



November 1, 2019

Physician-Focused Payment Model Technical Advisory Committee
c/o U.S. DHHS Asst. Secretary for Planning and Evaluation Office of Health Policy
PTAC@hhs.gov

**RE: Letter of Intent – Michael Barr, MD and Shari Erickson, MPH
Medical Neighborhood APM**

On behalf of the American College of Physicians (ACP) and the National Committee for Quality Assurance (NCQA), we are pleased to resubmit our Physician-Focused Payment Model for PTAC review. We would like to thank PTAC for your insightful feedback on our initial submission of this model. We made several improvements and clarifications to the model based on your input.

Payment Model Overview

The Medical Neighborhood APM is a multi-payer model that focuses on specialists that: a) receive referrals from primary care providers in CMS models Comprehensive Primary Care Plus (CPC+) and/or Primary Care First (PCF); and b) have achieved a set of robust clinical transformation standards such as NCQA's MACRA-recognized Patient-Centered Specialty Practice (PCSP) Recognition Program.

Clinicians would receive a small monthly care coordination fee plus performance-based incentive payments, adjusted retroactively each year based on financial and quality performance. A lower risk Track 1 would operate on a normal fee-for-service (FFS) basis with small incentive opportunities based on quality and cost performance. Track 2 would feature reduced FFS pay with greater financial incentives and quarterly prospective risk-adjusted population-based payments. The model would also feature a modest care coordination fee similar to Medicare's CPC+ Model. The model would risk adjust results using HCC risk score quartiles.

Quality measurement would mirror the structure of CPC+, featuring a core set of cross-cutting measures and a menu of specialty-specific electronic clinical quality measures (eQMs). ACP will vet measures for statistical and clinical validity using a modified version of the Appropriateness Method developed at RAND and UCLA. The measurement framework will focus on multiple high-priority domains including utilization, behavioral health, patient-reported outcomes, patient experience, and care coordination (where applicable). Inclusion of eQMs will help to minimize burden and leverage richer clinical data from electronic sources such as electronic health records (EHRs) and registries such as ACP's Genesis Registry, which support specialty-specific measures and help to reduce reporting burden.

Expected Participants

We suggest initially piloting the MNM in a limited number of CPC+ and PCF locations in specialties that have a sufficient number of high-value eQMs and access to a MACRA-approved registry. We believe cardiology, infectious disease, and neurology currently meet these criteria. We could add additional specialties as more high-value eQMs and bundled pricing become available. This model would build off of the current CPC+ model, which has 2,851 primary care practices in 18 geographic regions with 55 aligned payers. Eventually, the MNM could expand to more specialties with sufficient high value eQMs.

NCQA has 3,043 unique clinicians at 546 Recognized PCSP sites. However, with AAPM rewards and development of high-value eQMs that allow for expansion of this AAPM to additional specialties, we expect interest to parallel that of NCQA's Patient-Centered Medical Home program, which now has 56,700 clinicians – nearly 20% of all primary care physicians – at 12,464 sites.

Goals of the Payment Model

The model will increase coordination and collaboration between primary care clinicians and the specialists to whom they make referrals. We believe that PCSP clinicians who partner with CPC+ and PCF participants make ideal APM candidates given the advanced clinical transformation criteria in each program.

The PCSP and Medical Neighborhood concept focuses on promoting meaningful collaboration between primary care clinicians and specialists. PCSP standards directly address these primary-specialty communication gaps that harm quality. To earn PCSP Recognition, practices must document that they meet specific consensus-based standards for high-quality patient-centered care through streamlined referral and care coordination. They emphasize patient and caregiver-focused care management, shared decision-making, continuous quality improvement, and use of certified EHR technology to promote interoperability. All these features improve primary-specialty coordination, close gaps in care, and improve outcomes.

Implementation Strategy

ACP is a professional medical organization of more than 159,000 specialists and subspecialists. ACP stewards the Genesis Registry, a Qualified Clinical Data Registry (QCDR) which provides seamless integration with participating EHRs to collect and submit quality measure data. ACP also provides education and support to clinicians achieving NCQA PCSP.

NCQA rates and accredits health plans and clinicians using rigorous standards for quality measurement, transparency and accountability. NCQA stewards the PCSP Recognition Program and is developing a platform to ingest quality measure data to support this recognition. NCQA will develop and test new and innovative quality measures that assess high-value care in order to scale this model for other specialists.

Timeline

We expect to submit the Medical Neighborhood APM proposal on November 1, 2019 and are ready to implement as soon as Spring 2020.

Respectfully submitted,

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