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December 9, 2016

PTAC
c/o Scott R. Smith, ASPE
200 Independence Ave. SW
Washington, DC 20201

Dear Mr. Smith,

The American College of Radiology (ACR), representing more than 36,000 diagnostic radiologists, radiation oncologists, interventional radiologists, nuclear medicine physicians and medical physicists appreciates the opportunity to comment on the Physician-Focused Payment Model Technical Advisory Committee's (PTAC) document entitled "Processes for Reviewing and Evaluating Proposed Physician-Focused Payment Models- DRAFT FOR PUBLIC COMMENT".

Physician-Focused Payment Models (PFPMs)

National medical specialty societies have been working to develop Physician Focused Payment Models (PFPMs) to be implemented under the Medicare Access and CHIP Reauthorization Act (MACRA) legislation. These models take considerable time to develop, pilot test, and implement and therefore should have every opportunity to qualify as advanced alternative payment models (APMs) under MACRA. The ACR appreciates the flexibility the PTAC offers in the development of PFPMs for specialists and those who, to date, have had limited or no opportunity to participate in APMs. Much work needs to be done to ensure that all physicians, including radiologists, have an opportunity to participate in APMs and work toward the goal of improved care and lower costs.

The ACR supports the development of radiology-appropriate PFPMs as a pathway to advanced APMs.

We appreciate that the initial PTAC three-person review team will include at least one physician. However that physician cannot realistically have the diverse clinical expertise necessary to evaluate the clinical aspects across each model. Therefore we concur there should be clinical experts available to the PTAC review team to assist with technical questions which arise. The ACR is aware that through the Office of the Assistant Secretary for Planning and Evaluation, expertise is available through contractual arrangements with the Perelman School of Medicine at the University of Pennsylvania Medical School and the Urban Institute. However, we believe this to be inadequate and offer this alternate option.

The ACR recommends that the PTAC request submission of a list of clinical experts either with the PFPM letter of intent or with the PFPM completed application, whichever is optimal for PTAC operations.

The PTAC has announced that it will allow for a 12 month process, to review and determine if the Centers for Medicare and Medicaid Services (CMS) will accept an APM. **We agree that this timeframe is preferable to the initial 18 months that was proposed.**

The PTAC has also announced that if an APM submission does not meet their criteria, the submitter is not expected to start over. Rather, the submitter may resubmit and address specific PTAC or CMS comments/concerns. **The ACR agrees with this approach that there be an appeal process and opportunity for resubmission if an APM submission is not initially accepted for testing and implementation.**

CMS offers "supplemental information elements" stakeholders may include in their PFPM proposals to assist agency review. CMS does not require these elements as PFPM criteria but instead to increase transparency of the process. CMS defers to the PTAC on how it may approach requesting any supplemental information beyond that required to meet PFPM criteria. To that end, the ACR noticed that CMS finalized the quality and cost criteria in which a PFPM is expected 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. The ACR understands that this is CMS' ultimate goal. However, CMS also acknowledges that applicants may not be able to analyze the full impact a proposed PFPM may have on quality of care and cost. We agree with this conclusion and believe there may be additional clinical considerations. For example, use of an imaging centered preventive service or better follow up care on pertinent indeterminate findings found on imaging may increase imaging volume, but also increase early detection of cancers. Both of these scenarios may not have immediate cost reductions, but instead reduce future costs by preventing unnecessary downstream tests and therapeutic interventions. The cost savings associated with early intervention and preventive services may take considerable time to quantify. **Therefore, the ACR agrees that the submission of supplemental information to explain such clinical circumstances would be useful, and may help an application move more successfully through the review and approval process.**

In response to commenters that expressed concern about the role of non-physician clinicians and non-physician services, CMS modified the proposed definition of PFPMs to include models that include a broader group of clinicians and their services. CMS also declined to define PFPMs to be provider-led. The ACR agrees that MACRA encompasses the participation of all eligible clinicians in APMs. **However, the ACR cautions CMS and the PTAC to carefully review APMs submitted by non-physicians to ensure that the scope of the model does not infringe upon the role of the physician and their requirement to treat patients under their required training and certification guidelines. In particular, state scope of practice laws should be respected. The ACR believes there is a role for all non-physician eligible clinicians in APMs but one which compliments a physician's expertise and does not sacrifice quality of care.**

The ACR looks forward to working with the PTAC and CMS on the development of APMs that focus on the quality care radiologists can provide to patients in a cost-effective manner.

Sincerely,

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Chief Executive Officer

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