

Physician-Focused Payment Model Technical Advisory Committee

Preliminary Review Team Report to the Physician-Focused Payment Model Technical Advisory Committee (PTAC)

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November 15, 2017

In accordance with PTAC's proposal review process, proposals for Physician-Focused Payment Models (PFPMs) that contain the information requested by PTAC's *Proposal Submission Instructions* will be assigned to a Preliminary Review Team (PRT). The PRT will draft a report containing findings regarding the proposal for discussion by the full PTAC. This PRT report is preparatory work for the full PTAC and is not binding on PTAC. This report is provided by the PRT to the full Committee for the proposal identified below.

A. Proposal Information

1. **Proposal Name:** Multi-provider, bundled episode-of-care payment model for treatment of chronic hepatitis C virus (HCV) using care coordination by employed physicians in hospital outpatient clinics
2. **Submitting Organization or Individual:** New York City Department of Health and Mental Hygiene
3. **Submitter's Abstract:**

"Project INSPIRE is a demonstration project funded by a three-year Centers for Medicare & Medicaid Services (CMS) Health Care Innovation Award (HCIA) received by the Fund for Public Health in New York, the NYC Department of Health and Mental Hygiene and five community partners – Mount Sinai Medical Center, Montefiore Medical Center, Weill Cornell Medical College, VNSNY Choice and Healthfirst – to focus on treating HCV in NYC.

Project INSPIRE NYC (Innovate and Network to Stop HCV and Prevent complications via Integrating care, Responding to needs and Engaging patients and providers) provides Medicare and Medicaid beneficiaries a comprehensive model of care that combines the use of care coordination, health promotion, medication adherence support and expert tele-mentoring consultation to support hepatitis C infection-centered primary care integrated with mental health, behavioral health and social services to achieve the Triple Aim:

1. *Better care*, by increasing the number of patients starting hepatitis C therapy, strengthening management of behavioral health problems, reducing hospitalizations and emergency department visits, and maintaining a high level of satisfaction among enrollees;
2. *Better health*, by increasing hepatitis C cure rates, reducing hepatitis C-related complications, and increasing screening for depression and alcohol abuse; and
3. *Lower costs*, by reducing expenses from preventable hospitalizations, emergency department visits, and complications of hepatitis C infection.

The value proposition associated with implementation of a payment model supporting the INSPIRE care delivery model is far-reaching across many different health sector participants.

- For policymakers, the goal is to substantially impact liver-related population health metrics by reducing the prevalence of end-stage liver disease and liver cancer due to chronic hepatitis C by increasing cure rates among infected patients. Policymakers may also be interested in value-based efforts that achieve population health milestones, such as the now realizable goal of hepatitis C elimination in the United States.
- Patient participation will likely improve the quality of care in the diagnosis, treatment and cure for hepatitis C and co-morbid conditions by providing coordination of care, care navigation, medication adherence support and better access to care through personal attention, reminders, and referrals for support services.
- For payers, the opportunity to reduce both short- and long-term healthcare costs by preventing ineffective health care utilization and the onset of end-stage liver disease and liver cancer is potentially significant.
- For hospitals, the model presents the proposition of expanding hepatitis C health services to the primary care setting through training and knowledge dissemination, and consultations with specialists allowing providers to treat more patients, which is ultimately necessary in order to achieve policymakers’ population health goals.”

B. Summary of the PRT Review

The proposal was received on May 18, 2017. The PRT met between June 6, 2017 and September 21, 2017. A summary of the PRT’s findings are provided in the table below.

PRT Rating of Proposal by Secretarial Criteria

Criteria Specified by the Secretary (at 42 CFR§414.1465)	PRT Rating	Unanimous or Majority Conclusion
1. Scope (High Priority)	Does Not Meet	Unanimous
2. Quality and Cost (High Priority)	Meets	Unanimous
3. Payment Methodology (High Priority)	Does Not Meet	Unanimous

4. Value over Volume	Meets	Unanimous
5. Flexibility	Meets	Unanimous
6. Ability to be Evaluated	Does Not Meet	Majority
7. Integration and Care Coordination	Does Not Meet	Unanimous
8. Patient Choice	Meets	Unanimous
9. Patient Safety	Meets	Unanimous
10. Health Information Technology	Meets	Unanimous

C. PRT Process

1. Proposal Summary

The PRT reviewed the New York City Department of Health and Mental Hygiene proposal as well as additional information provided by the submitter in written responses to questions from the PRT. The submitter also participated in a phone call with the PRT. The proposal, questions and answers, and call transcript are available on the PTAC [website](#).

The proposal is based on a Health Care Innovation Award (HCIA) Round Two demonstration project, *Project INSPIRE*, in which the submitter is involved. The proposal focuses on integrated care coordination of patients, particularly higher-need patients (e.g., dual-eligible patients, patients with behavioral health and substance abuse disorders, etc.) with HCV to ready them to initiate and adhere to pharmacotherapy. Ultimately, the proposed model aims to reduce avoidable health care utilization (e.g., emergency department visits) and costs associated with this patient population.

Under the proposed model, patients would undergo a comprehensive psychosocial evaluation to identify barriers to care and medical evaluation to determine the complexity of liver disease. The care team would then assist patients in overcoming barriers through various means such as the following: referrals for psychosocial issues or other comorbid conditions; direct counseling services (except those separately billed for by the provider), including health promotion, alcohol counseling and treatment readiness assessment and counseling, or medication adherence measurement and counseling; helping patients navigate appointments; and assistance with prior authorization.

Expected model participants are employed physicians in hospital outpatient clinics who treat HCV. The model requires that all such physicians at a given facility participate. Primary care physicians would take on a greater role in managing patients with HCV, particularly those without advanced liver disease or other medical complexities. The proposal indicates that primary care physicians will be trained by hepatologists or other gastroenterologists through tele-mentoring. However, less emphasis was placed on tele-mentoring in the proposal compared to the HCIA Round Two demonstration project; the

proposal did not provide details on how the care coordination payments would support the tele-mentoring activity. Specialists, nurse practitioners, and physicians assistants across the specialties of infectious diseases, hepatologists and other gastroenterologists, and mental health specialists would be included in the model's implementation to varying degrees based on patient need. Non-clinician staff (e.g., care coordinators) would also play a key role.

Under the proposed payment model, the APM Entity would receive a bundled episode payment for each patient enrolled in an episode. The payment primarily supports the integrated care coordination of patients and secondarily the training of primary care physicians to manage HCV. The episode is comprised of three phases: (1) pretreatment assessment involving care coordination, (2) the treatment period, (3) the report of SVR12. The episode is not expected to exceed 10 months. Based on their demonstration project experience, the submitter suggests a \$760 episode payment amount, at least initially. The submitter notes that CMS may want to geographically adjust this payment.

In addition, the APM Entity would be eligible for bonus payments or at risk of paying penalties based on its sustained virological response (SVR) rate, the proportion of enrolled patients who complete a full course of antiviral treatment and have undetectable HCV ribonucleic acid (RNA) 12 weeks after treatment cessation. The APM Entity's SVR rate would be adjusted for patient clinical and demographic characteristics known or suspected to be associated with achieving SVR. The APM Entity's risk-adjusted rate would then be compared to a benchmark set by CMS (e.g., the average SVR for all participating facilities). An APM Entity with a risk-adjusted SVR rate at or above the benchmark would receive a bonus payment for each patient that achieved SVR. An APM Entity with a rate below the benchmark would be required to pay back a penalty for each patient who did not achieve SVR. These bonus payments for each patient who achieved SVR would be calculated by applying a CMS-determined shared savings rate or rates to the product of the following formula:

$$\text{Expected annual cost (from continued HCV infection) avoided} \times \text{Life years gained with SVR}$$

The proposal indicates that this payment model design is intended to award the greatest bonuses to providers curing patients in a fibrotic or cirrhotic state, especially patients in younger age categories. How penalties would be calculated is unclear. However, in the case of penalties, only the episode payment amount would be at risk.

APM Entities can choose one of two options a priori to address instances in which the facility receives an episode payment for an enrolled patient, but the patient does not begin treatment: (1) the APM Entity returns a portion of the episode payment (approximately \$400), and this patient is not included in the SVR rate calculation; or (2) the APM Entity keeps the full episode payment, but this patient is included in the SVR rate calculation.

2. Additional Information Reviewed by the PRT

a) Literature Review and Environmental Scan

ASPE, through its contractor, conducted an abbreviated environmental scan that included a review of peer-reviewed literature as well as a search for relevant grey literature, such as research reports, white papers, conference proceedings, and government documents. The abbreviated environmental scan is available on the PTAC [website](#).

Documents comprising the environmental scan were primarily identified using Google and PubMed search engines. Key words guiding the environmental scan and literature review were directly identified from the letter of intent (LOI). These documents are not intended to be comprehensive and are limited to documents that meet predetermined research parameters, including a five-year look back period, a primary focus on U.S.-based literature and documents, and relevancy to the LOI.

In addition, the PRT reviewed the portion of the *Health Care Innovation Awards Round Two — Second Annual Report* on Project INSPIRE.

b) Data Analyses

The PRT sought additional information regarding the characteristics, utilization, and expenditures of traditional Medicare beneficiaries with HCV. The Office of the Assistant Secretary for Planning and Evaluation (ASPE), through its contractor, produced data tables that are available on the PTAC [website](#).

The data indicate that traditional Medicare beneficiaries with HCV are younger than the Medicare population overall, with two-thirds initially entitled to Medicare due to disability. Many of these beneficiaries have substantial comorbidities, including behavioral and mental health conditions. In 2016, 36% of this patient population had a diagnosis of depression and 31% had a diagnosis of anxiety, both twice as high as the overall Medicare population. This patient population also had higher rates of chronic kidney disease (23%), chronic obstructive pulmonary disease (22%), diabetes (31%), and heart failure (14%) than the overall Medicare population (21%, 12%, 27%, and 13%, respectively). Beneficiaries with HCV are also high cost, with total annual expenditures (Parts A, B, and D) averaging \$41,380 per beneficiary.

c) Public Comments

The PRT reviewed four public comment letters on the proposal. The public comment letters are available on the PTAC [website](#).

d) Other Information

The PRT spoke with a physician expert on HCV from the University of Pennsylvania. The call transcript is available on the PTAC [website](#). The PRT also obtained information from the Centers for Medicare & Medicaid Services' (CMS) Office of the Actuary regarding the proposal.

D. Evaluation of Proposal Against Criteria

Criterion 1. Scope (High Priority). Aim to either directly address an issue in payment policy that broadens and expands the CMS APM portfolio or include APM Entities whose opportunities to participate in APMs have been limited.

PRT Qualitative Rating: Does Not Meet Criterion

Strengths:

- HCV is a high-impact condition, affecting nearly a quarter of a million beneficiaries in 2016. Many of these beneficiaries have substantial comorbidities, and this patient population is high cost. Therefore, having an HCV-specific APM may have merit. Care coordination could have a major beneficial impact on this patient population.
- There are issues in payment policy regarding HCV, particularly due to the high cost of pharmacotherapy. This model attempts to get at some of these issues. For example, care coordinators assist patients in accessing pharmaceutical company-sponsored patient assistance programs. Care coordinators also play a key role in avoiding breakdowns in the Medicaid and Medicare Part D prior authorization processes.

Weaknesses:

- Care coordination for this patient population likely could be supported and incentivized within the current Medicare Physician Fee Schedule (which is further discussed under the payment methodology criterion).
- The risk-sharing formula does not account for treatment costs, including considerable pharmacotherapy costs. It has important but limited impact and can be tackled in other ways.
- The proposal could in theory be generalizable. However, the proposed model is designed for employed physicians in hospital outpatient clinics, not all physicians providing care for patients with HCV. In addition, as written, the proposal seems rather specific to the large integrated health systems in New York City and to circumstances specific to the New York practice environment for largely dual-eligible beneficiaries (e.g., Medicaid prescribing rules, ability to obtain VA pricing for HCV drugs).

Summary of Rating:

The proposal states, "With the recent expansion of Medicare monthly chronic care management codes, key supportive services (such as health promotion and medication adherence support that are critical for patients to achieve self-sufficiency and treatment completion) are now reimbursable to providers and can foster creation and adoption of a

payment model to support integrated care leading to a cure for HCV.” Although there are some restrictions on how these codes can be used, the PRT believes that care coordination can be accommodated under current care coordination payment methodologies that are already a part of the Medicare fee schedule.

Criterion 2. Quality and Cost (High Priority). Are anticipated to improve health care quality at no additional cost, maintain health care quality while decreasing cost, or both improve health care quality and decrease cost.

PRT Qualitative Rating: Meets Criterion

Strengths:

- Under the proposed model, the SVR rate is used to measure quality. Coordinating care for higher-need patients with HCV in a careful and concentrated way, and providing health education, appointment navigation, and connection to supports and services seem likely to increase the proportion of patients who achieve SVR.
- The care coordination activities would likely also be an improvement over current care.
- Activities that increase the number of patients who are treated and cured would reduce costs associated with complications. Higher cure rates would also reduce disease transmission and subsequent costs.
- Medicare beneficiaries with HCV frequently have substantial comorbidities, including behavioral and mental health conditions, and are high cost. Therefore, focusing on this patient cohort seems likely to reduce certain costs, such as those associated with avoidable emergency department visits for comorbid conditions. The submitter provided data from Project INSPIRE to support this conclusion.

Weaknesses:

- The proposal is based on a HCIA Round Two demonstration project, Project INSPIRE, in which the submitter is involved. However, final evaluation results, which could provide information on the effectiveness of the delivery model, are not yet available but are expected soon.
- The payment model may not be adequately designed to control costs (which is further discussed under the payment methodology criterion).

Summary of Rating:

The PRT concludes that the proposed care model would likely improve quality. While the PRT believes the model could likely help control costs, or at least certain costs, the net effect is less clear. The final HCIA Round Two evaluation would help the PRT better understand the model’s potential impact on quality and cost. The PRT unanimously finds that the proposed PFPM meets this criterion, particularly the quality portion of this criterion. The PRT places more weight on cost concerns under the payment methodology criterion.

Criterion 3. Payment Methodology (High Priority). Pay APM Entities with a payment methodology designed to achieve the goals of the PFPM criteria. Addresses in detail through this methodology how Medicare and other payers, if applicable, pay APM

Entities, how the payment methodology differs from current payment methodologies, and why the Physician-Focused Payment Model cannot be tested under current payment methodologies.

PRT Qualitative Rating: Does Not Meet Criterion

Strengths:

- The proposal directly ties payment to a meaningful outcome measure — the proportion of patients who complete treatment and achieve SVR — and uses a straight-forward episode-based approach for providing the care coordination funding.

Weaknesses:

- Under the proposed model, shared savings are based on costs (from continued HCV infection) avoided and life years gained. This approach is untested, and to the extent that it has merit, should first be tested in a manner that is specifically designed to study the feasibility of ‘life savings’ and how to incorporate this methodology within an alternative payment model. The PRT’s rationale for this position includes, but is not limited to, the bonus model of rewarding lifetime estimates of health care savings is unprecedented in Medicare (and in health care more generally) and seems inappropriate to a payment approach that is simply trying to support physicians and others to provide needed care coordination services. Such a precedent would likely lead to other parties, including the makers of the pharmacotherapy and other clinicians with a similar claim to lifetime savings, to argue that they also deserve substantial rewards for estimates of program savings.
- Further, the shared savings/losses approach also raises operational questions and concerns. The shared savings rate or rates have not yet been determined, but the precedent of rewarding physicians and staff practicing good standards of care with what are potentially huge bonuses using imprecise data is worrisome. Again, the shared savings calculation does not take into account the cost of pharmacotherapy. In addition, sharing in lifetime savings fails to account for new, potentially less expensive therapies or methods of prevention. These multi-year savings estimates also raise questions about attribution of these patients to other payment models in future years. These questions and uncertainties make it difficult to determine the effect the model would have on cost.
- Patient eligibility and attribution under the proposed model are unclear. It seems as though the participating physician would determine whether a patient was in need of additional support. The criteria for making that determination were also not specified. This method of attribution, especially in the absence of adequate risk adjustment, could lead to “cherry picking,” avoiding patients who are more complex and high cost.
- The proposal notes that CMS may want to geographically adjust the episode payment. However, there does not appear to be any risk adjustment to the episode payment. As noted above, physician-determined attribution and a lack of adequate risk adjustment could lead to imbalances in patient selection (cherry picking).
- Under the Medicare Physician Fee Schedule, the 2018 national facility rate for the complex chronic care management code (99487) is approximately \$53; the facility fee

under the Outpatient Prospective Payment System is approximately \$72. Therefore, the hospitals that employ the physicians participating in this APM could be reimbursed approximately \$125 per enrolled patient per month (not taking into account geographic adjustments). This amount over 10 months would be more than the \$760 episode payment, which suggests that the care model could be supported under current payment methodologies.

Summary of Rating:

The PRT has concerns about the payment methodology design, including the shared-risk arrangement, attribution methodology, and lack of risk adjustment. The PRT is also not convinced that a new payment model is necessary to support the care model. Billing the current complex chronic care management codes would seem to provide payment in line with the proposed episode payment. However, the PRT recognizes that there are some restrictions on how the current codes can be used, suggesting that fixes to the predominant fee schedule-based payment model are worthy of consideration rather than a new payment model. The PRT also acknowledges that the model holds participants accountable for a meaningful outcome measure. However, the PRT notes that there are opportunities under the Merit-based Incentive Payment System to link payment to activities and outcomes that providers want to focus on. Therefore, the PRT unanimously finds that the proposal does not meet the criterion.

Criterion 4. Value over Volume. Provide incentives to practitioners to deliver high-quality health care.

PRT Qualitative Rating: Meets Criterion

Strengths:

- The proposal focuses on increasing the number of patients who are treated and cured, which would reduce utilization and costs associated with continued HCV infection. Tying payment to a meaningful outcome measure — the proportion of patients who complete treatment and achieve SVR — provides a powerful incentive.
- Medicare beneficiaries with HCV frequently have substantial comorbidities and are high cost. Therefore, focusing on this patient cohort seems likely to reduce utilization and costs associated with avoidable emergency department visits for comorbid conditions.

Weaknesses:

- Physician-determined attribution, especially in the absence of adequate risk adjustment, could lead to the avoidance of patients who are more complex and high cost.

Summary of Rating:

The proposal is focused on and provides incentives for practitioners to deliver high-quality health care, increasing the number of patients who are treated and cured and reducing utilization and cost associated with continued HCV infection as well as the possible risk of further spreading of the disease. Although the PRT has concerns regarding attribution and risk adjustment, it unanimously finds that the proposed PFPM meets the criterion.

Criterion 5. Flexibility. Provide the flexibility needed for practitioners to deliver high-quality health care.

PRT Qualitative Rating: Meets Criterion

Strengths:

- Under the proposed model, the care team appears to have broad flexibility in meeting the unique needs of each patient. The model places emphasis on the outcome measure rather than inputs and processes.
- The delivery model supports tele-mentoring of primary care physicians to enable them to take on a greater role in managing patients with HCV.

Summary of Rating:

The PRT unanimously finds that the proposed model would provide greater flexibility in delivering high-quality health care for patients with HCV.

Criterion 6. Ability to be Evaluated. Have evaluable goals for quality of care, cost, and any other goals of the PFPM.

PRT Qualitative Rating: Does Not Meet Criterion

Strengths:

- The proposal incorporates a meaningful outcome measure: the proportion of patients who complete treatment and achieve SVR.

Weaknesses:

- Physician-determined attribution and a lack of adequate risk adjustment could lead to patient selection imbalances (cherry picking) and create other selection effects that would undermine accurate evaluation.
- One can model what lifetime savings might be to provide bonuses, but whether that modeling is in any way accurate would take a lifetime.

Summary of Rating:

The majority of the PRT finds that the proposed PFPM does not meet the criterion due to the attribution, risk adjustment, and shared savings concerns. The dissenting member agrees with these concerns but believes that with some improvement the model could be evaluable.

Criterion 7. Integration and Care Coordination. Encourage greater integration and care coordination among practitioners and across settings where multiple practitioners or settings are relevant to delivering care to the population treated under the PFPM.

PRT Qualitative Rating: Does Not Meet Criterion

Strengths:

- The proposal focuses on integrated care coordination of patients, particularly higher-need patients, with HCV.
- The proposal supports tele-mentoring of primary care physicians to enable them to take on a greater role in managing patients with HCV.
- Participants include employed physicians in hospital outpatient clinics. The submitter notes that an advantage of implementing the model in hospital-based clinics is the ability for care coordinators to make referrals to other diagnostic and treatment services within the same facility. These facilities are also likely to have integrated electronic health record (EHR) systems.

Weaknesses:

- Medicare beneficiaries with HCV frequently have substantial comorbidities. There does not seem to be continuity between care coordination for purposes of accomplishing HCV treatment and care coordination for comorbidities. Predominantly dual-eligible beneficiaries would likely benefit from care coordination before, during, and after their HCV-related treatment, yet the proposal does not address how care coordination occurs across outpatient department settings and with other providers.
- Non-clinical care coordinators seem to have a central role in the proposed model. However, this criterion is specific to integration and care coordination among practitioners.

Summary of Rating:

- The PRT recognizes that the proposal is a care coordination proposal and believes that what the submitters are trying to accomplish is important. Targeting this high-need patient cohort makes sense. However, the PRT believes that the proposal lacked adequate specificity on the intervention. The PRT is particularly concerned that there does not seem to be continuity between care coordination for purposes of accomplishing HCV treatment and care coordination for comorbidities. Therefore, the PRT unanimously finds that the proposed PFPM does not meet the criterion.

Criterion 8. Patient Choice. Encourage greater attention to the health of the population served while also supporting the unique needs and preferences of individual patients.

PRT Qualitative Rating: Meets Criterion

Strengths:

- Patients have a choice of whether or not to enroll in the model.
- The proposed model would provide greater attention to the health of a high-cost patient population.
- The proposal considers patients' unique needs and preferences. For example, patients would receive referrals for conditions, such as substance abuse, that may interfere with their readiness to initiate and adhere to pharmacotherapy for HCV.

Summary of Rating:

The PRT unanimously finds that the proposed PFPM meets the criterion. Nothing in the

proposed model would seem to limit patient choice.

Criterion 9. Patient Safety. Aim to maintain or improve standards of patient safety.

PRT Qualitative Rating: Meets Criterion

Strengths:

- Helping patients complete treatment and achieve SVR would reduce risks of complication from continued HCV infection.
- The model targets a patient population with high rates of mental and behavioral health issues. Coordinating care for these patients and helping them overcome issues that may interfere with their readiness to initiate and adhere to pharmacotherapy for HCV would improve patient safety.

Weaknesses:

- The proposal does not fully describe the attribution methodology. Therefore, it is somewhat unclear whether the model might incentivize exclusion of patients who might benefit from the intervention or include patients who are or could become poor candidates for treatment.

Summary of Rating:

Overall, the PRT unanimously believes that the proposal would improve patient safety.

Criterion 10. Health Information Technology. Encourage use of health information technology to inform care.

PRT Qualitative Rating: Meets Criterion

Strengths:

- Participants include employed physicians in hospital outpatient clinics. Therefore, the participants are more likely to have EHR systems that are integrated across the facility.

Weaknesses:

- The proposal does not adequately describe coordination with non-participating providers outside of the facility, and it seems likely that there could be interoperability challenges with these providers.
- Interoperability may be less challenging for large integrated health systems in New York City; however, the proposal does not address how this model might work outside of these large systems.

Summary of Rating:

The PRT finds that the proposed PFPM meets this criterion because the model would be implemented in a facility that is likely to have an integrated EHR system. However, the PRT recognizes that the proposal does little to further the use of health information technology.

E. PRT Comments

The submitter's commitment to the delivery model and experience gained through participation in HCIA Round Two are to be commended. The PRT agrees that care coordination of higher-need patients with HCV is important and has the potential to improve quality and reduce costs. The efficacy of pharmacotherapy for HCV enables payment to be tied to a meaningful outcome measure.

The PRT does not support the idea that a new payment model is necessary to support the care model. The proposal could be accommodated within current payment methods — whether through the Medicare Physician Fee Schedule or the Outpatient Prospective Payment System. We note that the lifetime savings approach outlined in the proposal is problematic in that it does not provide a viable approach to assuring accountability for the care coordination episode proposed. Moreover, the PRT has specific concerns regarding the payment methodology proposed, including the shared-risk arrangement, attribution methodology, and lack of risk adjustment. Physician-determined attribution and a lack of adequate risk adjustment could lead to cherry picking and other selection effects that would undermine accurate evaluation.

While the proposal is a care coordination proposal, the PRT believes that the proposal lacked adequate specificity on the intervention. In addition, Medicare beneficiaries with HCV frequently have substantial comorbidities, including behavioral and mental health conditions. However, there does not seem to be continuity between care coordination for purposes of accomplishing HCV treatment and care coordination for comorbidities. Finally, completing the final HCIA Round Two evaluation would aid in considering the model's merit and the PRT feels strongly that these efforts should be incorporated into evaluating this model going forward to more fully understand its potential.