AMA
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The Honorable Alex M. Azar, II
Secretary
U.S. Department of Health and Human Services
Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201

Dear Secretary Azar:

On behalf of the physician and medical student members of the American Medical Association (AMA), I write to thank the Department of Health and Human Services (HHS) for its letter of June 13 responding to the recommendations from the Physician-focused Payment Model Technical Advisory Committee (PTAC). The AMA is disappointed that HHS does not want to test the alternative payment models (APMs) that PTAC recommended and we urge the department to reconsider.

The physician-developed, PTAC-recommended APMs are designed to lower costs and improve care for patients with needs ranging from primary care to renal disease to palliative care. Instead of committing to work with PTAC and the proposal developers to refine and test these models, the response indicates that the Centers for Medicare & Medicaid Services (CMS) continues to explore designing its own models, which may address some of the same patient needs that are addressed in the PTAC-recommended APMs.

We are especially concerned because the statute to reform Medicare physician payment provided only six years of bonus payments to facilitate physicians' migration to APMs. We are approaching the three-year mark for the initial implementation and there is still not a robust APM pathway for physicians.

The AMA views the large number of good proposals that have been developed by physicians and submitted to PTAC as evidence that physicians embrace APMs if they are designed in ways that improve care for patients and are feasible for physicians to implement, in addition to saving money for Medicare. Your letter states that "the best ideas for improving outcomes often come from individuals and organizations on the front lines of the health care delivery system." The AMA strongly agrees, and the 10 models recommended by PTAC were developed by those frontline physicians and withstood rigorous review by PTAC. Although HHS acknowledges that models are needed for palliative care and home hospitalization, the letter says that the department is not willing to implement the specific models that physicians developed and that PTAC agreed were meritorious. We are concerned that this will send a discouraging signal to the physicians who worked to develop the current proposals and their colleagues who want to participate in physician-focused APMs. In addition, other physician groups and specialty societies may find it difficult to justify continuing their efforts to develop APM proposals to submit to PTAC if there is little reason to believe they will actually be implemented for Medicare patients.

We recognize that the APMs recommended by PTAC needed some refinements. The physicians and organizations that designed the models did not have access to CMS data, and most have not yet had an

opportunity to pilot test their models. Data and pilot test experience likely would help in addressing some of the concerns raised by both PTAC and HHS. PTAC indicated in its recommendations to HHS that it felt the issues it had identified could be resolved with assistance from CMS. Moreover, PTAC concluded that the positive attributes of the APM proposals outweighed the concerns they had identified, but the department does not seem to agree with that assessment.

We strongly urge HHS to re-evaluate the APM proposals that were recommended by PTAC, giving greater weight to the benefits they would create and making a commitment to help these pioneering applicants make the changes needed to address the technical issues HHS has identified. A more detailed explanation of our concerns with the HHS response to several of the proposed APMs is provided below.

Hospital at Home

The proposed payment model submitted by the Icahn School of Medicine at Mount Sinai would enable many patients who would otherwise be admitted to a hospital for acute care to instead receive the care in their own homes. Australia and other countries have used similar programs to save money and improve patient outcomes. The APM is based on a pilot project that CMS supported with a Health Care Innovation Award. That project has produced savings for Medicare and better care for patients, but since there is no way to sustain the services under the current Medicare payment system or to expand the services to other sites, the proposed physician-focused APM would both continue the Mount Sinai program and support nationwide implementation of the same approach.

The PTAC letter recommending this APM "recognizes several strengths" of the model, but the HHS letter simply states that "we will not implement this model as proposed." The rejection seems to be based on an assertion that participants in the model would not be accountable for readmissions, emergency department visits, and other services, even though that accountability is clearly described in the model, i.e., "these services would be included in the measure of spending used for calculating shared savings/losses."

A different APM to support similar services was jointly submitted by the Marshfield Clinic and Contessa Health, based on a successful program they have implemented through Medicare Advantage plans but cannot expand to patients in traditional Medicare without an APM to provide payment support. In recommending implementation of this model, PTAC stated that both APMs focusing on delivering hospital-level services in the home provide flexibility for different types of physician practices to implement the services in different communities. The HHS letter commits only to have "discussions on future payment models." In our view, it seems that adapting a successful Medicare Advantage model to the Medicare fee-for-service program should be among the more straightforward approaches for the department to consider.

End-Stage Renal Disease (ESRD)

The PTAC-recommended payment model developed by the Renal Physicians Association (RPA) aims to reduce costs and improve care for patients on dialysis. CMS has already demonstrated the potential for significant savings for care of ESRD patients through its Comprehensive ESRD Care Model, but only 10 percent of nephrologists are able to participate in that program.

We think that there may be some confusion about how many patients are already insured by Medicare due to their age or disability when they develop ESRD, as the letter states that "there may only be a small

number of beneficiaries eligible under the criteria proposed." When PTAC examined this issue, it found that approximately 45,000 patients who had already been receiving Medicare benefits started dialysis each year. In 2016, Medicare spent an average of $41,000 on these patients during the six months following initiation of dialysis, which represents about $1.8 billion in annual Medicare spending. In contrast, the total annual spending for patients currently participating in the CMS Comprehensive ESRD Care model is about $1.4 billion. This suggests that the RPA APM could have a significant impact.

Palliative Care

PTAC recommended two palliative care services proposals to help primary care physicians and specialists ensure that their patients with advanced illnesses receive better, lower-cost care. The importance of these models was recently cited by former Senators Bill Frist and Tom Daschle in a column in The Hill.

Although it is good news for patients and palliative care providers that the department is exploring development of a palliative care payment model, we believe that Congress intended for stakeholder-developed, PTAC-recommended APMs to be considered for implementation on their own merits, not just to be one of many considerations used by CMS in developing its own models. CMS and the Center for Medicare and Medicaid Innovation (CMMI) have always had the ability to solicit input from practicing physicians. In the past, however, specialty societies have expressed frustration that their discussions with CMMI have not led to their APM ideas being tested for Medicare patients. It seems to us that Congress envisioned a different result when it created PTAC.

We were also surprised by the statements that eligibility requirements have to be "aligned with Medicare administrative data" and that "clinician assessment-based criteria would be difficult for CMS to verify." Information on patient diagnoses that is critical for many aspects of CMS payment systems is present in CMS administrative data today because physicians have determined those diagnoses and recorded them on Medicare claim forms. Since functional and nutritional status are important factors in determining the amount and type of palliative care patients need, it would be inappropriate to limit the data used in these APMs to the information currently in CMS administrative data. As described in the proposals, physicians would provide information about functional and nutritional status, and one of the strengths that the AMA noted in its letter of support for the proposal from the American Academy of Hospice and Palliative Medicine is its use of the Palliative Performance Scale.

Specialty Medical Homes

The first payment model PTAC recommended was a payment model developed by frontline physicians—an independent gastroenterology practice, the Illinois Gastroenterology Group (IGG). The gastroenterologists in the practice have demonstrated that they can help their patients with Crohn's Disease avoid hospitalizations by using nurse care managers to provide proactive outreach to the patients as part of what they called "Project Sonar." However, this service cannot be supported under the current fee-for-service system. Illinois Blue Cross Blue Shield provides monthly payments to IGG to support the proactive outreach to patients and care management between visits because it helps patients and reduces overall spending by the health plan, but the Medicare Fee Schedule payments are not adequate to support the service, which is why IGG developed a Medicare APM and submitted it to PTAC.

PTAC recommended that the IGG model be tested in Medicare, but then-Secretary Price stated that CMS would not test the model due to a concern also noted in the current HHS letter that the proposal "mainly

involve[s] testing … proprietary technology." PTAC had already confirmed that this APM can support multiple methods of proactive patient outreach, including traditional telephone contacts, and is not reliant on the specific technology that IGG has been using. In a meeting with the submitter at CMMI in which the AMA participated, CMMI staff outlined how the IGG model could be used to develop modules that would improve care for patients with a number of different chronic diseases, or with multiple diseases, potentially achieving significant savings for the Medicare Trust Fund. To date, however, neither the IGG model nor anything similar has been implemented by CMS.

Additional Comments

The HHS June 13 letter also indicates that "CMS would not implement a model that pays physicians solely for … following established guidelines for care." The statutory authorization for CMMI states: "The Secretary shall select models to be tested from models where the Secretary determines 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." We do not believe that physicians need incentives to deliver high quality care; they need APMs to remove the barriers they face to doing so. APMs that give physicians adequate resources and flexibility to deliver evidence-based care are the best way to reduce spending for Medicare without harming patients.

Finally, we were surprised at the letter's comment regarding the lack of interest in limited-scale testing since the Request for Information on a "new direction" for CMMI specifically sought comments on "Small Scale Testing." Comments submitted by the AMA and other organizations said that CMS should adopt a "rapid prototyping" approach that assumes every model that is initially tested will require some degree of refinement once there is experience with it, before it can be tested more broadly and a summative evaluation can be conducted.

Conclusion

Physicians have grown increasingly enthusiastic and even passionate about the benefits of APMs in helping them overcome the problems they and their patients face in the fee-for-service payment system. When Congress encouraged physicians to submit APM proposals and created the PTAC to review them, there was an expectation and hope that CMS would fully embrace the opportunity to pilot these innovative models. We therefore urge HHS to demonstrate its commitment to innovation and physician-led care by revisiting the proposals recommended by PTAC and implementing as many of them as possible. Thank you for considering our views.

Sincerely,

James L. Madara, MD