AMA
AMERICAN MEDICAL ASSOCIATION

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March 1, 2019

The Honorable Alex M. Azar, II
Secretary
U.S. Department of Health & Human Services
200 Independence Avenue, SW
Washington, DC 20201

Adam Boehler
Deputy Administrator for Quality and Innovation
Centers for Medicare & Medicaid Services
200 Independence Avenue, SW
Washington, DC 20201

Dear Secretary Azar and Deputy Administrator Boehler:

On behalf of the American Medical Association (AMA), I am writing to follow-up on the discussion at your January 31 roundtable and thank you for including our senior staff, Richard Deem and Margaret Garikes, in this important conversation. The AMA would like to work with the Department of Health and Human Services (HHS) and the Centers for Medicare & Medicaid Services (CMS) to improve the quality and affordability of health care, and these opportunities for dialogue can help to build the trust and mutual understanding needed for a successful partnership.

The AMA strongly supports the creation of a more value-based health care delivery system. We offer the following policy recommendations for CMS and HHS to consider as a means of generating more successful alternative payment models (APMs) that will achieve better outcomes for patients and more savings for Medicare.

1. **Limit Accountability to Costs and Outcomes Physicians Can Control**

Many physicians would be comfortable taking accountability for getting complex conditions under control and preventing acute exacerbations that lead to emergency visits and hospital admissions, but they are concerned about taking risk for patients' other medical conditions that are being managed outside of their organization, or costs they cannot influence like drug prices. Physicians should not be forced to choose between the fee-for-service system or an APM that places them at risk for costs that are beyond their control. APMs also need to better support outpatient specialty care and collaboration between primary care and specialist physicians to achieve accurate diagnosis and effective treatment for patients with challenging health problems. We recommend modifying the APM financial risk rules to: apply them only to a percentage of a physician practice's own service revenues; account for start-up and ongoing costs practices incur to deliver care within an APM; and establish lower risk thresholds for all small practices, not just primary care medical homes.

2. **Make Payment Models Simple but Flexible**

Simplicity is a desirable goal, but patients often have very different needs that require different approaches to treatment. Also, resources available in small communities may require different approaches to achieve the same outcomes as in large ones. One-size-fits-all models are less likely to achieve significant savings than APMs that allow services to be tailored to the unique needs of patients. We suggest developing ways to support collection of information that physicians believe has a significant impact on costs and outcomes, such as data on patients' clinical characteristics and the social or environmental challenges that patients face in accessing care or adhering to treatment plans, then using this information to create more effective risk-adjustment methods.

3. **Provide Physicians with Data Needed to Deliver High-Value Care**

It has been difficult for physicians to deliver higher-value care and succeed under APMs because they do not have access to the data needed to do so. We recommend providing easy, affordable ways for physicians to access and analyze Medicare claims data—even before they apply to participate in an APM—and establishing effective Health Information Exchanges so that physicians can identify opportunities to reduce spending, measure the impacts of care delivery changes, and quickly identify when services for patients need to be changed.

4. **Encourage APMs Developed by Practicing Clinicians**

We strongly agree with your past comments that the best ideas for improving outcomes come from those on the front lines of the health care delivery system. For this reason, we are extremely pleased to hear that CMS is working to implement multiple APMs based on the many innovative proposals developed by physicians and recommended to HHS by the Physician-Focused Payment Model Technical Advisory Committee. Nonetheless, we are concerned that the recent decision to prioritize APMs that will save at least $10 billion annually will impede specialist participation and discourage models focused on prevention. Although we agree that widespread adoption of well-designed APMs could ultimately place this level of savings within reach, we note that the recent Medicare Shared Savings regulation predicted far less than $10 billion per year in savings even after eight years of experience with this nationwide APM. Instead, we recommend that savings goals be defined relative to current spending on the health conditions or patient populations that are the focus of the model.

5. **Try Multiple Approaches**

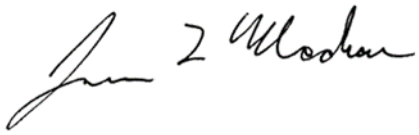
Prior to implementation, no one can predict which payment and delivery reforms will succeed. Venture capitalists involved in other types of innovations do not limit their investments to one or two start-ups; they invest in multiple companies with the hope that a few will yield big returns. Similarly, under the Medicare Modernization Act, the Bush Administration allowed physicians to design a variety of payment demonstrations, and it allowed insurers to design many different Part D drug benefit plans. We would like to work with you to create mechanisms to allow physician groups and specialty societies to help develop an array of different payment and delivery models in order to encourage innovation and more quickly identify the approaches that

will be most successful.

6. **Extend Medicare and CHIP Reauthorization Act (MACRA) APM Incentives**
   MACRA was enacted almost four years ago, but most physicians still do not have opportunities to participate in APMs that meet the criteria for the bonus payments authorized by Congress. Congress authorized these payments not just as an incentive to participate in APMs, but because it recognized the time and costs physicians will face in transitioning to APMs. MACRA only authorized six years of APM bonus payments, and the current 2019 performance period is halfway through the available time to earn them. We urge the Administration to ask Congress to extend this time period for more years so that physicians will have the opportunity to receive all of the support that Congress intended.

We hope you agree that these recommendations are both feasible and have the potential to significantly accelerate progress on the priorities you have established. We would appreciate the opportunity to work with both of you and your staffs to refine and implement them this year.

Sincerely,



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