- Where applicable, is patient attribution prospective rather than retrospective? Prospective attribution is preferable, because it allows physicians to know up front for which patients they will be responsible under the payment model. Particularly if CMS expects PFPMs to involve EAPM entities, which, in turn, involves bearing financial risk, the physicians involved need to know for which patients they are at risk.

Among the criteria that CMS does propose to include, we are troubled by the one labeled "Scope" and defined 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." We disagreed with a similar criterion in the RFI.

First, we believe that the opportunity for physicians to participate in proposed PFPMs should not be limited by the fact that they may have had the opportunity to participate in another PFPM with CMS. Prior opportunity does not equate to prior participation, and prior participation should not restrict a physician from future participation in innovative payment models.

Another reason we disagree with this particular proposed criterion is that it seems intent on fostering a plethora of specialty-specific PFPMs, and we believe CMS should focus on primary care PFPMs. We do not need to replace the current fee-for-service system, and its multiplicity of subspecialists driving volume rather than value, with APMs driven by a multiplicity of sub-specialist PFPMs.

Elsewhere in the proposed rule, CMS states that it believes concurrently implementing multiple PFPMs that attempt to solve the same clinical or payment issue may not be the most efficient use of limited resources, and may complicate the evaluations of some or all of the relevant models. Such thinking seems designed to preclude innovation in the form of alternative or new ways of addressing existing problems. Innovation is not, and should not be, limited to uncharted territories. In medicine, there is often more than one way to address a problem, and the preferred solution may vary depending on the circumstances. Further, new solutions may prove preferable to old ways of doing things. For example, the treatment of polio gave way to prevention with the introduction of the polio vaccine.

We strongly urge CMS to either not include this criterion or, failing that, modify it, so it is more in line with Innovation Center criterion No. 5, which states, "Demographic, clinical and geographic diversity – Does the model target key diverse patient and practitioner populations that CMS has yet to engage in other models, or geographic regions with previously low participation in CMS models?"

d. Facilitating CMS Consideration of Models Recommended by the PTAC
To facilitate and potentially expedite the consideration of models for testing following PTAC review and recommendation, CMS suggests "supplemental information elements" stakeholders may include in their PFPM proposals to assist in CMS's review. CMS does not propose to require these elements as PFPM criteria and defers to the PTAC on how it may approach requesting any supplemental information beyond that required to meet the PFPM criteria.

(3) Supplemental Information Elements Considered Essential to CMS Consideration of New Models
There are three pieces of information CMS considers fundamental to evaluating new models: