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Dear Co-Chairmans Mills and Pulluru:

On behalf of the American College of Physicians (ACP), I am pleased to share our response to the Physician-Focused Payment Model Technical Advisory Committee (PTAC) RFI to assist in its review of Population-Based Total Cost of Care (PB-TCOC) models 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 161,000 internal medicine physicians, 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.

1. What should be the vision for developing PB-TCOC models that can help to ensure that every Medicare beneficiary with Parts A and B is in a care relationship with accountability for quality and total cost of care (TCOC)?

Achieving the vision of PB-TCOC models requires a focus on patient-centered care, equitable access, and adaptability. APMs designed with physicians at the core have proven critical in transitioning toward value-based care. However, progress has been hindered by fragmented implementation across regions and payers, as well as an enduring reliance on fee-for-service (FFS) structures that often undermine efforts to reward value and efficiency.

For PB-TCOC models to succeed, they must prioritize comprehensive and coordinated care. Models should address the needs of patients with complex and chronic conditions while reducing disparities in care. They must be able to fully integrate specialty care into accountable care frameworks to ensure equitable participation and continuity of care coordination.

Additionally, scalability and flexibility are essential to accommodate the diversity of practice types, geographic locations, and resource availability, particularly for rural and small practices.

2. What are the necessary components for PB-TCOC models to be successful in achieving the goal of having all Medicare beneficiaries with Parts A and be in accountable care relationships?

To maximize participation, PB-TCOC models must offer a clear and structured pathway for practices to transition from one-sided to two-sided risk in a way that is not unduly burdensome. Hybrid payment structures that combine FFS for select services with appropriate and timely per-member-per-month (PMPM) payments will allow physicians to gradually transition to full risk-bearing arrangements while ensuring financial stability. PMPM payments provide practices with predictable and consistent revenue, enabling investments in infrastructure, workforce development, and care coordination. This financial stability was exemplified by the Comprehensive Primary Care Plus (CPC+) model, which supported practices during the COVID-19 pandemic and underscored the importance of consistent funding mechanisms to keep practice doors open and allow access to physicians during a critical time.

To address challenges related to downside risk, ACP recommends designing arrangements with risk corridors, stop-loss provisions, and phased-in requirements to protect physicians from financial harm caused by factors beyond their control, such as patient noncompliance and social drivers of health. Thoughtful risk adjustment and aligned incentives will ensure that PB-TCOC models can alleviate financial concerns and promote wider participation from physicians.

3. Considerations for Payment Models by Specialty, Condition, or Setting

As outlined in our August 2020 PTAC RFI, ACP urges PTAC to prioritize models that 1) fill the current void of models for specialty care internal medicine physicians, 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.

ACP envisions a health care system where value-based payment programs incentivize collaboration among clinical care team–based members and use only appropriately attributed, evidence-based, and patient-centered measures. As described in ACP's Vision for a Better Health Care System for All, 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.

ACP strongly encourages PTAC to consider the current gaps in opportunities for specialty care. The integration of specialty clinicians is fundamental to achieving comprehensive, population-based care. Payment models could reflect the diverse needs of specialties, offering tailored approaches such as bundled payments for procedural specialties or condition-specific PMPM arrangements for chronic care physicians.

Flexibility and customization are essential to ensure these models align with specialty-specific practices while maintaining the overarching goals of accountability for quality and cost. Additionally, there should be a mechanism to ensure that funds collected are used specifically in primary care and specialty practices, preventing diversion towards unrelated projects or profits. Offering appropriate payment adjustments for high-cost conditions can help these specialties equitably integrate into PB-TCOC frameworks.

4. What gaps still exist within the current portfolio of value-based payment models, and what features need to be implemented in future models to close those gaps?

Significant gaps persist within the current portfolio of value-based payment models. Specialty care clinicians are often underrepresented, resulting in fragmented care and missed opportunities for comprehensive management of complex conditions. Furthermore, many models lack the scalability and resources necessary to support small and rural practices, discouraging their participation in value-based care initiatives. The lack of real-time, interoperable data sharing across practices and care settings also creates barriers to effective care coordination and performance measurement. More on-ramps for model participation are needed, especially for small and rural practices. These on-ramps could include tailored support programs that provide dedicated resources, technical assistance, and simplified reporting requirements to reduce administrative burdens. Additionally, flexible payment structures account for the unique challenges small and rural practices face and the formation of collaborative networks to share resources and best practices.

Future models should prioritize expanding multi-specialty and multi-payer approaches to streamline participation and align incentives. Advanced health IT infrastructure investments are critical to enable real-time data sharing and actionable insights across care settings. Financial and technical assistance programs should also be established to help small practices transition to accountable care. Enhanced incentives for collaboration between primary care and specialty clinicians will ensure that PB-TCOC models are comprehensive and equitable. Additionally, analyzing the cost of patient care without financial incentives will provide a clearer picture of

the necessary service expenses. This will help identify gaps, understand how funds are allocated, and adjust needs in the different models accordingly.

Conclusion

ACP appreciates the opportunity to provide input on PTAC's evaluation of PB-TCOC models and remains committed to supporting efforts that advance value-based care. The future of PB-TCOC models relies on their ability to align incentives, reduce disparities, and foster collaboration across the health care continuum. By addressing specialty needs, closing existing gaps, and emphasizing hybrid payments and thoughtful downside risk arrangements, PTAC can create an environment where physicians feel empowered to participate in accountable care.

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. Please contact Anna Hallowell, Senior Analyst, Regulatory Affairs for the American College of Physicians, at ahallowell@acponline.org or (202)-261-4519 with comments or questions about the content of this letter.

Sincerely,

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