AMA
AMERICAN MEDICAL ASSOCIATION

James L. Madara, MD
CEO, EXECUTIVE VICE PRESIDENT

james.madara@ama-assn.org

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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 and Human Services
200 Independence Avenue, SW
Washington, DC 20201

RE: Request for Public Input on Care Coordination and Physician-Focused Payment Models

Dear Dr. Bailet:

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 the role of care coordination in the context of Physician-Focused Payment Models (PFPMs) to the Physician-Focused Payment Model Technical Advisory Committee (PTAC). When patients have multiple or complex health conditions and require services from multiple physicians and/or other health professionals, those services should be coordinated to avoid gaps, duplication, and conflicts in patient care. Effective coordination requires more than just a willingness by a physician to coordinate care; it requires that the physician assume the responsibility for making that coordination happen. This responsibility requires significant time and effort by the coordinating physician and the practice staff, as well as the other members of the care team.

Unfortunately, the current fee-for-service (FFS) system does not provide payment sufficient to support the time required to provide this type of care coordination. Moreover, even though one of the goals of creating Accountable Care Organizations (ACOs) is to improve care coordination, the Medicare Shared Savings Program does not provide enhanced payments to support care coordination. Rather than paying a physician to coordinate care, many ACOs and health plans have hired care coordinators and care managers to perform this function. As Dr. Sachin Jain observed during PTAC's June 10 meeting, these care coordinators are typically "strangers" that have no established relationship with the patient and are first introduced during what is already likely a highly stressful time for the patient. Additionally, these care coordinators may have no relationship with the physician and no ability to change the way the patient receives services. As a result, this approach can add another layer of services that may complicate care.

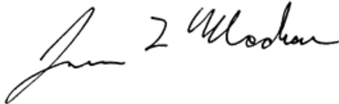
In addition, if one or more of the services a patient receives is not adequate or appropriate to meet their needs, coordination will not solve the problem. There are many situations in which there are inadequate payments in either standard FFS or alternative payment models (APMs) to support the services that a patient needs (such as home-based care, transportation to physician offices, palliative care, etc). In some cases, a patient is forced to receive multiple uncoordinated services because there is no payment for the single, coordinated service. The solution is to pay for the service the patient actually needs rather than trying to coordinate less-than-ideal services.

The PFPMs that physicians developed and submitted to PTAC are designed to address the specific barriers in the current payment system that prevent a patient from receiving the best care at the most

affordable cost. As PTAC's review demonstrated, most of these models include provisions for care coordination. By design, physicians proposed ways to provide coordination as an integral part of the patient's care, rather than as a separate program.

The AMA urges the PTAC to strongly advocate for implementation of the PFPMs it has already recommended without delay—doing so is one of the best ways to ensure the delivery of better, more coordinated care for Medicare beneficiaries. We thank the Committee for the opportunity to comment.

Sincerely,



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