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

JUN 07 2021

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

Dear Chairman Bailet:

I want to thank the Physician-Focused Payment Model Technical Advisory Committee (PTAC) for its steadfast examination of submitted proposed models, and recognize the Committee's dedication to encouraging stakeholder engagement in transforming health care delivery. I appreciate the PTAC's expert analysis and informed deliberation of proposed physician-focused payment models (PFPMs) submitted by stakeholders. We are inspired by stakeholder participation in the PTAC process, and by the comments and recommendations of the PTAC for proposed models voted on during the September 2020 public meeting[1].

We are also encouraged by the recent PTAC Public Meeting Round Table discussions of telehealth in payment and care delivery models, and look forward to future theme-based studies. As the Centers for Medicare & Medicaid Services (CMS) Center for Medicare and Medicaid Innovation (Innovation Center) works to lower costs and improve the quality of care for Medicare beneficiaries, we are drawing from the PTAC's recommendations and comments when designing and testing payment and service delivery models. Likewise, we will continue to engage with submitters to discuss the valuable ideas presented in their proposed PFPMs.

I look forward to working with the members of the PTAC, engaging with those who submit proposed PFPMs and other innovative stakeholders, and exploring ideas considered in the Round Table sessions. As we continue to move toward a value-driven delivery system, I am encouraged by the PTAC's robust analysis and notable reports. I hope that my responses to the most recent PTAC comments and recommendations (see Appendix) support and assist those who plan to submit proposed PFPMs in the future, and encourage stakeholders to continue to participate in transforming American health care delivery.

Sincerely,

Xavier Becerra

Enclosure: Appendix

[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 Act.

Appendix

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

The *Medical Neighborhood Advanced Alternative Payment Model (AAPM)* (revised version) submitted by the American College of Physicians (ACP) and the National Committee on Quality Assurance (NCQA); and

The *Patient-Centered Oncology Payment Model* (PCOP) submitted by American Society of Clinical Oncology (ASCO)

The American College of Physicians and the National Committee on Quality Assurance

I would like to thank the American College of Physicians (ACP) and the National Committee on Quality Assurance (NCQA) for their submission of the *Medical Neighborhood Advanced Alternative Payment Model (MNM)*[2] to the Physician-Focused Payment Model Technical Advisory Committee (PTAC) for its expert review[3]. The submitters aim to propose an Advanced Alternative Payment Model (Advanced-APM) that lowers cost by improving care management and coordination across a "neighborhood" of primary care and specialty care providers.

The MNM proposed model is constructed around an agreement between referring primary care providers and specialists that creates incentives and a process for care management and coordination. The proposed model establishes procedures relying on practices sharing electronic records for e-consults, referrals, diagnostic testing, patient-focused care, electronic clinical quality measures (eCQMs), planning and goal setting with patients and caregivers. Participating practices would be required to meet NCQA standards for care management (or a non-proprietary comparable set of standards), shared decision-making, and quality improvement, and would encompass practices participating in the Centers for Medicare & Medicaid Services (CMS) Comprehensive Primary Care Plus (CPC+) and Primary Care First (PCF) Models.

I agree with the PTAC's conclusion that the proposed model requires further development, specifically in its approach to attribution, payment methodology, quality measures, benchmarking, and risk adjustment. For example, patient attribution would rely on primary care providers selecting patients into the proposed model by initiating an e-consult or making a referral to a specialist, introducing cousiderable bias into the proposed model design. Under the proposed model, all participating practices would receive a monthly Care Coordination Fee (CCF) per beneficiary, adjusted for risk and geography, and a Performance-Based Payment Adjustment (PBPA) hased on spending relative to an annual benchmark. Specialty practices would choose either to continue to be paid under the Medicare Physician Fee Schedule (MPFS) or receive 25 percent of the MPFS payment in addition to the CCF, PBPA, and a Comprehensive Specialty Care Payment (CSCP). The CSCP would allow specialty practices to share in earned savings when minimum standards for all quality and utilization performance measures are met.

I also agree with the PTAC that ideas presented by the submitter that better support care coordination and data-sharing between primary care and specialty care practices may be used to inform current and potential CMS Innovation Center payment and service delivery models involving specialty care. Therefore, I have asked the CMS Innovation Center to reach out to the submitters for further discussion on how we can better engage with specialty care practices in innovative payment and service delivery models.

I want to thank the PTAC for its critical review and discussion of this proposed model. I also want to thank ACP and NCQA for their revised submission, and for engaging with the CMS Innovation Center to help drive transformative innovation in American health care.

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[2] https://aspe.hhs.gov/system/files/pdf/261881/ProposalACPNCQA-Resubmitted.pdf

[3] https://aspe.hhs.gov/system/files/pdf/226776/ReporttotheSecretaryACPNCQA-Resubmitted.pdf

American Society of Clinical Oncology

I appreciate the longstanding dedication of the American Society of Clinical Oncology (ASCO) to value-based care in oncology, including their thoughtful proposal to the Physician-focused Payment Model Technical Advisory Committee (PTAC). The Patient-Centered Oncology Payment Model (PCOP)[4] proposal seeks to create an alternative payment model (APM) that would engage a range of stakeholders in a united effort to improve care for patients with cancer. I express my thanks for the careful review provided by the PTAC[5], which identified some concerns with the PCOP proposal while also highlighting innovative aspects that could inform the design of a future oncology APM.

The PCOP Model would create regional communities of payers, providers, employers, patient advocates, and other stakeholders that would work together to refine and implement the model. To encourage clinical practice transformation, PCOP participants would be required to implement certain care delivery requirements, for example related to patient engagement and team-based care. The payment methodology includes monthly care management fees combined with performance incentive payments based on use of clinical pathways and achievement on quality, utilization, and cost metrics. The model offers the option for PCOP participants to move away from fee-for-service for certain services (e.g., evaluation and management visits, Part B drug administration, add-on portion of the Part B drug payment) by bundling a portion or all of payment for those services into the monthly care management fees.

The PTAC highlighted several aspects of the PCOP Model for consideration, including the model's proposal for geographically based communities of stakeholders that would engage with one another to determine and implement the final model design. I appreciate ASCO's emphasis on the importance of multiple stakeholders collaborating for value-based care transformation, but like the PTAC, I am concerned that allowing various geographic regions to tailor the model (e.g., quality measure selection) could limit the ability of an evaluation to successfully identify the model's impact. Further, as the PTAC noted in their thorough review, it is unclear if the PCOP Model would garner sufficient savings to overcome the model's incentive payments.

As the PTAC acknowledged, the current Oncology Care Model (OCM), which is being tested by the CMS Innovation Center through mid-2021, has much in common with the PCOP Model. In late 2019, the CMS Innovation Center published an informal Request for Information and held a public listening session to hear feedback about a potential Oncology Care First (OCF) Model. ASCO and many other stakeholders provided helpful insights and comments throughout this process. To that end, I have asked the CMS Innovation Center to consider key insights from the PCOP proposal along with lessons learned from OCM and feedback on a potential OCF Model as work continues to develop a future oncology model.

Building on existing efforts to improve the value and quality of care in oncology is an important priority for me, and I look forward to continuing working with ASCO and others in this effort.

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[4] https://aspe.hhs.gov/system/files/pdf/261881/ProposalASCO.pdf

[5] https://aspe.hhs.gov/system/files/pdf/226776/ReporttotheSecretaryASCO.pdf