

May 25, 2021

Elizabeth Fowler, PhD, JD
Deputy Administrator and Director
Center for Medicare and Medicaid Innovation
200 Independence Avenue, SW
Room 310G-04
Washington, DC 20201

Dear Deputy Administrator Fowler:

On behalf of the undersigned physician organizations, we congratulate you on your appointment to lead the Center for Medicare and Medicaid Innovation (CMMI). We look forward to partnering with you and your team to advance new models that can improve patient care while lowering health care costs. We are encouraged to learn that CMMI is reassessing its strategy and considering different approaches to health care transformation. We believe that utilizing models designed by practicing physicians will enable CMMI to accelerate value-based payment and care delivery for patients with Medicare and Medicaid.

As you know, the physician community worked with Congress and the Obama Administration to eliminate the Sustainable Growth Rate formula and enact the Medicare and CHIP Reauthorization Act (MACRA) in 2015. A fundamental goal of MACRA was to help physicians to transition to alternative payment models (APMs). Congress created the Physician-focused Payment Model Technical Advisory Committee (PTAC) to facilitate development of APMs in which physicians could successfully participate.

The physician community has devoted significant effort to develop well-designed APM proposals that can help transform Medicare's payment system consistent with the goals of MACRA. Many frontline physicians who have experienced the barriers to value-based care in their practices have put in years of work to develop patient-centered APMs that could offer meaningful benefits to patients and savings for the Medicare program if implemented by CMMI. These APMs would improve care for patients with asthma, cancer, kidney disease, inflammatory bowel disease, and other conditions, and enable physicians to deliver primary care, emergency care, surgery, palliative care, and outpatient specialty care to patients in higher-quality, lower-cost ways. Attached are a few examples of the kinds of APMs that physicians have developed that we believe merit implementation by CMMI.

Unfortunately, six years after passage of MACRA, most physicians do not have the opportunity to participate in an APM designed for the kinds of patients they treat or the level of risk they are equipped to take on. Existing models are also often geographically limited, excluding physicians in other areas who are interested and well-equipped to participate. Below we outline two sets of recommendations that we believe will address these problems and help the Biden Administration to both improve patients' health outcomes and control spending without harming patients or physician practices.

1: Improvements in the Way CMMI Designs and Implements APMs

- **Increase Transparency and Stability of CMMI APMs:** We urge CMMI to be more transparent about the models it is developing and to provide ample opportunities for stakeholder involvement during both the design and implementation phases. Although there has been stakeholder outreach early in the development process for some models, CMMI needs to actively engage with physicians who will be participating in these models throughout both the model development and implementation processes. Sufficient data and methodological details must be made available to allow stakeholders to

understand how financial models are derived, provide feedback to CMMI on the accuracy of assumptions, and assess likely impacts on practice revenues to inform participation decisions. Public input should be sought on APM payment amounts, risk requirements, quality measures and other key elements. CMMI should respond to the feedback it receives and publicly announce all changes that it makes. Improving the transparency and stability of models will foster trust and encourage participation among physicians. Participating practices require stable payment methods and need assurance that models will not be abruptly ended or changed without their input.

- Enable APMs to Reduce Health Inequities: We urge CMMI to provide adequate resources to help practices achieve better health outcomes for high-risk patient populations. All patients with Medicare coverage do not have equal opportunities to achieve good health outcomes, so one-size-fits-all models are more likely to widen than reduce disparities. APM payments and performance measures should account for risk factors such as lack of access to food, housing, and/or transportation that affect patients' ability to adhere to treatment plans. APM payment methodologies should be designed to support and encourage practices to address patients' social needs, including by providing care management services and coordinating services across interprofessional teams.
- Extend Incentive Payments for APM Participation: Far fewer physicians than Congress intended have been eligible for MACRA's APM incentive payments. Recently enacted legislation stabilized the revenue threshold required for physicians to be eligible for the five percent incentive payments for Qualified Participants (QP), but the last year that these payments can be made under current law is 2024 based on 2022 APM participation. We hope you will join us in supporting legislation to extend QP payments and maintain the current QP threshold for an additional six years (through 2030) so that the assistance envisioned under MACRA is available when more and better APMs become available. CMMI should also explore ways to coordinate and increase model options across Medicare and Medicaid in order to remove the barriers that prevent participation in Medicare Advantage and Medicaid APMs from helping physicians meet the QP threshold. The extension and cross-payer collaboration are vital for sustaining and expanding physician participation in APMs.
- Invest in Care Transformation by Medical Practices: We urge CMMI to provide start-up funding to APM participants so they can invest in data analytic capabilities, care managers, training, and other practice changes needed to improve care delivery and facilitate successful APM participation. We also urge that APMs be designed with "on-ramps" that give participants time as well as resources to transform their practices before being expected to take on downside risk. Physician practices, particularly small and rural practices and those serving marginalized patients, do not have financial reserves available to fund practice changes in advance of shared savings payments or to pay large penalties to CMS if their patients need expensive care. Failure to provide adequate funding not only poses a barrier to participation by small and medium practices, it will lead to greater industry consolidation.

2: Greater Physician Engagement in Development of APMs

- Jointly Set Goals and Process: CMMI, PTAC, and the physician community need a common set of priorities for APMs and a coordinated process for developing, testing, and implementing priority models. We request that you join us in convening multi-stakeholder workshops designed to build consensus on: (1) priorities for APM development; (2) how models can be structured to make them successful; (3) revisions needed in PTAC's criteria for evaluating APM proposals; (4) reasonable timelines for implementation of physician-developed APMs by CMMI; and (5) next steps for APMs

recommended to date by PTAC that have not been tested or implemented by CMMI.

- Dedicate Funds to Support Development and Testing of Physician-Developed APMs: We urge that a portion of CMMI's funding be dedicated for use in refining, testing and implementing physician-developed APMs, including those recommended by PTAC. Most existing APMs are focused on hospital-based care, even though most health care services are delivered outside of hospitals. To correct this imbalance, resources should be specifically dedicated to create and implement more physician-designed, patient-centered models.
- Provide Feedback and Data: It would be extremely helpful for physician organizations that want to develop APMs to be able to have a constructive dialogue with CMMI and receive data and feedback from the agency on the models being developed. In meetings with CMMI, proposal developers have been told that CMMI cannot test the models because they would not be approved by the Medicare Office of the Actuary (OACT), even though the statute explicitly states that budget neutrality is not a condition for initially testing models (SSA §1115A(b)(3)(A)). Further, proposal developers have not been provided with constructive suggestions about how models could be modified in ways that would allow them to be tested. Finally, it is not possible for organizations to develop financial models that could meet OACT and CMMI standards without access to the data the agency uses when it estimates financial impacts.

Representatives from our organizations would be pleased to meet with you and your team to further discuss the above recommendations and provide more information about how physician-developed models could benefit Medicare and Medicaid patients. Please contact Sandy Marks (sandy.marks@ama-assn.org) at the American Medical Association if you would like us to arrange a meeting.

Sincerely,

American Medical Association
AMDA- The Society for PALTC Medicine
American Academy of Allergy, Asthma & Immunology
American Academy of Child & Adolescent Psychiatry
American Academy of Dermatology Association
American Academy of Family Physicians
American Academy of Hospice and Palliative Medicine
American Academy of Neurology
American Academy of Ophthalmology
American Academy of Physical Medicine & Rehabilitation
American Association of Neurological Surgeons
American College of Allergy, Asthma & Immunology
American College of Cardiology
American College of Emergency Physicians
American College of Obstetricians and Gynecologists
American College of Osteopathic Surgeons
American College of Physicians
American College of Radiation Oncology
American College of Rheumatology
American College of Surgeons

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American Osteopathic Association
American Society for Clinical Pathology
American Society for Dermatologic Surgery Association
American Society for Gastrointestinal Endoscopy
American Society for Radiation Oncology
American Society of Addiction Medicine
American Society of Anesthesiologists
American Society of Cataract & Refractive Surgery
American Society of Clinical Oncology
American Society of Hematology
American Society of Plastic Surgeons
American Society of Retina Specialists
American Urogynecologic Society
Congress of Neurological Surgeons
Heart Rhythm Society
Medical Group Management Association
Renal Physicians Association
Society for Cardiovascular Angiography and Interventions
Society for Vascular Surgery
Society of Gynecologic Oncology
Society of Interventional Radiology
Spine Intervention Society
The Society of Thoracic Surgeons

Attachment

Examples of Physician-Developed and Proposed APMs

- The Acute Unscheduled Care Model (AUCM) would allow emergency physicians to avoid hospital admissions for patients seen in the emergency department (ED) while also ensuring safe discharges to the home and fostering post-discharge care coordination. Patients who receive ED care often have post-discharge events such as repeat ED visits, inpatient admissions, or observation stays within 30 days of receiving ED care. The current payment system does not support emergency physician services aimed at providing appropriate care transitions for patients who receive ED care and are discharged to their home, and who avoid a hospital admission. The AUCM model would fill this gap.
- The Patient-Centered Oncology Payment (PCOP) model would correct problems in both the fee-for-service system and the Oncology Care Model that make it difficult for oncology practices to support: comprehensive diagnostic work-ups; patient-physician shared decision making about treatment plans; education and counseling on patient self-management and nutrition; team-based care; after-hours access; active monitoring during months when patients are not receiving cancer treatment; and cancer survivorship as well as end-of-life care. PCOP emphasizes quality of care by measuring adherence to evidence-based treatment pathways and patient satisfaction with their cancer care, as well as integrating patient access to clinical trials into the model.
- The Patient-Centered Asthma Care Payment (PCACP) model would enable asthma specialists to provide a complete diagnostic work-up, develop an initial treatment plan, provide patient education and self-management training, and manage the patient's condition for an initial period of time until their asthma symptoms are well-controlled. Effectiveness of the treatment plan in controlling symptoms would be measured to ensure the diagnosis is accurate. Continuing care for most patients whose symptoms become well-controlled would be provided by their primary care physician, who would have access to the specialist if the patient's asthma symptoms worsened. This approach could be extended to diagnosis and management of other chronic conditions that are best treated by specialists and primary care physicians working together over time.
- The Medical Neighborhood Model (MNM) proposal cited data indicating a severe problem of poor coordination between specialists and primary care physicians. As many as half of referring primary care physicians have no idea if their patients ever see the specialist to whom they are referred, and specialists report receiving referral information for only 35 percent of referred patients. These communication gaps lead to care delays, inappropriate care, and errors, all of which could be prevented with MNM's coordinated approach. A chief criticism of the current payment system is that it promotes fragmentation in care. Patients tell us that what they want most is for their entire treatment team to collaborate on and implement their treatment plan seamlessly, instead of having to start from square one with each physician they see. MNM can repair this fragmented system.