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Jeffrey Bailet, MD
Chair, Physician-Focused Payment Model
Technical Advisory Committee
Office of the Assistant Secretary for
Planning and Evaluation
U.S. Department of Health & Human Services
200 Independence Avenue, SW
Washington, DC 20201

Dear Dr. Bailet:

On behalf of the physician and medical student members of the American Medical Association (AMA), I am writing to respond to the Physician-Focused Payment Model Technical Advisory Committee (PTAC) request for input on several topics related to its experience to date and the future direction of its work. The AMA appreciates the opportunity to provide feedback on these issues.

1. Reflecting on the issues and topics presented in the care delivery, payment model or other issues that are addressed in the proposals that PTAC has reviewed, what are the other current challenges in healthcare delivery and payment? What is needed to push forward on addressing care delivery issues and alternative payment models? Are there other actual and potential PFPMs that have not heretofore been addressed in proposals submitted to PTAC?

   The PTAC has reviewed and recommended to the Secretary of the U.S. Department of Health and Human Services (HHS) a number of excellent proposals. AMA staff have had discussions with many of the proposal submitters and nearly all of them expressed great appreciation for the PTAC's thorough review and ideas for potential refinements to the models that emerged from the PTAC process. Proposal submitters have expressed great concern, however, that their proposals have not been tested or implemented for Medicare patients.

   The AMA believes that what is needed most in order to push forward on addressing care delivery issues and alternative payment models (APMs) is for the PTAC, the Centers for Medicare & Medicaid Services (CMS), and the stakeholder organizations to develop a common set of goals and a process for working together to achieve them. Currently each group is working in isolation and they are seemingly at odds with each other more than in alignment. Stakeholders developing proposals to submit to the PTAC do not receive assistance, data, or guidance from CMS or the PTAC (although more recent submitters have been able to receive "initial feedback"), and their proposals are often criticized by the PTAC or CMS for weaknesses that could only have been addressed with help from the PTAC or CMS, such as the data needed to estimate the impacts of the proposals. CMS, principally through the Center for Medicare & Medicaid Innovation (CMMI), develops its own APMs with only limited input from physicians and other stakeholder organizations, even when APMs for similar purposes have already been submitted, reviewed, and recommended by

the PTAC. As a result, it is not clear why stakeholders should continue to submit proposals to the PTAC when there appears to be no pathway for a stakeholder-developed model to actually be tested or implemented by CMMI.

We urge that a process be established that would allow the physician community, CMS, and the PTAC to jointly agree on the aspects of Medicare services where APMs are most needed, the design components that need to be included in APMs that would enable all three entities to support them, and the types of assistance that CMS and the PTAC will provide to physicians who want to develop those types of APMs. CMMI should provide input to the PTAC early on in PTAC's review of proposals, including any considerations that would affect CMMI's ability to implement proposed APMs. The PTAC should provide stakeholders with access to data and expert advice while a proposal is being developed rather than after it has already been completed. It would also be desirable for the CMS Office of the Actuary to help with estimates of the potential Medicare savings that proposed APMs could achieve.

The AMA recommends that the PTAC and CMMI work together with the physician community to revisit the proposals that previously have been recommended to HHS by the PTAC. The need for these APMs has not diminished. The PTAC, CMMI, and the proposals' developers should re-examine each recommendation and determine what areas need to be revised or further developed and how the models could be implemented in some way in the Medicare program. In nearly every proposal review, the PTAC has found that the submitters have identified a significant gap in care delivery and/or payment. These gaps in care delivery and payment still exist, and well-designed APMs are needed to address them. The PTAC has recommended the kinds of refinements that are needed in many proposals, so rather than simply calling for more proposals, PTAC should also help revise those that have already been recommended, and work with CMMI to ensure they are implemented successfully.

2. Reflecting on the issues and topics presented in the proposals submitted, in addition to the evaluative criteria, what other factors are those that stakeholders believe would be important to take into consideration to inform PTAC's evaluation of proposals, including factors related to engagement and adoption of models? For example, what attributes may serve to facilitate or act as barriers in the adoption and engagement in models for rural and small practices as well as large integrated delivery systems?

   The problems that led to the creation of the PTAC–a lack of APMs focused on particular conditions, and a lack of APMs in which specialists and small practices can participate–still exist today, so it should be a priority for PTAC to encourage both the submission and implementation of APMs that address these gaps. The current public health emergency has heightened awareness of how difficult it is to sustain practices with a payment system that is based on billing of fragmented, individual in-person services. It is also difficult to appropriately manage patient care with this type of payment system. Several of the proposals that have been submitted to PTAC would have created payment systems that would have given practices more flexibility and more stable revenues, and so we urge that PTAC give greater weight to these considerations in reviews of future proposals and also to revisit its earlier recommendations in some cases.

   The AMA believes that the PTAC has given too much weight in its reviews to the amount of downside financial risk that would be imposed on physician participants under an APM instead of on

the ability of the APM to eliminate barriers in the current payment system that prevent physicians from implementing more cost-effective approaches to care. APMs in which physicians take accountability for keeping patients healthier and avoiding disease progression and complications could potentially achieve significant savings for Medicare, but it is inappropriate to expect physicians to guarantee the savings themselves.

Two areas that warrant greater attention are risk stratification of patients and how to implement proposed models. Current risk adjustment systems do not take into account many factors that significantly affect the complexity of managing patient care, such as functional status, access to a caregiver in the home, nutrition, genomics, and social determinants of health. The PTAC could help physicians improve APMs by supporting development of better data and tools for risk adjustment in APMs. Also, since PTAC has raised concerns about the complexity of proposals, it should examine how it can assist physicians and CMS to operationalize and implement effective models.

3. How might a proposed PFPM build on the learnings from earlier models?

   It is impossible to learn anything from previous proposals until they are implemented. As recommended above, the PTAC should work with CMS to find ways to implement the proposals that have been recommended.

4. How might care models that are included in the proposals reviewed by PTAC be incorporated in broader models, like Accountable Care Organizations (ACOs)? Direct Contracting? What factors would be important to take into consideration, such as barriers or facilitating factors for adoption?

   Patient attribution can make it difficult to incorporate proposals in broad models like ACOs. Attribution in ACOs is based on primary care services, so in a model focused on a condition managed by a specialist-led team, the team's patients might not be attributed to the ACO even if the model participants were part of the ACO. Also, the AMA recommends that the PTAC give stronger support to models designed to support physicians who are not part of ACOs.

The AMA appreciates the opportunity to share our views regarding the future direction of the PTAC's work and thanks the committee for its consideration of our recommendations. If you have any questions please contact Margaret Garikes, Vice President of Federal Affairs, at margaret.garikes@ama-assn.org or 202-789-7409.

Sincerely,

James L. Madara, MD