THE SECRETARY OF HEALTH AND HUMAN SERVICES
WASHINGTON, D.C. 20201

JAN 14 2021

Jeffrey Bailet, MD
Chair
Physician-Focused Payment Model Technical Advisory Committee
200 Independence Avenue SW
Room 415F
Washington, DC 20201

Dear Chairman Bailet:

I appreciate the role of the Physician-Focused Payment Model Technical Advisory Committee (PTAC) and its significant contribution to value-based transformation. The Committee's work with stakeholders continues to support the Department of Health and Human Services' (HHS) commitment to improving health care delivery, lowering costs and improving the quality of care for Medicare beneficiaries. I appreciate the well-vetted input PTAC provides to the Centers for Medicare & Medicaid Services (CMS) Center for Medicare and Medicaid Innovation (CMS Innovation Center) model development and implementation. I encourage new ideas for proposed physician-focused payment models (PFPMs) that address the health care needs of Americans and encourage physician participation in value based health care delivery and payment models, and I am pleased to respond to the comments and recommendations of the PTAC for proposed models voted on during the June 2020 public meeting.[1]

In August 2020, the CMS Innovation Center announced The Community Health Access and Rural Transformation (CHART) Model[2]. This new innovative payment and service delivery model provides funding for rural communities to build systems of care through a Community Transformation Track and is enabling providers to participate in value-based payment models where they are paid for quality and outcomes, instead of volume, through an Accountable Care Organization (ACO) Transformation Track.

On September 18, 2020, the CMS Innovation Center announced the Radiation Oncology (RO) Model, a model expected to improve the quality of care for cancer patients receiving radiotherapy services and reduce Medicare expenditures that allow providers to focus on delivering high-quality treatments. The RO Model[3] encourages value-based care by creating

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[1] This response and accompanying documents comprise the Secretary's detailed response to PTAC comments and recommendations, posted on the CMS website, in accordance with the statutory requirement at §1868(c)(2)(D) of the Social Security.

[2] https://innovation.cms.gov/innovation-models/chart-model

[3] The RO Model is included in the final rule entitled Medicare Program; Specialty Care Models to Improve Quality of Care and Reduce Expenditures. The final rule (CMS-5527-F) can be downloaded at: https://innovation.cms.gov/media/document/specialty-care-models-rule. Due to the ongoing public health emergency, we also revised the RO Model's Model Performance Period in the CY 2021 OPPS final rule and interim final rule (CMS-1736-FC, 1736-IFC) which is available here.

simpler, more predictable payments to incentivize cost savings and improve quality and outcomes. The RO Model will make prospective, modality agnostic, episode-based payments in a site-neutral manner for 16 different cancer types.

The CMS Innovation Center also announced the End-Stage Renal Disease (ESRD) Treatment Choices (ETC) Model[4] in September 2020. This is an innovative payment model that aims to test whether greater use of home dialysis and kidney transplantation for Medicare beneficiaries with ESRD will reduce Medicare expenditures, while preserving or enhancing the quality of care furnished to beneficiaries with ESRD. Under the ETC Model, payment adjustments will offer the incentive to participating ESRD facilities and Managing Clinicians to work with beneficiaries and caregivers in the choice of treatment modality, and to provide additional resources to support greater utilization of home dialysis and kidney transplantation.

As we design new CMS Innovation Center payment and service delivery models, we are drawing from the recommendations and comments from the PTAC's review of proposed PFPMs. CMS is incorporating PTAC's analysis, and specific design elements or features that were recommended by the PTAC into the CMS Innovation Center's payment and service delivery models. In addition, we routinely follow-up with submitters to discuss various ideas presented in their proposed PFPM.

I look forward to working further with the PTAC, those who submit proposed PFPMs, and other stakeholders as we all move toward a value-driven delivery system. I hope that my responses to the most recent PTAC comments and recommendations (see Appendix) encourage and assist those who submit proposed PFPMs in the future as they advance transformative innovation in American health care.

Sincerely,

Alex M. Azar II

Enclosure: Appendix

[4] The ETC Model is included in the Medicare Program; Specialty Care Models to Improve Quality of Care and Reduce Expenditures Final Rule. The final rule (CMS 5527-F) can be downloaded at: https://innovation.cms.gov/media/document/specialty-care-models-rule

Appendix

This appendix contains responses from the Secretary of HHS to PTAC comments and recommendations on three PFPM proposals from the following submitters:

The Eye care Emergency Department Avoidance (EyEDA) Model submitted by the **University of Massachuesetts Medical School**; and the

Patient-Centered Asthma Care Payment: submitted by the **American College of Allergy, Asthma & Immunology**

The University of Massachusetts Medical School

I am extending my appreciation to the University of Massachusetts Medical School for submitting the *Eyecare Emergency Department Avoidance (EyEDA)* proposed model to the Physician-Focused Payment Model Technical Advisory Committee (PTAC) for its expert review. This proposed model aims to lower costs and improve the quality of care by encouraging optometrists and ophthalmologists to treat patients with non-emergent eye-care conditions in an office-based setting in lieu of more expensive Emergency Department (ED) care.

I agree with the PTAC's recommendation that the proposed model should not be implemented as presented, although EyEDA model concepts should be considered for future potential CMS Innovation Center payment and service delivery models involving specialty care. While I am always looking for ways to further payment models for physician specialists, this model is very narrow in scope. As the PTAC highlights in its thoughtful review, the success of the proposed EyEDA model would depend on an individual opthalmology or optometry practice's willingness to expand their services and office hours under a payment methodology that largely discounts current fee-for-service payment. The PTAC further points out other payment methodologies and a broader model scope to include other providers, such as the emergency department and primary care, could more effectively encourage office treatment of non-emergent eye conditions. Encouraging treatment of certain eye conditions in alternative, appropriate, and safe settings other than the emergency department is an important focus for evolution in value-based care.

I want to thank the University of Massuchusetts Medical School for its continued engagement with the CMS Innovation Center and for helping to drive transformative innovation in American health care. Every proposed model submitted to the PTAC and reviewed by the Department contributes to public discourse around value-based care and identifies potential pathways toward that critical goal. To that end, I have asked the CMS Innovation Center to reach out to the submitters for further discussion on how we can better engage with speciality care practices, and particularly optometry and ophthalmology practices, in innovative payment and service delivery models.

I look forward to the continued engagement of all stakeholders in developing payment models as we work together to strengthen the Medicare program.

The American College of Allergy, Asthma & Immunology

I appreciate the American College of Allergy, Asthma & Immunology (ACAAI) submission of the proposed *Patient-Centered Asthma Care Payment (PCACP) Model* and the Physician-Focused Payment Model Technical Advisory Committee's (PTAC) thorough and thoughtful review. The proposed model incentivizes asthma specialists, such as allergists and pulmonologists, and primary care physicians to collaboratively treat patients with asthma and asthma-like symptoms through a bundled payment to avoid hospital emergency room visits, inpatient hospital stays, and higher treatment costs, particularly asthma medications.

The overall concept of changing payment to help patients better manage a chronic condition epitomizes the goals of value-based care. I agree with the PTAC's overall assessment that the PCACP model proposal needs additional development in several areas, including model scope, payment methodology, and risk adjustment, as well as additional detail on primary care and specialist team based care, diagnoses, and quality. It also is not clear that additional development by the Centers for Medicare & Medicaid Services (CMS) Center for Medicare and Medicaid Innovation (CMS Innovation Center) could create a model that would achieve quality and reduce cost. Potential savings from the model in the Medicare population with established asthma and other comorbidities is not as clear as it is for younger populations, and the Medicare population with unmanaged asthma is diffuse. That said, I agree with the PTAC that PCACP has put forward several interesting concepts, such as team based care, that could inform future models addressing chronic disease management.

I am interested in exploring the concepts in the PCACP model further to inform development of payment and service delivery models at the CMS Innovation Center. I have asked the CMS Innovation Center to reach out to the submitters for further discussion.

I want to thank the American College of Allergy, Asthma & Immunology for your continued engagement with the CMS Innovation Center and helping to drive transformative innovation in American health care. I also want to thank the PTAC for its critical review of this proposed model.