AMA
AMERICAN MEDICAL ASSOCIATION

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The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
Attention: CMS-5540-NC
7500 Security Boulevard, Mail Stop C4-26-05
Baltimore, MD 21244-1850

Re: File Code CMS-5540-NC. Request for Information; Episode-Based Payment Model

Dear Administrator Brooks-LaSure:

On behalf of the physician and medical student members of the American Medical Association (AMA), I appreciate the opportunity to respond to the Request for Information (RFI); Episode-Based Payment Model published in the Federal Register on July 18, 2023 (88 Fed. Reg. 45872) and to provide input regarding the design of future episode-based payment models by the Centers for Medicare & Medicaid Services (CMS) and the CMS Innovation Center (CMMI).

Essential Elements for Success in Creating Episode-Based Payment Models and Other APMs

The AMA is disappointed that, eight years after the passage of the Medicare Access and CHIP Reauthorization Act (MACRA) and over a decade after the creation of CMMI, most physicians still do not have the opportunity to participate in an Alternative Payment Model (APM) designed for the kinds of patients they treat. Many frontline physicians who have experienced barriers to value-based care in their practices have devoted years of work to develop patient-centered APMs that could offer meaningful benefits to patients and savings for the Medicare program, but none of these APMs have been implemented by CMMI or CMS.

In this context, it is encouraging to read in the RFI that CMMI is planning to develop and implement new episode-based payment models. However, we urge CMMI to be more transparent about the models it is developing than in the past, and to provide ample opportunities for involvement by practicing physicians during both the design and implementation phases. Soliciting input through this RFI is a positive step, but more transformative changes are needed to ensure that new payment models will address the needs of physicians and their patients or that the payment models will be successful in achieving the objectives that CMS has defined. If CMMI is truly committed to developing successful APMs that support meaningful improvements in care for patients, we strongly believe that it must consider the following recommendations:

- **Actively engage with relevant physicians throughout all model development and implementation stages**, including making sufficient data and methodological details available to physicians and other interested parties so they can understand, assess likely impacts, and provide feedback to CMS on proposed payment models.

- **Seek public input on APM payment amounts, risk requirements, quality measures, and other key elements** long before they are formalized in program guidelines or proposed rulemaking and respond publicly to all feedback that is provided.

- **Implement payment models that have already been developed by physicians** before trying to develop new models from scratch. This will enable faster implementation of new models, higher participation in APMs, and greater likelihood of success.

- **Ensure that new payment models place physicians at the center of decision making about care delivery, give them the resources and flexibility they need to deliver services that can achieve good outcomes for all types of patients with lower overall spending for Medicare, and do not place them at risk for outcomes or costs they cannot control.** New APMs should utilize prospective payments designed to support the costs of high-quality care, rather than merely providing bonuses and penalties based on CMS estimates of Medicare savings. APMs should also include waivers of any regulations that prevent or impede the delivery of care in more effective ways. New APMs should not hold physicians accountable for outcomes they cannot control or place them at financial risk for services or prices that they cannot control.

- **Design new APMs to provide adequate payments and flexibility that will ensure access to high-quality care for patients with higher levels of need.** The risk adjustment systems CMS currently uses were not designed for APMs and they can exacerbate inequities for vulnerable and high-need patients. Instead, physicians should be able to assign higher-need patients to different patient need categories and receive higher payments in exchange for delivering enhanced services for those patients through the APM.

- **Provide start-up funding to APM participants** so they can invest in the data analytic capabilities, care managers, training, and/or other practice changes that are needed to improve care delivery and facilitate successful APM participation. This is particularly important to enable successful participation by small, independent, rural, and safety net practices.

- **Increase payments annually to ensure they continue to be adequate to cover the costs of high-quality care.** Payment increases should cover cost increases that are due to inflation, to changes in technology, and to changes in evidence about the effectiveness of services.

- **Commit to providing Medicare claims data to APM participants in a timely manner and in an easily accessible and usable format**, consistent with the recommendations in the Voluntary Best Practices in Data Sharing report developed by the America's Health Insurance Plans (AHIP), AMA, and the National Associations of ACOs (NAACOS).

- **Commit to continuing models for a long enough period of time to allow practices to make significant changes in care delivery and provide assurance that payment models will not be terminated or changed abruptly.** Significant changes in care delivery can require new or different staff and partners, education for both staff and patients, purchase of new equipment, and

other changes that take time to implement and cannot be easily abandoned after a few years. CMS should also recognize the significant time and costs physician practices can incur when the requirements of APMs are changed, and it should only make changes after seeking input from the participants and allowing adequate time for transitions.

- **Make participation in all models voluntary.** APMs that provide adequate support for high-quality care will attract physician participants without the need for mandates. Conversely, mandates can result in adverse consequences that can jeopardize the viability of small, rural, independent, and safety net practices and create potential access issues for the vulnerable patients they serve.

- **Ensure that any new APMs will help sustain high-quality, financially viable medical practices.** An APM can only improve care for patients if there are physicians who can deliver that care, and there are growing concerns about whether there will be an adequate number of physicians to take care of patients in the future. Low payments for services and high administrative burdens under both current payment systems and current APMs are making it increasingly difficult for physicians to sustain their practices. New APMs should be designed in a way that will not only better sustain existing physician practices but also attract more talented young people to practice medicine, particularly in underserved communities.

In the remainder of this letter, we will attempt to respond to the issues and questions included in the RFI. However, because of both the general nature of those questions and the broad range of medical conditions and procedures where episode payments and other alternative payment models could potentially be used, our responses must also be similarly high-level. We would be happy to provide more specific responses and feedback on specific areas or payment model concepts when CMMI determines where it plans to focus its efforts.

A. Care Delivery and Incentive Structure Alignment

When Congress created CMMI in 2010, it explicitly required that CMMI test a model only if it determined "that there is evidence that the model addresses a defined population for which there are deficits in care leading to poor clinical outcomes or potentially avoidable expenditures" (42 U.S.C. 1315a(b)(2)(A)). Although CMMI was also required to focus on models expected to reduce Medicare spending, it is not sufficient under the law to design a payment model with the sole or primary purpose of reducing spending. Moreover, the statute explicitly states that preference must be given to models that "improve the coordination, quality, and efficiency of services" delivered to patients.

The primary goal of any episode payment model created by CMMI should be to correct specific problems with current Medicare payment systems that are preventing or discouraging physicians, hospitals, and other entities from delivering better care to patients. The savings from any episode payment model developed by CMMI should come from reductions in truly avoidable services, not simply from reducing payments for services or shifting risk for spending to physicians.

Merely providing "incentives" to physicians to reduce spending during episodes of care, as current CMMI models do, will not be successful because this fails to address the barriers in current Medicare payment systems that prevent the delivery of care in better ways. Moreover, incentives focused purely on reducing spending can harm patients by preventing physicians from using the most effective treatments and services and discouraging them from treating high-need patients. While it may be desirable to "align

specialty care incentives with population-based model initiatives," this alone is not sufficient to enable specialists to deliver care in better ways for all patients in an equitable way.

APMs that are developed by physicians consistent with the above principles would address many of the other issues identified in the RFI. For example:

- **Supporting coordination of specialty care and primary care.** Specialists want to focus on the subset of patients and services that require their unique skills and expertise and provide assistance to primary care practices when needed to help those practices manage the care of their patients. Enabling specialists to practice in this way ensures that patients are managed in the most appropriate setting, reduces waiting time for access to specialty services, and reduces patient out-of-pocket costs. However, current payment systems do not support this approach to delivering specialty care and coordinating with primary care. Additionally, because current CMMI payment models put physicians at risk for total spending on all services their patients receive, these models can actually penalize specialists for involving other physicians in the care of their patients. If a payment model is designed to support the services that can best be delivered by specialists to the kinds of patients who need those services, specialists will want to coordinate with primary care practices and refer patients back to them when their care can safely and effectively be managed in primary care settings.

- **Encouraging and supporting physician participation without mandates.** There is no shortage of physicians who want to be part of well-designed payment models that will enable them to deliver better care. The reason many physicians have avoided or dropped out of current CMMI APMs is not because the physicians are unwilling to accept different methods of payment, but because the payment models do not provide the support the physicians need to improve the delivery of care to their patients and/or the APMs require the physicians to accept unmanageable levels of risk. Not every physician or physician practice has adequate time and resources to make significant changes in care delivery, particularly during the initial years of implementation of a new payment model as it is still being refined. This is particularly true for small, independent, rural, and safety net practices. If models are appropriately designed, there will be no need to mandate participation. By actively involving a wide range of physician practices in the design of APMs, barriers to participation can be identified and overcome. In contrast, mandating participation in poorly designed models could force small practices to close and reduce access to care for already underserved patient populations. Because of this, the AMA will only support new episode-based models that are voluntary, and it will strongly oppose the creation of mandatory payment models.

- **Supporting equitable, person-centered care and patient choice.** Physicians are in the best position to understand which services need to be delivered in a coordinated way to achieve optimal outcomes for their patients and how physician-led teams should be organized to deliver those services. Physicians also understand which patients have needs that are too complex for a baseline payment model that is focused on a specific health condition or procedure. In order to achieve equity in access and outcomes for all patients, physicians should be permitted and encouraged to select different patient need categories and different payment methods within models for appropriate subgroups of patients that will enable physicians to address all patients' unique needs. Creating sufficient flexibility within models to accommodate the full range of patient needs will enable as many physician practices as possible to participate in APMs is ultimately the best way to preserve patient choice and promote equity.

- **Supporting multi-payer alignment.** Alignment of the ways Medicare and private insurance plans pay for care is essential so that physicians can provide high-quality care to all of their patients, regardless of the type of insurance they have, and to reduce the administrative burden and cost for physician practices. The need for alignment is becoming more important every year as the payments physicians receive for delivering services to Medicare beneficiaries increasingly come from Medicare Advantage plans operated by private insurance companies, not directly from CMS. Private payers will be far more likely to align their payments with episode payment models that are designed to enable patients to receive better care, enable payers to achieve savings, and physicians will voluntarily participate in. One of the reasons that private payer participation in past CMMI models has been limited is because some or all of those characteristics have been missing.

- **Utilizing home and community-based services.** A well-designed episode payment model should provide physicians with the flexibility to work with appropriate community-based partners to facilitate the delivery of truly patient-centered care, including services in settings that are not supported by current payment systems. These types of services can be critical to overcoming barriers to care, addressing social determinants of health, and advancing health equity. To date, most CMMI models have continued to pay only for traditional Medicare-covered services, which has precluded most physicians from utilizing innovative home and community-based services.

B. Clinical Episodes

We urge that CMMI implement the payment models that have already been developed by physicians rather than attempting to select clinical episodes and develop new payment models itself. Models have been developed by physicians that were explicitly designed to achieve CMS' triple aim of improving care for individual patients, advancing population health, and reducing avoidable spending for Medicare, so they should be priorities for CMMI to pursue. For example:

- **Unscheduled Acute Care Episodes.** The Acute Unscheduled Care Model (AUCM) developed by the American College of Emergency Physicians is designed to give emergency physicians the time and resources necessary to enable more patients to be treated for an acute episode and safely discharged to home rather than being admitted to the hospital. The AUCM APM would be used for patients who come to an Emergency Department (ED) with a condition such as abdominal pain, chest pain, altered mental status, or syncope that often result in unnecessary hospital admissions. Under the APM, emergency physicians could be paid for coordinating care with primary care physicians, for delivering transitional care management services to a patient prior to and following discharge, and for delivering telehealth visits and home visits with the patient after discharge. The physician would be accountable for reducing the total cost of services delivered to the patients during the 30 days following discharge, including the cost of return ED visits and inpatient admissions.

- **Outpatient Surgery Episodes.** The current CMS episode payment models for surgery are focused on inpatient surgeries and surgeries performed in hospitals, whereas many common surgeries are primarily performed in ambulatory surgery centers. Cataract surgery is one example of this. The Bundled Payment for Same-Day Bilateral Cataract Surgery (BPBCS) was developed by the American Society of Cataract and Refractive Surgery and the American Society of Ophthalmic Administrators so that cataract surgeons can deliver same-day bilateral cataract surgery to appropriate patients at a lower cost for both patients and Medicare. Instead of each member of the Cataract Surgery Team (the surgeon, facility, and anesthesiologist) receiving

separate payments for each individual service, the Team would receive a single bundled payment for all services the patient needs as part of the surgery, and the patient would have a single cost-sharing amount for those services. The bundled payment would give the Team the flexibility to redesign the way surgery is delivered in order to achieve the best outcomes at the lowest possible cost. The BPBCS payment would cover both the costs of the surgery and the complications that most commonly occur following surgery so neither Medicare nor the patient would pay more if those complications occurred.

- **Procedural Episodes.** Many non-surgical procedures also involve one or more physicians and facility staff working together as a team. Some of these physician-led teams have identified barriers in the current payment system that prevent them from delivering the highest-quality, lowest-cost care, and they have developed bundled or episode payments to remove these barriers. For example, there is a detailed design for a bundled payment for colonoscopies developed by gastroenterologists.[1] In addition, the American Society for Radiation Oncology has developed designs for episode payments that would enable radiation oncologists to deliver the most appropriate types and lengths of radiation therapy for cancer in a way that adequately supports the high cost of radiation therapy equipment and services.

- **Diagnosis and Initial Treatment Episodes for New Chronic Conditions.** A number of different medical specialties, such as allergy/immunology, neurology, and rheumatology, have developed payment models designed to support better care for patients with the chronic conditions they treat, such as asthma, headache, and rheumatoid arthritis. One of the components in all of these payment models is designed to give specialists and primary care physicians the resources and flexibility to more accurately diagnose a patient who is experiencing new or unresolved symptoms and, if the patient does have the chronic condition that is the focus of the model, the payment model would enable the physicians to develop an effective plan for treating or managing that condition. Ensuring that a chronic condition is diagnosed accurately and that an effective treatment is found quickly not only benefits the patient but saves money by avoiding treating the wrong disease or delivering an ineffective treatment.

There are detailed designs for these models that describe how they work and what CMMI would need to do to implement them. Because the designs have already been completed and because they were developed by physician specialty societies whose members are already interested in participating, these models could be implemented for initial testing far more quickly than any new model that CMMI would develop on its own. This would enable physicians to begin improving care for a wide range of patients and saving money for Medicare as early as 2024, whereas the RFI indicates that the earliest CMMI could develop and implement a new model would be 2026.

Although these and other payment models developed by physicians have many similarities, they also differ in significant ways because they focus on different health conditions and because the opportunities to improve care while safely reducing avoidable spending for those conditions are different. **There is no single episode payment model that can appropriately support the kinds of care needed by patients with significantly different health conditions, comorbidities, and social barriers to care. Consequently, any effort by CMMI to develop a one-size-fits-all payment model will likely fail to**

[1] Brill, Joel & Jain, Rajeev & Margolis, Peter & Kosinski, Lawrence & Holt, Worthe & Ketover, Scott & Kim, Lawrence & Clote, Laura & Allen, John. (2014). A Bundled Payment Framework for Colonoscopy Performed for Colorectal Cancer Screening or Surveillance. Gastroenterology. 2014 Mar;146(3):849-853.

result in better care for many patients or produce significant savings for Medicare. Moreover, such an approach could exacerbate inequities rather than reduce them.

C. Participants

The AMA believes that the primary participants in any new episode payment model should be the physicians who will be providing care for the patients who have the health condition(s) the model is intended to address. In order for quality to be improved and for avoidable spending to be reduced, many patients need to receive care in a fundamentally different way than they do today. This can only happen if physicians have the ability to deliver services in different ways. In order to change care delivery without jeopardizing patient safety, the physicians who are delivering the services must be able to determine what care decisions will be made. If the physician participants in the model wish to contract with other organizations to provide analytics or support services such as care management the physicians should be able to enter into such contracts, but the physicians should remain in control of designing and managing patient care services under the model. Physicians should never be merely downstream subsidiary contractors to a "convener" organization that is not led by physicians or that is primarily focused on achieving financial success rather than optimal clinical outcomes for patients.

The fundamental reason for having an episode payment model, or other type of APM, should be to enable physicians to deliver care differently than is possible under the current payment system. Consequently, **the primary criterion for selecting physician participants in a payment model must be their willingness and ability to transform care delivery and improve patient care, not merely their willingness or ability to "assume financial risk."** Physicians who are not part of large health systems already take on significant financial risk under current payment systems by committing to pay salaries for their practice staff and signing leases for their practice facilities and equipment with no guarantee that their revenues will cover those costs. The risks are greatest for small, rural, and safety net practices. It is neither necessary nor desirable for episode payment models to require physicians to take on even greater financial risk in order to receive adequate payments to deliver the services they need.

If a physician is going to deliver care in a different way, they need to know they will be paid adequately for that care. That means that **any episode payment model must be designed to determine whether the patient is eligible to participate before care begins. Patients should not be "attributed" to an episode or to a physician after care has already been completed.** The retrospective attribution systems that CMMI has used in its payment models in the past are both inaccurate and administratively burdensome, and those systems should be abandoned. Instead, physicians should determine whether a patient is an appropriate candidate to receive services as part of an episode payment model, and both the patient and physician should agree in advance that care can and will be delivered in a way that is supported by that model.

Additionally, **in order for a physician to ensure that all relevant aspects of their patient's care are delivered in the most coordinated, effective, and efficient way, the physician must have the flexibility to choose the other physicians and other entities that will be involved.** The appropriate members of a team may differ for different types of patient health conditions and circumstances, such as patients who face social barriers to care. The team needs to be defined by the physicians who are responsible for the patient's care, without restrictive barriers created by CMS rules. This can only be accomplished if the patient chooses the physician and team before care begins; it cannot happen if a patient desires or expects to choose all the physicians and other health care service delivery organizations themself during the course of the episode or if patients are retrospectively assigned to the episode model by CMS.

The payment models developed by physicians, such as those described earlier, define the key participants in these physician-led teams. We strongly urge CMS to implement these models in ways that allow the use of teams as described. MACRA required the creation of "patient relationship categories" and corresponding codes in order to provide a way for physicians to explicitly indicate whether they are playing the lead role in managing a patient's care during an episode or delivering services ordered by another physician. CMMI to date has not used these codes as part of its models, but we think this could be a valuable way to enable physicians to indicate which patients, services, and other health care providers should be included in an episode of care.

It is important to emphasize that even when payment models are developed by experienced physicians who have devoted extensive time to develop a model design that would work well in practice, it is likely that unanticipated issues will arise during implementation of the different approaches to care delivery and payment. Any new payment model, including those developed by physicians, will need to be revised to address these issues. As a result, extensive time and effort will be required by the physicians who are the initial participants in new models as these issues are identified and resolved. Not every physician or physician practice will be able to devote that amount of time and effort during the implementation process while also trying to deliver high-quality care to the patients who need it at the same time.

This is another reason why **it is essential that any payment model, including those developed by physicians, be tested on a voluntary basis, and be refined as needed before being expanded to a larger number of physicians. The AMA will strongly oppose any effort to mandate that physicians participate in a new episode payment model or other APM because we believe that such mandates can harm both patients and physician practices.** As explained earlier, physicians want to be part of well-designed payment models that will enable them to deliver better care, so if the models are designed by physicians or with their active involvement and if they have been tested and refined adequately, there will be no need for mandates in order to achieve high levels of participation. Conversely, if a physician believes that what is required under a payment model could harm their patients or cause financial problems for their practice, mandating their participation could reduce access and quality of care for Medicare beneficiaries or result in unexpected increases in Medicare spending.

D. Health Equity

The only way to truly achieve equity in the delivery of health care is to ensure that each patient receives the types and amounts of services that will best meet their individual needs. This means that episode payments must be designed to support the delivery of services that are appropriate for each individual patient. Ensuring that underserved beneficiaries are "adequately represented" in payment models or giving APM participants financial incentives to include them does not ensure that the beneficiaries will actually receive the tailored care and support that they need or that physicians will have adequate resources to deliver that care. While providing higher payments to practices that serve larger numbers of patients from disadvantaged neighborhoods, or even providing higher payment amounts for individual patients who have greater needs is desirable, it will not achieve equity if the higher payment amounts are still not sufficient to cover the actual cost of delivering the specific services and support those patients need.

The best way to ensure that episode payments support appropriate care for underserved beneficiaries is to identify what kinds of beneficiaries are currently underserved, determine what services they need (including non-medical services) and what it will cost to deliver those services, and then establish payment amounts for those beneficiaries that are sufficient to cover the cost of the necessary services and support. The disparities in services under current CMMI models that are

described in the RFI are largely due to the fact that the payments in those models do not appropriately distinguish between patients with different levels of need. Current CMS risk adjustment models fail to adjust for many clinical characteristics that have a major impact on services and costs (e.g., the stage of cancer) and they fail to adjust for important individual health-related social needs. An episode payment model that is intended to serve patients with diverse needs should be stratified into multiple patient need categories, with each need category focused on a subgroup of patients who require a combination of services that is different from other subgroups. There should then be a separate payment amount for each patient need category that is based on the cost of delivering the combination of services appropriate for the patients in that category. The patient need categories must be developed by physicians or with the full participation of physicians in order to ensure they align with evidence-based differences in the services that should be delivered to patients. Many of the physician-developed payment models described earlier include multiple categories of payment with explicit criteria for the types of patients who would qualify for each category. In addition, the payments in these models are designed to provide physicians with the flexibility to deliver a broader range of services to address the individual needs of patients, whereas most current CMMI APMs pay only for the services that are currently paid for under standard Medicare payment systems. In addition to ensuring that the amounts Medicare pays for individual patients will enable physicians and physician-led teams to deliver adequate services to higher-need patients, additional adjustments or supplemental payments may be needed to address the higher costs faced by physician practices that are located in underserved communities or that serve large numbers of high-need patients.

In addition, **the physician who is treating the patient or managing their care should be responsible for determining which patient need category is most appropriate for an individual patient based on the unique clinical and social characteristics of the patient.** CMS should not attempt to assign patients to need categories itself based on information in claims data, because much of the relevant information needed to make such assignments is not contained in claims data or other data accessible by CMS, nor should CMS attempt to create expensive and burdensome new systems to collect additional data for this purpose. The most efficient way to obtain the information necessary for patient need category assignments is for physicians to document that information in the patient's record, just as physicians do now when they document diagnoses and services delivered. If there are any questions about the accuracy of these assignments, the documentation for them can be audited, just as CMS can do now for diagnosis and procedure codes used for billing.

E. Quality Measurement and Multi-Payer Alignment

Most current CMS APMs have not resulted in significant improvements in quality because they were primarily designed to reduce spending for Medicare, not to improve the quality of care for patients. Specifically:

- Current CMS episode payment models only provide financial rewards to physicians and hospitals if they reduce spending. There is no reward for achieving better outcomes for patients (e.g., if their patients have less pain or discomfort after surgery or can return to full functionality more quickly) unless spending has also been reduced. While participants may receive smaller performance-based bonuses if quality is deemed low, they cannot receive higher bonuses regardless of how good their outcomes are.

- There is also no penalty in any of the current CMMI models if the quality of care for patients worsens but spending remains unchanged, because quality measures only impact the bonus or penalties for the participants, and there are only bonuses or penalties if spending decreases or increases compared to CMMI benchmarks and targets.

- It is difficult for the participants in the current models to deliver new or different services that could improve the quality of care or outcomes because CMS continues to pay the same amounts for the same services as it does today. A physician or hospital that wants to deliver a service that is not currently paid for would have to do so with no upfront compensation and hope that they would receive a bonus payment through the APM in the future that is sufficient to cover the costs they have already incurred delivering services. That is not feasible for many small, independent, rural, and safety net physician practices.

Any future episode-based payment models should be explicitly designed to enable specific changes in care delivery that physicians believe will improve patient outcomes at the same or lower cost. This must include 1) providing upfront payments that are adequate to support the costs of new or different services, and/or 2) changes to current payment systems designed to overcome barriers to delivery of better patient care, such as waivers of regulations limiting the number or types of services that can be delivered.

If the payment model is explicitly designed to improve short-term outcomes that directly result from the services delivered to the patient, then it will be appropriate to measure whether those outcomes are being achieved as part of model performance. However, in most cases, it is very difficult or impossible to tie the payments in the model directly to outcome measures. Most important outcomes are affected by many factors other than just the services delivered by physicians and other health care providers, making it difficult to accurately adjust the outcome measures for those other types of factors. Moreover, many important outcomes occur well after services are delivered (such as the improved patient outcomes resulting from care management and prevention services), and it is impractical to withhold payments until outcome measures are collected or to attempt to retroactively adjust payments after the downstream impacts can be appropriately assessed, which is often years later. **We urge CMS to utilize physician-designed payment models, such as those described earlier, that include a combination of process and outcome measures that will ensure the delivery of high-quality care in a way that is within the control of clinical staff and administratively feasible for both the physician participants and CMS.**

Furthermore, any quality measures and scoring methodologies used in an episode payment model must be appropriate for the types of patients and physicians who are participating. It would be inappropriate to try and use the same measures and scoring rules as in the Merit-Based Incentive Payment System (MIPS), especially since CMS has continued to remove specialty specific measures from the program. Instead, **we urge that episode payment models and other APMs not only permit but encourage the use of clinical registries managed by specialty physician organizations, and that the payment amounts in APMs be set at levels adequate to support the maintenance and use of such registries.** Clinical registries were developed with specialty-specific expertise and have consistently proven to be one of the most clinically relevant and up-to-date quality data collection methods. In addition, the specialty societies that maintain these registries also refine and develop new evidence-based best practices based on what the registry data show about how outcomes vary across different patient populations. This helps to address health inequities and improve overall population health outcomes. However, this process requires significant time and money, and it will be difficult or impossible to sustain these registries if CMS does not adequately support their use in both MIPS and APMs.

F. Payment Methodology and Structure

As noted in the RFI, all of the current CMMI episode payment models are designed using the same basic approach – physicians and others who are part of the models are paid the same amounts for the same sets of services as those who are not participating in the models, and then, a year or more later, model

participants may either receive a bonus or be required to pay a penalty based on whether CMS determines that spending has decreased or increased relative to a target amount that CMS has chosen. As multiple evaluations have shown, this "incentive" approach has not resulted in significant savings or improvements in quality, except for savings on joint replacement episodes in communities where there had been unnecessary use of institutional rehabilitation following hospital discharge. Moreover, as the RFI indicates, the complex and varying methodologies CMS has used to implement this approach has caused many challenges for physicians who participate in these models.

Fortunately, the incentive approach CMMI has used to date is not the only way to structure episode payment models. **In light of the limited Medicare savings and quality improvement achieved under the current CMMI models, the challenges participants have faced, and the fact that current approaches have discouraged or prevented participation by many eligible physician practices, it is clearly time for CMMI to test different approaches to episode payments.**

Although the RFI indicates that CMMI is considering changes to its approach, we do not see why what is described in the RFI as a "value-based purchasing" framework would be better, and it seems likely that it would be worse. The approach described in the RFI appears to merely deliver the current incentive payments in a different way, with no changes in either the payment method when services are first delivered or in the method used to calculate the incentive payments. Moreover, increasing all of the payment rates for individual services that participants deliver in the future rather than providing a lump sum payment they can use to cover costs they have incurred in the past would cause cash flow problems for APM participants and create even greater complexity for both physicians and CMS.

We recommend that CMS consider a different approach to episode payment models in which physicians and physician-led teams would receive a prospective bundled payment or prospective payment amount designed to support delivery of appropriate, evidence-based services to patients who have a specific health condition or who are receiving a particular procedure. If a physician or team chose to participate in this payment model, it would agree to accept the prospective payment amount rather than the amounts Medicare normally pays for the individual services that are delivered to the patients for the condition or procedure. The amount of the payment should be determined jointly by the teams and CMS in order to ensure 1) that the payment is adequate to cover all of the costs the teams will incur in delivering the services, and 2) that the payment will be lower than the aggregate of what CMS has typically spent in the past on the services used to treat the condition or deliver the procedure.

After setting an adequate initial payment amount, **the payments should be increased annually based on the Medicare Economic Index (MEI) in order to ensure they continue to cover the costs of delivering services. Payments should also be adjusted for differences in supply costs and wage rates in different geographic areas.** Payments should never be revised downward in order to increase Medicare savings if the costs of delivering services have not decreased.

Under this approach, physicians would know how much they would be paid before they deliver care to a patient, and they would receive that payment promptly following the delivery of services. They would no longer need to wait a year or more for CMS to complete a reconciliation process, determine a final payment amount, and make supplemental payments, as is done today. This would make it easier for small, rural, and safety net practices to participate. This approach to payment is similar to what is already done for hospitals in the Inpatient Prospective Payment System (IPPS) and the Outpatient Prospective Payment System (OPPS), i.e., hospitals know before they deliver services exactly how much they will be paid for their services, and they have flexibility to deliver care in different ways within the boundaries of the bundled payments. Also, the payment amounts in IPPS and OPPS are updated each year based on

inflation, not based on calculations of whether the amounts are more or less than what CMS would have spent under a different or previous payment system.

Importantly, in order to ensure health equity, payments in any new APM should be higher for patients who need more services or who have a greater risk of complications. The difference in payment amounts should be based on the difference in the costs of delivering the services the patients need and treating unavoidable complications, not based on risk adjustment systems designed solely to predict total Medicare spending.

Examples of this approach can be seen in many of the physician-defined payment models that have already been developed, several of which were described earlier. CMS can and should proceed quickly to test this payment approach using these physician-developed models as a starting point, rather than trying to develop brand-new models on its own.

G. Model Overlap

The majority of the problems of duplicate payments and model overlap that are described in the RFI can be traced back to the way CMS has conceptualized APMs as retrospective "incentives" because it is difficult to determine exactly who is responsible for savings or increases in costs. **In order to avoid overlap problems, CMS should instead implement physician-designed episode payment models that use prospectively-defined payments.**

Value-based payment models can have a positive cumulative effect in terms of achieving optimal quality and cost outcomes. In some (but not all) cases, condition or specialty-specific episode payment models can achieve even greater savings when operating within and receiving support from a larger value-based entity such as an ACO. In these cases, CMS should welcome physician-developed payment models that would enable physicians to deliver higher quality of care to patients with lower spending for Medicare. If the episode payments are designed in close coordination with physicians to ensure the payments adequately support a different and better approach to delivering services, then CMS will receive savings for the episode, patients will receive better care, and the physician-led team will be paid adequately for the services they deliver, a win-win-win result for all patients, both those who are assigned to ACOs and those who are not. If a physician-led team believes it can only deliver lower-cost care in particular episodes if they can receive support from an ACO, or if the team believes it can accept a smaller amount of payment for the episodes if they receive support from an ACO, then CMS should pay the team the amount they have proposed for episodes associated with patients assigned to the ACO. In that case, Medicare spending will be lower on the episodes of care delivered to patients in the ACO, and the ACO will receive a share of the savings because the payments for the episodes will be lower for patients who are part of the ACO than for those who are not.

However, the specialists who are delivering services under the episodes will be paid enough to cover the cost of the services they deliver to their patients without being dependent on whether and how much the ACO receives in shared savings payments based on total spending for all of its patients. The ultimate goal of an episode payment model should be to support high-quality care for patients, not to "leverage" physicians to join an ACO, as is suggested in the RFI. If physicians can deliver better care for some or all of their patients as part of an ACO, then they will want to be part of the ACO. However, they should not be forced to join an ACO because CMS payment systems are purposefully designed to prevent them from delivering high-quality care to patients outside of ACOs.

Regarding specialty integration in APMs more generally, there is growing recognition that shared savings and "population-based" payments have not been successful in engaging specialists in care improvement initiatives or supporting better coordination between primary care physicians and specialists and, perhaps as a result, do not always result in higher-quality, more integrated care for patients. Over a year ago, CMMI asked the AMA to recommend ways of addressing these problems. In response, we developed **Payments for Accountable Specialty Care (PASC)**, a mechanism through which CMS could support the ability of physicians and Accountable Care Organizations to implement episode payments and other physician-focused payment models in a coordinated way. Details on PASC and how it could be used to improve the success of ACOs and other population-based payment models are included in the May 5, 2023 letter to the Physician-Focused Payment Model Technical Advisory Committee (PTAC) that we sent in response to PTAC's request for input on this issue.

Conclusion

Thank you for the opportunity to respond to the Request for Information. If you have any questions or would like additional information about our responses, or if we can be of assistance to you in designing and implementing episode-based payment models consistent with our recommendations, please contact Margaret Garikes, Vice President of Federal Affairs, at margaret.garikes@ama.assn.org or 202-789-7409.

Sincerely,

James L. Madara, MD