



September 7, 2018

Jeffrey Bailet, MD
Chairman
Physician-Focused Payment Model Technical Advisory Committee
PTAC@hhs.gov

Re: Request for Public Input on PTAC Processes and Requirements

Dear Chairman Bailet,

On behalf of the American College of Physicians (ACP), I am pleased to share our comments on the Physician-Focused Payment Model (PFPM) Technical Advisory Committee (PTAC)'s request for public input on the committee's processes and requirements. The College is the largest medical specialty organization and the second-largest physician group in the United States. ACP members include 154,000 internal medicine physicians (internists), related subspecialists, and medical students. Internal medicine physicians are specialists who apply scientific knowledge and clinical expertise to the diagnosis, treatment, and compassionate care of adults across the spectrum from health to complex illness.

We appreciate PTAC for hosting this opportunity to solicit feedback from the stakeholder community and general public. The College is an ardent supporter of this committee and the important work it does to facilitate the widespread adoption of more PFPMs. We have been closely tracking PTAC's deliberations and recommendations, as well as the Department of Health & Human Services' (HHS) responses to those recommendations. Recently, in our comments responding to proposed revisions to payment policies under the Medicare Physician Fee Schedule and Quality Payment Program for Calendar Year 2019, we underscored the invaluable role PTAC plays in facilitating the growth of PFPMs and how valuable this pipeline of new physician-focused models could be to expanding the Advanced Alternative Payment Model (AAPM) pathway. In our letter, we urged HHS to work more collegially both with this committee and model developers by providing more transparent criteria and earlier, more frequent feedback. We also called on HHS to provide more robust technical assistance to developers, including access to Medicare claims data, and called on the Secretary to codify a timeframe by which he would be held accountable to respond to PTAC recommendations, which presently appear to occur on an ad hoc basis with gaps as long as a year between when a model was submitted for recommended approval and when the Secretary responded. We noted the importance of a transparent review and approval process by HHS to PTAC and model developers, who may start to lose faith given the fact that zero models recommended for

adoption by PTAC have been approved for either limited-scale testing or full-scale implementation by HHS.

The themes of transparency and more frequent communication should also be applied in this case to improve the proposal submission, review, and recommendation processes. All parties share the same goal: to foster the development and growth of PFPs. Accordingly, it is paramount that all parties share the same clearly defined criteria and regularly communicate throughout the proposal, recommendation, and approval processes so the process can be as productive as possible and yield more fruitful results. We offer more specific recommendations below organized by subtopic in PTAC's comment solicitation.

New process for providing initial feedback

The College appreciates changes made in the Bipartisan Budget Act (BBA) that authorizes PTAC to provide initial feedback on model submissions. We believe by directly engaging with developers about possible shortcomings in their models and providing feedback earlier in the process, the PTAC approval process will save developers countless time and energy and yield more fruitful results. However, we have some concerns that the process for providing initial feedback described in the referenced "[Implementing New Authority Provided by the Bipartisan Budget Act of 2018](#)" may be unnecessarily restrictive.

According to that document, initial feedback will be given "only to stakeholders who submit written proposals that meet PTAC's existing proposal completeness criteria," which does not move the needle much from the current process where committee members deliberate and provide feedback during a public forum two months later. By the time the proposal is submitted, critical details must already be fleshed out including quality and cost criteria, payment methodology, and ability to be evaluated. Countless hours and expense would have been put into financial modeling for a payment methodology that may have inherent flaws or concerns at a surface level that could have been addressed much earlier in the process. By that point, a small tweak could require re-calculating all of the numbers, which would lead to countless additional hours of work and expense. Developers may not be able to keep investing time and energy into running financial modeling time and again, particularly when the likelihood of a model being implemented is unclear, if not unlikely.

We urge PTAC to reconsider this policy and to instead provide initial feedback to any stakeholder that has submitted a preliminary proposal or written letter of intent. By providing feedback earlier in the process, PTAC will save developers immeasurable hours and costs by addressing any surface level concerns from the onset and at least sending the developers on the right path as they then proceed with actual modeling, surveying, and/or testing, as the case may be. Moreover, we feel that providing feedback at this earlier stage more so embodies the spirit of "initial feedback" intended under the BBA and also mirrors HHS' plan to "work with the individual stakeholders who submitted proposals to consider design elements for testing and make changes as necessary."¹ In addition, we feel this will save time and efforts spent by PTAC

¹ 42 CFR Parts 414 and 495 p. 77492

because by providing earlier feedback, models would be steered down the right track and would therefore be more likely to meet PTAC criteria by the time the proposal is submitted and the PTAC preliminary review committee spends time conducting a more in-depth analysis of the proposal.

The same document notes that PTAC will not provide instructions on how to remedy or fix any identified shortcomings, data or analysis to aid further development of the proposal, individualized consultation, or technical assistance. PTAC has expressed previously that “it has been advised [by HHS] that it may not provide technical assistance.” However, these are the very areas that could make an instrumental difference and yield exponential returns in terms of the quality and completeness of proposals. Feedback earlier in the process has appreciating returns and requires less work for all parties in the long run.

Developing an APM requires massive amounts of data, time, and expertise in financial modeling. Private sector developers are eager to support the transition to value-based reimbursement, however, in most cases they are simply not equipped to single-handedly develop, test and model a new APM from the ground up without substantive support from PTAC and HHS. **For the best chance of creating a steady pipeline of sophisticated, physician-led alternative payment models, model developers need to be supported by both PTAC and HHS to the maximum extent possible with data, technical assistance, and specific, tangible feedback including alternative solutions.** The members of this Committee were selected based on their industry expertise; they are some of the candidates best-suited to provide constructive suggestions to improve model designs and offer alternative solutions. Stifling their ability to provide tangible, specific feedback only does a disservice to the process, model developers, and the physician community as a whole. We have iterated these same points to HHS directly; urging HHS to allow PTAC to provide more robust feedback, as well as do everything in its own power to support model developers, including providing technical assistance itself and access to data, which is critical for financial modeling purposes.

As it stands, model developers enter into a black box with very little if any feedback until they are essentially at the end of the drafting process. This is not a recipe for results. All stakeholders have the same goal, to have approved innovative, well-constructed physician-led payment models that will improve quality and reduce costs. **To maximize efficiency and results, PTAC should establish a collegial relationship with HHS and model developers with opportunities for feedback early and often.**

Previous requirements for proposal submissions

The College generally supports the Committee’s previous requirements for proposal submissions and understands that they align with criteria finalized by the Centers for Medicare & Medicaid Services (CMS) in the 2018 Quality Payment Program (QPP) final rule. In that rule, CMS places great emphasis on the scope criterion as “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.” This sentiment does not appear to be reflected in the corresponding optional information questions for that category. We

encourage the Committee to place more emphasis on questions that specifically address how the model would address needs currently unmet by existing Medicare models.

In its June 13 [letter](#) to PTAC explaining why it will not implement any of the dozen models submitted for consideration by PTAC, HHS lists several additional considerations for model submissions. These include “potential for significant impact... in ways [HHS] can conduct a robust evaluation,” the use of proprietary tools being an “obstacle,” and “providing care in accord with current standards or accelerating adoption of emerging standards.” These considerations appear to be reoccurring reasons why HHS does not adopt PFPs. In the interest of consistency and increasing the likelihood that models are adopted by HHS, PTAC should consider formally incorporating these into its own criteria for evaluating models.

The College wishes to underscore our support for the third criterion related to adhering to current or emerging standards of care. ACP has developed our own set of [clinical practice guidelines](#) precisely because we agree that following the most current and evolving clinical guidelines and recommendations is paramount in the delivery of effective medicine, particularly high-quality, low-cost medicine.

The College supports the Letter of Intent requirement but as we stated earlier, we find it would be an exponentially more useful exercise if PTAC provided initial feedback in response to that document or a form of preliminary proposal, as opposed to the full proposal. In the interest of maximizing the Committee’s time and making this feedback as purposeful as possible, we encourage PTAC increase the strict two-page requirement. We feel this more appropriately balances the need for conciseness with the complex nature of the material and would increase the utility of this document.

Consistent with our comments to CMS, we urge PTAC to count quantifiable up-front investments toward the financial risk associated with a model. These investments are very real risk for the practices investing in starting an APM, and should be counted toward risk.

Proposal review and recommendations process

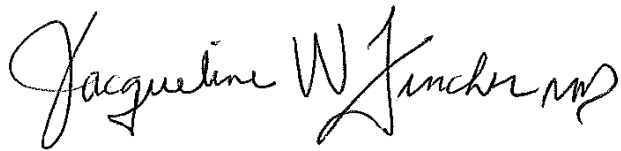
The College is generally supportive of the proposal review and recommendation process, though as we noted earlier, we would support a process that is more collegiate in nature with more opportunities for more frequent, informal feedback to help the process be as effective as possible. We appreciate the Committee’s clear commitment to transparency and engaging the public by making all of the materials and recordings of deliberations available through its website. We also appreciate the opportunities for making public comments on specific proposals and general PTAC policies and processes such as this.

In conclusion

Thank you again for the opportunity to comment. It is our hope that these recommendations will help to improve the model submission process for future developers. We look forward to continuing to support PTAC in the important work it does to advance the development and

growth of physician-led, innovative payment models that drive quality improvement and cost reduction for the patients they serve. If you have any questions, please contact Suzanne Falk at (202) 261-4500 or sfalk@acponline.org.

Sincerely,

A handwritten signature in black ink that reads "Jacqueline W. Fincher MD". The signature is written in a cursive, flowing style.

Jacqueline W. Fincher, MD, MACP
Chair, Medical Practice and Quality Committee
American College of Physicians