Informing PTAC's Review of PFPMs: We Want to Hear from You Reponses

On June 22, 2020, the Physician-Focused Payment Model Technical Advisory Committee (PTAC) requested input from the public on information that could help inform the Committee's review of future proposals. PTAC received seven responses from the following stakeholders that are listed below in the order in which their responses were received:

1. American Academy of Family Physicians
2. American Medical Association
3. American Academy of Neurology
4. American College of Physicians
5. As signatories to a joint letter:
    - American Academy of Allergy, Asthma & Immunology
    - American Academy of Hospice and Palliative Medicine
    - American Academy of Neurology
    - American College of Allergy, Asthma & Immunology
    - American College of Chest Physicians
    - American College of Physicians
    - American College of Rheumatology
    - American Gastroenterological Association
    - American Society for Gastrointestinal Endoscopy
    - American Society of Clinical Oncology
    - Infectious Diseases Society of America
    - Society of General Internal Medicine
    - The Society for Post-Acute and Long-Term Care Medicine
6. Coalition to Transform Advanced Care
7. American Academy of Home Care Medicine

For additional information about PTAC's request, see PTAC's solicitation of public input.

AMERICAN ACADEMY OF FAMILY PHYSICIANS

July 21, 2020

Jeffrey Bailet, MD
Committee Chair
Physician-focused Payment Model Technical Advisory Committee (PTAC)
Assistant Secretary for Planning and Evaluation (ASPE), Room 415F
U.S. Department of Health and Human Services
200 Independence Avenue, SW
Washington, D.C. 20201

Dear Dr. Bailet:

I am writing on behalf of the American Academy of Family Physicians (AAFP), which represents more than 136,700 family physicians and medical students across the country, in response to the request for public input on PTAC's review of physician-focused payment models (PFPMs). We understand PTAC is seeking additional information to further enhance its reviews and believes it is important to obtain additional input and guidance from stakeholders on what issues they believe are material to PTAC's review of proposals.

The AAFP was an early participant in the PTAC review process with our proposal for an Advanced Primary Care Alternative Payment Model (APC-APM) and remains fully supportive of the PTAC's role in evaluating PFPMs as well as ASPE in providing operational and technical support to PTAC. We are pleased to respond to this current request for public input and will address each of the questions in turn.

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 COVID-19 pandemic is the dominant, current challenge in healthcare delivery, and the accompanying challenge in payment, at least for primary care, is how to sustain a practice model dependent on fee-for-service (FFS) when the volume of patient visits has decreased by more than 50% in most cases, with telehealth services only partially compensating for that decline. We believe there is a window of opportunity to push forward in pursuit of the kind of health care system America wants and needs. What is needed to push forward in that window is to shift our focus from incremental achievements toward a better future for family medicine in favor of implementing big, substantive, consequential, and disruptive changes. We need a plan

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bold enough to fundamentally change our health care system and consequential enough that the lives of future generations will be impacted by its scope. Here is where we should start on what some are already calling the Primary Care Marshall Plan.

Our health care system is largely a top-down model in which most of the spending is allocated to the least-used services. According to Health Affairs, health care spending in 2018 was $3.6 trillion, of which physician and clinical services represented about 20%. Hospital spending represented 33% of overall spending. Best estimates are that primary care represents about 5% of overall spending.

Meanwhile, according to statistics from the Robert Graham Center for Policy Studies in Family Medicine and Primary Care for 2018, a little less than 22 million people -- about 7% of the population -- received care in a hospital compared to the more than 190 million people -- roughly 60% of the population -- who received care from a family physician. Thus, an overwhelming majority of people rely on their family physicians and other primary care clinicians, yet we invest only pennies on the dollar in our primary care system.

FFS is incapable of supporting the primary care system that our health care system needs and that patients deserve. The whole construct of FFS, and especially the resource-based relative value scale (RBRVS), has failed primary care. Primary care is comprehensive, continuous, holistic, portable and patient-centered. The RBRVS is, by design, the complete opposite. It is focused on units of care, units of time, and sites of service. Family medicine has politely whispered for years that FFS was an illogical payment construct for primary care, and the COVID-19 pandemic simply put a giant spotlight on this issue.

The pandemic has brought to light how inflexible and unresponsive our health care system has become. Prospective payment would change this. Individuals within the commercial health insurance sector have told us that capitated primary care practices are coping better and more effectively with the current crisis. Imagine if every family physician would have had an attributed panel of patients and an associated prospective payment for each when the crisis hit. Transformation from office-based to virtual workflows would have been easier and quicker. When units of care and units of time no longer get measured, providing needed care to patients becomes the focal point. And, when providing care to patients is the focal point in an APM, family medicine wins.

The concept of prospective payments is not new. The AAFP has advocated adopting this type of payment model for years, and it was a key element of the APC-APM considered by the PTAC. Our model is the foundation of the Primary Care First model that the Centers for Medicare & Medicaid Services (CMS) will implement in 2021. We also have advocated for other global/prospective value-based APMs, such as direct contracting, physician-led accountable care organizations, and direct primary care arrangements. Although it is easy to focus on what makes these models different, it is more important to focus on what makes them similar: They all depend on population-based, advance payment for primary care.

In response to the COVID-19 crisis, Medicare, like other public and private payers, has altered benefit design and begun making advance payments to family physicians. We should build on this momentum and once and for all make a major shift away from the legacy FFS system

toward a new system that prospectively pays family physicians for the continuous, comprehensive, and coordinated care they provide.

This shift in payment models should be coupled with an increased investment in primary care. Research continues to show primary care is critical to the health of individuals and improves health outcomes. Primary care helps prevent illness and death and is associated with a more equitable distribution of health in populations. Patients who identified a primary care physician as their usual source of care had lower five-year mortality rates than patients identifying a specialist physician as their usual source of care. The populations of countries with higher ratings of "primary care orientation" experience better health outcomes and incur lower health care costs than populations in countries with lower degrees of primary care orientation.

Despite these benefits, primary care spending lags in the United States compared to similar investment in most other high-income countries. Across payers, including both public and private insurance, primary care spending in the United States amounts to approximately five to eight percent of all health spending, with an even lower percentage in Medicare, compared to approximately fourteen percent of all health spending in most high-income nations. As noted, nations with greater investment in primary care reported better patient outcomes and lower health care costs, and according to a Robert Graham Center analysis, states with higher levels of primary care investment also report better patient outcomes.

Accordingly, the AAFP recommends a doubling of primary care financing to 10– 12% of total health care spending. Such an investment, combined with a major shift toward prospective payment for primary care, would pay for itself through resulting reductions in overall health spending.

Primary care APMs, such as Comprehensive Primary Care Plus (CPC+) and the planned Primary Care First (PCF), have been inadequate, because they have not represented an increased investment in primary care. For instance, CPC+ helped primary care practices into advanced primary care, but the model did not represent a substantial increase in primary care investment, and it was incredibly burdensome for participating practices. Similarly, PCF expects practices to already be advanced primary care practices before it will invest in them. Primary care APMs need to increase investment in primary care to financially support small practices as they transition to and then sustain the advanced primary care functions required to be successful in value-based payment.

Consequently, the AAFP is embarking on a three-year project to develop and implement a new APM in collaboration with a commercial health insurance plan and primary care network yet to be determined. We will be happy to share the learnings from that project with PTAC at the appropriate time.

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?

Based on our experience and observations, we believe PTAC's evaluation of proposals would be better informed by the availability of technical assistance, particularly actuarial expertise, to those submitting proposals. From our perspective those who submit proposals to PTAC do their best. However, they may not always have the data or technical capacity to address questions raised in the PTAC's evaluation process. It would be helpful if technical assistance was available through the PTAC from such sources as the Center for Medicare & Medicaid Innovation (CMMI) and CMS Actuary.

As noted, actuarial expertise would be particularly useful in this regard. The PTAC is appropriately interested in the potential impact of proposals. However, those making proposals to PTAC typically lack actuarial expertise and the necessary data to effectively model impacts. PTAC members and staff also lack that expertise and data. It would be helpful to PTAC and those proposing models to have access to actuarial data and expertise (e.g., through CMS) to support modeling needed to answer questions the PTAC has.

Another factor, especially related to engagement and adoption, is CMMI involvement and consultation up front and throughout the PTAC process. Given that CMMI will ultimately be tasked with testing any models recommended by PTAC and deemed worth testing by the Secretary of Health and Human Services, we believe it would make sense to involve and consult with CMMI upfront and throughout the PTAC process. Making such consultation and involvement at least available, if not a formal part of the process, would be an improvement from our perspective.

Lastly, the attributes that serve to facilitate the adoption of and engagement in APMs by rural and small practices as well as their large integrated delivery system counterparts are those attributes that adequately support and sustain the transition to advanced primary care functions necessary for success under value-based payment. Rural and small practices need more than mere technical assistance and a burdensome set of "do's and don'ts" to adopt and engage in an APM. They need a substantial increase in the level of investment payers are making in primary care, and they need that increased investment in the form of stable, prospective payments.

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

The AAFP was appreciative of the ability to work with the PTAC preliminary review team (PRT) assigned to our proposal and receive feedback on the APC-APM. The PRT's questions and subsequent full PTAC deliberations led to the model's evolution and improvements from original submission. We have continued to build on what we learned as we have talked with CMMI staff about other APMs, such as Primary Care First. As we prepare to build a new, primary care oriented APM, we will take what we have learned to hopefully develop a model that:

- Continues to stress prospective patient attribution
- Is simpler in design
- Relies more on prospective payment
- Limits itself to measures that matter and over which physicians have control
- Appeals to both patients, physician practices, and payers

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?

Incorporating models reviewed by PTAC into ACOs and Direct Contracting may prove challenging and must be done with careful consideration. To date, most overlap between shared savings models has impacted benchmarking calculations when including any bonus or shared savings or losses from multiple programs in total expenditures. The AAFP believes transparent benchmarking methodologies that outline the impacts between all allowable overlapping models are critical for organizations making decisions about participating in multiple models. Additionally, to facilitate meaningful participation, reduce burden, and improve evaluability, we recommended aligning quality measures where appropriate. Finally, special considerations should be made when designing the evaluation methodologies for models that allow overlap to appropriately account for the impact of potential quality improvements and cost savings realized by dual participation.

Thank you for your time and consideration of this input. If you or the ASPE staff have any questions or the AAFP may be of further assistance, please contact Mr. Kent Moore, Senior Strategist for Physician Payment at the AAFP at kmoore@aafp.org or (913) 906-6398.

Sincerely,

John Cullen, MD
Board Chair

AMA
AMERICAN MEDICAL ASSOCIATION

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July 31, 2020

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?

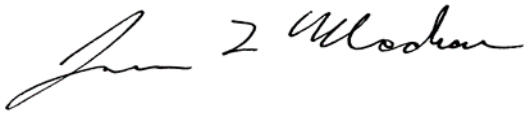
   It is impossible to learn anything from previous proposals until they are implemented. As recommended above, the PTAC should work with CMS to find ways to implement the proposals that have been recommended.

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,



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August 12, 2020

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

Dear Dr. Bailet,

On behalf of the more than 36,000 neurologists and clinical neuroscience professionals, the American Academy of Neurology (AAN) appreciates the opportunity to provide input to the Physician-Focused Payment Model Technical Advisory Committee (PTAC) on how to enhance the submission process of Physician-Focused Payment Models (PFPMs) that are reviewed by the committee.

The AAN has engaged with PTAC since its inception, including submission of a Patient-Centered Headache Care Payment model in 2017. While the AAN ultimately decided to withdraw its proposal after initial review by the PTAC's Preliminary Review Team (PRT) and has been disappointed with the lack of implementation of PTAC-recommended models by the Department of Health and Human Services, the AAN believes that PTAC guidance can facilitate the advancement of PFPMs at the federal level and positively affect physicians and other providers participating in these models. The COVID-19 pandemic has reinforced the need for provider reimbursement that does not rely solely on the current fee-for-service payment structure but instead incorporates alternative care delivery and reimbursement methodologies moving forward. We look forward to continued engagement and collaboration with PTAC in the PFPM space. In addition to our comments submitted via The American College of Physicians, we have additional responses to the questions posed by PTAC below.

1. ***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 (APMs)? Are there other actual and potential PFPMs that have not been addressed in proposals submitted?***

Reflecting on the issues and topics presented in the proposals that PTAC has reviewed over the years, the AAN perceives the ultimate challenge in PFPM development to be the lack of execution of models from which to learn. Models need sustained endorsement, administrative and financial support and an

understanding and commitment that improvement and refinement will happen over time. From our own experience and in observing others' submission experience, there is a lack of recognition from PTAC that "perfection is the enemy of good". PTAC is charged with reviewing and deliberating on physician-focused and physician-developed models, however, there has been a lack of serious consideration for these models since PTAC's inception. Given the distinct role and expertise that physicians and other providers developing these models have, it is frustrating to have models dismissed while also continuing to promote the message that physicians have the unique expertise to put forward these models. In addition to our own PTAC submission, the AAN has observed proposals from different specialties with similar aspects related to payment methodology, levels of care and care delivery workflows, therefore confirming our belief that these models are worthy of PTAC and CMMI endorsement and enactment. HHS should commit to piloting PTAC-recommended models and working with stakeholders to improve these models over time.

2. ***In addition to the evaluative criteria, what other factors would be important to take into consideration to inform PTAC's evaluation of proposals, including factors related to engagement and adoption of models? What attributes may act as barriers in adoption and engagement in models for rural and small practices, as well as large integrated delivery systems?***

Currently, neurologists lack substantive opportunities to participate in alternative payment models that meaningfully address the patients and services for which neurologists are responsible. As mentioned above, many PTAC submissions from specialty societies employ similar frameworks, suggesting applicability to various specialties. Providing scalable opportunities for specialties not previously engaged in value-based care models should be a priority for PTAC and HHS moving forward.

The disruption that physician practices experienced and continue to experience as a result of COVID-19 due to diminished fee-for-service, the rapid transition to telemedicine, the loss of income and in some cases, employment especially in small and rural practices, is unprecedented. Had PTAC-endorsed APM models previously been implemented, providers, payers and patients would have perhaps received reliable, consistent funding and care that fee-for-service could not offer during the public health emergency. PTAC should emphasize models that offer consistent payments such as the monthly payment proposed in the AAN's Headache model and many other PTAC submissions.

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

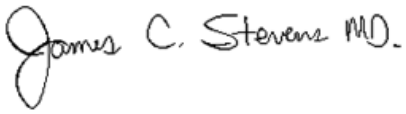
The AAN believes the integration of specialty or diseased-focused APMs into larger ACO systems could have positive implications for a given organization, its providers and patients, but must be piloted to better understand the implications of incorporating specialty APMs within an ACO. ACOs should benefit from the work specialists and others have done to develop specialty or diseased-focused APMs and use them in assessing those specialists.

In conclusion, the AAN believes that PTAC has been met with valuable, innovative proposals to provide physicians, especially those without specialty-specific opportunities for alternative

payment opportunities, since its inception. We believe that HHS must commit to providing support and implementing PTAC-recommended models, not only to continue PTAC's charge of improving the efficiency and effectiveness of the U.S. health care delivery system, but to signal that PTAC is a viable path for clinicians to meaningfully participate in value-based care models that directly apply to the care in which they provide.

Thank you for the opportunity to share the AAN's comments on PTAC's evaluation process and we look forward to continued engagement in the future. Please contact Leslie Kociemba, AAN's Care Delivery Program Manager at lkociemba@aan.com or (612) 928-6094 with comments or questions.

Sincerely,



James C. Stevens, MD, FAAN
President, American Academy of Neurology

American College of Physicians
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July 31, 2020

Jeffrey Bailet, MD
Chairman, Physician-Focused Payment Model Technical Advisory Committee
President and Chief Executive Officer, Altais

Dear Chairman Bailet,

On behalf of the American College of Physicians (ACP), I want to thank you for this opportunity to provide feedback on the Physician-Focused Payment Model Technical Advisory Committee (PTAC) in hopes of enhancing its review of physician-focused payment models (PFPMs) and informing its future recommendations to the Secretary of Health and Human Services (HHS). **The College continues its strong support of the PTAC and its mission to forward the development and implementation of private sector physician-focused payment models**.

ACP is the largest medical specialty organization and the second largest physician membership society in the United States. Our members include 163,000 internal medicine physicians (internists), related subspecialists, and medical students. Internal medicine physicians are specialists who apply scientific knowledge and clinical expertise to the diagnosis, treatment, and compassionate care of adults across the spectrum from health to complex illness.

The College collaborated with the National Committee for Quality Assurance (NCQA) to submit our own Medical Neighborhood Model (MNM) proposal,[i] which afforded us unique insights into the PTAC submission process. We wish to offer feedback informed by those experiences below. In addition to these comments, we will be sending a letter with additional feedback on behalf of numerous organizations from ACP's Subspecialty Advisory Group on Socioeconomic Affairs.

1. ***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 (APMs)? Are there other actual and potential PFPMs that have not been addressed in proposals submitted?***

As outlined in ACP's Vision for a Better Health Care System for All,[ii] ACP believes that a fundamental restructuring of health care payment and delivery in the United States is required to achieve a system that puts patients' needs first and supports physicians and their care teams to deliver high-value, patient- and family-centered care. We recommend increasing investment in primary care; aligning financial incentives to achieve better patient outcomes; reducing inequities in care; facilitating team-based care; allocating limited resources more efficiently to reduce costs; reducing unnecessarily burdensome administrative, billing, and documentation requirements; and leveraging health information technologies to enhance shared physician-patient decision making at the point of care.[iii] The College believes that APMs, particularly those designed with physicians at the center, are an increasingly important piece of a value oriented health care system. However, a fragmented implementation strategy resulting in a patchwork of varying models across payers and regions, coupled with an underlying fee-for-service (FFS) foundation that stands at odds with goals to reward value and efficiency, have limited the progress of APMs and hindered their growth to date.

ACP views the PTAC as playing a potentially invaluable role in bringing more physician-focused APMs to fruition. Unfortunately, the PTAC's influence has been limited by statutory restrictions on its authority, as well a general unwillingness from HHS to implement any PTAC-recommended models to date. ACP has previously called on HHS to work more collaboratively with PTAC and commit more resources to testing and implementing PTAC-recommended models.[iv] We continue to advocate for a more empowered Committee that is free from legislative and regulatory hurdles that hinder its ability to support stakeholders in PFPM development and offer HHS more general counsel on the subject of APM expansion, including identifying industry barriers and offering solutions to rectify competing incentives of APMs and an underlying FFS structure. We expand on these ideas in our complementary sign-on letter signed by numerous members of ACP's Subspecialty Advisory Group on Socioeconomic Affairs.

2. ***What other factors [do] 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? 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?***

ACP urges PTAC to prioritize models that 1) fill the current void of models for specialty care internists, particularly those that are scalable across a range of specialties; 2) encompass a significant portion of payments and/or patients; 3) improve continuity of care across settings; and 4) offer predictable, fixed payments. We expand on each of these points in detail below.

Fine-tuning and implementing a broader payment model that could be tailored to a multitude of specialties would quickly expand APM opportunities for specialists while streamlining development and implementation resources and mitigating potential downstream complications related to model overlap. One of the MNM's strengths is that the overall structure is general enough that it can apply to a range of specialties, while allowing for customization of quality measures. To date, HHS has largely prioritized primary care-focused and population-based models for its first wave of APMs. ACP was a strong supporter of the Comprehensive Primary Care Plus model and continues to work closely with HHS to support and improve the Medicare Shared Savings Program (MSSP) and Primary Care First Model. Now, PTAC and HHS must turn its attention to the current dearth of opportunities for specialty care internists to participate in APMs. In addition to the void of specialty-focused models, population based models fail to engage specialty care clinicians to the same extent as primary care clinicians. For example, though the MSSP does include specialty care clinicians as participants, they are not guaranteed to share in Accountable Care Organization's (ACO's) shared savings (or losses).

PTAC should give priority consideration to APMs that encompass a significant portion of payments or patients, including multi-payer models and population-based models. Of the specialty models that do exist, most are restricted to a single specialty. Many further limited to specific bundles of services. These types of models can be highly effective at improving quality and/or lowering costs for the episodes or services they target, but they inherently capture a smaller proportion of patients and services, so their impact is limited to a smaller scale. Having a significant portion of payments tied to traditional FFS can also create competing incentives and hinder a practice's ability to achieve savings under the model. When practices make the decision to invest in additional staff, build a technological infrastructure, and redesign their clinical workflows to fundamentally restructure to a holistic patient and value-driven mindset, this requires a system-wide commitment and substantial funding support. If practices receive supplemental payments to cover advanced coordination and support services for only 20 percent of their patient panel, many will not be able to afford to implement the type of system-level change that is necessary to succeed. Currently, practices must sew together a patchwork of payment arrangements

each with their own unique performance metrics and financial incentives. Population-based and multi-payer models offer an opportunity to align performance metrics to provide clear targets and sufficient funding for the necessary infrastructure changes. Models that cover a broader swath of a practice's payments and patients also increase the likelihood of qualifying for the Advanced APM bonus and are less subject to random variation, which means more reliable data, another criteria considered by the PTAC. The MNM sets itself apart from other specialty models in that it is a multi-payer, population-based model that utilizes a financial benchmark based on historic spending, similar to an ACO.

The PTAC should prioritize models that aim to connect and integrate care across settings or specialties. Fragmentation in health care increases medical errors and poor outcomes, system waste and inefficiencies, and dissatisfaction for all parties. These effects are compounded when patients have multiple clinicians involved in their care.[v] To date, many of the models assessed by the PTAC serve to enhance the function of and payment methodology for a single "silo" of care. PTAC should give priority consideration to models that support and reward cross-setting interactions. One of the central considerations when it comes to existing models is the lack of engagement between specialty and primary care clinicians. As noted earlier, the MSSP does not guarantee specialist care clinicians to share in the savings generated by the ACO. There is an opportunity for new models, or for existing models to expand in such a way that bridges the chasm between primary and specialty care and to engage specialists in a more robust way, including participating in the financial rewards and risks of the model, even if not to the same extent as the primary care clinicians. Importantly, these models may also provide opportunities to gather data insights into which interventions and care coordination strategies are most effective at improving patient outcomes and satisfaction. By intentionally building off the successes of the patient-centered medical home design and existing Medicare primary care models to create a complementary model targeted toward specialists, the MNM builds on concepts that have already proven successful and with which clinicians are already familiar. Importantly, it also recaptures some of the inefficiencies lost by the current patchwork of models that focus on a single setting of care.

The PTAC should prioritize models that offer consistent revenue streams, such as per-member per-month payments. COVID-19 has shed a spotlight on the shortcomings of FFS and its inability to respond to fluctuations in demand. Given steep revenue declines, practices may be more willing to join models that offer more financial predictability and security.[vi] Shifting towards more predictable revenue cycles will also help build the necessary infrastructure to weather future health crises.

In Conclusion

Thank you for this opportunity to submit comments to help inform the PTAC evaluation process. We strongly support the mission of the PTAC and offer our full assistance to support the Commission in its important work to progress the implementation and adoption of PFPMs. Please contact Suzanne Joy, Senior Associate, Regulatory Affairs for the American College of Physicians, at sjoy@acponline.org or 202-261-4553 with comments or questions about the content of this letter.

Sincerely,

Jacqueline Fincher, MD, MACP
President
American College of Physicians

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July 31, 2020

Jeffrey Bailet, MD
Chairman, Physician-Focused Payment Model Technical Advisory Committee
President and Chief Executive Officer, Altais

Dear Chairman Bailet,

The undersigned organizations appreciate this opportunity to provide feedback to the Physician-Focused Payment Model Technical Advisory Committee (PTAC) in the hopes of enhancing its review of physician-focused payment models (PFPMs) and informing its recommendations to the Secretary of Health and Human Services (HHS). **We strongly support the mission of the PTAC to forward development and adoption of payment models developed by the physician community.** We commend the Committee for its numerous successes to date, including reporting to the Secretary on 24 total models, recommending five for implementation, two for further development and implementation, and nine for testing on a limited scale all prior to the June 2020 meeting. In this letter, we offer detailed recommendations for Congress, HHS, and the PTAC that, if acted upon, would help to strengthen the authority and autonomy of PTAC to maximize its effectiveness at progressing the spread of PFPMs. We respond to each of the individual questions PTAC posed to the public in detail below.

1. ***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 (APMs)? Are there other actual and potential PFPMs that have not been addressed in proposals submitted?***

We believe APMs, particularly those designed with physicians at the center, are an increasingly important piece of transitioning to a value-oriented health care system that supports physicians and their care teams in delivering high-value, patient- and family-centered care while using limited health care resources more efficiently.[i] Unfortunately, a fragmented implementation strategy resulting in a patchwork of varying models across payers and geographic regions coupled with an underlying fee-for-service (FFS) foundation that stands at odds with goals to reward value and efficiency has limited the progress and growth of APMs up to this point.[ii] We view the PTAC as playing a potentially invaluable role in bringing more physician-focused APMs to fruition. Unfortunately, the Committee's influence has been limited by legislative and regulatory restrictions on its authority, as well as a general unwillingness from HHS to implement any PTAC-recommended models to date.

HHS should commit more support to the PTAC process, including providing funding and technical support for the fine-tuning and implementation of PTAC-recommended models. The fact that HHS has not implemented a single model that has come through the PTAC's screening process as submitted demonstrates the department's unwillingness to give physician-centered models the serious consideration they warrant. Model developers invest substantial time, resources, and expense into developing these models and are experts in their field. HHS should leverage this investment by supporting stakeholder development efforts with additional resources and guidance to produce viable models, rather than working on their own similar models in siloes. This would alleviate PTAC from expecting models to arrive fully developed and tested, which is an unrealistic expectation that is often out of the developer's control. Numerus organizations report inviting payers to test their models to no avail. Involving HHS earlier in the process would also expedite the process of readying the model for testing or implementation following PTAC's evaluation.

Specifically, HHS should make Medicare claims data available to the public. Doing so would help developers overcome logistic and cost barriers and enable them to perform the rigorous financial calculations needed to develop robust payment methodologies. It is worth noting that the payment methodology criterion is the lowest scoring criterion across PTAC's evaluations.[iii] Access to more robust claims and billing data on specific conditions, patient demographics, etc. could also support development of more targeted, evidence-based, and actionable performance metrics by the clinician community, which in turn could support the development of APMs, particularly specialty models. As with any release of data, patient privacy should be of paramount concern and reasonable precautions should be taken to protect patient privacy, including removing all patient identifiable information.

HHS should offer up-front investment opportunities, which is currently a major barrier to APM participation. Single ACOs require an average of nearly $2 million in startup capital.[iv] Many practices do not have this level of cash reserves at their disposal, which is part of the reason APM participants are disproportionately urban, larger, and/or integrated health systems.[v] In the midst of the COVID-19 Public Health Emergency (PHE), financial reserves are even lower,[vi] making up-front funding support more critical than ever, particularly for small, rural, and independent practices.

Congress should allow PTAC to consult with HHS and proposal submitters on implementation strategy following its formal recommendation. Due to current statutory limitations, the Committee has no role in model testing or implementation once it has submitted its recommendation to HHS, which may explain why HHS has not implemented a single PTAC-recommended model to date. We consider this a failure to fulfill congressional intent, as well as a missed opportunity to leverage what could be a powerful resource and ally in forwarding HHS' own goal of expanding APMs.

We are supportive of recommendations for Congress to broaden the authority and scope of PTAC and give it adequate resources to provide expert advice on a broader set of topics that directly affect the proliferation of APMs[vii] including how the underlying FFS structure, on which the vast majority of APMs are built, can often be at odds with the fundamental goals of APMs to reduce unnecessary services and spending. Target pricing for episodes of care and historic financial benchmarks are rooted in pricing for underlying services based on Medicare Physician Fee Schedule rates. Care management, coordination, and preventive services have historically been undervalued, if they are reimbursed for at all, despite their proven positive impact on patient care.[viii] Improving valuation for these services will have a direct impact on the accuracy of financial forecasting for APMs, which tend to rely heavily on these types of services to control costs for an assigned beneficiary population.

To encourage the continued development and clinician uptake of new payment models, Congress should extend the Advanced APM bonus and afford the HHS Secretary more discretion in setting the Qualified APM Participant (QP) thresholds at appropriate levels based on the current APM landscape. As it stands, the Advanced APM bonus is set to expire at the end of the 2022 performance year and the QP threshold is set to increase to 75% of payments and 50% of patients next year. Both changes risk drastically reducing the appetite for new models and would make it exceedingly difficult for the PTAC to continue its important work. House Resolution 7791, the "Value Act,"[ix] would address these and other barriers to future model development and participation.

2. ***In addition to the evaluative criteria, what other factors would be important to take into consideration to inform PTAC's evaluation of proposals, including factors related to engagement and adoption of models? What attributes may act as barriers in adoption and engagement in models for rural and small practices, as well as large integrated delivery systems?***

In the proposals that have been submitted to PTAC and those promulgated by HHS thus far, there is a general dearth of specialty focused APMs, particularly those that are scalable across a range of specialties. PTAC should give priority consideration to specialty models, particularly those that offer opportunities to test more targeted performance metrics, particularly cost measures. In general, HHS should be moving toward a more limited set of performance metrics across all of its value-based models and programs that meet independent standards for high statistical reliability, are actionable on the part of the clinician, and grounded in a strong base of clinical evidence. This may necessitate metrics that are more targeted toward a particular condition, specialty, or patient population. Specialty focused models offer a critical testing grounds for developing such metrics.

The PTAC should support models that encourage connecting and integrating care across settings or specialties. Fragmentation in health care increases medical errors and poor outcomes, system waste and inefficiencies, and dissatisfaction for all parties. These effects are compounded when patients have multiple clinicians involved in their care.[x] To date, many of the models brought to the PTAC serve to enhance the function of and payment for a single "silo" of care. PTAC should give priority consideration to models that support and reward high-value interactions across settings, such as having in place care coordination agreements. These models can also serve as vehicles to gather data on which interventions and care coordination strategies are most effective at improving patient outcomes and satisfaction.

The PTAC should not consider savings the only measure of a model's success. It should also give improvement on patient outcomes and/or satisfaction strong consideration, particularly for vulnerable patient populations that face access or treatment inequities due to social determinants of health.[xi] When evaluating models, the Committee should bear in mind savings often take multiple years to develop. It should consider models with a range of financial risk and savings projections, prioritizing those with an ability to ramp up risk over time. While savings is an important factor to consider, it is not the only criterion for which a model should be considered a success. Models that improve patient outcomes or satisfaction without increasing costs, particularly those that address inequities in access or outcomes for disadvantaged patient populations, should be considered equally important and successful. APMs generally deploy preventive care, enhanced care coordination, and other tactics to improve overall quality of care to reduce downstream complications. However, this is a long-term strategy. The PTAC should not automatically discount models that are not projected to achieve savings within their first few years of operation. The Medicare Shared Savings Program for instance yielded a net loss for its first three years before generating savings in its fourth and fifth years and increasing its net savings every year.[xii] Practices have differing abilities to take on risk based on myriad factors including patient panel size, geographic location, and specialty. Having a diverse offering of APMs with a range of risk levels is necessary to attract a diverse population of practices to join APMs, and in turn reach a more diverse patient population, particularly in rural areas of the country. Models that offer an opportunity to ramp up risk over time are particularly important as they allow practices to familiarize themselves with the model and develop comfort with risk before scaling up.

Multi-payer models, population-based models, and other models that can build on one another to encompass a significant portion of payments or patients should receive priority consideration. Models with larger population panels and less subject to random variation. It can be difficult for practices to succeed in value-based models when a significant portion of its payments are still tied to traditional FFS due to competing incentives and a lack of model-specific payments to cover their entire patient panel. Spillover effect is raised as a common criticism of models, including by PTAC.[xiii] Beyond reducing the so-called spillover effect and reaching a more diverse population of patients of all backgrounds and payer types, multi-payer or population-based models greatly increase a model's likelihood of qualifying for the Advanced APM bonus, a powerful incentive to engage clinicians in APMs.

The PTAC should prioritize models that offer consistent revenue streams, such as per-member per-month payments, particularly for primary care models. The COVID-19 PHE has shed a spotlight on the shortcomings of FFS, particularly its inability to respond to fluctuations in demand. Given steep revenue declines, practices may be more willing to join models that offer more financial predictability and security.[xiv] Importantly, shifting towards a more predictable revenue cycle, particularly for primary care, will also help to build the necessary infrastructure to weather future health crises.

Given the recent increase in remote and telehealth services in response to the COVID-19 PHE, the PTAC should consider how models plan to incorporate virtual and electronic services into their payment and delivery infrastructure. Many of these services are expected to become more permanent fixtures of health care delivery in the post COVID-19 environment. It will be important for models to address how they will incorporate virtual technologies, including how reimbursement will compare to in-person services. These services have the potential to expand access to clinicians, facilitate more frequent patient-clinician communication, and more efficiently manage chronic conditions, all of which are central to many APMs and their ability to improve care outcomes while controlling costs.

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

Models vary by design and incentive. In some cases, it is appropriate, even beneficial, for models to overlap. An episode-based payment model that targets improvements for a particular condition or patient population can complement quality improvement or coordination initiatives of broader population-focused models like ACOs. As noted earlier, allowing models to overlap also increases a clinician's chances of having a sufficient amount of their payments or patients tied to Advanced APMs to surpass the QP threshold and qualify for the Advanced APM bonus. In cases of overlap, it is important to clarify how each model would address patient attribution and financial calculations, etc.

One of the central considerations when it comes to existing models is the lack of engagement between specialty and primary care clinicians. The Medicare Shared Savings Program for instance does not guarantee specialists the opportunity to share in the savings generated by the ACO. **There is an opportunity for new models to be implemented or for existing models to expand in such a way that bridges the chasm between primary and specialty care and engages specialists in more robust ways, including by promoting specialist participation in the financial rewards and risks of the model.**

In Conclusion

Thank you for this opportunity to submit comments to help inform the PTAC evaluation process. We strongly support the mission of the PTAC and offer our full assistance to the Commission in its important work to support the implementation and adoption of PFPMs. Please contact Suzanne Joy, Senior Associate, Regulatory Affairs for the American College of Physicians, at sjoy@acponline.org or 202-261-4553 with comments or questions about the content of this letter.

Sincerely,

American Academy of Allergy, Asthma & Immunology
American Academy of Hospice and Palliative Medicine
American Academy of Neurology
American College of Allergy, Asthma & Immunology
American College of Chest Physicians
American College of Physicians
American College of Rheumatology
American Gastroenterological Association
American Society for Gastrointestinal Endoscopy
American Society of Clinical Oncology
Infectious Diseases Society of America
Society of General Internal Medicine
The Society for Post-Acute and Long-Term Care Medicine

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C-TAC
COALITION TO TRANSFORM ADVANCED CARE

900 16th Street NW
Suite 400
Washington DC, 20006

August 14, 2020

Physician-Focused Payment Model Technical Advisory Committee (PTAC)
Submitted to PTAC@hhs.gov

Re: Informing PTAC's Review of Physician-Focused Payment Models (PFPMs)

On behalf of the Coalition to Transform Advanced Care (C-TAC), we appreciate the opportunity to provide comments to your posted questions in regard to their effect on those living with serious illness.

C-TAC is a national non-partisan, not-for-profit organization dedicated to ensuring that all those living with serious illness, especially the sickest and most vulnerable, receive comprehensive, high-quality, person- and family-centered care that is consistent with their goals and values and honors their dignity. C-TAC is composed of over 140 national and regional organizations including patient and consumer advocacy groups, practitioners, health plans, faith-based and community organizations, and others who share a common vision of improving care for serious illness in the U.S.

We are pleased to respond to the questions PTAC is requesting feedback on. C-TAC is proud to have had our PTAC model proposal, the *Advanced Care Model (*ACM), recommended for further testing by PTAC members in 2018. Through the experience of developing the model in collaboration with key members and partners, we have a unique perspective on physician-focused alternative payment models and the PTAC process.

QUESTION 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?*

We would encourage the Committee to pay particular attention to the needs of those with serious illness in other models and, especially, how such models can address health inequities in this population.

Additional specific considerations include:

- Models should be incentivized that focus on care in both home and community settings, where the vast majority of those with serious and chronic illness prefer to receive care and support. Examples of how this can be achieved include supporting payment for programs like hospital-at-home and home based urgent care as well as the supporting infrastructure required to operate such programs eg. paramedicine, home-based radiology, lab testing and diagnostics.
- Capitated payments should be adjusted for both clinical, social, and functional risk, as well as access to care. That would require model participants to regularly assess and monitor such risk.
- Consideration should be given to carefully account for the most severely ill patients who require extensive home services so that clinicians and health care systems are not de-incentivized from taking care of such patients. Their needs and opportunities for savings differ and so models need to account for that.
- Sustainable funding mechanisms for the delivery of non-medical social supports by community-based organizations are needed. Payments should cover and promote coordination with needed community services such as transportation, nutrition, home safety, caregiver support, etc.
- Consider more robust integration and payment innovation for the integration of non-physician providers, such as community health workers, social workers, nursing aides, paramedicine professionals, and chaplains into APM payment and delivery structures.
- Many smaller but high-performing practices/health care entities need start-up capital support to develop the IT/data infrastructure so crucial for APM success.
- The focus on short-term savings/outcomes may be unrealistic for certain important preventative and maintenance interventions, expecially for those with chronic conditions.
- Protection for providers against taking inappropriate risk such as risk stratification, risk corridors or aggregate stop loss insurance.
- Balancing higher quality care with cost savings by assuring the appropriate treatment is delivered based on patient need.

PTAC QUESTION 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?*

- Specific impact of proposals on underserved and minority patient populations.

- Ensure that the proposal includes a plan for patient/beneficiary engagement /education about the model and how it might impact care delivery/payment experience of the end-user. Ensure that it includes a plan for engagement/education of family caregivers and community service organizations.

- Address challenges related to the fact that in shared savings & Pay for Performance (P4P) models there is still a foundational fee-for-service (FFS) structure that constrains value-based payment based on proven "high-value" services that result in positive patient and family outcomes:

    - Under typical P4P and Shared Savings systems, physicians and hospitals are still paid the same amounts for the same services as under standard fee-for-service payments, and they receive no new payments or higher payments for high-value services.

    - Under typical P4P and Shared Savings systems, the only change in payment is a bonus paid based on savings or quality/cost performance in a previous year. This raises the issues of how providers can cover the upfront costs of high-value care and requires savings and adequate payment for services

PTAC QUESTION 3: *How might a proposed PFPM build on the learnings from earlier models?*

- We recommend that future models build on learning from both models in use and those being tested by CMMI.

- HHS could either allow PTAC to provide data and technical assistance to APM developers or create a separate mechanism for doing so.

- Another option is to develop a PTAC-sponsored peer learning collaborative.

- Additional help would be a robust and frequent formalized program monitoring of APM implementation and outcomes and identifying where previous models have successfully identified avoidable spending areas such as avoidable hospital admissions, unnecessary tests and procedures, unnecessarily expensive treatments, preventable complications of treatment, and treatment of late-stage disease.

PTAC QUESTION 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?*

C-TAC's ACM proposal itself included such guidance:

> "The ACM is flexible in several ways. First, the model is open to a broad range of providers who can demonstrate capability and relevant experience to be successful with the ACM requirements. Examples of ACM-eligible entities include physician groups, CINs, ACOs, hospitals, hospices, and home health agencies. Second, the ACM proposes a consortium structure to support simple aggregation of small physician

practices that can span state borders. Third, ACM entities have flexibility over how they organize the entity as well as distribute payments among participating providers and contractors. Fourth, the ACM services are available to a broad range of advanced illness beneficiaries, including cancer and non-cancer disease as well as geriatric frailty in rural or metropolitan areas across social-economic and ethnic backgrounds. The ACM therefore can be applied to multispecialty practices or specific specialties such as primary care or cardiology. Lastly, there are various degrees of ACM implementation: (1) standalone new APM, (2) part of MSSP and or (3) overlap with another model such as OCM or CPC+ or IAH."

We would be happy to be a resource working with PTAC to explore ways to incorporate PTAC models into other broader models.

Thank you for the opportunity to provide these comments. If you have any questions, please contact Dr. Marian Grant, Senior Regulatory Advisor, C-TAC, at 443-742-8872 or mgrant@thectac.org.

Sincerely,

Marian Grant

Marian Grant, DNP, CRNP, ACHPN, FPCN
Senior Regulatory Advisor
The Coalition to Transform Advanced Care (C-TAC)
900 16th Street, NW, Suite 400
Washington, DC, 20006

August 20, 2020

SUBMITTED ELECTRONICALLY VIA
PTAC@hhs/gov

Jeffrey Bailet, MD
Committee 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 Information: Informing the Physician-Focused Payment Model Technical Advisory Committee's (PTACs) Review of Physician-Focused Payment Models (PFPMs)

Dear Chairman Bailet:

In response to the Request for Information (RFI) issued by the Physician-Focused Payment Model Technical Advisory Committee (PTAC), regarding the future reviews of physician-focused payment models (PFPMs), the American Academy of Home Care Medicine (Academy) is pleased to offer this comment letter.

The Academy has been serving the needs of thousands of home care medicine (HCM) professionals since 1984. Our members include home care physicians, nurse practitioners (NPs), and physician assistants (PAs) who make house calls, care for homebound patients, act as home health agency and hospice medical directors, and refer patients to home care agencies; home care organizations; medical directors of managed care plans; and administrators of medical groups interested in home care. Their specialties include internal medicine, family practice, pediatrics, geriatrics, psychiatry, and emergency medicine. The Academy delivers on the promise of interdisciplinary, high-value health care in the home for all people in need by promoting the art, science, and practice of home care medicine.

The patients we care for are home-limited due to multiple chronic illnesses, frailty, and disability. The Academy and its members are, thus, well-informed to offer comment on the current RFI. Our comments are also based on Academy member participation in alternative payment models (APMs) like the Independence at Home (IAH) Demonstration Program, Medicare Shared Savings Program (MSSP), Comprehensive Primary Care Plus (CPC+), other team-based home care medicine (HCM) models across public and private markets, as well as members who have applied to the Primary Care First (including Seriously Ill Population track) and Direct Contracting models. Through their participation in these models, HCM providers have demonstrated the ability to manage costs while optimizing quality of care and outcomes. For example, the IAH demonstration has resulted in significant savings for the Medicare program (and Medicaid, subsequently), providing 54,331 patient-years of care and generating over $100 million in

savings throughout its short-lived 5-year lifespan.[2] These savings were generated by a small group of 14-17 practices (including a consortium of practices) throughout the duration of the demonstration. Additionally, a HCM-focused accountable care organization (ACO) has also demonstrated significant savings and has ranked in the list of top ACOs contributing savings to the MSSP. However, experience with these and other models have highlighted continued delivery and payment reform challenges faced by HCM.

Current Challenges in Health Care Delivery and Payment for HCM and Recommendations for Modifying Existing Models and for Consideration of Future Models

The principal goals of APMs directly align with those of HCM practice—to provide comprehensive primary care and management to prevent unnecessary institutionalized care and improve patient and caregiver quality of life. Applied to the most medically complex and vulnerable populations, APMs can yield significant savings and help scale a HCM workforce limited under the current fee-for-service (FFS) landscape. Yet, despite this alignment and the demonstrated value of participating in APMs and other arrangements there are several limitations that impede HCM provider enrollment in such models. These limitations are summarized below.

Need for Appropriate Reimbursement

Under a FFS structure, the U.S. health care system undervalues primary care and care management services, especially within the context of HCM. This undervaluation raises concerns about the workforce for primary care, including home-based primary care (HBPC) providers and geriatricians in the U.S. (especially in comparison to other specialties).[1] As primary providers of high-touch and integrated primary care and care management for medically complex and vulnerable populations, it is crucial that payment systems more accurately reimburse the high-value care HCM providers provide to the most vulnerable populations.

Recommendation

Payment under value-based arrangements, regardless of how they are structured (e.g., fully or partially capitated payments, care management fees, flat visit fees, etc.), must adequately capture, reimburse, and support the provision of the enhanced level of services provided under a HCM model. Additionally, payment models should provide additional coverage for addressing social determinants of health and other community resources such as nutrition, transportation, caregiver support, home safety, etc.

Upfront Payments for Investing in Care Delivery Resources

Another challenge HCM practices often face is the lack of appropriate upfront funding for investment into the HCM model. Under the HCM care delivery model, HCM providers travel to patients' home and community settings to furnish care. This requires appropriate staffing to schedule these appointments, reliance on mobile diagnostic and other services, telehealth and other telemedicine technologies, etc. Investing in the full breadth of resources, and to the full extent necessary, to meet patients' needs can be a challenge for many HCM practices.

While the eventual benefits generated by APMs, either through shared savings or incentive payments, can significantly improve practice revenue, the time lag between performance and payment can generate notable cash flow issues for HCM practices. This is especially concerning considering the unpredictable

[1] 2019 MedPAC Report. Retrieved at: http://medpac.gov/docs/default-source/reports/jun19_ch5_medpac_reporttocongress_sec.pdf?sfvrsn=0

complexity and costs involved with treating and managing vulnerable populations. Uptake of APMs within the HCM field have been largely limited due to such potential cash flow disruptions.

Recommendation

Upfront payments are necessary and important to help alleviate the cashflow-related concerns. Upfront payments allow for not only a level of predictability, but also greater investment into infrastructure and other care delivery resources (e.g., telehealth technology) that positively impact patient care and outcomes.

Glide Path to Support Transitions Between Models and "Nesting" of Appropriate Models

While several payment model participation options exist for physicians and other providers, there are often limitations that restrict participation to a single model. While the Academy is supportive of ensuring that there is no "double dipping" into shared savings and other quality incentives, the broader participation limitations may hinder greater adoption and participation in more beneficial models to maximize the delivery of high-quality care.

Recommendation

To maximize engagement in APMs, models should be "nested" within each other, when appropriate and without jeopardizing program integrity. Allowing such models to operate amongst/within each other allows HCM providers to minimize cash flow issues which inhibit individual model participation. This flexibility exists for ACOs and other non-shared-savings APMs and should remain a key feature of ***any*** APM that is developed to encourage engagement in value-based models of care for HCM providers, and other providers treating the most medically complex patients.

Additionally, there needs to be greater support for transitions between models. Similar to the "glide path" offered under the MSSP, glide paths should be offered to support participants transitions between different models (e.g., from lower risk to higher risk models). While this is often done internally in models, via tracks, it is just as important to ensure there is continuity between different models, especially as older models may be replaced with newer models or versions.

Risk Adjustment

Current APMs and the HCC methodology as often adopted do not efficiently capture accurate patient acuity on a timely basis. Due to the nature of medically complex and seriously ill populations, patient acuity can oftentimes exacerbate within a small window of time. Under current methodologies of certain APMs, the risk measurement and adjustment processes are delayed, and risk scores/measures eventually utilized for payment adjustment can be significantly outdated. This undervaluation has a direct impact on both shared savings, and upfront cash flow (depending on the model of choice) for practices providing care to the most vulnerable populations.

Recommendation

APMs should feature more appropriate risk adjustment measures and timetables to account for the constant evolution of acuity and risk within medically complex patient populations. When considering any proposed model, PTAC should evaluate the accuracy and timeliness of diagnosis-based risk adjustment methods and ensure that patient acuity is more accurately tracked and adjusted (when necessary) throughout the performance period. As an alternative, future models could also improve the weight and utility of frailty adjusters so that practices can better account for spontaneous changes in functional impairment that are not sufficiently captured in traditional risk adjustment.

Need for Appropriate Quality Measures

The quality measures included in existing in programs like the MSSP and other Medicare programs and models are not clinically appropriate or applicable to a frail, seriously ill, and home-limited patient

population, i.e., those treated by HCM practices. We are concerned that even though they are delivering high-touch, high-quality, and clinically appropriate care to this medically complex patient population, these practices and providers are penalized and/or disadvantage under these programs due to the misaligned quality measures. Additionally, this deters others who may otherwise be interested in the model or program from actually participating due to concerns about their ability to achieve the applicable quality thresholds (which have been established for more traditional brick and mortar practices and the general Medicare patient population).

Recommendation

Given the reasons discussed, we highlight the need to adopt a more clinically appropriate measure set for HCM and other complex, chronic patients across delivery and payment reform programs and efforts.

Need for Accessible Beneficiary Enrollment Thresholds

The minimum beneficiary thresholds for models are often too high for smaller practices like HCM practices, especially for higher risk models. involvement, despite certain model tracks (e.g. the High Needs Direct Contracting Entity (DCE) track) being developed to specifically address the beneficiary population HCM serves. While we understand the importance of sufficient sampling for evaluation, we believe that any APM that addresses medically complex populations should have flexible enrollment requirements. The HCM field, which consists of relatively low margin practices, as well as an attenuated workforce and professional pipeline (similar to other primary care fields), is unlikely to meaningfully participate in any APM with high enrollment threshold requirements.

Recommendation

Due to the nature of the population being treated, and the level of care and care management required per patient, HCM practices should not be incentivized to expand patient load solely to meet enrollment requirements, as this could diminish quality of care. Nevertheless, HCM provider participation should remain a primary goal of APMs, as such practices yield the most potential for program savings. Therefore, APMs should permit a reduced enrollment threshold for HCM providers that treat medically complex and seriously ill populations, at a level that is realistic to most practices (i.e., lower than the 500-patient threshold). Furthermore, HCM providers should have the flexibility to transition between risk-sharing tracks, within shared savings models, in a more fluid nature to better control for the limited number and unpredictable acuity of attributed enrollees.

Alternative Options for Voluntary Alignment

The Academy supports the need for patient choice and voluntary alignment for attribution for models. However, the current preferred approach of using MyMedicare.gov is often burdensome and a barrier for the most ill beneficiaries, especially those complex and frail patients cared for by HCM practices.

Recommendation

We encourage greater adoption of paper-based voluntary alignment, as has been recently introduced in the Direct Contracting model, as well as alternative options such as call-in telephone elections.

Broader Adoption of Waivers and Beneficiary Enhancements/Inducements Across Models

The Next Generation ACO model has incorporated many helpful waivers and beneficiary enhancements/inducements (collectively referred to as "waivers") that ensure the delivery of more effective and timely care. The waivers adopted as part of this model have slowly been adopted by other models, like the Direct Contracting model and the MSSP. However, their adoption has been restricted to ACO-like models.

Recommendation

The Academy believes that the waivers offered under the Next Generation ACO, MSSP, and Direct Contracting model should be applied and offered more broadly across APMs and demonstration models.

Conclusion

We thank you for the opportunity to inform the Committee's review efforts through this RFI. We look forward to continuing to work with PTAC in developing PFPMs that ensure access and quality care are available to the sickest, frailest, most vulnerable home limited patients. If you have any questions regarding this letter, please contact Brent Feorene, Executive Director, at bfeorene@aahcm.org.

Sincerely,

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