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Lauran Hardin, MSN, FAAN
Angelo Sinopoli, MD
Co-Chairs
Physician-Focused Payment Model Technical Advisory Committee
Office of the Assistant Secretary for Planning and Evaluation
U.S. Department of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20201

RE: Request for Input on Improving Care Delivery and Integrating Specialty Care in Population-Based Models

Dear Co-Chairs Hardin and Sinopoli:

On behalf of the physician and medical student members of the American Medical Association (AMA), thank you for the opportunity to provide our input on how to improve care delivery and integrate specialty care in population-based payment models. The AMA commends the Physician-Focused Payment Model Technical Advisory Committee (PTAC) for recognizing that "population-based" payments do not automatically result in higher-quality, more integrated care, and that current approaches to population-based payment have not been successful in engaging specialists in care improvement initiatives or supporting better coordination between primary care physicians and specialists. We urge you to recommend that the Centers for Medicare & Medicaid Services (CMS) implement a payment approach that we have developed, Payments for Accountable Specialty Care (PASC), to address these problems. PASC would also support partial implementation of many of the physician-focused payment model proposals that the PTAC recommended between 2017 and 2020.

Barriers to Improving Specialty Care in Population-Based Models

Many patients have health problems that require diagnosis or treatment from one or more specialists. Unfortunately, these specialists often face challenges in delivering the highest-quality care to their patients at the most affordable cost due to barriers created by the current payment system. These barriers may include lack of support for the detailed assessment of diagnosis, symptom monitoring, and patient-physician shared decision-making in conjunction with primary care physicians that is needed to avoid unnecessary testing, as well as for patient self-management training and care management services that could prevent hospitalizations. Many specialists say they cannot afford to use an approach that could improve outcomes or reduce the total cost of care because there are no payments for the new services they would need to provide (or the payments are less than the cost of delivering the services), and the time they would be spending providing those services would reduce the revenues needed to sustain their practices. Although Congress authorized CMS to create alternative payment models (APMs) as a means of correcting these types of problems, there are no APMs available that enable most specialists to deliver care in significantly different ways. Between 2017 and 2020, the PTAC recommended more than a dozen

physician-focused payment models that would support better specialty care, but the PTAC-recommended APMs have not been implemented by CMS.

In theory, a capitated or population-based payment would give an accountable care organization (ACO) the flexibility to pay specialists in different and better ways. However, as a practical matter, most ACOs do not have systems for paying individual physicians for the services they deliver. Consequently, changes in the way Medicare and other payers pay specialists are needed even when population-based payments are used.

Solution: Payments for Accountable Specialty Care (PASC)

Over a year ago, the CMS Innovation Center asked the AMA to recommend ways of addressing these problems. Drawing upon over a decade of work with many physician specialty societies, including those representing primary care physicians, the AMA developed PASC to complement shared savings and population-based payment systems. Under PASC:

1. A specialist or a specialist group would sign a PASC Agreement with an ACO describing how the specialist would deliver care in different ways for specific types of patients.

2. Primary care physicians participating in the ACO would refer the types of patients described in the Agreement to the specialist.

3. The specialist would deliver additional or different services to ACO patients in the ways described in the Agreement.

4. The specialist would receive Enhanced Condition Services payments from Medicare to pay for the cost of delivering the enhanced services to the patients.

5. In a shared savings payment model, CMS and the ACO would share the savings resulting from the delivery of higher-value care by the specialists, whereas in a population-based payment model, all of the savings would accrue to the ACO. In both cases, the ACO could share the savings with its participating primary care physicians.

Details of the PASC Agreement would differ for different types of health conditions:

- Chronic Conditions. For patients with chronic conditions (e.g., heart failure or rheumatoid arthritis), the PASC Agreement could focus on avoiding the use of unnecessary and unnecessarily expensive medications and/or reducing exacerbations that can result in emergency visits and hospital admissions.

- Acute Symptoms. For patients with acute symptoms (e.g., chest pain or fever), the PASC Agreement could focus on achieving prompt, accurate diagnoses without unnecessary testing, and on improving coordination of treatment and follow-up with the patient's primary care physician.

- Acute Conditions. For patients with acute conditions (e.g., an infection or injury), the PASC Agreement could focus on choosing the most appropriate treatment for patients and delivering treatment safely and cost-effectively.

Rather than expecting every ACO to develop the capability of directly paying specialists for individual services in new ways, PASC is based on having CMS agree to make three new types of payments to specialists when they deliver services authorized by a PASC Agreement:

- When a specialist delivers one-time services described in the PASC Agreement to an ACO patient, the specialist would be able to bill Medicare for an Enhanced Condition Services (ECS) payment for the patient. The ECS Payment would be in addition to any other payments the specialist would ordinarily be eligible to receive (unless the Agreement specified otherwise).

- If the PASC Agreement authorizes the use of Special ECS payments for a subset of patients with specific characteristics requiring additional time or assistance, and if the patient who is being treated by the specialist has those characteristics, the specialist could also bill Medicare for a Special ECS payment. This would be a direct way of addressing inequities in care delivery for patients with health-related social needs.

- If the primary care physician and specialist agree that the patient would benefit from continued services from the specialist and if the PASC Agreement authorized the use of Continued ECS payments, the specialist could bill Medicare for a Continued ECS Payment each month as long as the patient continued to need and receive the additional services supported by the payment.

How PASC Would Benefit Patients and Payers

PASC would enable specialists to implement better approaches to care for patients with specific types of health conditions. There are many types of conditions where specialists have already developed such care models, but current payment systems do not support the different types of services that need to be delivered. The ECS payments in PASC would fill that gap and enable the improved care models to be quickly implemented in many ACOs. Some of these care models have already been tested in demonstration projects, but there has been no way to continue them because the necessary payment changes have not been made by Medicare and other payers. For example:

- Reducing Hospital Admissions for Chronic Disease Exacerbations. One PTAC member developed a specialty medical home model for patients with Crohn's disease and ulcerative colitis using data and financial support from Illinois Blue Cross Blue Shield. Under the model, gastroenterologists receive payments that enable them to hire nurse care managers to proactively monitor patients' symptoms and identify when medication adjustments are needed. This approach cut the rate of hospitalizations in half for the participating patients. It was the first payment model recommended for testing in Medicare by PTAC in 2017, but it has never been implemented by CMS. The ECS and Continued ECS payments under PASC would enable gastroenterologists and other specialists to deliver these services to Medicare patients who have inflammatory bowel disease.

  Similar approaches have been developed by other specialists and specialty societies for other chronic conditions that have a significant risk for hospitalization, such as asthma, COPD, headache, and heart failure. ECS and Continued ECS payments could allow allergists, cardiologists, neurologists, pulmonologists, and other specialists who manage these types of conditions to provide the proactive services needed to reduce ED visits, hospitalizations, and post-acute care.

- Reducing Repeat Emergency Visits and Hospital Admissions. A team of emergency physicians in Colorado led by another PTAC member used grant funds from the CMS Innovation Center to improve care delivery for patients who utilize the emergency department multiple times per year. The award supported home visits by an interdisciplinary team following an emergency department (ED) visit. As described in a paper published in *Health Affairs*, the model was able to substantially reduce the rate of ED visits and hospitalizations for these patients, and it doubled their number of visits to primary care physicians. Enabling this approach to continue and be replicated was one of the reasons the American College of Emergency Physicians (ACEP) developed the Acute Unscheduled Care Model (AUCM). This payment model was recommended by PTAC in 2018, but it has never been implemented by CMS. The ECS payments under PASC would allow emergency physicians to deliver these kinds of services for patients assigned to an ACO, and the Special ECS payments would allow more extensive services to be delivered to dual eligible patients and other patients with more complex needs, similar to what was done in the CMS-funded project.

- Reducing Complications and Post-Acute Care for Higher-Risk Joint Surgery Candidates. An orthopedic surgeon in New Jersey, Dr. Stephen Zabinski, developed a program of intensive pre-operative care designed to reduce modifiable risks such as weight, anemia, diabetes control, and smoking for patients who needed joint replacement. These services are not supported by standard fee-for-service payment systems, but thanks to a payment arrangement with Horizon Blue Cross and Blue Shield, physicians were able to significantly reduce inpatient complication rates, more than double the percentage of patients discharged to their home instead of a rehabilitation or skilled nursing facility, reduce total costs, and achieve high patient satisfaction rates. ECS payments under PASC would enable surgeons to deliver similar kinds of services to Medicare patients even if they are not participating in CMS bundled payment models.

We are confident that more specialists would develop innovative care models for additional conditions and for specific subsets of patients who need different approaches to care when the physicians know there is a way to be paid for those care delivery approaches through the PASC program.

Responses to PTAC Questions

- **PASC would assist primary care physicians in making referrals to high-value specialists.** The PASC Agreements would define when and how specialists would deliver services in response to a referral from a primary care physician. This will make it much easier for primary care physicians to know which specialist to refer to in what circumstances and what to expect when a referral is made. Rather than primary care physicians choosing specialists based on limited data about what the specialists have done in the past under the current payment system, the PASC Agreement would specify what the specialist would do prospectively for the referring physician's current patients with support from the ECS payments, and the performance standards they would meet.

- **PASC would enable primary care physicians and other specialists to divide their roles and coordinate their services appropriately for patients with chronic conditions.** The PASC Agreements would provide a formal mechanism to define when a primary care physician should manage care of a chronic condition with assistance from the specialist, when the specialist should manage ongoing care of the patient, or when primary care and specialist physicians should share ongoing management responsibilities. The one-time ECS payment would support the ability of specialists to provide the short-term assistance that primary care physicians often need during the

diagnosis, care planning, and initial treatment phase of chronic condition care. For the subset of patients who require ongoing management by a specialist, the Continuing ECS payments would provide needed support for the specialist to do that while also ensuring that the specialist continues to coordinate services with the primary care physician, as specified in the PASC Agreement.

- **PASC Agreements would provide a mechanism for primary care and specialist physicians to define the methods they would use to communicate about and coordinate patient care.** For example, PASC Agreements could incorporate the principles and processes for care coordination described in *Beyond the Referral: Principles of Effective, Ongoing Primary and Specialty Care Collaboration* developed by the American College of Physicians.

- **PASC would support greater equity in services and outcomes for underserved populations and patients with health-related social needs.** The Special ECS payments would be specifically designed to support improved services for patients with health-related social needs or other more complex needs. For example, Special ECS payments could be used to support having community health workers assist patients in obtaining medications and food after discharge from an ED or hospital and ensuring that they see their primary care physician for follow-up care.

- **PASC would improve timely access for patients to specialists.** Most specialists want to be more accessible to patients, but their schedules are often filled with visits from many patients who do not really need to see them or who have not been referred to the right specialist. The PASC Agreement could define which patients should be referred to the specialist and how the ACO primary care physicians can get assistance from the specialist to determine whether a referral is needed. The PASC Agreement could also include standards regarding timeliness of the specialist's response when contacted by the primary care physician for information or a referral. By providing support for the enhanced services that specialists would provide, the ECS payments would enable specialists to hold more appointment slots open for the types of referrals covered by the PASC Agreements.

- **PASC would provide incentives for specialists to deliver high-value care without requiring them to take on unmanageable financial risk.** A specialist could only receive an ECS payment for a patient if the specialist has a PASC Agreement with the ACO, and they could only continue to receive payments for patients if they meet the performance standards specified in the PASC Agreement. This means the ECS payments are inherently "performance-based" payments, but the performance standards and the penalties for failure to perform would depend on the specific agreement. For example, falling short of the performance standards could potentially lead to the ACO not renewing the agreement with the specialist.

- **PASC would enable the use of performance measures that match the specific types of care being delivered and the outcomes expected.** There are no quality measures used in the Medicare program for many aspects of the care delivered by specialists. PASC Agreements would define appropriate performance measures for specific types of patients: (a) that would support the ACO's overall goals for delivering quality care and controlling costs, and (b) that the specialist would be able to meet with the additional resources available from the ECS payments. These could be measures of quality, utilization, or both. If a quality or cost measure used in the Merit-Based Incentive Payment System (MIPS) or an ACO quality measure is appropriate, it could be used, but PASC performance measures would not be limited to current MIPS or ACO measures. For example, if a specialist has agreed to follow a specific evidence-based clinical pathway for ordering a specific

medication, test, or procedure, the specialist would document whether that pathway was followed for each patient who has the condition that is the focus of the PASC Agreement. The specialist would then provide documentation to the ACO on the percentage of patients who received services consistent with the pathway.

Paying for the Care Patients Need

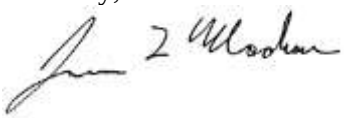
Eight years after the passage of MACRA, most physicians still do not have the opportunity to participate in an APM designed for the kinds of patients they treat or the level of risk they are equipped to take on. Many frontline physicians who have experienced barriers to value-based care in their practices have put in years of work to develop more patient-centered approaches to care delivery for patients, but they cannot implement these approaches without appropriate changes in the Medicare payment system. PASC would enable them to do so.

The use of telemedicine during the pandemic illustrates the critical role of payment policy as both a barrier and potential catalyst for the uptake of care delivery reforms with known potential to improve value. The 2020 expansion in access was made possible only because Medicare and other health plans started paying adequately for these services for the first time.

To achieve higher-quality, more affordable care while addressing our nation's chronic disease epidemics and unacceptable health inequities, we need to accelerate efforts to remove the barriers created by our current payment systems. Population-based payments will not remove these barriers unless Medicare and other payers make specific changes in the way individual physicians are paid for services. Implementing PASC would be a win-win-win – it would enable better care for patients, reduce spending for Medicare and other payers, and help to attract and retain high-quality physicians in medical practice.

Thank you for your work on this important issue and for considering our input. If you need any additional information, please contact Sandy Marks at sandy.marks@ama-assn.org or by phone at 202-789-4585.

Sincerely,



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