



August 13, 2020

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

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 as 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 PFFM 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 PFPs. 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

-
- ⁱ The “Medical Neighborhood” Advanced APM Proposal. American College of Physicians. National Committee for Quality Assurance. aspe.hhs.gov/system/files/pdf/261881/ProposalACPNCQA-Resubmitted.pdf
- ⁱⁱ Doherty, Robert. Cooney, Thomas. Mire, Ryan. Engel, Lee. Envisioning a Better U.S. Health Care System for All: A Call to Action by the American College of Physicians. *Annals of Internal Medicine*. Jan. 21, 2020. <https://www.acpjournals.org/doi/10.7326/M19-2411>.
- ⁱⁱⁱ Erickson, Shari. Outland, Brian. Joy, Suzanne. Rockwern, Brooke. Envisioning a Better U.S. Health Care System for All: Health Care Delivery and Payment System Reforms. *Annals of Internal Medicine*. Jan. 21, 2020. www.acpjournals.org/doi/10.7326/
- ^{iv} ACP comments on 2019 Proposed Physician Fee Schedule and QPP Proposed Rule. 9.10.18. https://www.acponline.org/acp_policy/letters/acp_comments_2019_qpp_pfs_proposed_rule_2018.pdf
- ^v Sheikh F, Gathecha E, Bellatoni M, Christmas C, Lafreniere JP, Arbaje AI. A call to bridge across silos during care transitions. *The Joint Commission Journal on Quality and Patient Safety* 2018; 44:270-278.
- ^{vi} Oyekan, Elizabeth. Could the COVID-19 Pandemic Create New Opportunities for the Adoption of APMs and Be a Catalyst for the Movement from Volume to Value? *AJMC*. June 12, 2020.