this, around the CPC+, or to have it be aligned with CPC+, there were really a variety of reasons.

But one of those was that we thought it would be ideal for this to fit well with the other models already under way within Medicare, that may be subject to expansion in the future, would offer opportunities for those specialists that are working with those primary care practices, some of whom are also in Shared Savings Programs, et cetera, to become a part of those activities.

And that was really one of the major thought processes that went into the design of the payment model around it. And so, it also allows those specialty practices to have sort of a vetted set of primary care practices that they could work with, in order to ensure that high

quality care coordination.

As you mentioned, I think we did offer some options as to how it could be implemented with other primary care practices as well.

And so, it's helpful to hear your thoughts on that and around alignment with CPC+ and whether that's not appropriate or if it is appropriate, perhaps, but we just need to better articulate, it sounds like, the payment model that really is more specific to the specialty practices. And that, I think is something that we can absolutely do.

Michael, did you want to add anything, sort of in an up-front response to the feedback that they've provided so far?

DR. BARR: Sure, thanks, Shari. And just let me thank both Harold and Kavita, this is already very, very helpful.

I think, in general terms, your critiques, I think are spot-on, given how we approached the draft that we're trying to create something that could be applicable to multiple

specialties, so we didn't really specify any. And so, we can certainly draw that into an updated proposal and give you concrete examples about how that might work.

And so, I think Shari's question about CPC+ and the connection is probably more pressing, if you could share with us a perspective, recognizing you may not be able to. But that would be important, in terms of any response, if you could share something.

DR. PATEL: Michael, let me start. So, it might actually help, because I was actually, when Shari was speaking, I was thinking, all right, we did ask -- if we could go to the evaluation criterion? I'm trying to do as much as I can to not get into what is technical.

When you think about, let's say, for example, practices outside of CPC+, which is, in our reading of the proposal, a possibility, since we think that -- I will speak for myself, and we articulated it in the report, we wondered exactly how could practices outside of CPC+ be handled.

And to that extent, for, I think your reference of some of the changes that make CPC+ kind of primary care practice is the right hub, so to speak, and you think about specialty networks, so what are some of the limitations of what we learned from the actual CPC+ evaluations that would apply to that?

And so, I don't even know if -- I think it's fair to say we certainly don't have a point of view about what it is, whether it's CPC+ or not.

But I do think it is important, if you are going to build from that bench of alternative payment models that exist, be they Shared Savings, NextGen, name all the acronyms, that it's just as important to still extract these little details.

And you may not feel like you have room in the 25 pages; we welcome appendices. But it's those details around flow of funds, exit and entry, how you think about mitigating overutilization, because you could also make an

argument -- because in this PRT, you have myself, a general internist, and Harold, who's actually like an honorary allopathic physician, and then, you've got Jeff Bailet, who's a surgeon. So, we actually had a great spectrum of practitioners.

And so, what was clear is that you could actually see how this model might make it such that a specialist wants to hold onto a patient for a time.

So, it was just -- having some type of detail, I think, I will say, we don't have a point of view of CPC+ or not, it was just, what aspects of CPC+ are kind of the, like, what you would list and almost put into this model?

Harold, would you add more to that, without getting technically assistive?

MR. MILLER: Well, yes, I think I guess I would say, and I think you said this, maybe in a different way, but what wasn't clear was to draw out the implications of that decision that you were making about tying it to CPC+ practices.

CPC+ has its limitations in the sense

that it's only in states where payers participate and it's only a subset of the practices in those states that are participating.

And so, the question becomes, well, how does that work for a specialist, who presumably is getting referrals from a variety of primary care practices, who may or may not be CPC+ practices? And we don't know that, we don't know, maybe you don't either, but it would be helpful to know, had you thought that through?

One of the things that CPC+ tried to do was have the criteria that 60 percent of the practice's patients would be included in the model from all the payers. I don't remember off the top of my head whether you had anything in here, but that question would come up.

So, could that restriction be helpful, in terms of the patients -- the linkage with the CPC+ practices, is it helpful in terms of that relationship, because the CPC+ practice is getting paid differently, but harmful for the specialty practice, because it would limit the

proportion of their patient panel that could be included?

And so the implications of that really weren't drawn out. So, I would have to say, my reaction to it was just uncertain. And I assume that that's the question you were asking, was that issue about CPC+ referral linkages. That was the question of Michael, I think, was that the question that you were asking about? Or maybe Shari asked that question.

MS. ERICKSON: Yes, I think we both did. And that's very helpful. I think that's part of it, we wanted to better understand, I guess.

We gathered a lot of what you just re-articulated here from the feedback, the first round of feedback. And I guess we wanted to better understand your thought process around, and your perhaps concerns or questions about how we have aligned with CPC+.

And I think what you just talked through now I found quite helpful, in terms of

better helping us think through what we can do to provide you with what information you need to better, I guess, analyze the model.

DR. BARR: I agree. And the other issue about volume or retention of patients inappropriately, I think we can deal with in the follow-up commentary.

I think we would all agree that some volume might go up, appropriately and obviously, we're trying to drive down inappropriate volume, and maintain cohesiveness of care with primary care, where it makes sense, but also, appropriate referrals to specialties.

So, we can work on that in some additional detail. And I think your --

DR. PATEL: And some of that, Michael --

DR. BARR: Go ahead.

DR. PATEL: Sorry, no, no, no, go ahead, please. Sorry.

DR. BARR: No, I think the -- it was very instructive and helpful for you to tell us.

We kind of made some assumptions that you're helping clarify, with respect to the level of detail that needs to be provided, or in our case, not provided with respect to CPC+.

Obviously, there are additional things that we need to work on, that you've stimulated thought on. So, that's helpful, especially the idea about the appendices. So, thank you.

DR. PATEL: And all I was going to add, Michael, was that -- I'm not necessarily going to read through each criterion, but our third one was very specific, value over volume criterion, which, again, we didn't make these up.

We did kind of reference that we actually do agree that there probably are scenarios where you want to see a redistribution and there may be an increase in certain specialty spending, but that potentially could -- just in our read of the proposal, the way it initially reads is that there might be a disincentive to do that, because of the way benchmarks are set or financial success is determined in the model.

So, we also wanted to -- we know from all the work that's been done in primary care, kind of specialty payments, that it's extremely complicated. So, we just wanted to actually propose that you could potentially walk through what some of those scenarios might be and how CMMI might respond to them.

And just as a reminder, we actually, I want to remind something about something, you can ask Shari, that's been long buried in some of our documents, to support the proposal submitters.

We actually welcome the opportunity for you to kind of reflect on where are there things that would require additional regulatory relief to satisfy maybe some of these questions around redistribution of care, for example? I'm just using that as an example, and it's something we've referenced in our supportive documents for submitters.

And also, kind of walk through, we talk about, you did meet the criterion around

flexibility. I raised a couple of the issues around the ability to be evaluated, which is part of what led to the, quote, does not meet criterion.

And we can describe some of that, and we interpreted, in that section on evaluability, there is -- we bring up this issue of minimum volume of eligible patients.

And there was kind of this mention of 100 patients and then, what is the eligibility? It gets into that, what triggers, what deems that patient to be eligible, that would actually be counted in that?

Integration and care coordination, and let me actually kind of go into this in a little bit more depth, because I think it also is related to what we felt like was the more information that would be useful.

Do we think that there are some minimum practice requirements that would actually be required for this appropriate care coordination? And what are some examples of

those requirements?

And then, if you were to think about who is ultimately, quote, responsible for the coordination? It could end up just being the beneficiary, and are there any -- is that true?

Are there mechanisms in place to help the beneficiary? And what responsibility do staff have? We obviously know it takes a team, so what level of kind of staff involvement would this be?

And maybe another way to think about it, to the ACP and NCQA team, is, maybe walk through, like, the kinds of practices that you really do visualize that would be kind of the front leaders in this and really kind of help us understand what things look like from the patient coming in the door and the mechanism of enrollment, et cetera, all the way through the care coordination with the specialist and vice versa. And that may be a helpful example to think through.

DR. BARR: Kavita, this is Michael.

Thank you, that was really helpful. And again, I think we, to try to get as much in, we left out some key parts that might help with the issues you just described.

The Patient-Centered Specialty Practice Recognition Program has some criteria and expectations that align very well with what you just outlined as sort of missing.

So, I think, I'm not asking your opinion, obviously, because I know you can't say, but I think, in a resubmission, I think that would be much clearer, in terms of what we expect of practices, how would we expect them to operate, and who has what responsibility, within the team, and what's the patient's share of the responsibility, and all that, it's not just all on the patient. So, thank you for pointing that out.

MS. ERICKSON: Yes, this is Shari. I really do envision that we would be able to walk through sort of a vignette, I guess, of how it would actually work in a practice very

specifically.

That's something that would be certainly helpful, even on our end, to pull together to better articulate to you all how we think it could work.

MR. MILLER: That would be helpful. Let me just also, though, raise one of the things that we constantly struggle with in these proposals.

Which is that the submitter, you, come in because you want to solve some problem or make some improvement in the current care delivery mechanism, and you develop a payment model that would support that.

The problem is, we also have to think -- so, we need to understand that, and what I was saying is I couldn't even quite understand that, so doing an example would be helpful. But we also have to understand how the model would protect against problems. And that's some of the issues that Kavita was raising.

And the natural assumption is, well,

we would never do that. Well, we understand that you might never do that, but from the PTAC perspective and the CMS perspective, as I'm sure you well know, there's this constant thinking about, where could there be abuse and where could there be problems?

And so, there also needs to be not only a how would it work in an ideal sense, but also, what are the protections in the model against problematic behavior going on?

And that's this issue of volume over value and how long does the specialist keep the patient is one of those issues. If the specialist just sees the patient only as long as the patient really needs to be seen and only gets the payment for as long as that, then everything is hunky-dory.

But there wasn't anything in the model that made it clear what protects you against the specialist who gets a monthly payment for every single patient they've ever seen for the past 20 years.

And so, those things, that kind of the countering the problems component has to be in the explanation too, in order for us to really evaluate the model against some of these criteria that we have.

DR. BARR: Very helpful, thank you, Harold.

MS. ERICKSON: Yes, I agree, thank you.

DR. PATEL: And that's part of, I mean, I can go through the patient safety and health IT, but you see a little bit more of that same kind of theme throughout.

And in fact, this is a complicated issue of not putting an undue burden on the beneficiary unintentionally, is something that I think is part and parcel.

And just, I'll make a side note about the HIT, I think it's been pretty clear that we want to make sure that everything we're reading is aligned with the way you intended, but it did feel like it wasn't as clear about how kind of better patient coordination and some of those

things that are involved -- obviously, if you're in a very integrated system and everything's under one system, that may not be as problematic. But that also doesn't reflect most of what we deal with in the real world.

So, that was another kind of chance to expand on, here's what some minimum expectations might be around the capabilities of the types of practitioners that would be, quote-unquote, eligible.

So, it's not just whatever specialty that might be appropriate, but here are the essential components, while balancing that with allowing for what we also applauded and think that is a strength of this proposal, which is the broad reach of the scope.

DR. BARR: This is Michael. Thanks for the comments on health IT. I have to admit, and again, I don't expect a reaction, we're a bit puzzled by sort of kind of leaning on what we expect to be in advanced practices, in terms of health IT implementation, to support this model,

both in the expectations of what ONC has, but also, obviously, in the Specialty Practice Recognition Program, what we would expect as an entry point.

But we'll be clearer about that in a follow-up, making sure we don't say something that can't be done by the practices that we would love to have in this kind of program and that could demonstrate this type of coordination of care. But thanks for the comments.

DR. PATEL: And, Michael, maybe I -- someone's going to have to tell me if I'm not supposed to say this.

I think that the details around kind of the Specialty Practice Recognition Program, the certification program, were -- that was absolutely acknowledged, and all three of us read that.

I think where we wanted to understand is how that -- so, a couple of things. Number one, does that mean that if someone was not officially certified, they would absolutely not

be able to participate? And that might be an appropriate question to ask.

And then, number three, your comment about the ONC standards, it has been our feedback, and somewhat, experience, that that might not be enough. So, I'm just kind of separating those two.

But your clarification might be helpful in understanding if ACP and NCQA feel like, yes, they must be certified, and then, number two, the ONC standards are already moving towards this data blocking, et cetera. So, that might be helpful to clarify as well.

MS. SELENICH: And I, this is Sarah, I just want to jump in really fast, Kavita, since you were concerned.

So the statutory language, I know that Julia probably went over at the beginning of the call, really says, you know, that the PTAC can provide this initial feedback to submitters, the extent to which their proposals are meeting the ten criteria, and then, also the basis for that

feedback.

So, what you just described, Kavita, is kind of like the basis for how you all reached that conclusion. At least, that would be my interpretation, so I think you're okay. So, I'm just turning it back over to the submitters to respond.

DR. BARR: Well --

MS. ERICKSON: I would say --

DR. BARR: Go ahead, Shari.

MS. ERICKSON: Yes. I would say, thanks for the clarification and the background on that. I think that was very helpful. I think, I agree with Michael, we were a little bit challenged in terms of thinking through how to address this, and this has been a little bit more helpful in terms of clarifying that.

And I do think, also, as you mentioned, there is a new rule out there, so I think that, that obviously wasn't available at the time that this was submitted, and I think that that may also have some helpful components

in it that we could include as part of our discussion.

DR. BARR: Perhaps we can ask --

DR. PATEL: Harold, anything on that point? I'm sorry, Michael, Harold, anything you would like to add to that?

MR. MILLER: No. For what it's worth, we struggle with how to apply these criteria, too. So, when you're struggling with how to respond to them, we're struggling with how to evaluate them.

DR. PATEL: Yes.

MR. MILLER: So, we're kind of all in it together, if it helps you feel any better about it. It's not like we're sitting here with some secret answer that we're simply not telling you what it is, we're just --

DR. PATEL: No.

MR. MILLER: -- we're kind of all feeling our way through.

DR. BARR: That's --

DR. PATEL: And since Sarah allowed for

me to have a little bit of an open door, opening through the door, if that's the analogy, Sarah, we did not go over the language of the statute, we just kind of casually referenced it.

MS. SELENICH: Oh, okay.

DR. PATEL: So, let me just say, it might be -- one thing that is public and has informed our thinking has been the current Secretary's responses to our recommendations.

And one of our initial sets of proposals had what was described as a proprietary technology component, and that was something the Secretary indicated clearly that for any model, they would not feel -- I forget the exact words, but you can look them up. But for any model, they would not necessarily really welcome something that was, quote, proprietary.

Michael, I'm not implying that certification is, quote, proprietary, but it again begs the question of, well, what if you don't have that certification, would you kind of deconstruct what could be elements that underlie

that certification, and would that be a way to generalize? So, that was just in spirit of what informed some of that conversation.

DR. BARR: Thank you for that, Kavita. I think that is something our team also talked about, ACP and NCQA.

Where we struggled was the idea that the kind of practices that we expect to perform better are those that could emulate and could demonstrate some of the criteria that the Specialty Recognition Program has. And that is kind of hard to assume others have it without some sort of demonstration.

So, I hear you, in terms of the proprietary nature. It is something that gets credited in terms of the current quality payment programs, so it's already one of the programs, and it's currently the only Specialty Recognition Program in that category for MIPS. But point well taken.

DR. PATEL: Actually, that might be --

DR. BARR: We'll try to adjust that.

DR. PATEL: Let me interrupt you. That might be something worth pointing out, because that does put you -- I mean, just to offer that I think that type of clarity could be useful for everybody's education, writ large.

DR. BARR: Okay, thanks.

MS. ERICKSON: That's very helpful, thank you.

DR. PATEL: So, Shari --

DR. BARR: I was going to ask --

DR. PATEL: -- do you want me to -- oh, go ahead, Michael.

DR. BARR: I'm sorry, I was going to ask some of the ACP or NCQA staff if they had any additional questions. I know we're coming up on the final few minutes and I do think we want to ask a couple of questions about logistics.

But on content, did anybody have additional questions or clarifications that they'd like to ask the PRT team?

MR. CASTIGLIONE: Nothing from Joe.

MR. COTTON: Nothing from Paul.

MR. OUTLAND: This is Brian. I would like to, just maybe hear a little bit more. I know, Harold Miller mentioned the payment portion of it. If you could just go over that again and just provide some more information around that aspect of it, the payment model itself.

MR. MILLER: Well, I guess I'll start, Kavita, and then you can fill in. The, I guess the way I would describe it is, what I saw you saying was, here's what we want to have the specialty practice be able to do.

And then, here's the CPC+ payment model and we're going to give it to the specialty practice. It didn't explain -- and there's a variety of things about CPC+ which are designed for primary care practices. The adaptation wasn't clear.

So, in CPC+, you're getting the payment if the patient is attributed to the practice, and I'm not saying the CPC+ is good or bad, I'm just saying that that's what it does.

And the question is, how does that

work for a specialty practice, so it gets attributed to the practice based on whether or not the patient is seeing the -- having the majority of their visits with the primary care practice.

And CMS even has this sort of clawback provision for the monthly payments, to be able to take some of it back if the patient goes somewhere else. So, all of that is articulated in CPC+. It wasn't at all clear how that would work in a specialty practice.

As I mentioned earlier, the issue of, you said the practice would continue to see the patient as long as the patient needed to continue to be seen. Okay, but how exactly is that determined and what's the signal to CMS that it should stop paying?

And as I said earlier, you'd have to then at least discuss, not sort of what the best, most well-motivated specialist would do, but what would be the protections against someone abusing that?

It was confusing in the proposal, honestly, about this issue of the accountability, because at one point, it sounded like you were using the CPC+ model and then, in the other, and I think you clarified that you really didn't mean that; you meant you're going to something like ACOs or what they were trying to do in the original CPCI.

But there wasn't any explanation about how that would work for a specialist. What do you mean by the baseline for a specialist? Nobody agrees on what the baseline is for an ACO, much less a specialist.

So, if you've figured out what that is, you need to say what that is, because we couldn't understand it. And if we can't understand it, then we can't evaluate it. Does that help?

MR. OUTLAND: Yes, very helpful. Thank you.

MR. MILLER: Kavita, anything you want to add to that?

DR. PATEL: No, nothing.

DR. BARR: This is Michael, I have another question. And I think -- should one of the perhaps incorrect assumptions we made was that, after submission, there would be additional collaborative work with CMS to develop some of these detailed analyses or the evaluation.

Is there anything you can say to us about whether that was appropriate or inappropriate? Or -- you know what I mean? Because some of the detail would require expertise beyond perhaps the team that we have and would be at CMS. So, can you help us with that at all?

MR. MILLER: Well, I think --

DR. PATEL: Sarah?

MR. MILLER: Go ahead.

MS. SELENICH: Yes. Kavita, I'm happy to respond, if you would like.

DR. PATEL: Yes.

MS. SELENICH: Okay. So, and again, I just want to introduce myself really fast. So,

I'm Sarah Selenich. I'm the Designated Federal Officer for PTAC.

And I, again, apologize, I wasn't able to join right at 4:00. And I work in the Office of the Assistant Secretary for Planning and Evaluation in the Department of Health and Human Services.

So, what I heard you saying is that you were thinking that when you submitted the proposal, after PTAC reviewed it, that there would be collaboration between you and CMS, to work through some of the aspects of the proposal. Is that right?

DR. BARR: That is correct. So, some of the more detailed analyses or what potential evaluation methodologies, based upon data CMS would have that we might not have, would be possible.

So, that's sort of the direction I'm asking the question in, not to get into details of the actual, the questions that Kavita and Harold are asking us, more along the lines of

sort of implementation evaluation strategy, based upon what capabilities CMS would bring to the table.

Shari, is that a fair question? I want to make sure I'm not --

MS. ERICKSON: Yes, I mean, maybe --

MS. SELENICH: No -- go ahead.

MS. ERICKSON: And maybe these are the -- this is Shari. But maybe these are the process questions you can help answer, Sarah.

I guess, my understanding, at least, is, some of the models that were recommended by PTAC in some way before, previously, and I understand the Secretary's decision, but there was work that had gone on on some of those models with the Innovation Center staff, to better sort of see how they could operate and be rolled out.

And that's, I think, what our thinking was, that there would be some opportunity for that at some point, whenever that would be appropriate.

MR. MILLER: I think that's true,

Shari, let me just jump in. But the issue, in all cases, we don't expect that we're getting perfect, comprehensive, every detail worked out. But there has to be enough information for us to evaluate it. I mean, in --

MS. ERICKSON: Sure.

MR. MILLER: -- some sense, I mean, to take the extreme approach, right?, you could just send us an abstract and say, here's an idea, and we'd say, sounds like an interesting idea, then go work out the details with the CMMI.

So, somewhere, there has to be, we have to have enough information or you have to then say, this specific thing, we would need to work out in the following way.

One of the things that we've asked submitters to do is, if they don't have the data to do x, to say, we don't have the data to do x and here's what we would need to do if we got that data, so that it was clear that you actually thought about that, and you would have liked to have done that, but you weren't able to do it.

That's different than sort of not even addressing the issue at all.

DR. BARR: So, Harold, that was perfect, because that's kind of what I was trying to discern. Because, clearly, there are areas that we need to work on and resubmit and give you clarity that you're pointing out was lacking.

And that last part about sort of what we can't do or what we would need help doing, that's extremely helpful to us, so we know where that needle lies. Thank you.

MS. ERICKSON: Right. Yes, that was extremely helpful. Thank you. And now, we know where we can articulate those pieces, and absolutely would be able to do that.

DR. BARR: So, Shari, I think there were some logistics questions we had. I'm not --

MS. ERICKSON: Yes.

DR. BARR: -- I'm looking for those, I don't know --

MS. ERICKSON: Yes.

DR. BARR: -- if Brian --

MS. ERICKSON: I have those. And we have --

DR. BARR: Okay.

MS. ERICKSON: We have a few of them. And perhaps this is maybe, Sarah, what you were planning to address. But what the timeline and process is for reconsideration, whether we answer these questions or rework and resubmit the proposal.

The timing around that, whether it needs to have the 16 weeks, as we did for the initial proposal, time frame in advance. A few other things like that. So, I'm hopeful that you'd be able to cover that for us, so we can make our plans on our end.

MS. SELENICH: Sure. So, I think typically, what we've done, rather than have it here, when submitters have had questions, we basically just have the staff here in ASPE working with submitters to, like, go through the options in the emails, because I know you received that email with the initial feedback

from the ptac@hhs.gov email. So, we're happy to do that, if you, either after this call or tomorrow.

But in general I'll just say, in that email, it lays out the four options of not making any changes, maybe if there was a case where you're like, well, no, I don't agree, and just kind of proceed on the path. Or not changing your proposal, but responding to some of the comments in writing.

This call kind of allows you to have some of that dialogue back to the PRT. Or, yes, you could withdraw the proposal and say, well, that's what we think is best at the time.

And then, there's the revise and resubmit option, which is you take back the proposal and you incorporate the changes that you think you would like to make to the model or major changes that are really big fleshing out or better explaining the model. And then, it gets resubmitted.

And generally, we have the same PRT

review the proposal, so there's some efficiencies in that. So, I think that, really, as far as these options go, based on how your sort of -- what you've taken back from the PRT and whichever path you think makes the most sense for you all, you're welcome to pursue.

But, yes, you have all four of these options open. And again, happy to answer questions about them or talk to you more about them, as you kind of think through each of the options.

DR. BARR: Sarah, this is Michael, I just have one quick question, because I know we're coming down to the end of the time limit.

MS. SELENICH: Yes.

DR. BARR: If we revise and resubmit, does it go through the same 16-week, I think was one of Shari's question, does it have to be 16 weeks in advance or is it a different pathway?

MS. SELENICH: So, I think that the 16 weeks that was laid out was really just to give folks an estimate of where they're at. The

proposal review process entirely depends on the back-and-forth with the submitter, like what kinds of expertise needs to come in, how quickly you all can respond to additional questions.

That wasn't like a rule, like it has to be. It was just sort of back of the envelope, I think, math on how long it might feasibly take. But some proposals go much faster, some take a little bit longer, depending on the review process.

So, I think that we're not saying, oh, yes, it's going to be 16 weeks at least, because it could potentially go much faster. It's just, so much depends on how much you're thinking about changing or clarifying and any additional Q&A or expertise that the PRT might think it needs to really go through the review process.

MR. MILLER: Let me just say, and Sarah can disagree if this is not accurate, but I mean --

MS. SELENICH: Sure.

MR. MILLER: -- if you're going to

change the proposal really dramatically, it doesn't much matter, because, I mean, if you would send in a whole bunch of new stuff to us, we would have to take a bunch of time to review it.

It's not like as if we could just sort of turn that around in a couple weeks. And so, if you revise and resubmitted, it would be kind of the same thing.

I think our general attitude has been, if you're really going to substantially change the substance of the proposal, it's a new proposal.

And if all you're doing is explaining a lot better what you submitted the first time, then it's the same proposal with a better explanation. And I think that's a key distinction is, are you changing what you propose or are you just explaining it better?

MS. SELENICH: Yes, I think that's right, Harold.

DR. PATEL: So, Harold, the only thing

I would augment that by saying is that, it's going to be our same team. So, it isn't --

MR. MILLER: Yes.

DR. PATEL: Let me just make that clarification. It is the three of us; it's myself, Harold, and Jeff. So, to the extent that you're dealing with a team that's kind of seasoned in what was in the original proposal, you'll have that.

DR. BARR: Thank you very much, that was very helpful.

MR. OUTLAND: So, I'd like to just ask another little process question. So, as we think about, as you mentioned, the proposal and we think about it from attribution to exit of the model, as we write about, and put that into writing and all, would that be helpful for you to see that entire process in writing, from a specific specialty?

DR. PATEL: Michael, I don't know if you meant to cut off, but I would say, for myself, that would be extremely helpful, yes.

DR. BARR: This is Michael, but it was Brian, but thank you, that's was a good answer.

DR. PATEL: Oh, sorry, Brian, sorry.

MS. SELENICH: And this is Sarah, again. I just want to flag, because I think that you all, when you submitted your proposal, you might have come in at the time when the Committee had gotten a lot of feedback about its proposal submission instructions from the stakeholder community and then, had revised those instructions.

So, you could look to the PTAC website. We're also happy to send you a link to the revised proposal submission instructions that I think were designed to give more flexibility, and might be helpful to you, if you decide that you want to revise and resubmit.

MS. JOY: Quick question related to that. This is Suzanne from ACP. Is there -- if we do revise and resubmit, would it still be the 25-page limit? Just given that we would be adding, as we talked about, kind of quite a bit

more detail.

MS. SELENICH: So, there's still a page limit, but the layout and the kind of requirements about how you organize your information are much more flexible.

MS. JOY: Right. Okay. And then, there's always the appendices --

MS. SELENICH: Yes.

MS. JOY: Okay.

MR. MILLER: There's always the appendices.

DR. PATEL: Which we do read.

MR. MILLER: We do read them. I mean, what we, just to be -- we say, there's no guarantee, but, I mean, if they're relevant, we'll read them.

MS. ERICKSON: And it sounds like it would be helpful, if we decide to do the revise and resubmit, that we would clarify when resubmitting that this is a revised, or this is a clarified version, versus a more significant revision of the model, which I expect that would

be more of a clarification and details provided through larger appendices, that we would be able to provide.

And so, just being sure that we clarify up front, so you all can go in knowing ahead of time, sort of what you're looking at, whether we view it at least as a more significant revision versus it being a clarified presentation.

MR. MILLER: Well, I would just say, for whatever it's worth, I mean, don't do a bad job of describing what you're trying to do, because you're trying to make it look just like the earlier one, to make it -- because I think the idea is, you want to submit the best proposal you can.

MS. ERICKSON: Right, of course.

DR. BARR: Thank you.

MR. MILLER: Because, I mean, remember, the PRT, there's three of us that have looked at this, and we will look at it again, but ultimately, the decision is made by the 11

members of PTAC. They're going to read that proposal.

And the fact that we three read something before and read something again gets through the PRT process, but ultimately, the votes are made by 11 people who will be reading your proposal. And so, that's what will really count for them.

MS. ERICKSON: That's helpful consideration, thank you.

DR. BARR: Thank you, Harold. That plus your insight that not everybody will be as familiar as the three of you with the CPC+, so we should include the appropriate details in the proposal, to explain what we kind of assumed, that was really helpful. Thank you.

MS. SELENICH: So, this is Sarah, again --

MS. ERICKSON: I think I --

MS. SELENICH: Oh, go ahead.

MS. ERICKSON: I'm sorry. I think I hit on the major process questions that we had

and we've covered some of the other ones. I think we've covered the main ones that we had in our notes, as far as I can tell, unless somebody else on our team has something to add. But I also know and recognize that we're at 5:04 and want to be sensitive to the time.

MS. SELENICH: And this is Sarah. And that's why I wanted to add, we're happy to -- don't feel like you have to have all your questions right now.

Staff are happy to touch base with you tomorrow and answer questions about the four options. We can reach out to you all, so you don't feel like you have to come up with them all right at this moment.

DR. BARR: Thank you very much. And I think Shari and I and the team will convene and respond, as you've requested, via email and follow up with questions and give you a direct response to the four options via email.

We really appreciate the time and effort that went into review of this and the

insights that were shared today. So, thank you very much.

MR. MILLER: We appreciate your efforts in actually putting together a proposal, because that's what we're all about.

MS. ERICKSON: Yes, and I just want to echo the team's thanks here at ACP, along with Michael, NCQA, for your thorough review and input, that we can take back to think through what to do next.

DR. BARR: So, Sarah, thank you and your team also. And I guess that is -- we're over time, so we want to let you all go. Thank you.

MS. SELENICH: Bye.

DR. BARR: Okay. Thank you all, bye-bye.

MS. SELENICH: Thanks, everyone.

(Whereupon, the above-entitled matter went off the record at 5:05 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

Before: Physician-Focused Payment Model Tech. A/C

Date: 03-07-19

Place: teleconference

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

Neal R Gross

Court Reporter