

The “Medical Neighborhood” Advanced Alternative Payment Model (AAPM) Environmental Scan

April 7, 2020

I. Overview

The purpose of this environmental scan is to provide members of the Physician-Focused Payment Model Technical Advisory Committee (PTAC) with background information on the “Medical Neighborhood” Advanced Alternative Payment Model (AAPM) which was submitted by The American College of Physicians (ACP) and The National Committee for Quality Assurance (NCQA) and was determined to have met the administrative requirements on February 11, 2020. This proposal is a resubmission of a proposal with the same name that was submitted in November 2018. This environmental scan updates the prior environmental scan that was done for the initial submission, focusing on revised components of the model and any new literature published since the initial environmental scan was completed in December 2018.

The environmental scan focuses on five topics:

1. Specialty referrals and care coordination between primary care providers and specialists, with particular focus on cardiology, infectious disease, and neurology.
2. Medicare payment policy affecting specialty referral and care coordination.
3. Existing and proposed specialty alternative payment models.
4. The problems in care delivery resulting from current patterns in specialty referral, care coordination, and communication.
5. Results from existing models on which the proposed model would build.

Appendix A includes additional information on the questions addressed in this scan, search terms, and sources used to identify the research summarized below.

Information on Submitters

The **American College of Physicians** is a national organization of internists, the largest medical-specialty organization, and second-largest physician group in the United States. The ACP was founded in 1915 to promote the science and practice of medicine, and its members include internists, internal medicine subspecialists, medical students, residents, and fellows. ACP works actively in the field of performance measurement and develops policy papers and performance measurement commentaries and recommendations.

The **National Committee for Quality Assurance** is a private, not-for-profit organization that was founded in 1990 and is dedicated to improving health care quality. The NCQA accredits and certifies a wide range of health care organizations, and recognizes practices and clinicians in key areas of performance. The NCQA’s Patient-Centered Specialty Practices (PCSP) Recognition is designed to help facilitate team-based care by improving collaboration with primary care practices and recognizing specialists who streamline and improve health care delivery. Additionally, the NCQA’s Patient-Centered Medical Home (PCMH) Recognition program was not required for Comprehensive Primary Care Initiative (CPCI) or Comprehensive Primary Care Plus (CPC+) participation, but the criteria are well-aligned with the CPC+ program.

Referrals and care coordination between primary care providers and specialists

Medicare Referral Patterns. Referrals of Medicare beneficiaries from primary care providers to specialists have been increasing, with about one in 10 visits to a primary care provider resulting in a specialist referral in 2009 compared to one in 20 just 10 years earlier (MedPAC, 2018; Barnett, 2012). Patient complaints that lead to referrals stem most often from problems related to vision (21 percent), gynecology (18 percent), gastroenterology (18 percent), orthopedics (16 percent), dermatology (15 percent), and cardiology (15 percent) (Delaronde, 2017). There is high regional variability in the likelihood of seeing a specialist for common illnesses that are typically managed by both primary care providers and specialists (e.g. hypertension and diabetes), and this variation is not associated with beneficiary health status (Clough, et al., 2016). Referral patterns also vary by rurality; between 2005 and 2016, primary care visits were 1.9 percentage points more likely to result in a referral in nonrural area than in rural areas, and the gap has widened in recent years (Geissler, 2020). Individual primary care providers also vary significantly in their referral rates, with some more than five times more likely to make referrals as others (Mehrotra, et al., 2011). There are many reasons for this variation, including the fact that access to specialists varies across patient groups, driven by factors such as geography (Delaronde, 2017).

Comprehensive Primary Care Initiative (CPCI). The Center for Medicare and Medicaid Innovation's (CMMI's) Comprehensive Primary Care Initiative (CPCI) is the predecessor of CMMI's Comprehensive Primary Care Plus (CPC+) Model (described further below), on which the Medical Neighborhood Model proposes to build. Since CPCI's launch in 2012, the Centers for Medicare & Medicaid Services (CMS) has collaborated with commercial and state health insurance plans in seven regions to offer population-based care management fees and shared savings opportunities to promote five core primary care functions: risk-stratified managed care; access and continuity; planned care for chronic conditions and preventive care; patient and caregiver engagement; and coordination of care. The characteristics of Medicare fee-for-service (FFS) patients attributed to CPCI practices were similar to the Medicare population nationally: About 60 percent were women, 13 percent were also on Medicaid, and the average age was 72 (Mathematica, 2015).

CPCI and CPC+ encourage participating primary care providers to enter into collaborative care agreements (or care compacts) with specialists. These formalized agreements set communication expectations, referral protocols, care transition expectations, and care management responsibilities. Peikes, Anglin, and colleagues (2018) found that of those primary practices participating in the CPCI demonstration, only 41 percent established care agreements with specialists. Primary care practices that established care compacts most often did so with specialists in the fields of cardiology (64 percent of practices), gastroenterology (49 percent), orthopedic surgery (43 percent), behavioral health (39 percent), and obstetrics/gynecology (34 percent). Based on qualitative data obtained from 21 CPCI practices implementing collaborative care agreements, compacts were typically established with the specialists to whom they most frequently made referrals, with whom they had good relationships, who were in the same health system, and who used the same electronic health record (EHR). Some of the challenges in implementing care compacts noted by practices included: a lack of engagement from specialists due in part to the fact that current FFS payment incentives do not encourage specialists to engage with primary care providers; agreement on how information should flow between practices; and data-sharing across different EHR systems (Peikes, Anglin, et al., 2018).

Comprehensive Primary Care Plus (CPC+). The revised proposal suggests piloting the Medical Neighborhood Model in a subset of CMMI's CPC+ and/or the emerging Primary Care First regions. CPC+,

which launched in 2017, focuses on the same core tenants of CPCI and builds on the lessons learned from its predecessor. Like CPCI, CPC+ offers a monthly care management fee, but also prospectively pays a performance-based incentive based on measures of patient experience, clinical quality, and utilization. CPC+ also offers two payment options: Track 1 and Track 2. Track 1 practices bill using standard Medicare FFS billing and payment, while Track 2 shifts a portion of the FFS payment to quarterly lump-sum payments, and in exchange practices are expected to provide more comprehensive care services.

Baseline evaluation results of the CPC+ demonstration show that Medicare FFS beneficiaries assigned to CPC+ practices were, on average, slightly healthier than their counterparts in usual primary care (Mathematica, 2019). In the first year of CPC+, 2,905 primary care practices and 63 payers provided care to over 15 million patients, of whom 2.2 million were attributed Medicare FFS beneficiaries, 3.3 million were attributed by other CPC+ payers, and 9.7 million were other patients not attributed to the model (Mathematica, 2019). Frazee et al. (2018) found that the CPC+ model attracted small practices, most of which were owned by a health system. Practices in areas with higher income and educational levels and lower use of inpatient services were more likely to join; this pattern may exacerbate disparities in vulnerable populations' access to advanced primary care medical home models such as CPC+ and any NCQA PCSP specialty groups that might participate in the proposed Medical Neighborhood Model (Frazee et al., 2018).

Almost 75 percent of CPC+ practices formed collaborative care agreements with specialists—substantially more than the 41 percent of CPCI practices that did so (Mathematica, 2019). Practices most commonly established agreements with specialists in cardiology (37 percent), gastroenterology (32 percent), behavioral health (26 percent), and endocrinology (23 percent) (Mathematica, 2019). In-depth interviews with program administrators found that it was easier for system-owned practices to form collaborative care agreements with specialists because of shared technology, resources, and high-level system staff to facilitate communication. Independent practices noted that agreements only formalized existing relationships with specialists. Similar to concerns from CPCI practices, CPC+ practices reported that the financial incentives from FFS payments to specialists limited primary care practices' ability to reduce total patient costs.

Primary Care First. Beginning in 2021, the Primary Care First model will be offered in 26 regions, including statewide in 22 states and select areas in five additional states. Building on the principles of CPCI and CPC+, Primary Care First is designed as a multi-payer model that promotes advanced primary care, specifically for complex cases and seriously ill patients. Participating practices will take on increased financial risk in exchange for flexibility and more performance-based payments. Practices are also encouraged to assume greater accountability for high-risk/high-need populations, with an option to receive population-based payments for seriously ill patients.

NCQA Patient-Centered Specialty Practice (PCSP) Recognition. The Medical Neighborhood Model would require specialists to achieve recognition as NCQA PCSPs. Developed in 2013 by the NCQA, PCSP recognition standards emphasize care management, shared decision-making and quality improvement (Tirodkar et al., 2015). To achieve recognition, specialty practices must complete specific activities in seven concept areas and submit documentation annually (NCQA, Annual Reporting for PCSP Recognition, n.d.). Currently, there are approximately 530 NCQA recognized PCSP sites (NCQA, NCQA Report Cards, n.d.). The majority of practices are small, with an average of fewer than 4.5 clinicians per practice site.

Medicare payment policy issues affecting specialty referral and care coordination

Medicare Physician Fee Schedule or Chronic Care Management Services. The Medicare Physician Fee Schedule (PFS) currently covers the following care management services for FFS beneficiaries with multiple chronic conditions:

- management of transitions between and among health care providers and settings, including referrals to other clinicians;
- follow-up after an emergency department (ED) visit, or facility discharge;
- creation and exchange of continuity of care documents with other practitioners and providers;
- use of certified EHR technology (CEHRT);
- managing care for patients with cognitive impairments and behavioral health conditions;
- telehealth and prolonged non-face-to-face services; and
- comprehensive care management and care planning (Burton et al., 2017; MLN, 2019).

Accountable Care Organizations (ACOs). ACOs are well-positioned to address the Medicare FFS population's care coordination needs. By assuming shared savings and shared risk collectively under a global budget, primary care providers in an ACO share the consequences of referral decisions (Meyers et al., 2010; Song, Sequist et al., 2014). To date, ACOs have focused on primary care to improve outcomes for high-cost patients with conditions such as diabetes, congestive heart failure, and chronic obstructive pulmonary disease through enhanced care coordination and chronic disease management. However, they have been slower to engage other specialists. Specialists are still advantaged by FFS, and financial incentives for ACO participation are relatively weak, making it more difficult to engage specialists in ACOs and for ACO-affiliated primary care providers to work with specialists on improved referral and care coordination processes (Resnick et al., 2018).

ACOs led by primary care physicians have been described as being more selective about participating physicians and may not include specialists, while ACOs affiliated with health systems tend to include all employed physicians in the ACO and may have more specialists than primary care physicians (Winter, 2020). ACOs with high shares of primary care physicians reduced the number of specialist visits, but ACOs with high shares of specialists did not, suggesting that ACOs with more primary care physicians have stronger incentives to reduce use of specialty care (Barnett and McWilliams, 2018; Winter, 2020). When examining the proportion of ACO primary care visits, Herrel and colleagues (2017) found fewer ED, hospital, and SNF discharges in ACOs that had the fewest primary care providers visits compared to ACOs that had the most.

Proposed Condition-Specific Alternative Payment Models (APMs) for Specialists. There are a number of proposed frameworks for condition-specific APMs to engage specialists, including models proposed to the Physician-Focused Payment Model Technical Advisory Committee (PTAC) by the American Academy of Neurologists (AAN) and the American Society of Clinical Oncology (ASCO). AAN proposed the Patient-Centered Headache Care Payment (PCHCP)¹ and ASCO proposed the Patient-Centered Oncology

¹The Patient-Centered Headache Care Payment (PCHCP) was submitted by the American Academy of Neurologists (AAN) to the PTAC for consideration in November 2017.

Payment Model (PCOP)². These proposed APMs have not yet been implemented or evaluated, and no proposed model has addressed infectious disease.

Farmer and colleagues (2017) note that few existing or proposed APMs specifically address cardiology and that reforms are needed to better care for patients with cardiovascular disease. They note that primary care-focused models, such as patient-centered medical homes or ACOs, do not necessarily incorporate cardiology practices. Primary care providers receive data on care provided by cardiologists they refer to with the intention that they will use that feedback to refer to lower-cost cardiologists; however, providers often lack the data necessary to assess value, and cardiologists rarely receive advice on how they could improve the value of their care (Farmer et al., 2017).

There are a number of barriers to specialist participation in APMs. In a letter to CMS, the American College of Rheumatologists identified barriers to participation by subspecialists in an APM (Daikh, 2017). Many of these barriers stem from the fact that rheumatologists often have relatively small practices, leading to increased financial risk for providers. A statement to the U.S. House of Representatives written by the American Society for Gastrointestinal Endoscopy (2018) highlighted two areas impeding physician movement toward value-based care, including: 1) the lack of Advanced APM opportunities for physician specialists, and 2) the federal physician self-referral law or Stark Law, which prevents physicians from independent contracting involving shared savings or other nontraditional payment arrangements for fear of violating the law.

Problems in care delivery resulting from current patterns in specialty referral and care coordination

Quality and patient safety. Appropriate specialty referrals are critical because under-referral can lead to patients not receiving needed care, whereas over-referral can increase exposure to medically unnecessary procedures and unnecessary costs. Additionally, poor communication and poor referral-related care coordination result in quality and safety problems, including: increased risk for delayed, redundant, or unnecessary testing; inadequate treatment; and diminished self-care (Davidow, et al., 2018). Fragmentation of care increases with the number of physicians a patient sees, resulting in poor continuity and coordination of care for patients, which is also associated with more preventable hospitalizations, complications of chronic illness, and higher costs per episode of inpatient care (Song, Rose et al., 2014).

Patient experience. Studies have found that increased use of specialists is not associated with a corresponding increase in satisfaction with care, positive care experience, or perceived health status (MedPAC, 2018). Yet Medicare beneficiaries report difficulty obtaining certain specialty referrals, including dermatology, orthopedics, and psychiatry (MedPAC, 2018). Survey responses in the last year of CPCI found that practices were more timely in follow-ups to more beneficiaries after hospital or ED visits than comparison practices (Peikes, Anglin et al. 2018). Patient experience measures for the CPC+ demonstration have not yet been reported; however, nearly all CPC+ practices reported eliciting input from patients seeking care under the demonstration by establishing a Patient and Family Advisory Council (PFAC) (Mathematica, 2019). However, a separate analysis of patients and caregivers found that participants were largely unaware of the existence of PFAC (Dukhanin, 2020).

²The Patient-Centered Oncology Payment Model (PCOP) was submitted by the American Society of Clinical Oncology (ASCO) to the PTAC for consideration in January 2020.

Spending. The CPCI demonstration showed no significant impacts on spending (Peikes, Anglin, et al., 2018). Relative to comparison practices, CPCI practices saw two percent lower growth in outpatient ED visits over the course of the initiative (Peikes, Dale et al., 2018). CPC+ expenditures without care management fees were similar to comparison group expenditures in their first year of the demonstration—differing by less than half of a percentage point (Mathematica, 2019). Including care management fees, expenditures were significantly higher than comparison practices (Mathematica, 2019). Increases in expenditures for CPC+ practices between the baseline and year one of the evaluation were two to three percent higher for CPC+ versus comparison practices (Mathematica, 2019).

Health information technology. As of 2017, 80 percent of office-based physicians had adopted a certified EHR system, and an additional six percent percent had adopted a non-certified EHR (ONC, 2019). Overall, primary care providers have significantly greater uptake of CEHRTs compared to specialists, with 74 percent of specialists having a CEHRT in 2014. However, in 2014 only one-third of physicians with CEHRT shared information with external providers or unaffiliated hospitals (Jamoom et al., 2016). Literature suggests that ACOs with independent providers face more challenges in care coordination and quality improvement compared to ACOs under a single organization, in part due to having multiple EHRs (Lewis et al. 2017). Similarly, the 2019 evaluation of the CPC+ model found that system-owned practices often had system-level health IT staff responsible for coordinating with EHR vendors, and that these practices encountered fewer challenges working with health IT vendors than independent practices (Mathematica, 2019).

Quality reporting in CPCI and CPC+ practices and other key specialties. A barrier to better care coordination between primary care providers and specialists is the lack of availability of electronic clinical quality measures (eCQMs) and the burden of quality reporting requirements. For example, over the course of the CPCI demonstration, the number of eCQMs practices that were required to collect increased from one to three (Peikes, Anglin et al., 2018). In CPC+, nearly all practices met or exceeded utilization and eCQM review requirements, although several CPC+ practices reported concerns with incomplete EHR documentation, missing follow-up data, and inaccurately calculated eCQMs by EHR systems (Mathematica, 2019). Several qualified clinical data registries have been approved by CMS since 2017 for use by specialists in value-based payment models. CMS has developed interoperability measures and reporting requirements under the Promoting Interoperability Programs for specific Medicare providers (acute care hospitals, Prospective Payment System (PPS)-exempt cancer hospitals, and long-term care hospitals) which will be shared and considered by ACO and Bundled Payment for Care Improvement (BPCI) programs (CMS, 2020).

Results from Similar Models

Evidence for the NCQA'S PCSP Certification. Because NCQA'S PCSP recognition is relatively new, evidence on the effect of the certification on care coordination, quality, and patient experience of care is limited (Ward, et al., 2017). In 2017, Georgetown University'S Multiple Sclerosis (MS) and Neuroimmunology Center implemented a PCSP for MS patients. After the first year of the program, patients reported an increase in appointment availability, how well providers listened, and how well-informed providers were about patient care from a specialist (Geremakis et al., 2019). A recent observational study of one of the first cardiology clinics in the United States to obtain PCSP recognition found that the model improved access for new and follow-up patients, increased patient satisfaction, and increased care coordination and referral loop closure (Huang, 2019).

CPCI and CPC+. The final evaluation of the CPCI program found few statistically significant effects on claims-based quality-of-care outcomes or process measures such as delivery of evidence-based care for

diabetes care, transitional care, and continuity of care (Peikes, Anglin et al., 2018). However, relative to comparison practices, CPCI practices saw a two percent lower growth in outpatient ED visits over the course of the initiative (Peikes, Dale et al., 2018). Qualitative results from this evaluation show that CPCI practices indicated in interviews that they had improved the referral tracking process and their sharing of patient information by developing formal expectations and communication guidelines with specialists since participating in CPCI (Peikes, Anglin et al., 2018).

Similarly, an evaluation of the first year of the CPC+ program found that its effects on quality, utilization, and spending measures were minimal or modest. CPC+ demonstrations saw small (one percent or less) improvements in the proportion of Medicare FFS beneficiaries receiving preventative care for diabetes and screenings for breast cancer (Mathematica, 2019). In terms of utilization, the evaluation found significant reductions in the rate of outpatient ED visits for both Track 1 and Track 2 (1.2 vs. 1.6 percent), and slower growth rates of primary care ambulatory visits (1.6 vs. 1.8 percent) (Mathematica, 2019).

The Multi-Payer Advanced Primary Care Practice (MAPCP) Demonstration. In the MAPCP model, which ended in 2016, participating state agencies were responsible for aligning several aspects of their medical home program across multiple insurers, including Medicare, Medicaid, and commercial insurers. These aspects included care management fees, medical home activity requirements, quality standards, and payment incentives. The final evaluation found mixed results across demonstration states, with little evidence of improvement in access to care and care coordination. Two of eight states achieved statistically significant net Medicare savings relative to comparison groups, with Michigan accounting for the largest share. Only one of eight demonstration states (Rhode Island) saw an increase in primary care visits relative to comparison groups, and in two states (Vermont and North Carolina) specialist visits decreased relative to the control groups. One demonstration state (Michigan) saw a significant reduction in 30-day unplanned readmissions (Nichols, et al., 2017).

Medicare ACOs. Decreases in Medicare spending for beneficiaries in Pioneer ACOs relative to their comparison populations were related to significant reductions in utilization in a range of care settings (Nyweide, et al., 2015). Overall, these results were consistent with other research showing that patients in Medicare ACOs tend to report some improvements in the timeliness of their care and clinicians' knowledge of a patient's use of specialists, with otherwise no decrements in access (Nyweide et al., 2015). However, a recent study found that ACOs were doing little to focus on transforming specialty care (Lewis et al. 2019).

Notable impacts of the NGACO model included improvements in quality of care, utilization, and reduction in Medicare spending of \$18.20 per beneficiary per month (PBPM) in the first year of the model (NORC, 2018). NGACOs were associated with a reduction in acute care hospital days per month (1.3 percent), fewer nonhospital evaluation and management visits per month (1.5 percent), and an increase in annual wellness visits performed per year (11.9 percent) (NORC, 2018). Model-wide reduction in gross Medicare spending in the second year of the model amounted to \$4.18 PBPM (NORC, 2020). The 2017 cohort accounted for 70 percent of the total decrease in Medicare Part A and B spending (NORC, 2020). Unlike in the first performance year, there were no significant impacts on utilization patterns or quality of care measures in the second performance year aside from a 2.96 percent decrease in hospital readmissions from SNFs (NORC, 2020). Specialists accounted for about two-fifths of participating providers in NGACOs (NORC, 2020). NGACO leaders suggested that primary care providers perform well in value-based care models because of their focus on preventive care and care management (NORC, 2018).

II. Annotated Bibliography

American Society for Gastrointestinal Endoscopy. Examining Barriers to Expanding Innovative Value-Based Care in Medicare. September 2018. https://www.asge.org/docs/default-source/practice-support/advocacy/statement-to-e-and-c-subcommittee-on-health_asge_9-13-2018.pdf?sfvrsn=24933453_2.

Subtopic(s): Issues in payment policy

Type of Source: Letter

Objective: To express the opinion of the American Society for Gastrointestinal Endoscopy on value-based care.

Main Findings: There are two areas impeding physician movement toward value-based care, including: 1) the lack of Advanced APM opportunities for physician specialists, and 2) the federal physician self-referral law or Stark Law, which prohibits physicians from independent contracting involving shared savings or other nontraditional payment arrangements for fear of violating the law.

Strengths/Limitations: N/A

Generalizability to Medicare Population: Yes

Methods: N/A

Barnett ML, McWilliams JM. Changes in specialty care use and leakage in Medicare accountable care organizations. *Am J Manag Care*. 2018;24(5):e141-e149.

Subtopic(s): Issues in payment policy

Type of Source: Journal article

Objective: To examine changes in specialty care leakage and use associated with the Medicare Shared Savings Program.

Main Findings: Leakage of specialist visits decreased minimally from 2010 to 2014. For the most primary care-oriented quartile of ACOs in 2 of 3 entry cohorts, MSSP participation was associated with differential reductions in new specialist visits. For more specialty-oriented ACOs, differential changes in specialist visits were not statistically significant.

Strengths/Limitations: Unable to assess clinical appropriateness of specialty visits from claims data.

Generalizability to Medicare Population: Yes

Methods: Researchers used Medicare claims for a 20% sample of beneficiaries attributed to ACOs or non-ACO providers. ACO-level outcomes included the proportion of visits for ACO-attributed patients outside of the ACO (leakage) and proportion of ACO Medicare outpatient revenue devoted to ACO-attributed patients (contract penetration).

Barnett M. L., Song Z., & Landon B. E. (2012). Trends in physician referrals in the United States, 1999-2009. *Archives of Internal Medicine*, 172(2):163-170. doi:[10.1001/archinternmed.2011.722](https://doi.org/10.1001/archinternmed.2011.722)

Subtopic(s): Description of the issue

Type of Source: Journal article

Objective: To assess changes in the annual rate of referrals to other physicians from physician office visits in the United States from 1999 to 2009.

Main Findings: The report finds that during the 10 years between 1999 and 2009, the probability that an outpatient visit to a physician resulted in a referral to another physician increased from 4.8 percent to 9.3 percent ($p < 0.001$), a 94 percent increase. The absolute number of visits resulting in a physician referral increased 159 percent nationally during this

period, from 41 million to 105 million. This trend was consistent across subgroups, except for slower growth among physicians with ownership stakes in their practice.

Strengths/Limitations: A limitation is the age of the data; this study uses survey data from 1999-2009.

Generalizability to Medicare Population: Yes

Methods: Analysis of nationally representative cross-sections of ambulatory patient visits in the United States, using a sample of 845,243 visits from the National Ambulatory Medical Care Survey and National Hospital Ambulatory Medical Care Survey from 1993 to 2009, focusing on the decade from 1999 to 2009.

Burton R, Berenson RA, Zuckerman S. Medicare's Evolving Approach to Paying for Primary Care. Robert Wood Johnson Foundation and the Urban Institute; 2017.

https://www.urban.org/sites/default/files/publication/95196/2001631_medicares_evolution_approach_to_paying_for_primary_care_0.pdf.

Subtopic(s): Issues in payment policy

Type of Source: Report

Objective: To document changes in the implementation of national health reform as it relates to primary care so that states, researchers, and policymakers can learn from the reform process.

Main Findings: Policymakers disagree over whether to increase payments for current primary care services or to provide additional payments only for innovative new services not currently recognized in the fee schedule. Each approach has advantages and disadvantages. Adding new codes to the fee schedule allows CMS to tweak practitioner incentives, while demonstrations allow CMS to test new payment and delivery models.

Strengths/Limitations: Primary care practitioners are being paid higher and higher monthly payments for increasingly broad segments of the Medicare population, and payments have shifted from year-end bonuses to up-front payments. Practices are also being held accountable for a growing number and range of quality measures, but less is expected of them in terms of lowering cost of care.

Generalizability to Medicare Population: Yes

Methods: Qualitative review of changes to the physician fee schedule and new primary care payment model demonstrations.

Centers for Medicare & Medicaid Services (CMS). 2020 Medicare Hospital Inpatient Prospective Payment System for Acute Care Hospitals and Long-term Care Hospital Prospective Payment System Final Rule, CMS, 84 Fed. Rule 42044 (proposed August 16 2019) (codified at 42 CFR 495). Retrieved from <https://www.federalregister.gov/documents/2019/08/16/2019-16762/medicare-program-hospital-inpatient-prospective-payment-systems-for-acute-care-hospitals-and-the>

Subtopic(s): Results of other similar models

Type of Source: Federal regulation posting

Objective: To announce changes in reporting requirements.

Main Findings: To establish new requirements or revise existing requirements for quality reporting by specific Medicare providers (acute care hospitals, PPS-exempt cancer hospitals, and LTCHs). To also establish new requirements and revise existing requirements for eligible hospitals and critical access hospitals (CAHs) participating in the Medicare and Medicaid Promoting Interoperability Programs. To also update policies for the Hospital Value-Based Purchasing (VBP) Program, the Hospital Readmissions Reduction Program, and the Hospital-Acquired Condition (HAC) Reduction Program.

Strengths/Limitations: N/A

Generalizability to Medicare Population: N/A

Methods: N/A

Clough J. D., Patel K., & Shrank W. H. (2016). Variation in specialty outpatient care patterns in the Medicare population. *Journal of General Internal Medicine*, 31(11):1278-1286.

doi:10.1007/s11606-016-3745-8

Subtopic(s): Description of the issue

Type of Source: Journal article

Objective: To describe regional variation in outpatient visits for individual specialties and the association between specialty physician-specific payments and patient-reported satisfaction with care and health status.

Main Findings: These findings demonstrated high regional variability in the likelihood of seeing a specialist for common illnesses that are typically managed by PCPs and specialists. Multiple analyses suggested that this variation was not due to differences in beneficiary health status. An increased use of specialists was associated with a considerable increase in cost, without a corresponding increase in beneficiary overall satisfaction with care or perceived health status. The lowest quartile of specialist use was consistently associated with lower patient satisfaction with access to specialists, though overall satisfaction was high and similar across the three highest quartiles.

Strengths/Limitations: This is an observational study, which cannot establish a causal relationship between specialty use and outcomes. Generalizability limited by the inclusion and exclusion criteria listed in methods section below.

Generalizability to Medicare Population: Yes

Methods: Retrospective cross-sectional study utilizing demographic data from the beneficiary summary files, claims data from the carrier files, and patient-reported data from the 2012 Medicare Current Beneficiary Survey (MCBS) for a 20 percent random sample of Medicare FFS beneficiaries in 2012. The study included beneficiaries who were 65 years or older at the beginning of 2012 and had full Part A and Part B eligibility during the entire year. Beneficiaries who had missing race or gender data (.3 percent) were enrolled in a Medicare Advantage plan at any point during 2012, or had any claims for which Medicare was a secondary payer were excluded.

Daikh D. Centers for Medicare & Medicaid Services: Innovation Center New Direction. November 2017. <https://www.rheumatology.org/Portals/0/Files/ACR-Comments-CMMI-RFI-2017.pdf>. Accessed March 9, 2020.

Subtopic(s): Issues in payment policy

Type of Source: Letter

Objective: To express the American College of Rheumatology's (ACR) input on the CMS Innovation Center New Direction request for information

Main Findings: The ACR feels that there are several barriers participation in an APM by subspecialists such as rheumatologists, many related to the fact that rheumatologists' practices are small.

Strengths/Limitations: N/A

Generalizability to Medicare Population: Yes

Methods: N/A

Davidow S. L., Sheth J., Sixta C. S., & Thomas-Hemak L. (2018). Closing the referral loop: Improving ambulatory referral management, electronic health record connectivity, and care coordination processes. *Journal of Ambulatory Care Management*, 41(4):240-249. doi:[10.1097/JAC.0000000000000247](https://doi.org/10.1097/JAC.0000000000000247)

Subtopic(s): Problems in care delivery

Type of Source: Journal article

Objective: The aim of the pilot project was to improve the efficiency and effectiveness of the referral process between the PCPs and the cardiologists (each pair comprising a “dyad”). Twelve dyads of primary care and specialist physicians sought to improve ambulatory referrals by mapping the referral process and using care compacts, metrics, and EHRs.

Main Findings: Referrals closed on time increased from 40 percent to 70 percent. Clinical questions answered increased from 50 percent to 75 percent. Adoption of the change package and lessons from this project may significantly improve ambulatory referral management.

Strengths/Limitations: Limitations in the Closing the Referral Loop (CRL) pilot project included participant representation from a small geographic region; greater than expected time needed to complete care compacts and referral process mapping; and limited capacity to assess patient engagement and understanding of and satisfaction with the referral process.

Generalizability to Medicare Population: N/A

Methods: Eleven dyads (PCP and specialist, as well as their staff) completed the pilot project, collected data on a defined set of measures, and attended monthly improvement webinars and in-person meetings to share challenges, solutions, and lessons learned. Participants collected data monthly over the 18 months of the pilot. The measures were percentage of closed referrals; percentage of urgent referrals completed within seven days; percentage of priority referrals completed within 14 days; percentage of routine referrals completed within 28 days; percentage of referrals with specialist reports sent within seven days of patient appointment; percentage of clinical questions answered by the specialist; PCP satisfaction with the referral process (five survey questions, 5-point Likert scale); specialist satisfaction with the referral process (six survey questions, 5-point Likert scale); and patient satisfaction with the referral process (six survey questions, 5-point Likert scale).

Delaronde S. (November 17, 2017). The specialist referral: Do primary care providers have all the information they need? *3M Inside Angle*. Retrieved from <https://www.3mhisinsideangle.com/blog-post/specialist-referral-primary-care-providers-information-need/>

Subtopic(s): Description of the issue

Type of Source: Health information systems blog

Objective: To describe barriers to specialist referral by PCPs.

Main Findings: This article describes reasons for variation in referral practice. Because most PCPs rely on their clinical judgment rather than guidelines when making referrals, and specialist access is not the same for all patient groups, wide variation is inevitable. The variability in referral patterns can lead to under-referral as well as over-referral. Under-referral can lead to patients not getting the expert opinion and care that they may need to treat their condition, whereas over-referral can lead to higher risk and unnecessary cost. It is acknowledged among most specialty groups that up to one-third of procedures are medically unnecessary and expose the patient to unnecessary risks.

Strengths/Limitations: N/A

Generalizability to Medicare Population: Yes

Methods: N/A

Dukhanin, V., Feeser, S., Berkowitz, S., & DeCamp, M. (2020). Who represents me? A patient-derived model of patient engagement via patient and family advisory councils (PFACs). *Health Expectations : An International Journal of Public Participation in Health Care and Health Policy*, 23(1), 148–158. <https://doi.org/10.1111/hex.12983>

Subtopic(s): Problems in care delivery

Type of Source: Journal article

Objective: To obtain rich insights about what patients who are not PFAC members expect of PFACs.

Main Findings: Forty-two patients and caregivers participated in five focus groups that included individuals of different ages, races, health statuses and socio-economic statuses. Participants were largely unaware of PFACs. Participants wanted to know who represented them (interpreted as a form of political representation) and emphasized the need for representatives' diversity. Participants expected that all patients should be able to communicate with PFACs and that meaningful engagement could enhance perceptions of health systems.

Strengths/Limitations: Participants were largely unaware of the committee.

Generalizability to Medicare Population: Yes

Methods: From July to September 2018, authors conducted a qualitative study using focus groups.

Farmer SA, Darling ML, George M, Casale PN, Hagan E, McClellan MB. Existing and Emerging Payment and Delivery Reforms in Cardiology. *JAMA Cardiol.* 2017;2(2):210.

[doi:10.1001/jamacardio.2016.3965](https://doi.org/10.1001/jamacardio.2016.3965)

Subtopic(s): Issues in payment policy

Type of Source: Journal article

Objective: To outline current and potential payment and delivery reforms for cardiology.

Main Findings: Most cardiology models are modified fee-for-service or address procedural or episodic care, but population models are emerging. Existing programs have significant limitations and adoption has been slow.

Strengths/Limitations: None of the proposed models have been implemented or evaluated.

Generalizability to Medicare Population: Yes

Methods: Reviews four examples of payment and delivery reforms: a commercial incentive program, an episode payment model, a physician-led ACO, and a health system participating in multiple models.

Fraze T. K., Fisher E. S., Tomaino M. R., Peck K. A., & Meara E. (2018). Comparison of populations served in hospital service areas with and without Comprehensive Primary Care Plus medical homes.

JAMA Network Open, 1(5):e182169-e182169. [doi:10.1001/jamanetworkopen.2018.2169](https://doi.org/10.1001/jamanetworkopen.2018.2169)

Subtopic(s): Description of the issue

Type of Source: Journal article

Objective: To describe practices that joined the CPC+ model and compare hospital service areas with and without CPC+ practices.

Main Findings: According to this study, although a diverse set of practices joined the CPC+ program, practices in areas characterized by patient populations with greater advantage were more likely to join, which may affect access to advanced primary care medical home models (such as CPC+) for vulnerable populations.

Strengths/Limitations: Secondary data sources such as IMS Health Care Organization Services (HCOS) data on primary care practices could include errors because practice characteristics can change regularly.

Generalizability to Medicare Population: Yes

Methods: This study followed the Strengthening the Reporting of Observational Studies in Epidemiology (STROBE) reporting guideline. To examine the characteristics of practices participating in the CPC+ program, the authors used publicly available data from the CMS8 and identified CPC+ practices, then extracted data describing ownership and characteristics of health systems and practices using IMS HCOS data from 2016.

Geissler, KH. Differences in referral patterns for rural primary care physicians from 2005 to 2016. (2020) *Health Services Research*. 55(1):94-102. <https://www.ncbi.nlm.nih.gov/pubmed/31845328>

Subtopic(s): Description of the issue

Type of Source: Report

Objective: To examine differences in referral patterns between primary care physicians (PCP) practicing in rural vs nonrural areas and changes over time.

Main Findings: A PCP visit was 1.9 percentage points (95% confidence interval: 0.1 pp, 3.8 pp) more likely to result in a referral in nonrural areas than rural areas, controlling for physician and patient characteristics, a 17 percent increase. This difference is driven by a widening gap in referral rates between nonrural and rural areas over time, with large differences in later periods. The regression-adjusted predicted probability of a PCP visit resulting in a referral was 71 percent higher in nonrural than rural areas in 2013-2014 and 92 percent higher in 2015-2016.

Strengths/Limitations: This study quantifies differences in referral patterns in a nationally representative sample between primary care physicians practicing in rural vs nonrural areas and assesses changes in these patterns over the 2005-2016 period. A limitation is that the analysis relies on the NAMCS physician sample, which excludes physicians practicing in community health centers and hospital outpatient departments and does not include nurse practitioners or other nonphysician practitioners. The study also uses a limited definition of rurality, based on whether the PCP is located in an MSA. This definition is one of two used by the federal government and may potentially undercount rural areas as areas within MSAs may be rural.

Generalizability to Medicare Population: Yes

Methods: Multivariate logit regression models using the 2005-2015 National Ambulatory Medical Care Survey

Geremakis C, Campagnolo D, Stuart A, Ahmad A, Hu N, Tornatore C. The impact an MS patient-centered specialty practice has on patient-reported outcomes related to their care team experience. In: ; 2019. <https://onlinelibrary.ectrims-congress.eu/ectrims/2019/stockholm/278386/caroline.geremakis.the.impact.an.ms.patient-centered.specialty.practice.has.on.html?f=listing%3D3%2Abrowseby%3D8%2Asortby%3D1%2Amedia%3D1>. Accessed February 28, 2020.

Subtopic(s): Issues in payment policy

Type of Source: Poster

Objective: To evaluate the implementation of a patient-centered specialty practice model at an MS center on patient-reported outcomes.

Main Findings: Patients reported an increase from baseline in the following measures: ability to get an appointment quickly, how well provider was perceived to have listened to the patient, and how informed the physician was about patient care from a specialist.

Strengths/Limitations: Study limited to one practice site.

Generalizability to Medicare Population: Limited

Methods: Analysis of patient-reported outcomes at baseline and after model implementation.

Herrel LA, Ayanian JZ, Hawken SR, Miller DC. Primary care focus and utilization in the Medicare shared savings program accountable care organizations. *BMC Health Services Research*. 2017;17(1):139. doi:10.1186/s12913-017-2092-8

Subtopic(s): Issues in payment policy

Type of Source: Journal article

Objective: To evaluate the association between primary care focus and health care utilization and spending for ACOs in the Medicare Shared Savings Program (MSSP).

Main Findings: The proportion of ambulatory evaluation and management (E&M) services delivered by a PCP ranged from less than 38 percent (quartile of ACOs with the least primary care focus) to more than 46 percent (quartile of ACOs with the most primary care focus). ACOs in the highest quartile had higher adjusted rates of acute hospital admissions and ED visits, compared with ACOs in the lowest quartile. ACOs in the highest quartile of primary care focus achieved no greater savings per beneficiary relative to their spending benchmarks.

Strengths/Limitations: Data were at the ACO-level, so although greater PCP focus was associated with higher spending for the ACO, this may not be true for individual physicians or beneficiaries. Data also did not include beneficiary-level information, so cannot fully account for differences in patient complexity across ACOs.

Generalizability to Medicare Population: N/A

Methods: An eConsult option was introduced into the EHR referral platform at a multisite Academic Medical Center (AMC) with a shared EHR system. PCPs were encouraged to submit any clinical question provided that: 1) a specialist could address the question based upon the available data and without an in-person evaluation; 2) an eConsult response would meet the patient's needs; and 3) the question would warrant an office-based referral in the absence of the eConsult program. To describe the impact of the eConsult program from a provider perspective, the authors conducted surveys to assess PCP and specialist acceptability of the eConsult system. To examine the impact of the eConsult program from the patient and the delivery system perspective, they measured PCP referral rates, specialty clinic new-patient visit rates, the time to access specialty care, ED visits, hospitalizations, and pro-fee-associated costs.

Huang X, Larson LJ, Wang L, Rosenthal M. Transforming Specialty Practice in Pursuit of Value-Based Care: Results from an Integrated Cardiology Practice. *NEJM Catalyst*. March 2019.

Subtopic(s): Results from similar models

Type of Source: Journal article

Objective: To conduct an observational study of one Providence Heart Clinic, one of the first cardiology clinics in the U.S. to be recognized as a patient-centered specialty practice (PCSP).

Main Findings: Following implementation of the PCSP, new patient access improved. Compared with 2013, the average number of new patient visits per physician available clinic hour increased by 31.8% in 2016. Follow-up patients seen per physician available clinic hour also increased slightly. One-hundred percent of charts were closed in 2016, compared with 92.6% at baseline. Overall doctor rating increased from 83% to 85.6%.

Strengths/Limitations: Limitations of this study include the observational design and the lack of vigorous controls.

Generalizability to Medicare Population: Yes

Methods: Observational study of access, care coordination, and patient satisfaction at Providence Heart Clinic.

Jamoom, E. W., Yang, N., & Hing, E. (January 2016). Adoption of certified electronic health record system and electronic information sharing in physician offices: United States, 2013 and 2014. NCHS data brief, no. 236. Hyattsville, MD: National Center for Health Statistics.

Subtopic(s): Problems in care delivery

Type of Source: Data brief

Objective: This report uses the National Electronic Health Records Survey (NEHRS) to describe physician adoption of certified EHR systems from 2013 to 2014 across the United States and the extent to which physicians with certified EHR systems share patient health information.

Main Findings: In 2015, the percentage of office-based physicians with certified EHR systems increased from 67.5 percent in 2013 to 74.1 percent. In 2014, the percentage of physicians who had a certified EHR system ranged from 58.8 percent to 88.6 percent. Also in 2014, 32.5 percent of office-based physicians were electronically sharing patient health information with external providers. Finally, the percentage of physicians with a certified EHR system electronically sharing patient health information with external providers ranged from 17.7 percent to 58.8 percent. Statements of differences in estimates are based on statistical tests with significance at the $p < 0.05$ level, and all differences are statistically significant unless stated otherwise.

Strengths/Limitations: Information on the 2013 NEHRS methodology is not provided and therefore the comparability of the two surveys cannot be ascertained.

Generalizability to Medicare Population: N/A

Methods: The data for this report are from the 2013 and 2014 NEHRS. Information provided on the methods of the 2014 NEHRS included that the sample was 10,302 physicians, nonrespondents to mail survey received follow-up telephone calls, one-half of the 2014 NEHRS sample were randomly selected to receive a long-form questionnaire, and the 2014 NEHRS was conducted from May through October 2014. In terms of response rates, the unweighted response rate of the 2014 NEHRS short-form questionnaire was 67 percent (66 percent weighted), whereas the unweighted response rate of the 2014 NEHRS long-form questionnaire was 61 percent (60 percent weighted), and the unweighted overall response rate was 64 percent (63 percent weighted).

Lewis V. A., Schoenherr K., Frazee T., & Cunningham A. (2019). Clinical coordination in accountable care organizations: A qualitative study. *Health Care Management Review*. doi: [10.1097/HMR.0000000000000141](https://doi.org/10.1097/HMR.0000000000000141)

Subtopic(s): Results of other similar models

Type of Source: Journal article

Objective: ACOs are becoming a common payment and delivery model. Despite widespread interest, little empirical research has examined what efforts or strategies ACOs are using to change care and reduce costs. Knowledge of ACOs' clinical efforts can provide important context for understanding ACO performance, particularly to distinguish arenas where ACOs have and have not attempted care transformation. The aim of the study was to understand ACOs' efforts to change clinical care during the first 18 months of ACO contracts.

Main Findings: ACOs in the first year of performance contracts are most commonly focusing on four areas: transforming primary care through increased access and team-based care; reducing avoidable ED use; strengthening practice-based care management; and developing new boundary spanner roles and activities. There was little ACO activity around transforming specialty care, acute and post-acute care; or standardizing care across practices during the first 18 months of ACO performance contracts.

Strengths/Limitations: Findings are based on a set of 30 ACOs; this work cannot address how ACO strategies are related to performance on either quality or cost outcomes. **Generalizability to Medicare Population:** N/A

Methods: The authors conducted semi-structured interviews between July and December 2013. Their sample includes ACOs that began performance contracts in 2012, including Medicare Shared Savings Program and Pioneer participants, stratified across key factors. In total, they conducted interviews with executives from 30 ACOs. Iterative qualitative analysis identified common patterns and themes.

Lewis, V., Tierney, K., Colla, C., & Shortell, S. (2017). Care transformation strategies and approaches of Accountable Care Organizations. *Medical Care Research and Review*, 76(3), 291–314. Retrieved from <https://doi.org/10.1177%2F1077558717737841>

Subtopic(s): Problems in care delivery

Type of Source: Journal article

Objective: Although ACOs proliferate, little is known about the activities and strategies ACOs are pursuing to meet goals of reducing costs and improving quality.

Main Findings: The authors identified two overarching ACO approaches to changing clinical care: a practice-based transformation approach, working to overhaul care processes and teams from the inside out; and an overlay approach, where ACO activities were centralized and delivered external to physician practices. The authors additionally identified four methods ACOs were using to achieve their aims: using patient support roles; targeting clinics, events, programs, and interventions; standardizing clinical process; and tracking and identifying patients on which to focus resources. The authors expect that ACOs using either of the major approaches can succeed under current ACO programs, but that as value-based payment programs mature, ACOs will need to undertake practice-based approaches to be successful in the long term.

Strengths/Limitations: Results are based on interviews with leadership at 16 ACOs, which is not a statistically generalizable sample.

Generalizability to Medicare Population: Yes

Methods: The authors used semi-structured interviews with executives at 16 ACOs to understand ACO approaches.

Mathematica. *Evaluation of the Comprehensive Primary Care Initiative: First Annual Report*. January 2015:196.

Subtopic(s): Description of the issue

Type of Source: Report

Objective: To report on the first year of the CPCI program, including who participated, the supports practices received, how practices implemented CPCI, and the impacts of CPCI on cost, service use, and quality outcomes.

Main Findings: In the first year of the program, CMS partnered with 502 practices and over 2,000 clinicians. Those practices provided care to 2.5 million patients.

Strengths/Limitations: Results are limited to the first year of the program.

Generalizability to Medicare Population: Yes

Methods: Evaluators analyzed surveys and interviews of providers, payers, beneficiaries, contractors and vendors, program documentation, practice-reported financial data, electronic clinical quality measures, and Medicare claims data.

Mathematica. Independent Evaluation of Comprehensive Primary Care Plus (CPC+) First Annual Report Supplemental Volume. April 2019:267.

Subtopic(s): Description of the issue

Type of Source: Report

Objective: To report on the first year of the CPC+ program, including who participated, the supports practices received, how practices implemented CPC+, and the impacts of CPC+ on cost, service use, and quality outcomes.

Main Findings: In the first year of the program, CMS partnered with almost 3,000 PCPs and 63 payers across 14 regions. CPC+ practices served approximately 15 million patients, including 2.2 million Medicare FFS beneficiaries and 3.3 million who were attributed by other payers partnering with CMS. Practices focused on risk stratification to identify patients who need the most intensive care management, hiring care managers, and integrating behavioral health services.

Strengths/Limitations: Results are limited to the first year of the program.

Generalizability to Medicare Population: Yes

Methods: Evaluators analyzed surveys and interviews of providers, payers, beneficiaries, contractors and vendors, program documentation, practice-reported financial data, electronic clinical quality measures, and Medicare claims data.

Medicare Learning Network. Chronic Care Management Services. Center for Medicare & Medicaid Innovation; 2019. <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/ChronicCareManagement.pdf>.

Subtopic(s): Payment Policy

Type of Source: Fact Sheet

Objective: Background on payable chronic care management service codes, eligible practitioners and patients, and details about Medicare Physician Fee Schedule billing requirements.

Main Findings: N/A

Strengths/Limitations: N/A

Generalizability to Medicare Population: Yes

Medicare Payment Advisory Commission (MedPAC). (March 2018). Report to the Congress: Medicare payment policy. Chapter 4: Physician and other health professional services. Washington, DC: Medicare Payment Advisory Commission.

Subtopic(s): Specialty referrals, communication, and care coordination; problems in care delivery

Type of Source: Government report

Objective: To provide a report and recommendations to Congress on research areas, including ambulatory care settings; beneficiaries and coverage; delivery and payment reforms; drugs, devices, and tests; hospitals; Medicare spending and financing; physicians and other health professionals; post-acute care; private plans; and quality. The focus of this entry is chapter 4: Physician and other health professional services. MedPAC uses the following factors to assess payment adequacy for physicians and other health professionals: beneficiaries' access to care, the supply of providers, volume growth, quality, and Medicare payments and providers' costs.

Main Findings: The Commission finds that many specialists are currently involved in alternative payment models. For example, based on an analysis of the 2015 ACO public use file, roughly twice as many specialists as primary care providers are participating in MSSP ACOs. Moreover, three out of seven models identified by CMS as advanced APMs for the 2017 reporting year

focused on conditions generally treated by specialists. However, few structures exist in Medicare to hold providers accountable for a beneficiary's full spectrum of care, even when they make the referrals that dictate additional resource use. Moreover, beneficiaries report more difficulty in finding a primary care doctor relative to finding a specialist. This pattern is consistent with prior years, as well as with the privately insured population.

Strengths/Limitations: N/A

Generalizability to Medicare Population: Yes

Methods: MedPAC assesses payment adequacy by reviewing beneficiaries' access to care provided by physicians and other health professionals, the supply of physicians and other health professionals, volume growth, quality of care, and Medicare's payment rates relative to commercial rates for preferred provider organizations.

Mehrotra A., Forrest C. B., & Lin C. Y. (2011). Dropping the baton: specialty referrals in the United States. *Milbank Quarterly*, 89(1):39-68. doi:10.1111/j.1468-0009.2011.00619.x

Subtopic(s): Description of the issue

Type of Source: Journal article

Objective: This article reviews the literature on the specialty-referral process in order to better understand what is known about current problems with the referral process and what solutions have been proposed.

Main Findings: PCPs vary in their threshold for referring a patient, which results in both the underuse and the overuse of specialists. Many referrals do not include a transfer of information, either to or from the specialist, and when they do, it often contains insufficient data for medical decision-making. Care across the primary-specialty interface is poorly integrated: PCPs often do not know whether a patient actually went to the specialist or what the specialist recommended. PCPs and specialists also frequently disagree on the specialist's role during the referral episode.

Strengths/Limitations: This literature review was conducted through 2008, and the findings may be out of date.

Generalizability to Medicare Population: Yes

Methods: Narrative review of five databases, including MEDLINE, CINAHL, LocatorPlus, National Library of Medicine (NLM) Gateway, and PsycINFO, for articles published between January 1970 and January 2009, in the English language, using select search terms. Specialty referrals for input on diagnosis or management were concentrated on. Referrals for radiology/pathology services, hospice, postacute care, dental care, specific procedures (e.g., endoscopies), immunizations, disability evaluation/occupational medicine, physical and/or occupational therapy, alternative/complementary medicine, clinical trials, and anticoagulation clinics were excluded.

Meyers D., Peikes D., Genevro J., et al. (2010). *The roles of patient-centered medical homes and accountable care organizations in coordinating patient care*. Rockville, MD: Agency for Healthcare Research and Quality.

Subtopic(s): Issues in payment policy

Type of Source: AHRQ report

Objective: To describe the goals of care coordination and the central role for primary care, describe the specific activities involved in care coordination, and summarize the evidence on the effectiveness of different care coordination activities that PCMHs and ACOs can pursue.

Main Findings: The structures and functions of ACOs allow them to ensure high-quality care coordination by incentivizing both cooperation across care teams and settings and the transfer of accountability and information. Additionally, ACOs are well suited to aligning resources to

meet population care coordination needs. A concept that bridges the PCMH and ACO perspectives on care coordination is integrated care. At the center of integrated health care delivery is a high-performing PCP who can serve as a medical home for patients. As this definition indicates, a well-functioning patient-centered medical home is a necessary component of integrated care—but it is not sufficient. True integration also requires the type of cohesive medical neighborhood that is envisioned as a product of ACOs.

Strengths/Limitations: N/A

Generalizability to Medicare Population: Yes

Methods: N/A

National Committee for Quality Assurance. Annual Reporting for PCSP Recognition. NCQA.

<https://www.ncqa.org/programs/health-care-providers-practices/patient-centered-specialty-practice-recognition-pcsp/current-customers/annual-reporting-for-pcsp-recognition/>. Accessed March 5, 2020.

Subtopic(s): Description of the issue

Type of Source: Website

Objective: To outline the reporting process for practices to achieve PCSP Recognition.

Main Findings: N/A

Strengths/Limitations: N/A

Generalizability to Medicare Population: Limited

Methods: N/A

National Committee for Quality Assurance. NCQA Report Cards.

<https://reportcards.ncqa.org/#/practices/map?recognition=Patient-Centered%20Specialty%20Practice>. Accessed March 4, 2020.

Subtopic(s): Description of the issue

Type of Source: Website

Objective: To show which practices have NCQA recognitions.

Main Findings: N/A

Strengths/Limitations: N/A

Generalizability to Medicare Population: Limited

Methods: N/A

Nichols D., Haber S., Romaine M., et al. (June 2017). Evaluation of the Multi-Payer Advanced Primary Care Practice (MAPCP) Demonstration: Final report. Prepared for the Centers for Medicare & Medicaid Services by RTI International, the Urban Institute, and National Academy for State Health Policy.

Subtopic(s): Results of other similar models

Type of Source: Evaluation report

Objective: To assess the impacts of the Multi-Payer Advanced Primary Care Practice (MAPCP) Demonstration and determine how contextual factors influenced these impacts. The evaluation is organized around six major domains: state initiative implementation, practice transformation, access to care and coordination of care, beneficiary experience with care, quality of care and patient safety, and effectiveness (utilization of health services and expenditures).

Main Findings: Despite the many transformation efforts of participating practices, the initiatives had limited impacts on claims-based measures of quality of care, coordination of care, access to care, utilization of services, and expenditures among Medicare and Medicaid beneficiaries.

Although there were some high points, there were no consistent impacts within or across states.

Strengths/Limitations: There were limitations in the data available to identify PCMH status and in Medicaid claims data. Analyses are limited by the small number of states participating in the MAPCP Demonstration.

Generalizability to Medicare Population: Yes

Methods: The evaluation used a mix of qualitative and quantitative methods to capture each state's unique features and develop an in-depth understanding of the transformative processes occurring within and across the states' health care systems and participating PCMH practices.

NORC at the University of Chicago. Next Generation Accountable Care Organization (NGACO) Model Evaluation: First Annual Report. August 2018

<https://innovation.cms.gov/Files/reports/nextgenaco-firstannrpt.pdf>

Subtopic(s): Results of other similar models

Type of Source: Evaluation report

Objective: To summarize model performance of the NGACO model after the first year of implementation.

Main Findings: Participating practices tended to adopt the lower-risk track in addition to smaller savings/risk caps in order to protect against potential losses.

Strengths/Limitations: Results limited to the first year of model implementation.

Generalizability to Medicare Population: Strong; NGACO model focuses on the Medicare population.

Methods: Mixed methods evaluation, including claims, survey data, and interviews.

NORC at the University of Chicago. Next Generation Accountable Care Organization (NGACO) Model Evaluation: Second Evaluation Report. January 2020

<https://innovation.cms.gov/Files/reports/nextgenaco-secondevalrpt.pdf>

Subtopic(s): Results of other similar models

Type of Source: Evaluation report

Objective: To summarize model performance of the NGACO model after the second year of implementation.

Main Findings: The model continues to generate gross savings but demonstrates few significant findings on quality or utilization measures.

Strengths/Limitations: Results limited to quantitative data.

Generalizability to Medicare Population: Strong; NGACO model focuses on the Medicare population.

Methods: Difference-in-differences study design.

Nyweide D. J., Lee W., Cuerdon T. T., et al. (2015). Association of pioneer accountable care organizations vs traditional Medicare fee for service with spending, utilization, and patient experience. *JAMA*, 313(21):2152-2161. doi:[10.1001/jama.2015.4930](https://doi.org/10.1001/jama.2015.4930)

Subtopic(s): Results of other similar models

Type of Source: Journal article

Objective: To determine whether FFS beneficiaries aligned with Pioneer ACOs had smaller increases in spending and utilization than other FFS beneficiaries while retaining similar levels of care satisfaction in the first two years of the Pioneer ACO Model.

Main Findings: In the first two years of the Pioneer ACO Model, beneficiaries aligned with Pioneer ACOs, as compared with general Medicare FFS beneficiaries, exhibited smaller increases

in total Medicare expenditures and differential reductions in utilization of different health services, with little difference in patient experience.

Strengths/Limitations: First, CMS selected these ACOs to participate in the Pioneer Model because they demonstrated the capacity to manage the care of a patient population; many also had experience in risk contracting arrangements—hence, by design they deliver care inherently different from the care received by the typical FFS beneficiary. Second, since it would not be operationally feasible to identify a control group of similarly structured and experienced organizations as Pioneer ACOs, neither the participating physicians nor their aligned beneficiaries were randomized, which means that despite efforts to control for differences in patient characteristics and disease burden, the analyses may not have accounted for unmeasured differences between ACO and comparison beneficiary populations. Third, because each ACO’s comparison group comprised similar populations of geographically bounded FFS beneficiaries, any spillover in practice patterns from physicians affiliated with ACOs to patients not aligned with ACOs would attenuate differences in outcomes between them. Fourth, total spending does not include Part D drug spending or cost-sharing payments by beneficiaries. Fifth, the response rate for the ACO CAHPS survey was only 52.8 percent, and no information is available about nonresponders in any of the CAHPS surveys.

Generalizability to Medicare Population: Yes

Methods: Participants were FFS Medicare beneficiaries aligned with 32 ACOs (n=675,712 in 2012; n=806,258 in 2013) and a comparison group of alignment-eligible beneficiaries in the same markets (n=13,203,694 in 2012; n=12,134,154 in 2013). Analyses comprised difference-in-differences multivariable regression with Oaxaca-Blinder reweighting to model expenditure and utilization outcomes over a two-year performance period (2012–2013) and two-year baseline period (2010–2011), as well as adjusted analyses of CAHPS survey responses among random samples of beneficiaries in Pioneer ACOs (n=13,097), FFS (n=116,255), or Medicare Advantage (n=203,736) for 2012 care.

Office of the National Coordinator for Health Information Technology (ONC). (January 2019). Office-based Physician Electronic Health Record Adoption, Health IT Quick-Stat #50. Retrieved from dashboard.healthit.gov/quickstats/pages/physician-ehr-adoption-trends.php

Subtopic(s): Problems in care delivery

Type of Source: Government website

Objective: Describe office-based physician electronic health record adoption.

Main Findings: N/A

Strengths/Limitations: N/A

Generalizability to Medicare Population: N/A

Methods: N/A

Peikes D., Anglin G., Dale S., et al. (2018). Evaluation of the Comprehensive Primary Care Initiative: Fourth Annual Report. Mathematica Policy Research.

Subtopic(s): Results from similar models

Type of Source: Report

Objective: To describe the implementation and impacts of CPCI over its full intervention period (October 2012 – December 2016).

Main Findings: CPCI reduced hospitalizations and ED visits for Medicare FFS beneficiaries attributed to CPC practices more than beneficiaries attributed to comparison practices. Additionally, Medicare expenditures for attributed beneficiaries grew less for CPC practices than for comparison practices, but the savings were not enough to cover Medicare’s CPC care

management fees. CPC had little impact on beneficiaries' experience of care, except for an increase in transitional care.

Strengths/Limitations: The analysis was limited to Medicare and Medicaid FFS beneficiaries attributed to CPC practices. Additionally, the models used are likely far less complex than any true relationships. Lastly, the lack of strong incentives under CPC limited the ability to detect relationships between better care delivery approaches and improvements in key outcomes.

Generalizability to Medicare Population: Yes

Methods: Mathematica conducted a five-year, mixed-methods, rapid-cycle evaluation which relied on a variety of survey data, practice- and payer-level qualitative data, and Medicare and Medicaid claims data. To assess CPCI's effects on costs and quality for Medicare and Medicaid FFS patients, and on stakeholder experience, outcomes for CPC practices were compared with a set of practices that were similar before the start of CPCI.

Peikes D., Dale S., Ghosh A., et al. (2018). *The comprehensive primary care initiative: Effects on spending, quality, patients, and physicians.* *Health Affairs*, 37(6):890-899.
[doi:10.1377/hlthaff.2017.1678](https://doi.org/10.1377/hlthaff.2017.1678)

Subtopic(s): Problems in care delivery

Type of Source: Journal article

Objective: To evaluate the Comprehensive Primary Care (CPC) Initiative initiative's effects on care delivery and outcomes for FFS Medicare beneficiaries attributed to initiative practices, relative to those attributed to matched comparison practices.

Main Findings: CPC practices reported improvements in primary care delivery, including care management for high-risk patients, enhanced access, and improved coordination of care transitions. The initiative slowed growth in ED visits by 2 percent in CPC practices, relative to comparison practices. However, it did not reduce Medicare spending enough to cover care management fees or appreciably improve physician or beneficiary experience or practice performance on a limited set of Medicare claims-based quality measures.

Strengths/Limitations: First, practices were not randomly assigned to treatment and control groups. Second, measurements of patient experience, physician experience, and quality were limited. They did not measure patient or physician experience before CPC and thus cannot rule out prior differences between CPC and comparison respondents. The measures did not fully capture patient experience or include electronic clinical quality measures that were the focus of quality improvement in CPC. Third, the selected sample and the purposefully flexibly defined model limit the generalizability of findings.

Generalizability to Medicare Population: Yes

Methods: The authors compared the 497 practices that were participating at the end of CPC's first quarter to a set of 908 comparison practices. Data sources included Medicare claims files, practice surveys, site visits, phone interviews, and patient surveys. The primary outcome measures were annualized Medicare Parts A and B spending per beneficiary per month with and without accounting for care management fees. Both measures excluded beneficiary payments and Medicare capitated payments for prescription drugs.

Resnick M. J., Penson D., & Buntin M. B. (January 18, 2018). *How to engage specialists in accountable care organizations.* *NEJM Catalyst*. Retrieved from <https://catalyst.nejm.org/engage-specialty-care-accountable-care-organizations>

Subtopic(s): Results of other similar models

Type of Source: Article

Objective: To offer a business-based framework for making strategic decisions about whether and how to include specialists in ACOs and for working toward a common goal of delivering high-quality, low-cost care. Given the number of common high-cost diseases treated in the specialty care setting, it will become increasingly important to provide financial incentives, including bonuses for meeting cost and quality goals, to make ACO participation advantageous for both primary care and specialist physicians. Currently, specialists are advantaged through FFS, and financial incentives for ACO participation are weak at best.

Main Findings: There is no optimal “one-size-fits-all” approach to aligning incentives between primary and specialty care physicians. Given the heterogeneous nature of contemporary ACOs, individual organizations will have to continually evaluate the strategic value of specialist integration, as well as the financial benefit (or liability) of partnerships with specialists. Market and organizational factors will mediate these predictions, and both ACO leadership and specialist physicians alike must consider both the potential positive and negative downstream effects of integration.

Strengths/Limitations: N/A

Generalizability to Medicare Population: N/A

Methods: N/A

Song Z., Safran D. G., Landon B. E., et al. (2011). Health care spending and quality in Year 1 of the Alternative Quality Contract. *New England Journal of Medicine*, 365(10):909-918. doi:[10.1056/NEJMsa1101416](https://doi.org/10.1056/NEJMsa1101416)

Subtopic(s): Results of other similar models

Type of Source: Journal article

Objective: To isolate the treatment effect of the Alternative Quality Contract (AQC) in comparisons of spending and quality between the intervention group and the control group. In 2009, Blue Cross Blue Shield (BCBS) of Massachusetts implemented the AQC, a global payment system. Provider groups in the AQC system assume accountability for spending, similar to ACOs that bear financial risk. Moreover, groups are eligible to receive bonuses for quality.

Main Findings: The AQC system was associated with a modest slowing of spending growth and improved quality of care in 2009. Savings were achieved through changes in referral patterns rather than through changes in utilization. The long-term effect of the AQC system on spending growth depends on future budget targets and providers’ ability to further improve efficiencies in practice.

Strengths/Limitations: The study population was young and included only members enrolled in a BCBS HMO or point-of-service program. Therefore, the results may not be generalizable to the Medicare population, enrollees in a preferred-provider organization or indemnity plan, or persons who live in other states. The authors did not examine the details of each AQC contract, which varied to some degree, or collect information on whether providers had risk contracts with other payers. Formal evaluation of outcome measures could not be conducted owing to the lack of enrollee-level outcomes data before the implementation of the AQC.

Generalizability to Medicare Population: Limited

Methods: Seven provider organizations began five-year contracts as part of the AQC system in 2009. The data analyzed included 2006–2009 claims for 380,142 enrollees whose PCPs were in the AQC system (intervention group) and for 1,351,446 enrollees whose PCPs were not in the system (control group). A propensity weighted difference-in-differences approach, adjusting for age, gender, health status, and secular trends, was used to isolate the treatment effect of the AQC in comparisons of spending and quality between the intervention group and the control group.

Song, Z., Rose, S., Safran, D., Landon, B., & Day, M. (2014). Changes in health care spending and quality 4 years into global payment. *The New England Journal of Medicine*, 371(18), 1704–1714. doi: 10.1056/NEJMsa1404026

Subtopic(s): Results from similar models

Type of Source: Journal article

Objective: Spending and quality under global budgets remain unknown beyond two years. The authors evaluated spending and quality measures during the first four years of the Blue Cross Blue Shield of Massachusetts Alternative Quality Contract (AQC).

Main Findings: In the 2009 AQC cohort, medical spending on claims grew an average of \$62.21 per enrollee per quarter less than it did in the control cohort over the four-year period ($P < 0.001$). This amount is equivalent to a 6.8 percent savings when calculated as a proportion of the average post-AQC spending level in the 2009 AQC cohort. Analogously, the 2010, 2011, and 2012 cohorts had average savings of 8.8 percent ($P < 0.001$), 9.1 percent ($P < 0.001$), and 5.8 percent ($P = 0.04$), respectively, by the end of 2012. Claims savings were concentrated in the outpatient-facility setting and in procedures, imaging, and tests, explained by both reduced prices and reduced utilization. Claims savings were exceeded by incentive payments to providers during the period from 2009 through 2011 but exceeded incentive payments in 2012, generating net savings. Improvements in quality among AQC cohorts generally exceeded those seen elsewhere in New England and nationally.

Strengths/Limitations: Selection bias is a concern because participation in the AQC is voluntary. Internal validity is also threatened if control states underwent payment reform. However, the authors know of no broad-scale reforms among large private insurers in these states during the study period. The results may not be generalizable to ACOs in Medicare. Most Medicare ACO contracts are one-sided, with shared savings only.

Generalizability to Medicare Population: No

Methods: The authors compared spending and quality among enrollees whose physician organizations entered the AQC from 2009 through 2012 with those among persons in control states. The authors studied spending changes according to year, category of service, site of care, experience managing risk contracts, and price versus utilization. The authors evaluated process and outcome quality.

Song Z., Sequist T. D., & Barnett M. L. (2014). Patient referrals: a linchpin for increasing the value of care. *JAMA*, 312(6):597-598. doi:10.1001/jama.2014.

Subtopic(s): Payment policy; problems in care delivery

Type of Source: Journal article

Objective: To discuss issues related to payment policy and outpatient referrals within ACOs.

Main Findings: The success of ACOs under global payment may depend in part on a common yet poorly understood clinical decision: the patient referral in the outpatient setting. Fundamental to collaboration among physicians and other health care professionals, patient referrals have been largely ignored in the payment reform debate. Given their meaningful influence on the volume, cost, and quality of care, referrals should be better evaluated and managed by ACOs.

Strengths/Limitations: N/A

Generalizability to Medicare Population: Yes

Methods: N/A

Szigethy E. M., Allen J. I., Reiss M., et al. (2017). White Paper AGA: The impact of mental and psychosocial factors on the care of patients with inflammatory bowel disease. *Clinical Gastroenterology and Hepatology*, 15(7):986-997. doi:[10.1016/j.cgh.2017.02.037](https://doi.org/10.1016/j.cgh.2017.02.037)

Subtopic(s): Results of other similar models

Type of Source: White paper

Objective: To provide examples of psychosocial care that is integrated into inflammatory bowel disease (IBD) practices plus innovative methods that provide remote patient management.

Main Findings: Patients with medically complex and chronic diseases often have comorbid mental health conditions and psychosocial challenges that, if adequately addressed, are associated with improved health outcomes. Psychosocial interventions cannot substitute for effective medical therapies, but a combined, integrated approach will be of substantial value to IBD patients. Managing mental health, psychosocial, and health system factors will enhance IBD care.

Strengths/Limitations: N/A

Generalizability to Medicare Population: N/A

Methods: The American Gastroenterological Association (AGA) commissioned a task force to review current literature and identify examples of integrated IBD care within both academic and community settings. The task force performed an extensive literature review, reached out to a sample of practices that have developed such care, and met to identify priorities for this report. The consensus statement summarizes findings and highlights several overarching factors that, if managed well, will enhance IBD care.

Tirodkar MA, Acciavatti N, Roth LM, et al. Lessons From Early Implementation of a Patient-Centered Care Model in Oncology. *JOP*. 2015;11(6):456-461. doi:[10.1200/JOP.2015.006072](https://doi.org/10.1200/JOP.2015.006072)

Subtopic(s): Problems in care delivery, results from similar models

Type of Source: Journal article

Objective: To describe the implementation of new standards for patient-centered oncology practices in five pilot practices.

Main Findings: Referral coordination and care management were the most demonstrated functions, while functions related to tracking and coordination of tests and medications were less commonly demonstrated.

Strengths/Limitations: Results limited to the early months of the intervention, and impacts of new standards take time to fully implement.

Generalizability to Medicare Population: Weak; study population not focused on Medicare population.

Methods: Auditor review of workflows and documentation, as well as interviews of clinicians, staff and patients.

Ward L., Powell R. E., Scharf M. L., Chapman A., & Kavuru M. (2017). Patient-centered specialty practice. *CHEST*, 151(4):930-935. doi:[10.1016/j.chest.2017.01.006](https://doi.org/10.1016/j.chest.2017.01.006)

Subtopic(s): Results of other similar models

Type of Source: Journal article

Objective: To describe the PCSP model. Efforts to improve the care model in primary care, such as the patient-centered medical home, have enjoyed some success. However, primary care accounts for only a small portion of total health care spending, and there is a need for policies and frameworks to support high-quality, cost-efficient care in specialty practices of the medical neighborhood.

Main Findings: The PCSP model offers ambulatory-based specialty practices one such framework, supported by a formal recognition program through the NCQA. The key elements of the PCSP model include processes to support timely access to referral requests, improved communication and coordination with patients and referring clinicians, reduced unnecessary and duplicative testing, and an emphasis on continuous measurement of quality, safety, and performance improvement for a population of patients. The PCSP model, like its predecessor, PCMH, offers a path for specialty practices to coordinate care, improve access and communication, and reduce duplicate testing. As health reform efforts to improve quality and experience of care move forward, pulmonary and other specialists have an opportunity to shape the vision of patient-centered care through adoption of the PCSP model of care.

Strengths/Limitations: N/A

Generalizability to Medicare Population: N/A

Methods: N/A

Winter A. The Role of Specialists in Alternative Payment Models and Accountable Care Organizations. Presented at the: March 5, 2020; MedPAC. http://medpac.gov/docs/default-source/default-document-library/specialists_in_acos_0320_public.pdf?sfvrsn=0.

Subtopic(s): Issues in Payment Policy

Type of Source: Presentation

Objective: To explore whether specialists have opportunities to participate in alternative payment models and ACOs and whether ACOs with specialists are more likely to reduce volume and spending.

Main Findings: Specialists do have opportunities to participate in ACOs, but ACOs determine the role of physicians. Limited evidence suggests ACOs with more specialists do not reduce volume and spending, and may do the opposite.

Strengths/Limitations: Data are preliminary and are subject to change.

Generalizability to Medicare Population: Yes

Methods: Overview of evidence of specialist involvement in ACOs

III. Appendix A: Research Questions, Search Term, Data Sources, and Key Word Table

The environmental scan includes a review of information from existing peer-reviewed and non-peer-reviewed publications. We conducted a formal search of major medical, health services research, and general academic databases. We also conducted targeted searches of content available in the grey literature. We reviewed the websites of professional associations/societies and CMS for relevant evaluation reports and program documentation. The table below lists the research questions motivating this environmental scan, as well as the sources and search terms used.

Table 1. Search Strategy

Research Questions	Preliminary Search Terms	Sources
Referrals and care coordination between primary care providers and specialists		
<p>Clearly define the issue / population by addressing the following:</p> <ol style="list-style-type: none"> 1. What are the characteristics of the Medicare FFS beneficiaries in the CPCI demonstration? How similar or different are these beneficiaries from other Medicare FFS beneficiaries? 2. To what kinds of specialists are CPCI beneficiaries referred to, for which services, and how often? 	<p>CPCI Medicare beneficiaries characteristics including to which specialist they are referred and their utilization of specialty services</p> <p>PCSP certification+ specialists</p> <p>CPCI Medicare beneficiaries + utilization</p>	<p>Pubmed Google scholar</p>
Problems in Care Delivery		
<ol style="list-style-type: none"> 1. What are the characteristics of CPCI practices and do any of these characteristics have a potential impact on referral patterns and care coordination? 2. What are the barriers to coordination between PCPs and specialists within the CPCI model? 3. Is there evidence that current referral and care coordination practices pose quality, patient safety, and patient experience of care issues within the CPCI model? 4. What eQMs are available to specialists? How well do these eQMs align with those most frequently used by CPCI providers? 5. How many specialists have EHRs? Can those EHRs produce eQMs and/or exchange information with providers in the CPCI program? 	<p>CPCI model+ practice applicants participating practices</p> <p>CPC+ program information on participating practices if available and relevant</p> <p>CPCI model+ barriers care coordination care management patient-centered care patient safety patient satisfaction patient experience of care shared decision-making quality improvement EHR/CEHRT HIE and Interoperability</p> <p>eQMs + CPCI</p> <p>EHRs + CPCI</p>	<p>NCQA CMS Measures Inventory Tool PubMed</p>

Research Questions	Preliminary Search Terms	Sources
Issues in Payment Policy		
<ol style="list-style-type: none"> 1. What are the Medicare FFS payment guidelines for care coordination between primary care providers and specialists? How does reimbursement vary between specialties? 2. What are the existing APMs for key specialties? Have these been implemented and/or evaluated? 3. What are other existing Medicare or CMMI payment reforms support care coordination? (e.g. Medicare Physician Fee Schedule Chronic Care Management Services, Multipayer Advanced Primary Care Practice (MAPCP), Accountable Care Organizations (ACOs), Bundled Payments for Care Improvement (BCPI), Oncology Care Model (OCM), Comprehensive Care for Joint Replacement (CJR)) 	<p>Medicare reimbursement guidelines+ care coordination Specialty care</p> <p>Payment structure+ Comprehensive Primary Care Initiative (CPCI) Medical Neighborhood ACOs MAPCP BCPI CJR</p>	<p>MedPAC Medicare coverage database Pubmed Google scholar</p>
Results of Proposed or Similar Models		
<ol style="list-style-type: none"> 1. Is there literature available on the proposal submitter? (ACP and NCQA) 2. What effect do other similar Medicare or commercial models have on care coordination & referral management? Is there variation in outcomes related to geography, rurality, or healthcare market factors? 3. What effect do other similar Medicare or commercial models have on patient choice, satisfaction, and experience of care? 4. What evidence is available for the effect of the NCQA PCSP model on referral management and care coordination? 5. What are the results of similar Medicare models promoting coordination between PCPs and specialists? (e.g., Medicare Physician Fee Schedule Chronic Care Management Services, Multipayer Advanced Primary Care Practice (MAPCP), Accountable Care Organizations (ACOs)) 	<p>ACP NCQA Specialty care payment model</p> <p>MAPCP BCBSNC Blue Quality Physician Program Anthem + Enhanced Personal Care</p> <p>Name of Medicare (not CPCI) or commercial model + barriers care coordination care management patient-centered care patient safety patient satisfaction patient experience of care shared decision-making quality improvement EHR/CEHRT HIE and Interoperability</p>	<p>Google Google Scholar CMMI PubMed</p>

PHYSICIAN-FOCUSED PAYMENT MODEL TECHNICAL
ADVISORY COMMITTEE (PTAC)

+ + + + +

PRELIMINARY REVIEW TEAM (PRT)

CONFERENCE CALL WITH
FAMILY MEDICINE PHYSICIAN EXPERT
FOR THE
AMERICAN COLLEGE OF PHYSICIANS (ACP) AND THE
NATIONAL COMMITTEE FOR QUALITY ASSURANCE (NCQA)
(REVISED VERSION) PROPOSAL

+ + + + +

THURSDAY, MAY 28, 2020

3:00 p.m.

PRESENT:

KAVITA PATEL, MD, MSHS, PTAC Committee Member
JEFFREY BAILET, MD, PTAC Committee Member
ANGELO SINOPOLI, MD, PTAC Committee Member

SALLY STEARNS, PhD, Office of the Assistant
Secretary for Planning and Evaluation
(ASPE)

STELLA (STACE) MANDL, ASPE
AUDREY MCDOWELL, ASPE

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

RICHARD SHONK, MD, PhD, Chief Medical Officer, The
Health Collaborative

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

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

2 3:02 p.m.

3 DR. PATEL: I'll go ahead and start.
4 I'm going to be brief. My name is Kavita Patel.
5 I'm an internal medicine physician and one of the
6 members of the Preliminary Review Team for the ACP
7 NCQA Medical Neighborhood Model.

8 And I'm very happy, Dr. Shonk, to have
9 you as our guest for the hour. And I'll hand it
10 over to Angelo.

11 DR. SINOPOLI: Hi, this is Angelo
12 Sinopoli. I'm a pulmonary critical care doc. And
13 I'm on PTAC and on this PRT Committee also.

14 DR. STEARNS: And, Dr. Shonk, if you
15 want to go ahead, we'll -- Jeff should join us in
16 a minute.

17 The other thing I do want to make sure
18 that everybody on the call understands is that the
19 call is being recorded and will be transcribed.

20 But, Dr. Shonk, go ahead.

21 DR. SHONK: Sure. So I'm Richard
22 Shonk. I'm a family physician by training. I also

1 have a Ph.D. in pharmacology.

2 And I have had a rather varied past. I
3 was in private practice for about 12 years. I was
4 the -- I then was in hospital administration at two
5 large tertiary care systems, as chief medical
6 officer at Riverside in Columbus, and then as the
7 Director of Quality at the Cleveland Clinic.

8 And then I also served as a Market
9 Medical Director for UnitedHealthcare for about
10 seven years. And as I am fond of saying, when I
11 was recruited to the Health Collaborative my boss
12 said you know what, you're kind of a
13 multi-stakeholder in one.

14 So I've been working for the Health
15 Collaborative for about six years, seven years now.
16 And we were involved in CPC¹ Classic, so the initial
17 seven regions of CPC.

18 And then we also participated in the
19 extension of that to CPC², and are the largest CPC+
20 demonstration site in the country with 560
21 practices participating in the project.

1 Comprehensive Primary Care

2 Comprehensive Primary Care Plus

1 DR. STEARNS: Terrific. And since
2 Jeff hasn't joined us yet, Kavita and Angelo, do
3 you want to just get started and Jeff will catch
4 up?

5 DR. SINOPOLI: Yes. I think so.
6 Kavita, what do you think?

7 DR. PATEL: Yeah. I think so. And I
8 think, Dr. Shonk, you hopefully have, I believe,
9 Sally, correct me if I'm wrong, you actually have
10 some of the questions that we were curious to get
11 your impressions on. I don't know if we can get
12 through all of them.

13 But that might be a good place to start.
14 Is that fair, Sally? Did you send these in
15 writing?

16 DR. STEARNS: Yes.

17 DR. PATEL: Or do I need to reread them?

18 DR. STEARNS: No.

19 DR. PATEL: What's the best way?

20 DR. STEARNS: Most people have a
21 version. And it is a version where there was one
22 question that was taken off. So it's the version

1 dated May 26 that you'll be using. And that was
2 attached to the appointment.

3 So that's --

4 DR. SHONK: So do you want me to just
5 start running with the questions? And we'll see
6 --

7 DR. PATEL: I'll -- I can go ahead and
8 -- I can go ahead and read through them if it's
9 helpful. It sounds like you've described your
10 practice.

11 But if you want to elaborate any more
12 on the Health Collaborative for which you're the
13 Chief Medical Officer. And then maybe just segue
14 into that to just talk through general impressions
15 of the -- and we'll refer to it as MNM³, which might
16 be a little mouthful for the transcriptionist.
17 But it just makes it easier.

18 So the general impressions of the
19 proposal, the MNM proposal, strengths and
20 weaknesses.

21 DR. SHONK: Sure. So the Health

3 Medical Neighborhood Model

1 Collaborative, I've been doing this now for about
2 eight years. And I've been leading it. We do a
3 combination of work for the CPC+ practices. One,
4 we do the learning and diffusion work. That is
5 going out and coaching practices and helping them
6 adjust to and do the process improvement overall
7 involved in comprehensive primary care.

8 We also do the claims data aggregations
9 for the now 12 payers that are active in this region
10 and including CMS. And we combine that claims data
11 into a report that we -- that goes out to the
12 practices every quarter as to how they're doing in
13 their project.

14 And then more recently, we have been
15 designated as a convener of the payers, where we
16 trying to find common guidelines, boundaries,
17 approaches that the payers can take in facilitating
18 this work.

19 So in general my impression of the
20 Medical Neighborhood or MNM is that it is really
21 the logical next step. When we've been dealing
22 with the CPC+ work, it's frequently a concern on

1 the part of the practices that the specialists with
2 whom they work, and with whom they -- and to whom
3 they refer aren't really incentivized, if you will,
4 along the same lines that CPC is.

5 And having that lack of alignment and
6 incentives with the specialists being pretty much
7 still on a fee-for-service model, and they being
8 more comprehensive advanced payment methodology,
9 can create tension.

10 And I think that the idea of bringing
11 specialists into and connecting them with the
12 primary care models is really a much needed
13 approach. And it also is an approach that will,
14 I think, have a lot of significant opportunity as
15 -- of advancing the quality and the cost of
16 healthcare.

17 I've seen studies, and I'm sure
18 everybody else on the phone has as well, but as much
19 as 30 percent of the healthcare dollar is
20 essentially wasted, i.e., duplicative or wrong
21 study, wrong place, wrong time. And it is
22 something that I think if there is better

1 coordination among those physicians, we can make
2 a dent into that 30 percent.

3 So that's basically my general
4 impressions. And if there's any specific
5 questions about that, I hope this is more of a
6 dialogue and Q&A, as opposed to me just talking.

7 DR. STEARNS: And I just want to
8 interrupt. Thank you. That was very useful
9 review.

10 And somebody joined. I want to know if
11 Jeff has joined yet?

12 CHAIR BAILET: Yeah. Jeff has joined.
13 Sorry I'm late.

14 DR. STEARNS: No worries. So we had
15 Dr. Shonk just get started really on the first
16 question. A little more description of the Health
17 Collaborative.

18 I think you heard most of it. But if
19 you want to just give your brief introduction, and
20 then we'll let Kavita or the rest of you continue.

21 CHAIR BAILET: Yeah. I appreciate,
22 Richard, you providing this insight for us. And

1 I'm Jeff Bailet. I'm an ENT surgeon out here in
2 California leading Altais, which is a spinoff of
3 Blue Shield of California, a physician services
4 organization.

5 It's great talking with you today.

6 DR. SHONK: Great. Thank you. So --

7 CHAIR BAILET: So I'm assuming -- I'm
8 assuming that my other two PRT colleagues are on
9 the line? I've got to believe they are.

10 DR. STEARNS: They are. And we did the

11 --

12 (Simultaneous speaking.)

13 DR. PATEL: Yes. We are.

14 CHAIR BAILET: Great.

15 DR. PATEL: Yeah, sure. We can just --
16 it would be great to dig in a little bit more into
17 what makes you feel like this is the next step. And
18 perhaps maybe you can also speak to what
19 specifically the proposal alludes to, which is
20 three particular specialties, cardiology,
21 infectious disease, and neurology.

22 So maybe I'm just kind of building on

1 your statement about how this is the next step.
2 And since you're a CPC leader, maybe incorporate
3 how those particular specialties might also be part
4 of that next step?

5 DR. SHONK: Yeah. So, yeah. I think
6 that in general, I think those are three prime
7 specialties that would add a lot. The cardiology
8 I think is probably front and center. So many of
9 the primary care practices work with and have
10 patients with serious cardiac issues.

11 And then neurology similarly.
12 Anything from stroke to seizures to, you know,
13 other, you know, the various newer neurological
14 syndromes that have come to bear, I think is another
15 great area.

16 One of the -- and infectious disease,
17 I'm not as high on the infectious disease side. I
18 think that most infectious disease in the primary
19 care space tends to be rather straightforward and
20 not really necessitating that much in the way of
21 consultation.

22 It's really in the inpatient setting

1 where more and more of the primary care physicians
2 have pretty much given up inpatient care. That
3 they would -- the infectious disease specialty, I
4 think, would be more applicable there. Certainly
5 for any ongoing infectious disease treatment,
6 post-hospitalization, that certainly would have
7 some bearing and would be worth having a plan
8 around.

9 If we're talking about specialties,
10 other areas, I think, and other specialties that
11 might be worth thinking about in the future, would
12 be oncology. I think there is an awful lot of
13 activity going on there that could benefit from the
14 holistic approach. And I think where primary care
15 adds a lot to that discussion is knowing the patient
16 as well as they do, helping them with the decision
17 making process that goes on in that treatment.

18 There's also the other side of it. And
19 that is the screening and the, you know, the more
20 prompt referral for possible oncology cases that
21 I think both would pay off considerably.

22 So I don't know if you want me, you know,

1 if we're starting with just those three, we can just
2 keep the conversation focused on those three and
3 use those examples. But there are a few other
4 specialties that I think might be worth thinking
5 about as we go down the road with regard to Medical
6 Neighborhood.

7 DR. PATEL: Do you have any -- I'll just
8 ask one question, and then Angelo and Jeff can
9 interject.

10 Do you have any examples in kind of the
11 -- either with a private payer or someone else where
12 you've had some sort of arrangements? Maybe not
13 with these particular specialties, but other types
14 of specialists?

15 DR. SHONK: Yeah. I think that -- I
16 certainly with cardiology, many. And also
17 neurology.

18 I have not -- I am not presently -- I'm
19 not clinically active presently. So I don't have
20 any individual cases that I've managed. I
21 certainly did back when I was in private practice
22 and also during my time at the Cleveland Clinic.

1 But I don't, as far as what I'm seeing
2 in today's world and in the primary care world, I
3 think cardiology is one of those areas that is
4 really ripe for this. There are now so many
5 different studies that can be done in cardiology.
6 And sorting through those studies, and when they're
7 indicated, and when they should be ordered, I think
8 is an area that's ripe for primary care specialist
9 discussion and developing a plan of approach.

10 I think that the whole area of neurology
11 is something that is, again, becoming much more
12 prevalent. And I've seen cases where anything
13 from the management of the dementia, as well as the
14 discussions around the appropriate aftercare of a
15 stroke patient, I think is very ripe for better
16 integration and more efficiencies.

17 Oncology in my mind is, I think, one of
18 the prime areas that could really benefit from more
19 interaction in that area. Many of the oncologists
20 do manage the case of a patient once they come under
21 their care. And tend to do it across the board.
22 In fact, most of those patients will turn to their

1 oncologist first.

2 But it's amazing the number of times
3 those patients also come back to their primary care
4 physicians, and inadvertently the primary care
5 physician can create confusion, create difficulty
6 for the plan of care for the oncologist, especially
7 with regard to some of the medications that are in
8 use now in oncology.

9 So all those areas I think I've seen,
10 you know, an example, one example of how better
11 integration leads to a better outcome. You know,
12 one area that I think is also very important in all
13 of this discussion, is the -- is patient goals.
14 What are patients interested in accomplishing with
15 regard to their care?

16 And sometimes the primary care
17 physician is in a better position to have that
18 discussion. So whether it's end of life care, or
19 whether it's how much do you want to go through for
20 this particular diagnosis, what's your, you know,
21 preferred approach, and the like.

22 So I think those are all areas that

1 really primary care and specialty care could really
2 collaborate on.

3 DR. SINOPOLI: So this is Angelo. As
4 a specialist, I have a question in regards to the
5 structure and incentive plan around the MNM model.

6 So it seems to be very focused on kind
7 of administrative functions, making sure that the
8 referral has all the appropriate records, et
9 cetera, et cetera, the more front office kind of
10 functions. Do you think the structure and payment
11 model, the way it's posed presently, will actually
12 help improve outcomes?

13 Or is there a better way to structure
14 that? Or do you think the present model will
15 actually accomplish improved clinical outcomes?

16 DR. SHONK: Yeah. So I think with
17 regard -- I, if anything, I would be emphasizing
18 the agreement between the specialist and the
19 primary care. And I would make sure that certain
20 issues get covered in that agreement. Here's what
21 the expectation is of the practice as they're
22 making the referral. Here's what the expectation

1 is for the specialist in responding to that
2 referral.

3 And having a preplanning meeting, if
4 you will, upon a referral, that somehow lines up
5 the goals. And it lines up what the care is really,
6 what the referral is specifically for.

7 You know, and one of the things that I
8 think the literature also supports, and I think
9 it's quoted in the proposal, that there is a real
10 disconnect between what specialists say they get,
11 and what primary care says they -- say they send,
12 and vice versa.

13 And to me, there's probably a whole
14 research paper that you could do on why those gaps
15 exist because it seems like both sides think they
16 are doing it. And yet both sides are saying
17 they're not seeing it.

18 And so I think that it is a -- I think
19 that pre-agreement aspect of it would be the place
20 to make sure that the right information gets sent,
21 that it is something that's readily accessible to
22 the physician and the treatment teams, and making

1 that all come to, you know, clarifying those
2 expectations, if you will.

3 Is that answering your question?

4 DR. SINOPOLI: Yes. Thank you.

5 DR. SHONK: Okay.

6 CHAIR BAILET: Richard, this is Jeff.
7 I have sort of a global question. I was struck by
8 the proposal, one of the -- and this is my
9 phraseology. I think there's an air traffic
10 control problem here.

11 DR. SHONK: Mm-hmm.

12 CHAIR BAILET: With, you know,
13 attribution, people popping in, people popping
14 out. It seemed to me to have a lot of logistical
15 burden.

16 DR. SHONK: Yeah.

17 CHAIR BAILET: And I would love your
18 read on that if you could. With your experience
19 with CPC+ and the attribution and assignment, and
20 all of the mechanics of bringing this into reality,
21 adding in the specialties. Tell me a little bit
22 about, you know, do you see that as -- because you

1 did, again, I'm teeing like Kavita on your comment
2 that this is where the sort of where the puck is
3 going.

4 So help me understand your read on is
5 that -- how difficult it is right now for air
6 traffic control?

7 DR. SHONK: Yeah. Well, you've hit on
8 one of the major tension points within CPC+. And
9 that is attribution. There isn't a week that goes
10 by that I don't hear from a primary care practice
11 about the attribution models within CPC+ and
12 whether or not they have been properly attributed
13 or not.

14 I have come to the conclusion that there
15 is no perfect attribution model, and I tell the
16 physicians that. It just needs to be good enough
17 so that you're getting the necessary reimbursement
18 in that attribution on a per member/per month rate,
19 that you can afford to hire those care managers that
20 actually do the work of being the traffic
21 controller, if you will.

22 And that is the -- I think that's the

1 expectation that you have to generate in these
2 types of programs. What usually happens with
3 physicians, and it goes along with our training,
4 is that we get very much into the specific case.
5 And so if a physician sees that this 12 or 20
6 patients were not attributed to them, even though
7 they are caring for them, they lose sight of the
8 -- 200 to 500 that are attributed to them.

9 And they just focus on those, and saying
10 why is that? What can you, you know -- and so
11 they're not -- it's difficult to get physicians to
12 think in a different way about that.

13 For physicians who work for systems,
14 it's not as much of a problem. It's really the
15 private practices that really get hung up on the
16 attribution model.

17 While we're talking about attribution,
18 one of the concerns I had about the proposal was
19 that there, as I was reading through the proposal,
20 it seems like the primary care physician was
21 essentially being asked at times to refer to a
22 participating specialist. But then also at times

1 to be referring to a non-participating specialist.

2 And I think that really needs to be
3 thought about. Because based on what we know in
4 payment models and in coordination of care, you're
5 asking a primary care physician to essentially
6 delegate or refer to a less cost effective
7 approach. And that's going to reflect badly in
8 their performance within CPC+ or Primary Care
9 First. And so that will be a -- that will be a hang
10 up for the primary care physician.

11 I think, if I read between the lines,
12 the reason for that is to do some type of
13 comparative analysis of those patients who are
14 referred to participating specialists versus those
15 that are not. But I, you know, I think that it's
16 going to be problematic unless there's some
17 allowance given to the primary care physician in
18 their own numbers to say hey, we're not
19 participating in this Medical Neighborhood
20 Program. I'm being asked to refer to what I think
21 is maybe not the most cost effective.

22 I'm not saying anything about quality.

1 I mean, obviously they would still refer to what
2 they would consider a quality specialist. But
3 maybe they're not being the same level of
4 coordination, it may not be as cost effective.

5 Does that make sense? Or, you know,
6 any questions about that? Or concerns?

7 CHAIR BAILET: That's helpful. And
8 we're going to have to sort of get underneath that
9 a little bit more because implementing, you know,
10 implementing a program like this, even as elegantly
11 as it's designed --

12 DR. SHONK: Mm-hmm.

13 CHAIR BAILET: I'm still trying to find
14 a path where implementation is possible.

15 DR. SHONK: Yeah, yeah.

16 CHAIR BAILET: And I'm hearing you say
17 that it probably is possible.

18 DR. SHONK: Mm-hmm.

19 CHAIR BAILET: I'm sort of, I'm reading
20 between the lines. But that's the takeaway from
21 your answer. Is that accurate?

22 DR. SHONK: Yeah. It is. In fact,

1 one of the ways that you could do that is that you
2 -- because this program won't be nearly as large
3 as the attribution to a CPC+ practice of all their
4 patients in CPC+, it would be such a smaller
5 sub-segment of that population that you could, for
6 the purposes of CPC+ evaluation, just exclude those
7 results and those costs from the evaluation.

8 You could just make it so that they
9 didn't have that. And we could do that in a
10 different, you know, it would just be an exclusion,
11 if you will, from their data so they aren't
12 penalized for it.

13 CHAIR BAILET: Okay. I have other
14 questions, but I want to make sure my colleagues
15 get, can --

16 DR. PATEL: No, this is good, Jeff. I
17 think -- I would be very interested -- I have a
18 feeling I know where you're going directionally.
19 And I would be interested in kind of drilling down
20 a little more. Because just --

21 CHAIR BAILET: Yeah.

22 DR. PATEL: Like you, I share just --

1 I guess maybe thinking about it on the flip side
2 to Angelo's point, you know, I'm very interested
3 in maybe understanding and some of the
4 collaborative agreements maybe that you've had, or
5 conversations with cardiologists.

6 Kind of what is it that cardiologists
7 need to see on their side in order to make the
8 investment or kind of change of practice, you know,
9 worth it so to speak. Not necessarily financially
10 even, but just, I'd be personally curious about
11 that.

12 And then, Jeff, you know, please
13 continue in that thread you're --

14 CHAIR BAILET: Yeah. Go ahead,
15 Kavita. I think you're -- I think I'd like to hear
16 the response to that.

17 And then I'll jump back in after Angelo.
18 Maybe Angelo's got another comment to make as well.

19 DR. SHONK: So the question is what
20 does it look like in a, say this is the cardiology,
21 and why would the cardiologist want to participate
22 in this approach? Is that -- is that a good summary

1 of the question?

2 DR. PATEL: Yeah. And that can be from
3 either the standpoint you've had some dialogue, not
4 around the MNM proposal obviously. But it sounds
5 like maybe as part of your CPC, or maybe private
6 kind of -- payer conversations.

7 DR. SHONK: Mm-hmm.

8 DR. PATEL: It would be interesting to
9 compare that. And then if you, if that's not
10 appropriate, to also then in the context of the MNM
11 proposal, thinking about, you know, if this is the
12 next step, what would it look like if cardiology
13 or even oncology is like the next logical partner.

14 DR. SHONK: Yeah.

15 DR. PATEL: What would it take on their
16 side? You know, what do they need to hear to be
17 interested?

18 DR. SHONK: Okay. So one area that I
19 find helpful, and what the MNM program tends to
20 approach, is kind of the ACO model. So if you look
21 at the way specialists and primary care interact
22 in an Accountable Care Organization (ACO), it's not

1 perfect. But there is more of this type of
2 activity that goes on, where there is more
3 coordination of care, more conversation, more
4 comparing notes.

5 Most ACOs do have the advantage of being
6 on the same electronic medical record (EMR). So
7 that does make it easier to get that accomplished.
8 I think that that really does expedite it, if you
9 will. In fact one of the weaknesses or, you know,
10 one of the things about the MNM proposal is that
11 it really does favor those types of systems that
12 have that type of common electronic medical record.

13 If you're talking about independent
14 specialists or independent primary care that are
15 on their own EMRs, then you've got to work out an
16 arrangement that that information can go back and
17 forth in a more ready fashion.

18 And there are networks there, the
19 Health Information Exchange (HIE) networks, and
20 there are other types of networks out there that
21 can do that. And you can sign them up in a way that
22 it's, you know, it's exclusive to these types of

1 agreements.

2 But it is an extra step. It is
3 something that the practice would have to, on both
4 sides, would have to get agreed on and figure out
5 how they're going to do that.

6 I think in the ACO world, with what some
7 of the best practices I've seen, especially in the
8 cardiology arrangements, is that the patient
9 begins to see a team of doctors, as opposed to
10 having individual visits to doctors. And many of
11 them have taken to developing these, you know, the
12 patient comes into the primary care office, they
13 do a virtual visit with the cardiologist.

14 They get both visits in at the same time
15 as a patient, and therefore it really is efficient
16 for them. They also see the agreement, if you
17 will, between the specialist and the primary care
18 doctor on this plan of approach.

19 Frequently when a primary care doctor
20 sees a patient, they may actually say the same thing
21 that the cardiologist says when the patient goes
22 to the cardiologist's office, but as we all know,

1 patients have different interpretations of the
2 words we use.

3 And sometimes what happens is, is that
4 even though the primary care doctor may have said
5 the exact same thing as the cardiologist said when
6 they visited them two weeks later, it is kind of
7 lost in translation, if you will.

8 So I think that those kinds of things
9 can be developed. And actually the Cleveland
10 Clinic was doing a lot of that type of primary care,
11 specialists, especially in cardiology, you know,
12 virtual meetings.

13 And it would go the other way around.
14 Sometimes the cardiologist would be seeing the
15 patient, and they would get the primary care doctor
16 on the call. Especially if there were issues
17 around other illnesses that the primary care doctor
18 was handling, medication changes, things of that
19 nature. So the vast majority though were primary
20 care doctors seeing the patient in their office,
21 and then piping in the specialist.

22 In some of those cases, and especially

1 if you start to think about Primary Care First, and
2 I don't know how familiar you guys are with the
3 Primary Care First model, but there is a
4 subcategory within primary care called the
5 seriously ill population.

6 And it would seem to me that that would
7 be a prime area that you would want to develop that
8 type of very close working relationship and be able
9 to manage those patients very closely between the
10 primary care and the specialist.

11 And that will be an area that, believe
12 me, if primary care physicians who get into that
13 seriously ill population, will be looking for all
14 kinds of ways of better interacting with the
15 specialists.

16 DR. PATEL: Thank you. Any -- well, if
17 you don't mind, I'd love to maybe kind of also, this
18 is coming, I'm jumping around a little bit, but it's
19 on the, also the list of questions.

20 Just maybe drilling down on the
21 thoughts about smaller, independent practices
22 because you're touching a little bit on what I think

1 we've seen in other PTAC proposals.

2 DR. SHONK: Mm-hmm.

3 DR. PATEL: And we are, we've become
4 very versed in some of the newer models, Primary
5 Care First, Oncology Care -- you know, some of the
6 different proposals.

7 DR. SHONK: Right.

8 DR. PATEL: But it would be great to
9 maybe give a lens, since you've talked about your
10 own background in private family practice, just how
11 you see potentially small independent practices
12 versus a large kind of integrated practices. And
13 maybe there's some others that we're not thinking
14 of.

15 DR. SHONK: Yeah. So one of the things
16 that happens in the smaller independent primary
17 care practices, and one of the reasons why they --
18 pretty much solo practice is becoming somewhat
19 extinct, at the very least they're joining
20 mid-sized groups, is because of these types of
21 arrangements and because it is a -- it does take
22 a lot of back office resources to make these things

1 work well.

2 And if you're -- the one thing that I've
3 advocated for in CPC is if you're a CPC practice
4 in a large system, you get paid the same PMPM⁴ that
5 an independent small group gets paid.

6 And it just doesn't -- it just doesn't
7 meet the need. There is efficiencies of scale that
8 the system practices have that the smaller groups
9 do not have.

10 And if we really want this to work in
11 a -- in the smaller setting and in maybe the more
12 rural or more remote city settings, there needs to
13 be some serious thought given to how do you increase
14 that financial reimbursement so that they can have
15 the resources that they need to be able to do this
16 type of -- and do it well, this type of work.

17 So it is a -- I think resources is a big
18 part of that. I think the independent practices
19 also are more -- needy is not the right word, but
20 it's the one that's coming to mind, in that they
21 -- they really have a -- and maybe I -- it's just

4 Per Member Per Month

1 they have a greater need for specialty input.

2 If they are in a smaller city or a
3 smaller town, they do not have the ready
4 availability of what we used to call a curbside
5 consult with a specialist. Which many of the
6 physicians who live in the bigger cities and are
7 in the bigger systems, are rubbing elbows with
8 those specialists. And oh, by the way, I saw so
9 and so, and this is their problem. And what do you
10 think? And that type of thing.

11 That type of accessibility is not there
12 in the -- in those practices. And I think building
13 into the model a way for those practices to have
14 more accessibility to that.

15 And that may be also something that in
16 the MNM model could be kind of addressed in that
17 agreement. That somehow, you know, let's tailor
18 this agreement to what both the specialist and the
19 primary care doctor needs and the way to make it
20 work well.

21 And if you're in a smaller town, a
22 smaller community, that's really kind of the thing

1 you need, is I need your access. I need to be able
2 to either call you, text you, get you on an email,
3 or whatever when something comes up

4 And that is a -- so I would, and I didn't
5 see it, but, you know, written out in the proposal.
6 But I think that would be something that would be
7 well worth consideration.

8 DR. PATEL: If my --

9 DR. SHONK: I can talk --

10 DR. PATEL: -- colleagues.

11 (Simultaneous speaking.)

12 DR. PATEL: Yes, no, no, no. That's
13 fine. That's great. Maybe we can touch on some
14 of the other questions.

15 It sounds like you mentioned a little
16 bit about kind of health information technology.
17 That some of this could be facilitated obviously
18 with existing, you know, some of the health
19 information exchanges.

20 DR. SHONK: Mm-hmm.

21 DR. PATEL: Are there any other -- and
22 then also keeping in mind some of what you just

1 mentioned about smaller practices, anything else
2 around kind of health information technology that
3 you want to elaborate on, building on what you've
4 done in CPC or kind of things that you've seen that
5 work well, so that you can have collaboration?

6 DR. SHONK: Yeah. I think that
7 there's the individual patient management level,
8 and then there's the aggregate result level. And
9 the individual patient management just really
10 requires regular communication in real time with,
11 you know, getting the results of that particular
12 test or that particular study.

13 It would be really neat, and some of the
14 system EMRs do this through a common medical
15 record, where the specialist visit and
16 interpretation of the test results are all there
17 for the primary care doctor to see. And many of
18 the primary care doctors will have their staff pull
19 that up prior to the visit of that patient so
20 they're cognizant of what the specialist is seeing,
21 advising, and planning for that patient.

22 But having that type of availability of

1 real time information is key if you're going to make
2 a difference in the outcome. And I think the, you
3 know, whether it's the prescribing patterns,
4 whether it's, you know, avoiding certain types of,
5 you know, I don't know, therapies.

6 But also, I think, one of the things
7 that the primary care doctor feeds back into that,
8 to the specialist, is the prioritization of the
9 patient's condition. So the primary care doctor
10 is much closer to the ground with regard to
11 interacting with that patient's family, with
12 knowing where they're coming from, oftentimes sees
13 multiple people within the family, sees the -- even
14 across generations, and knows what that patient is
15 dealing with.

16 And as much as we would like as
17 specialists for that patient to follow our care
18 guidelines, and say here's what you really need to
19 do, they're -- given that patient's particular
20 circumstance, it's not always possible.

21 And so what's the next best, or where
22 should we prioritize this patient's attention in

1 order to be able to get the best outcome that we
2 can, given their circumstances.

3 So it feeds both ways. And if you do
4 have a common EMR, it's easier to communicate that,
5 if the physicians are reading it.

6 The one thing we have to do is get much
7 better at EMRs. And so that there's not so much
8 junk in the EMR that you have to sort through in
9 order to get to the meat of it.

10 But if you have a way of communicating
11 that in a concise way, or have staff that pull up
12 that concise information, it really goes a long way
13 in management of the patient.

14 CHAIR BAILET: And, Angelo, I again
15 want to make sure you have air time. But when you
16 mentioned the EMR, I wanted to ask about reporting.

17 And reporting cuts both ways. So the
18 reporting coming from the practice, the individual
19 physicians, the specialists, and also what
20 information are you getting as a clinician? What
21 information is coming your way to help better
22 guide, you know, the care planning and the

1 treatment decision-making, if you will?

2 How do you -- do you see this -- it's
3 just, do you see this being overly burdensome? Do
4 you see it actually streamlining the
5 administrative burden? Could you help me with
6 your perspective about that?

7 DR. SHONK: Yeah. Interesting, I
8 actually asked all the PCPs⁵ in CPC+ that very
9 question about a year ago. I said one of the
10 theories of CPC+ was that it would reduce their
11 burden. And out of the almost 100 physicians that
12 responded, none of them said it reduced their
13 burden.

14 In fact, the majority of them said it
15 increased their burden. But it was a burden that
16 they were willing to bear. They said that it was
17 a -- because they saw it being more important.
18 They saw it as having a better impact on the
19 patient's care. And that gave them a lot of
20 professional satisfaction.

5 Primary Care Physicians

1 So it's one thing too just, you know,
2 report something out or have to fill out a form or
3 do whatever. That's just busy work, and it is
4 something that they hate.

5 If not, if they see that what they're
6 giving into this information feed is actually
7 impacting the level of care that the patient is
8 getting and their outcome, when that happens,
9 they're willing to put up with additional burden
10 because they see it as being valuable. And I
11 thought that was very telling when I inquired to
12 the CPC+ practices.

13 And I would think the specialists would
14 see the same thing. They would say, you know, yeah
15 there's a lot of stuff that I'm being asked to do,
16 but this is really important stuff because it does
17 actually impact the outcome.

18 DR. SINOPOLI: So this is Angelo. So,
19 again, as I hear all the conversation, I kind of
20 keep going back to the same questions. It does
21 seem like to make this work the way you're talking
22 about that it requires a lot of infrastructure that

1 I see as kind of common to an ACO --

2 DR. SHONK: Mm-hmm.

3 DR. SINOPOLI: -- in terms of the data
4 infrastructure, the reporting. And I wonder with
5 the cost and administrative burden of that, are the
6 specialists, because we're talking about -- so if
7 it's a practice in a big system, I can more easily
8 see it.

9 If it's a small, two-man primary care
10 practice in lower South Carolina, are they going
11 to really have enough volume to refer to the big
12 cardiology group in the capital of South Carolina
13 to get their attention to contract with them and
14 do things differently without being part of an ACO,
15 if it's just a two-man practice trying to contact
16 with a 50-man cardiology group?

17 And how would they, with that small
18 volume, monitor their outcomes and clinical impact
19 on that small group of patients? Does that make
20 sense?

21 DR. SHONK: Yeah. It does, yeah. So
22 a couple of thoughts on that is that the more remote

1 practices will work more with their closer
2 specialists.

3 So when I was on -- I practiced in a town
4 of 30,000 people. And we had two or three
5 cardiologists in town. And I worked much more
6 closely with them.

7 However, from time to time, as you say,
8 they need to go up to the university setting or the
9 tertiary care setting, and outside of the geography
10 that they normally operated within.

11 I saw the medical neighborhood
12 agreements being with both types of specialties.
13 And I would say that it is something that they --
14 it's important in the design of the program to pick
15 those types of conditions that are -- that are more
16 frequent in a primary care practice.

17 And I don't know how, if you guys are
18 familiar with something called a PQI⁶ series of
19 measurements? But there is one aggregate PQI
20 measure.

21 And don't ask me what PQI stands for

6 Prevention Quality Indicators

1 because I can't remember. But anyway, PQI 90
2 contains admission rates for the 12 or 14 most
3 common conditions within a primary care practice.
4 And what, rather than look at all admissions from
5 that practice, I would focus on those admissions.

6 And so in the proposal, it talked about
7 all cause readmission, all cause ED⁷ visits, I
8 would focus it more on where you really want primary
9 care to focus, and that is on these common
10 conditions.

11 So if I'm -- one of the PQI series is
12 -- I think it's PQI 5, it's for congestive heart
13 failure. Well, if indeed you are following that
14 admission rate for congestive heart failure, you
15 are honing down the number of admissions for that
16 particular condition, and you're following it
17 across their whole population of practices that see
18 -- or of patients in CPC+.

19 What I can envision in the Medical
20 Neighborhood Model is that that sub-segment that
21 I am participating with this patient by referring

7 Emergency Department

1 them to an MNM practice in cardiology, can I -- can
2 I see a difference if I use that type of
3 participating specialist versus all of my other
4 congestive heart failure patients?

5 And, yes, volume will be an issue.
6 There's no doubt about it, but there is -- but if
7 you take diabetes and hypertension and congestive
8 heart failure, and I'm trying to think of some of
9 the others, they -- the average practice, and
10 especially a group of three to five family
11 physicians in that practice, would generate enough
12 volume that I think you could get a statistically
13 valid outcome to say yes, it's improving or it's
14 not improving.

15 I think on the individual patient
16 level, obviously it's going to be how did that
17 individual patient do, and did I see the
18 professional satisfaction that this patient
19 actually did well because the care was coordinated
20 better.

21 But on a more global measurement system
22 you can, and we've seen it in CPC+, you can

1 generate. I think a one or two physician practice,
2 probably you're not going to get that level. But
3 there aren't too many one and two physician
4 practices anymore. I don't know, maybe in South
5 Carolina there still are.

6 But in Ohio I can tell you just about
7 every practice that I know has at least -- I think
8 the average number of physicians in a practice in
9 primary care is somewhere around three and a half
10 to four. And most of those practices are in a group
11 of anywhere from five to 20 practices that work
12 together on this.

13 And that's outside of systems if you
14 will. So that will be the -- that's the way I see
15 it kind of laddering up as far as volume.

16 Does that make sense?

17 DR. SINOPOLI: Yes. Thank you.

18 DR. SHONK: The one thing I wanted to
19 bring up, and I didn't see it in the proposal, and
20 this -- it was based on the -- and since, Jeff,
21 you're an ENT surgeon, it seems like the proposal
22 does not include episodic specialists. It seems

1 like it's more the cognitive specialists, so
2 neurology, cardiology, infectious disease.

3 CHAIR BAILET: Yeah.

4 DR. SHONK: And it seems like there's
5 opportunity in the more episodic specialist
6 consultation, you know, the surgeon who's seeing
7 a patient for a particular defined frame of time.

8 And then, say, you know, I don't know
9 whether it's gallbladder or whether it's, you know,
10 whatever. But they get in, and they get out. It
11 may be a six week window. It may be a three month
12 window.

13 But it seems like some of these
14 principles could apply there as well. And I'd be
15 interested in your thoughts, Jeff, because it seems
16 like you may have seen examples of where the surgery
17 didn't turn out too well because the patient didn't
18 follow the proposed care ritual or the guidelines.
19 And maybe a primary care doctor could have helped
20 in that regard.

21 Any thoughts on that?

22 CHAIR BAILET: Yeah. Well,

1 absolutely. So that kind of coordination and
2 dialogue between the specialist and the primary
3 care is invaluable. Think about just -- just think
4 about the work-up, you know, the revenue, the
5 resource consumption regarding, you know,
6 inappropriate or insufficient work-ups or work-ups
7 that were unnecessary with a specialist. And
8 especially in these acute situations where there
9 can be a tendency to lean towards a shotgun
10 approach.

11 And I think a highly coordinated
12 dialogue between the proceduralist and the primary
13 care physician mitigates quite a bit of that
14 unnecessary activity. And the patients do better
15 because they're not put through the wringer. You
16 know, they're not having invasive diagnostic
17 tests. They're not having -- or if they are,
18 they're having the right ones and not having to,
19 you know, repeat it.

20 And so I'm talking about -- you
21 mentioned the back end meeting, what happens after
22 the operation or the procedure happens. I'm also

1 seeing, and I think that that's equally important
2 because, as you know, medicine is as much of an art
3 as it is a science.

4 And there's not always one right
5 answer. So I think having the primary care
6 colleague that can help not only with the
7 appropriate work-up on the front end, but position
8 and set the right expectations for the patient
9 who's going for a procedure, and then help the
10 patient post-procedure, you know, sort of have that
11 alignment. Particularly if it's a patient who's
12 having a procedure that's complicated and the
13 recovery can be complicated, even under the best
14 of circumstances.

15 DR. SHONK: Mm-hmm.

16 CHAIR BAILET: That can, you know, I
17 think those relationships bear a lot of fruit and
18 could certainly contribute mightily to the cost of
19 healthcare and improving quality, which are the
20 goals obviously of these models.

21 So I don't -- and it wasn't clear to me,
22 I mean, I think that they picked the specialists

1 -- there's a reason they picked the specialties
2 that they picked.

3 Why do I know that? Infectious disease
4 is not one that I would have -- I would have
5 immediately grabbed onto. So we need to get
6 underneath that and understand.

7 But I do think that there -- if they can
8 get this right, and that's what we're trying to
9 pressure test here, is this thing -- can we
10 implement this in a way that -- in a way that you
11 can actually measure it and pay for it?

12 DR. SHONK: Mm-hmm.

13 CHAIR BAILET: Then having these
14 additional specialists layered on there would be
15 -- would be invaluable. And I'm not sure that the
16 model that they've constructed would have to change
17 significantly to take in the proceduralist.

18 But, like you said, the time window is
19 so much smaller, you know. That's probably why
20 they want to pressure test this with the chronic
21 disease patients first before they can get more
22 episodic activity in the model.

1 So I don't know if that helped, Richard,
2 but that's kind of how I'm looking at it.

3 DR. SHONK: I fully agree. And in fact
4 I think that having the primary care doc involved
5 in the work-up side of it is probably more important
6 than the post-procedure. So that -- I think you're
7 right. I hadn't thought about that. But that's
8 good insight.

9 DR. PATEL: I don't have -- this is
10 Kavita. I'm not sure -- this might be a good time
11 as you kind of were winding down, if there's any
12 other -- you mentioned in your comments just now,
13 if there's any other aspect of the proposal that
14 you think you want to highlight. Or maybe absence
15 of certain elements in the proposal? If there's
16 anything else?

17 And if not, I'll ask Angelo and Jeff one
18 more time if they've got a round of questions.
19 Otherwise, bring it to a close.

20 DR. SHONK: One other area that I had
21 was back to attribution. And one of the things
22 that I was a little bit -- it wasn't clear to me

1 when I read through it, that the specialists would
2 only remain attributed if they saw the patient, or
3 I guess had generated some type of claim or contact
4 every quarter.

5 And in some cases that attribution,
6 there are some conditions that that specialist is
7 going to be pretty much involved in that patient's
8 care probably for the rest of their lives. I'm
9 thinking of certain cardiology conditions,
10 congestive heart failure.

11 And so in my practice, I knew which
12 specialist was seeing that particular patient. I
13 knew they were going to have a chronic problem with
14 this. They were stage two, stage three, stage four
15 heart disease. And they were -- that specialist
16 was always going to need to stay involved in their
17 care.

18 So rather than to kind of artificially
19 frame in a certain frequency of visits, and
20 especially now that virtual visits are becoming
21 more normal, I wonder if there's an opportunity to
22 tweak that attribution?

1 You know, say the primary care doctor
2 got online with the specialist while the patient
3 was there in his office, and they had a conversation
4 about it, even though the specialist never actually
5 saw the patient. They, you know, that would count
6 as staying involved in the care and continuing with
7 the attribution.

8 So maybe that was already thought
9 through? But I just -- I didn't see it explicitly.
10 And I just wanted to point that out.

11 DR. PATEL: Great. Thank you.
12 That's good feedback.

13 CHAIR BAILET: So my question is if
14 this thing were to get launched, what do you think
15 the appetite is going to be amongst the specialists
16 to pursue it?

17 DR. SHONK: Yeah. I would probably
18 ask you that question. But I think that in the
19 time, and wherever I've seen it happen, is that the,
20 you know, is in the ACO model where they have some
21 financial risk along with the primary care doctor.
22 So I think that's helpful

1 The model that's in the Medical
2 Neighborhood doesn't have quite that degree. So
3 I think what would attract the specialists, in my
4 opinion, would be the fact that they have
5 essentially a team approach to the care of this
6 patient.

7 I am sure that specialists get
8 disgruntled patients from time to time and don't
9 really know why. They had a good procedure, or
10 they had a good visit. They seemed to be okay on
11 their medications. But you just don't understand
12 why they, you know, aren't thriving, why they're
13 not improving, or whatever.

14 And I think that just professional
15 satisfaction would be a big driver of this
16 approach. I would think that any physician worth
17 their salt wants to know am I actually doing any
18 good for this individual, and how do I make sure
19 that I'm doing some good for this individual.

20 CHAIR BAILLET: Right.

21 DR. SHONK: And I think that that's, to
22 me, this model does (audio interference) along with

1 that. It helps put it in context for the patient.

2 It gets more patient engagement in the
3 care so that now you've got a patient who is hearing
4 it from both specialist and primary care doctor and
5 probably has a care manager that's out there trying
6 to help them navigate this and understand it
7 better. I think that's really the thing that I
8 think a specialist would be interested in.

9 CHAIR BAILET: And interested to the
10 point where they're willing to take on the
11 administrative challenges that, that this --

12 DR. SHONK: Mm-hmm.

13 CHAIR BAILET: Okay. That's helpful.
14 Thank you.

15 DR. SHONK: Yeah. I think it would
16 grow with time. I think that, yeah, they wouldn't
17 want to jump in with both feet initially. But they
18 may be willing to try it and work with a few primary
19 care docs and see how it works for them and see what
20 kind of, you know, better patient outcomes, and
21 greater satisfaction they can get from it. And if
22 they see that, then I think they'll want more of

1 it, so.

2 CHAIR BAILET: Thank you.

3 DR. STEARNS: Okay. So it does look
4 like we're coming to the end of time. Kavita,
5 Jeff, or Angelo, if you have a last question, I
6 would say go ahead and ask it.

7 Otherwise, we will certainly thank Dr.
8 Shonk. I think it's been an incredibly
9 interesting and useful discussion.

10 And -- but we'll finish this call, which
11 is just one portion of the PRT meeting. So anybody
12 else have a remaining question or just I'm going
13 to thank Dr. Shonk?

14 DR. SINOPOLI: I'm fine. Thank you.
15 Appreciated your --

16 (Simultaneous speaking.)

17 DR. PATEL: Thank you.

18 CHAIR BAILET: Thank you very much.
19 Yes.

20 DR. SHONK: Good. I hope it was
21 helpful.

22 CHAIR BAILET: All right.

1 DR. STEARNS: I think this was great.
2 It's been a very successful call. So we'll
3 terminate this call. We are going to reconvene
4 separately through a separate number.

5 But, Dr. Shonk, thank you so much. And
6 if there are any details to finish up, Kelly Devers
7 from NORC will be in touch in terms of any final
8 arrangements. But, many, many thanks for your
9 time. I think this has been extremely helpful.

10 DR. SHONK: Good. All right. Thank
11 you. Goodbye.

12 CHAIR BAILET: Take care.

13 DR. STEARNS: Thank you.

14 (Whereupon, the above-entitled matter
15 went off the record at 3:58 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
Dr. Richard Shonk

Before: PTAC

Date: 05-28-20

Place: teleconference

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



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