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RE: Request for Information on Specialty Practitioner Payment Model Opportunities

Dear Dr. Conway:

The American Medical Association (AMA) appreciates the opportunity to provide our comments regarding the Center for Medicare & Medicaid Innovation (CMMI) Request for Information (RFI) on Specialty Practitioner Payment Model Opportunities. The AMA is gratified that CMMI has issued this RFI and pleased that the agency is seeking ways to support specialty physician efforts to identify opportunities to improve patient care while lowering health care costs.

AMA leaders and staff have been working for many months with the leaders and staff of national physician specialty societies to: identify ways that patient care can be improved and health care spending can be reduced; identify the barriers that exist within current payment systems to making those care changes; and develop payment models that overcome those barriers and give physicians appropriate flexibility and accountability to deliver higher quality, lower cost care. Our discussions with the specialty societies focus on the ways that physicians in their specialty could improve care for the different types of health conditions and episodes of care that they commonly see in their patients. We believe that if physicians in each specialty are given the opportunity to implement new payment and delivery models that are appropriate for a subset of their patients, they can more easily acquire the skill, experience, and confidence needed to prepare them to support payment and delivery reforms for larger proportions of their patient population over time. We are confident that, if CMMI implements an appropriately designed process of soliciting new payment models, it will receive a number of promising proposals that could rapidly help to reduce Medicare spending growth while improving patient outcomes.

The different types of health conditions managed by specialists may number in the hundreds, even thousands, and each has its own unique issues associated with diagnosis and treatment. Nevertheless, the barriers in the current payment system that specialists face in improving care for these diverse conditions have many common elements. Consequently, we believe that a relatively small number of different types of payment reforms can be developed that will be applicable to a broad range of specialties and the majority of patients within each specialty. The AMA is assisting specialties to define new payment models in common ways so it will be administratively easier for CMS and private payers to implement

these payment changes, and also to reduce the likelihood that patients will fall into the gaps between different models, or, conversely, the likelihood of double-counting savings. We have also been assisting physician groups and specialty societies to find partner organizations, such as Regional Health Improvement Collaboratives (RHICs) and other Medicare Qualified Entities. These partners can help obtain and analyze data on the conditions or episodes of care that particular specialists are addressing. In turn, that data can show the business case for payment reform, inform selection of quality measures reassuring patients that cost savings are not coming at the expense of high-quality care, and lead to connections with employers, health plans, hospitals, and other stakeholders whose participation and support is essential to successfully implement the models.

The AMA is committed to continuing to assist physicians and specialty societies in their efforts to develop and successfully implement accountable payment models. We would be pleased to work with CMMI to facilitate further discussions with physician groups and specialty societies, review drafts or concept papers, and help connect specialties to others who can help further the development of these models, obtain and analyze data, provide technical assistance, identify pilot sites, and solve implementation problems.

Recommendations for Supporting Specialty Payment Model Development

1. **Provide as many options as possible, with flexibility to submit options for the most innovative concepts.**

We commend CMMI for the flexibility it has provided in several recent solicitations. In the Bundled Payments for Care Improvement (BPCI) program, CMMI gave interested applicants a choice of four different types of payment models from which they could select. It also permitted applicants to indicate which specific conditions or procedures they wanted to focus on, the length of the episode to be included in the bundled payment, and the target price. The Health Care Innovation Awards are allowing applicants even greater flexibility to develop innovative proposals that would improve care and lower costs and that could be deployed within six months of the award. In addition, the BPCI program allowed non-provider organizations to serve as conveners, so that organizations with expertise in data analysis, payment, and proposal development could use those skills to help physicians and other providers develop and submit successful proposals.

The AMA recommends that any forthcoming requests for proposals (RFPs) for specialty payment models build upon the successful, flexible approaches used in these other solicitations. The specialists who take care of patients with particular conditions are in the best position to know what opportunities exist to improve care and what barriers prevent them from adopting these improvements within the current payment system. We urge that physician groups, Independent Practice Associations, and specialty societies be permitted to submit proposals to modify care delivery and payment for whichever health conditions or episodes they feel will benefit patients most, and to define payment models that will address the key barriers in the current payment system without placing unnecessary risk or financial burden on physicians. We also urge that medical specialty societies and multi-stakeholder RHICs be explicitly permitted to submit proposals on behalf of physician groups.

2. Obtain input on a draft RFP before it is finalized, provide adequate time to respond, and provide multiple windows for applications.

We urge that CMMI:

- Circulate each draft RFP to obtain input from the physician community on the particular application requirements before they are finalized.
- Provide as much advance notice as possible as to when an RFP is likely to be issued, so that interested physician groups, specialty societies and others can begin preparing to respond.
- Set realistic deadlines for submission of proposals. It is unreasonable to expect busy physicians to put together a proposal for a complex payment model within weeks of learning that an RFP has been issued.
- Allow multiple rounds of applications, rather than a single window for applications. More high-quality applications will be submitted, and the administrative burden on CMMI will be lower, if physicians and specialty societies can have adequate time to submit a well-developed, thorough, and detailed proposal.

3. Permit three types of responses to RFPs.

To facilitate this process, we recommend that CMMI solicit three different types of proposals during this process:

- Grants: For applicants that need grant funding to subsidize upfront costs, a competitive process for grant awards could be established similar to the Health Care Innovation Awards, ideally with two or more application windows.

- Noncompetitive Awards: For applicants that are seeking Medicare support for a new payment model, but no grant funds are needed, a noncompetitive process should be used with multiple, rolling deadlines for proposals to be reviewed. Such an approach would allow specialty societies and physician organizations to submit their applications as their models are developed, with models for a growing number of conditions approved over time.

- Planning Awards: A third type of award could be established for payment reform models that need additional analysis or research to reach the point where a proposal for either of the first two categories could be developed and submitted. In these cases, CMMI could agree to provide assistance in analyzing Medicare claims data and/or a small amount of grant funds to enable the applicant to purchase technical assistance to develop a proposal, with no guarantee that the proposal would ultimately be funded. This would be analogous to Model Design Awards and Model Pre-Testing Awards in the State Innovation Models program.

4. Provide Medicare claims data to assist applicants in preparing proposals.

CMMI should also work to provide data and basic analysis to those developing applications (physicians, physician organizations, specialty societies, etc.) to assist them in outlining the details of their proposals. The agency should not wait until after proposals have been approved to provide this data.

5. Provide rapid feedback on proposals.

Rapid feedback to applicants on their proposals is extremely important. Most physician groups and specialty societies have little to no experience in designing payment models or submitting proposals to CMMI. For those proposals that are not seeking grant funds and, therefore, do not need to be reviewed in a competitive fashion, we recommend that CMMI conduct an initial review of these applications soon after they are submitted, provide feedback to applicants on major weaknesses in their applications, and then allow them to submit revised proposals within a reasonable period of time.

6. Allow flexibility to adapt payment models to diverse practice settings and resources.

It is very important for CMMI to recognize that physicians provide care in a wide variety of settings. RFPs for payment reforms should provide flexibility for proposals designed by emergency physicians, radiologists, pathologists, home and long-term care physicians, and others, not just those in office practices or surgery. Models that promote integration between different specialties should also be encouraged.

7. Allow physician practices that propose new payment models to continue in those models as long as they wish to do so, unless there is evidence that Medicare spending is higher or quality is lower than it would have been otherwise.

In order for physicians to commit to developing or participating in a new payment model as a flexible tool to truly redesign care, they have to be confident that the new approach will continue on an ongoing basis. It is difficult, if not impossible, for physician practices to make major changes in the way care is organized for a temporary demonstration project. CMMI should provide assurances that, once new specialty payment models have been approved, they will be able to continue unless they are found to have adverse effects.

<u>Payment Models that CMMI Should Consider</u>

The RFI indicates that input is sought on procedural episodes, complex and chronic disease management episodes, and "other innovative arrangements." The AMA recommends that CMMI explicitly consider several other types of innovative arrangements, including medical management of acute conditions, uncomplicated chronic disease management, co-management by primary care and specialist teams, diagnostic episodes, and specialty-specific risk-adjusted global payments.

- **Medical management of acute conditions.** A number of acute conditions can be treated effectively by specialists using medical management rather than procedural interventions, including acute presentations of cancer, hepatitis C, stress urinary incontinence, and age-related macular degeneration. Under the current payment system, specialists can be financially penalized for spending the time needed to design and monitor a program of medical therapy or to treat patients with medical management instead of procedural episodes, even though the total costs to Medicare are generally higher for procedural episodes than for medical management due to the high facility and other costs involved. Episode payments designed around procedures and payments for patients with

chronic disease do not address these opportunities. By providing better support for specialist treatment planning and medical management of acute conditions, new payment models could increase utilization of less invasive and less expensive treatment options.

- **Uncomplicated chronic disease management.** Patients with "complex" conditions and multiple chronic diseases incur some of the highest amounts of spending and provide significant opportunities for savings. However, focusing narrowly on these patients misses the opportunity to prevent individuals from reaching this stage in the first place. There are significant opportunities to improve care and lower costs for patients who have not yet developed multiple chronic conditions nor developed the comorbidities that make them "complex" patients. New payment and delivery models should also be supported for patients with single chronic diseases, such as stable ischemic heart disease, inflammatory bowel disease, open-angle glaucoma, and chronic obstructive pulmonary disease.

- **Co-management by primary care and specialist teams.** There are many opportunities to improve diagnosis, treatment, and care coordination by facilitating more timely interactions between primary care physicians and specialists, yet current payment systems pay only for office visits by patients, not phone calls or electronic communications among physicians. New payment models could support "medical neighborhood" consultations that would allow primary care and specialist teams to better manage test orders and referrals. For example, there are already some initiatives involving psychiatrists and primary care physicians working in concert to manage patients with depression and other chronic conditions. Similar approaches might be employed in managing patients with diabetes or recurrent urinary tract infections. A variation on this approach would be a payment model for multidisciplinary teams of surgeons, oncologists, and primary care physicians caring for patients with ovarian, endometrial, and breast cancers.

- **Diagnostic episodes.** Discussions of bundling episodes generally focus on a particular procedure or treatment for a certain condition. However, the appropriate treatment depends heavily on having an accurate and timely diagnosis. Under current payment systems, physicians can be penalized financially for using fewer and/or less expensive tests to quickly and accurately arrive at an appropriate diagnosis. And patients can be harmed when prior authorization systems or coverage decisions make it difficult for them to get the most appropriate test in a timely manner. Consequently, different payment models are needed that provide physicians with the necessary flexibility and financial reward consistent with selection of the most appropriate tests needed for rapid and accurate diagnosis, and remove barriers for patient access to timely diagnosis.

- **Specialty-specific risk-adjusted global payments.** Larger physician practices and multi-specialty groups should be given the opportunity to design comprehensive, specialty-specific or condition-specific global payments that would cover all the services needed to treat a specified condition that is managed by the specialty. These could include the management of patients with epilepsy, or the creation and maintenance of arterio-venous fistulas for patients with chronic kidney disease requiring hemodialysis.

Key Elements of All Specialty Payment Models

If CMMI decides to propose specific payment models for consideration by physicians, we urge that these models have the following characteristics:

- **Flexibility to change the way care is delivered.** It is essential that any payment model offered by CMMI provide the necessary flexibility to physicians to deliver care in the most effective, efficient way possible without suffering inappropriate financial penalties. Unfortunately, we do not believe that typical "shared savings" models achieve this, because they do not make any modification in the underlying payment systems that allow a new or different mix of services to be offered to patients, in a financially feasible manner.

- **Accountability for costs and quality directly related to what the physician can influence.** Measures of the quality and costs of care associated with the payment model should be directly related to the specific types of care the physician is providing under that model. It is not appropriate to hold physicians accountable for the total cost of care when their control and influence are limited to one condition or procedure. Nor should physicians be held accountable for quality measures in areas they cannot influence.

- **Adequate, sustainable payment to cover achievable costs.** Payment levels in new models need to be grounded in analysis of data on costs and utilization. There must be adequate, sustainable funding for the care being provided under the model. Any expectations about savings from reductions in utilization need to be realistic and achievable. Payments should be defined in advance, not based on after-the-fact savings calculations. While expectations about savings may increase over time and build upon initial success rates, payment levels under the models should not be rebased every few years in ways that could undercut investments that physicians made to implement changes. Many physician practices have made significant investments to support current care models. Additional costs will be incurred in order to redesign the way care is delivered. Payment rates must provide physician practices sufficient revenue to cover both past and new investments.

- **Protection for physicians from insurance risk.** It is essential that payments be risk-adjusted to account for patients with different illness burdens. There should also be limits on the aggregate costs that physicians are responsible for with respect to any individual patient. Physicians should not be placed at financial risk for caring for patients who have health problems that need more care or more expensive care, or for patients with unusual problems that are not addressed by risk-adjustment models. Moreover, physicians should not be at financial risk for choices that are made by patients or other providers, such as hospitals or long-term care providers.

- **Phase-in of performance risk and adjustment of financial risk for smaller practices.** New specialty payment models should phase in financial risk for physicians and recognize the need for upfront transition costs. Narrower limits should be placed on upside and downside performance risk for smaller practices.

- **Realistic standards of performance.** The specialty payment models initiative should build upon lessons from previous reforms. For example, prices for bundles should incorporate realistic estimates of the number of times a service will be provided in a higher cost setting or a more expensive treatment plan will be indicated, and recognize that adverse events like readmissions will likely still occur, albeit at a lower rate. Quality measures also need to have realistic standards for improvement or outcomes based on what others have actually achieved. Any standards for the structure of practices, the processes they must use, or the accreditation requirements they must meet in order to participate in new payment models need to be based on evidence that those standards are necessary to deliver appropriate care.

- **Mutual, voluntary participation by patients and physicians.** As described in the AMA response to the Request for Information on Accountable Care Organizations, instead of attributing patients to physicians or organizations based on statistical rules, patients should be asked to voluntarily designate the specialist physician who is managing their disease or condition.

- **Frequent, timely, accurate feedback on performance.** Finally, the success of the specialty payment models will depend heavily on the providing timely, accurate data to enable physicians to benchmark and track the utilization and costs of their patients who are participating in the new models.

Based upon our ongoing discussions with specialty societies, the AMA anticipates that CMMI will receive many innovative proposals for better managing patient conditions and episodes of care if it invites a broad range of models rather than trying to pre-define a few models in advance. We recognize that CMMI may be concerned about its ability to implement a large number of different models. But we believe that a small number of generic models could encompass most of the concepts that will be proposed. **We would recommend that CMMI consider a two-step application process, similar to what was used with the BPCI. Rather than asking for extremely detailed proposals initially, CMMI should initially ask physicians and specialty societies to submit concept papers; then work with the AMA and the applicants to develop a feasible number of payment model categories that encompass as many of the concepts as possible; and subsequently invite more detailed applications.**

Responses to Specific Questions Posed in the RFI

Which procedures or conditions should be considered: We recommend that CMMI invite proposals or concept papers for any conditions or procedures where there is interest among specialty physicians in improving patient care in ways that cannot be supported under the current payment system. Specialty models should not be limited to particular specialties or high cost Medicare conditions. In some cases, a model that is developed for a disease that is not highly prevalent in the Medicare population will be able to be refined for use with more prevalent and expensive conditions in the future.

Whether accountability for drugs should be included: The most promising areas for new models are likely to be those where the physician has the most influence over treatment planning, costs and outcomes. Physicians in a new model may be comfortable taking accountability for the choice of which drugs to prescribe or administer. However, physicians should not be held accountable for drug prices, nor for patient adherence to medication regimens, both of which are beyond physician control.

Whether condition-based payment models should be considered: Condition-based payment models with multiple treatment options are under discussion by several specialties. This would be a good model for Medicare for those conditions where the physician can determine which treatment is selected and the payments can be risk adjusted based upon patient needs.

What will influence practitioner decisions to participate: Numerous factors will influence physician decisions about participation in the new specialty models. There is likely to be greater physician participation if:

- Physicians have data allowing them to assess the financial impacts in advance.
- Payment rates are set in advance based upon current costs and pre-defined savings targets.
- Timely data and feedback will be available to monitor performance.

- Risk corridors are established with higher degrees of performance risk phased in.
- Physicians are assured that rules will not change midstream without their input.
- Regulatory and antitrust barriers are waived to allow freedom in contracting and compensation decisions and negotiations.
- Physicians know they will be able to continue in the model for as long as it works for their practice and their patients.

The AMA urges the agency to give serious consideration to the comments on this RFI from the national physician specialty societies. We look forward to CMMI initiating a new program of specialty payment models and appreciate the opportunity to provide our input.

Sincerely,

James L. Madara, MD