



THE SECRETARY OF HEALTH AND HUMAN SERVICES

WASHINGTON, D.C. 20201

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I am pleased to respond to the comments and recommendations of the Physician-Focused Payment Model Technical Advisory Committee (PTAC) regarding proposed models voted on during the September and December 2018 public meetings.¹ I was delighted to join the Administrator of the Centers for Medicare & Medicaid Services (CMS) and the Director of CMS's Center for Medicare and Medicaid Innovation (CMS Innovation Center) and Senior Advisor on Value-Based Transformation and Innovation at the opening of the September public meeting. I recognize and appreciate the role that PTAC plays in supporting the Department of Health and Human Services' (HHS) commitment to transforming our healthcare system into one that pays for health and wellness rather than sickness and procedures. PTAC provides an important avenue for healthcare providers, associations, coalitions, and others to share their ideas for physician-focused payment models (PFPMs) with HHS and the public, and we appreciate the thoughtful discussions, recommendations, and comments from PTAC.

We seek model approaches that complement the Value-Based Transformation (VBT) vision HHS will use to prioritize model development. To successfully transform health care, we need strategies and models that provide better care at a lower price. We are not pursuing new models for the sake of new models, or those that are not responsive to the health care needs of Americans. Rather, HHS is driving toward value through four areas of focus: transforming beneficiaries into empowered consumers, enabling healthcare providers to be accountable patient navigators of the health system, paying for outcomes, and preventing disease before it occurs. I have outlined my VBT priorities for new model development on the CMS website at <https://innovation.cms.gov/Files/fact-sheet/ptac-value-fs.pdf>.

As we design new CMS Innovation Center payment and service delivery models, we are drawing from the recommendations and comments from PTAC's review of proposed PFPMs. HHS is interested in developing new models that are transparent, simple, and accountable. We are interested in exploring models that are focused on local delivery of health care, where patients and health care providers determine the best care plan, and providers are accountable for patients' outcomes. In particular, we are seeking transparent models that empower consumers to drive value through choice supported by interoperability and data, reduced complexity, and accountability. Priority will be given to proposed PFPMs that meet the PFPM criteria established by HHS in regulation and support our goals to improve quality, reduce expenditures, and increase beneficiary choice.

For example, we agree with PTAC on the importance of developing model tests with significant impact on quality and cost in the areas of primary care and oncology care. Our latest Primary Cares Initiative (PCI) will provide participating primary care practices and other participating

¹ This response complies with the statutory requirement at §1868(c)(2)(D) of the Social Security Act to review and respond to PTAC's comments and recommendations on proposed physician-focused payment models (PFPMs).

health care providers with new payment and service delivery model options designed to empower primary care providers to spend more time caring for beneficiaries while reducing overall health care costs. As with the CMS Innovation Center's new Primary Care First Model and the Serious Illness Population payment model options, we will continue to draw from PTAC's review of PFPM proposals and are focused on transforming health care, allowing health care providers to take greater control of managing the costs of care for a population of Medicare beneficiaries.

As we work on transforming American health care, I continue to see PTAC as a crucial avenue for new ideas and input from healthcare providers, associations, coalitions, and other innovators who play a key role in achieving value-based health care. In designing new innovative payment and service delivery models, the CMS Innovation Center builds on the lessons learned from and experiences of the previous models, and draws from PTAC's robust review of PFPM proposals and stakeholder feedback. In addition, I have asked that the CMS Innovation Center team meet with every proposal submitter that gets a positive assessment from the PTAC to further consider their ideas and how they could potentially be included in future models. With PTAC's expert analyses, discussions, and recommendations of proposed PFPMs, we can incorporate innovative, valuable ideas into the design of payment and service delivery models.

I look forward to reviewing more proposed PFPMs that present bold, new ideas for value-based health care delivery that inform and go beyond the scope of our current model portfolio and to working further with PTAC, PFPM submitters, and 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 future PFPM submitters as they advance transformative innovation in American health care.

Sincerely,



Alex M. Azar II

Enclosure: Appendix

Appendix

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

- **American College of Emergency Physicians**
 - *Acute Unscheduled Care Model: Enhancing Appropriate Admissions*
- **Jean Antonucci, MD**
 - *An Innovative Model for Primary Care Office Payment*
- **Dialyze Direct**
 - *APM for Improved Quality and Cost in Providing Home Hemodialysis to Geriatric Patients Residing in Skilled Nursing Facilities*
- **University of Chicago Medicine**
 - *Comprehensive Care Physician Payment Model*
- **Innovative Oncology Business Solutions, Incorporated.**
 - *Making Accountable Sustainable Oncology Networks*

American College of Emergency Physicians

I appreciate the ideas submitted to the Physician-Focused Payment Model Technical Advisory Committee (PTAC) by the American College of Emergency Physicians (ACEP) in its *Acute Unscheduled Care Model (AUCM): Enhancing Appropriate Admissions* proposal. I recognize PTAC's detailed and rigorous review of this proposed physician-focused payment model (PFPM), and the Committee's discussion of incentivizing improved quality associated with emergency department (ED) physicians and care coordination.

The AUCM is a creative proposal to address ED payment policy that focuses on the safe discharge of patients, follow-up care for 30 days post-ED visit, and hospitalizations or other avoidable post-ED visit events and their associated costs. We agree with PTAC that patients who visit the ED and are discharged home could benefit from the proposed model. Likewise, we recognize the opportunity to incentivize improved quality and decreased cost associated with ED discharge decisions and appreciate the proposal's goal of enhancing an ED provider's ability to be an effective patient navigator. We believe smooth transitions of care from the ED to the community are an important component of delivery system reform.

I agree with PTAC that ED providers can influence transitions of care from the hospital and serve as one critical link in broader efforts to deliver coordinated, value-based care. I am interested in exploring how the concepts in the AUCM model for care management by emergency physicians after an ED encounter could be incorporated into models under development at the Centers for Medicare & Medicaid Services (CMS) Center for Medicare and Medicaid Innovation (CMS Innovation Center). We have further discussed care transitions with ACEP, and I have asked the CMS Innovation Center to assess how key mechanisms of action in this model could operate as a component in a larger model dedicated to improving population health.

HHS is using every available lever to create innovative payment structures to move our health care system toward greater value by rewarding quality, innovation and improved health outcomes, and increase provider participation. I am encouraged by submitters like ACEP who continue to help drive transformative innovation in American health care toward a value-based delivery system.

Jean Antonucci, MD

I would like to thank Dr. Jean Antonucci for her submission of the *Innovative Model for Primary Care Office Payment* proposal to the Physician-Focused Payment Model Technical Advisory Committee (PTAC). PTAC was established to encourage individual and stakeholder engagement in the development of physician-focused payment models (PFPMs), and its detailed review of submitted proposals has added much to our approach to new primary care payment and service delivery models.

This proposal focuses on an approach to deliver primary care via a capitated payment model by proposing a unique, patient-centered method for measuring quality. The goals of Dr. Antonucci's proposed model align with many of my priorities for Value-Based Transformation (VBT) in the area of strengthening primary care. It is a bold proposal for rethinking primary care in a way that includes both payment reform (risk through capitation) and care delivery reform, significantly revised incentives and real-time data, and direct, open, and accessible patient engagement. Dr. Antonucci's innovative approach offers key transformative principles for individual primary care practices, particularly for small and rural primary care practices.

I welcome PTAC's thorough and thoughtful review of this proposed model. With PTAC, I appreciate the basic premise of capitation for primary care services, driven by patient input that underpins this model. In their recommendation and comments to the Secretary, PTAC identified several aspects of this proposed model that would need additional development and consideration before the model could be implemented.

The Centers for Medicare & Medicaid Services (CMS) Center for Medicare and Medicaid Innovation (CMS Innovation Center) had a valuable discussion with Dr. Antonucci in March 2019 regarding the proposed model. Further, the CMS Innovation Center based the design of the new Primary Care Initiative's payment and service delivery models on considerable input from stakeholders like Dr. Antonucci.

We are energized by stakeholder interest and engagement in strengthening primary care. As we work to design new innovative payment and service delivery models, we will continue to consult with experienced health care providers like Dr. Antonucci, and other stakeholders who propose models that help drive transformative innovation in American health care.

Dialyze Direct

I am thankful to Physician-Focused Payment Model Technical Advisory Committee (PTAC) for its skillful review of the *Alternative Payment Model (APM) for Improved Quality and Cost in Providing Home Hemodialysis to Geriatric Patients Residing in Skilled Nursing Facilities* proposal submitted by Dialyze Direct. I have publicly shared my personal interest in improving kidney care for Medicare beneficiaries, and I appreciate Dialyze Direct's dedication to helping improve kidney health at a reduced cost and greater quality.

Dialyze Direct's proposed model attempts to improve quality and reduce cost through on-site home hemodialysis therapy for beneficiaries with end-stage renal disease (ESRD) residing in skilled nursing facilities (SNFs). The ESRD Prospective Payment System (PPS) provides a patient-level and facility-level adjusted per treatment (dialysis) payment to ESRD facilities for renal dialysis services provided in an ESRD facility or in a beneficiary's home. Under Dialyze Direct's proposed model, nephrologists would be paid a one-time fee to educate patients about dialyzing in the SNF rather than transporting to ESRD facilities and have the opportunity for shared savings from averted patient transportation costs.

In its review of Dialyze Direct, PTAC stated that the proposed model was narrowly focused on one particular approach to providing dialysis in SNFs. The Committee recommended the proposal "for attention because of the need to address the opportunities the proposal identifies to improve outcomes and reduce spending for Medicare beneficiaries with ESRD who reside in SNFs and to overcome the barriers to doing so in current Medicare payment systems." Like PTAC, I am not convinced that the payment model proposed would overcome the current payment system barriers or ensure that higher quality and lower spending would be achieved.

I am fully supportive of innovation in the kidney care space consistent with Dialyze Direct's goals. On July 10, 2019, HHS announced several models dedicated to kidney care, including home dialysis and kidney transplants, as part of our Value-Based Transformation initiative dedicated to improving customized, patient-centered care (<https://innovation.cms.gov/Files/fact-sheet/ptac-value-fs.pdf>). These models are the proposed End-Stage Renal Disease (ESRD) Treatment Choices (ETC) Model and the Kidney Care Choices (KCC) Model.

I appreciate PTAC's valuable review of this proposal. I hope to continue to engage with passionate stakeholders like Dialyze Direct as I strive to improve quality, lower spending, and drive transformative innovation for beneficiaries with CKD and ESRD through the KCC model and, if finalized, the proposed ETC model.

University of Chicago Medicine

I am grateful to the University of Chicago Medicine for its dedication to improving primary care delivery for beneficiaries with serious illness and complex medical conditions. As always, the Physician-Focused Payment Model Technical Advisory Committee (PTAC) has done an exceptional job reviewing the University of Chicago Medicine's proposed *Comprehensive Care Physician Payment Model (CCP-PM)*. PTAC's thorough review will help guide our efforts to develop innovative primary care payment and service delivery models.

The proposed CCP-PM model targets a known gap in care continuity related to transitions between inpatient and outpatient settings for a high-cost segment of the Medicare population. The CCP-PM aims to increase beneficiary access to primary care and reduce avoidable events by incentivizing the same physician to provide inpatient and outpatient care for patients with diverse medical conditions. The proposed model empowers physicians as patient navigators, providing continuity of care for these high-risk patients.

I agree with PTAC that CCP-PM is a care model designed to foster the crucial role that primary care physicians may provide in delivering value-based care for highly complex and frail patients. I further agree that the attention to care transitions and care coordination presented in the proposed model may improve the quality of care for those patients. I am interested in exploring how the concepts in the CCP-PM model could be incorporated into models underway at the Centers for Medicare & Medicaid Services (CMS) Center for Medicare and Medicaid Innovation (CMS Innovation Center). Therefore, I have asked the CMS Innovation Center to assess how key mechanisms of action in this proposed model could operate as a component in a payment and service delivery model dedicated to improving population health.

The CMS Innovation Center recently announced two new payment and service delivery models that reflect key concepts in several primary care models reviewed by PTAC. The Primary Care First (PCF) model seeks to improve quality of care, and incentivize health care providers to reduce hospital utilization by significantly rewarding them through payment adjustments based on their performance. The Direct Contracting (DC) model options are expected to increase beneficiaries' access to innovative, affordable care while maintaining all Original Medicare benefits, and place an emphasis on voluntary alignment, empowering beneficiaries to choose the health care providers with whom they want to have a care relationship. These new models reflect input from advanced primary care practices that spoke to the CMS Innovation Center about accepting increased financial risk in exchange for greater flexibility and fewer requirements.

I want to thank the University of Chicago Medicine for helping to drive transformative innovation in American health care, and PTAC for their thorough review of this model proposal.

Innovative Oncology Business Solutions, Incorporated

I want to thank Innovative Oncology Business Solutions, Incorporated (IOBS) for its submission of the *Making Accountable Sustainable Oncology Networks (MASON)* proposal to the Physician-Focused Payment Model Technical Advisory Committee (PTAC), and for IOBS's interest and support in advancing oncology care for Medicare beneficiaries. I appreciate PTAC's fastidious review of this proposed physician-focused payment model (PFPM), and valuable comments and recommendations.

MASON utilizes an approach to cancer payment that relies on machine learning algorithms to define groups of patients, or Oncology Payment Categories (OPCs), based on disease state, comorbidities, and treatment plan. Similar to the proposal's goal of establishing data-driven bundled payments, HHS values transparent payment determined by successful episodes of care rather than discrete services. The proposal's attempt to engage patients as consumers is also recognized in the "virtual accounts," which are intended to empower patients and providers to collaboratively manage costs. HHS shares PTAC's reservation in the methods and software to calculate the OPCs that may be required of participants, and may be proprietary to IOBS. Also, the proposed model holds oncologists accountable for non-drug, cancer related expenditures, rather than total cost of care.

In July 2016, HHS began testing the Oncology Care Model (OCM), an episode payment model that aims to provide higher quality, more highly coordinated oncology care at the same or lower cost to Medicare. While OCM and MASON are both episodic oncology care models, there are distinct differences, such as episode initiation based on cancer diagnosis in MASON versus the start of cancer treatment in the OCM. I recognize that from the submitter's own OCM experience, these differences may be design features other OCM participants would appreciate.

As the submitter is a current participant in OCM, the Centers for Medicare & Medicaid Services (CMS) Center for Medicare and Medicaid Innovation (CMS Innovation Center) already has an existing relationship with the submitter and has met with them multiple times regarding improvements to OCM, most recently in March 2019 regarding the MASON proposal. The OCM is scheduled to run until June 30, 2021. However, I am considering next steps for models in oncology care, and as PTAC recommended, I will ask the CMS Innovation Center to engage further with the submitter and other stakeholders to discuss enhancements to that existing model and other potential models intended to improve oncology care.

I am encouraged by submitters like IOBS who continue to help drive transformative innovation in American health care. HHS will continue to work with PTAC and proposed PFPM submitters as we develop payment and service delivery models and move toward a value-based delivery system.