August 13, 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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