

June 27, 2016

Andrew M. Slavitt  
Acting Administrator  
Centers for Medicare & Medicaid Services  
U.S. Department of Health and Human Services  
Hubert H. Humphrey Building, Room 445-G  
200 Independence Avenue, SW  
Washington, DC 20201

Re: CMS-5517-P  
Merit-Based Incentive Payment System (MIPS) and Alternative Payment Model (APM) Incentive Under the Physician Fee Schedule, and Criteria for Physician-Focused Payment Models; Proposed Rule

Dear Acting Administrator Slavitt:

In response to the request for comments on the proposed rule for implementation of the Merit-Based Incentive Payment System (MIPS) and Alternative Payment Models (APMs) authorized by the Medicare Access and CHIP Reauthorization Act (MACRA), I urge that you make the following changes in the final rule:

## **I. Requirements for Alternative Payment Models in Medicare**

In MACRA, Congress clearly intended to encourage the development and implementation of Alternative Payment Models. Congress did not use the term “advanced” to describe alternative payment models, nor did it in any fashion indicate that physicians should only be rewarded for participating in a narrowly defined subset of “advanced” Alternative Payment Models. Indeed, Congress established a very small number of simple requirements to define which APMs should be encouraged:

- APMs should involve more than nominal financial risk;
- APMs should measure quality; and
- APMs should use certified EHR technology.

It is inappropriate for CMS to override Congressional intent by administratively determining that APMs need to be “advanced” and redefining the statutory criteria using elaborate and restrictive standards. The section of the proposed regulations that is designed to implement this statutory provision clearly goes far beyond what was envisioned by Congress and would serve as a serious

barrier to progress in designing, implementing, and encouraging physician participation in Alternative Payment Models.

All of the references in the regulations to an “Advanced” APM should be replaced with the term “Qualified APM,” and the three specific criteria for Qualified APMs should be redefined as described below.

## 1. Revising the Criteria for Financial Risk for Medicare

Section 414.1415(c) of the final regulations should be changed to read as follows:

### § 414.1415 Qualified APM criteria

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**(c) *Financial risk.* To be a Qualified APM, an APM must either meet both the financial risk standard and nominal risk standard described in this section or be an expanded Medical Home Model as described in paragraph (c)(5) of this section.**

**(1) *Financial risk standard.* To be a Qualified APM, an APM must, based on whether an APM Entity’s actual expenditures for which the APM Entity is responsible under the APM exceed expected expenditures during a specified performance period, do one or more of the following:**

**(i) Withhold payment for services to the APM Entity or the APM Entity’s eligible clinicians;**

**(ii) Reduce payment rates to the APM Entity or the APM Entity’s eligible clinicians;**

**(iii) Require the APM Entity to owe payment(s) to CMS; or**

**(iv) Cause the APM Entity to lose the right to all or part of an otherwise guaranteed payment or payments.**

**(2) *Nominal amount standard.* To be a Qualified APM, either:**

**(i) the minimum total annual amount that an APM Entity must potentially owe or forego under the APM must be at least 4 percent of the APM Entity’s total Medicare Parts A and B revenue, or**

**(ii) the APM entity must document that (a) it is using its own resources to deliver new or expanded services to beneficiaries that are not directly paid for by Medicare and (b) the amount of those resources are equal to or greater than 4% of the APM Entity’s total Medicare Parts A and B revenues.**

**(3) *Expected expenditures.* For the purposes of this section, expected expenditures is defined as either:**

**(i) the payment to the APM entity, if the APM entity will be responsible for paying for all of the services to be delivered under the APM, or**

**(ii) the spending target established under the APM for the total spending on all of the services to which the APM applies.**

**(4) *Capitation.* A full capitation arrangement meets this Qualified APM criterion. For purposes of this subpart, a capitation arrangement means a payment arrangement in which a per capita or otherwise predetermined payment is made to an APM Entity for all items and services furnished to a population of beneficiaries, and no settlement is performed to reconcile or share losses incurred or savings earned by the APM**

**Entity. Arrangements made between CMS and Medicare Advantage Organizations under the Medicare Advantage program (42 U.S.C. section 422) are not considered capitation arrangements for purposes of this paragraph (c)(4).**

**(5) Medical Home Model Expanded under section 1115A(c) of the Act. A Medical Home Model that has been expanded under section 1115A(c) of the Act meets the financial risk criterion under this section.**

MACRA requires that in order for a physician to be exempt from MIPS and to qualify for the bonus payments authorized by Congress, the alternative payment entity must bear “financial risk for monetary losses under ... [an] ... alternative payment model that are in excess of a nominal amount.” The term “financial risk for monetary losses” in MACRA clearly refers to *losses in the operations of the alternative payment entity*, not to losses or increased spending in the Medicare program. The gains or losses of the alternative payment entity are a function of both the *costs that the alternative payment entity incurs* to implement the model and the *revenues it receives under the model*. If the alternative payment entity hires or pays for new staff to deliver services to patients under the alternative payment model, if it acquires new or different equipment to deliver services, or if it incurs other kinds of expenses to implement the alternative payment model, and if those expenses are not automatically or directly reimbursed by Medicare, then the alternative payment entity is accepting financial risk for monetary losses.

Although many people seem to think that “financial risk” is only associated with alternative payment models, there is financial risk involved in any payment system other than one which reimburses physicians or other providers for their actual costs. Today, physician practices incur financial risk for monetary losses under the fee-for-service payment system because the costs they incur for office space, equipment, and staff are not directly reimbursed by Medicare, and if the practice does not deliver enough services to generate fee-for-service payment revenues in excess of those costs, it could be forced to declare bankruptcy. The measure of a good alternative payment model should not be how much it *increases* financial risk for physician practices and other providers, but rather how effectively it *realigns* their financial risk so that financial losses result from delivering lower quality care rather than fewer services.

Financial risk cannot be defined simply in terms of the potential reduction in revenues the alternative payment entity could receive from Medicare. The alternative payment entity could easily incur monetary losses under an alternative payment model even if the entity has no obligation to repay losses that the Medicare program has incurred, as long as the entity could incur costs that exceed its payments. For example, even under an “upside only” shared savings model, a physician practice or other provider incurs financial risk if it incurs costs to implement programs that are designed to reduce Medicare spending, since the provider could fail to qualify for the shared savings payment it needs to pay for those costs.

It is also not appropriate to measure the amount of risk accepted by a physician practice or other provider in terms of the percentage change in total Medicare spending for which the provider is responsible. For many physician practices, a 4% change in Medicare spending could represent 20%, 40%, 60%, 80%, 100% or even more of the practice’s revenues, particularly the revenues of a small practice, and it would represent an even larger percentage of that practice’s *profit margin*. Because the payments to a physician practice generally represent only a small percentage of total Medicare spending on a patient’s care, a physician practice could be forced

out of business if it is held responsible for paying for even a very small percentage change in the total Medicare spending for the practice's patients.

Consequently, an alternative payment entity's "financial risk for monetary losses" under an alternative payment model should be defined as the potential difference between the amount of costs the entity incurs or is obligated to pay as part of the alternative payment model and the amount of revenues that it could receive under the APM. The greater the costs it incurs or the lower the revenue it could potentially receive, the greater the financial risk it will face under the APM.

If Congress had wanted alternative payment entities to accept *substantial* financial risk, it could easily have explicitly required that, so it is clear that in using the term "more than nominal financial risk," Congress did not mean "substantial" financial risk. Logically, "more than nominal" risk should also be significantly less than what would be considered "substantial" risk.

In MACRA, Congress has placed all physicians' payments "at risk" under the Merit-Based Incentive Payment System (MIPS). In the initial year of the program (2019), physician payments could be reduced by 4%, and the maximum reduction increases to 9% in 2022. These amounts are presumably "more than nominal" if Congress expected them to influence physician performance on the measures defined in MIPS, which includes resource measures.

Consequently, "more than nominal" risk for APMs should be defined using the maximum reduction amounts that are used in MIPS. In 2019, since a physician's payments could be reduced by 4% under MIPS even with no change in the physician's costs, an alternative payment entity should be viewed as being at "more than nominal financial risk" if the amount of costs that it incurs under an alternative payment model could exceed the amount of revenue it receives under the model by at least 4%.

## 2. Use of EHR Technology

**Section 414.1415(a)(2) of the final regulations should be changed to read as follows:**

### **§ 414.1415 Qualified APM criteria**

**(a) *Use of certified electronic health record technology.* The following constitutes use of CEHRT:**

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**(2) *Required use of certified EHR technology.* To be a Qualified APM, an APM Entity must store clinical data in CEHRT regarding the care delivered to patients with financial support from the APM.**

MACRA requires that participants in an alternative payment model "use" certified EHR technology. After several years of HHS trying to define "meaningful use" of EHRs, there is widespread agreement that detailed requirements regarding how clinicians should use EHRs have increased costs and harmed quality rather than improving it. Since MACRA simply requires "use" of the EHR, regulations regarding use of EHRs in APMs should only require that clinical data about the patients receiving care as part of the alternative payment model be stored in a certified electronic health record system. It is impossible to prescribe how a physician or other provider should "use" the technology beyond this without potentially interfering with the

provider’s flexibility to deliver services in the most effective way or imposing unnecessary costs and administrative burdens on the provider. A physician practice participating in the APM will have a strong incentive to use the EHR if the EHR has capabilities that will improve the practice’s success, regardless of any specific requirements imposed by HHS. Any specific requirements for “use” of EHRs that are imposed in regulations should be treated as a cost that increases the financial risk for a physician practice to participate in the APM if the cost is not explicitly supported by the APM itself.

### 3. Use of Quality Measures

**Section 414.1415(b)(1) of the final regulations should be changed to read as follows:**

#### § 414.1415 Qualified APM criteria

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**(b) *Payment based on quality measures.***

**(1) To be a Qualified APM, an APM must ensure that the quality of care for patients receiving services under the APM is maintained or improved.**

MACRA requires that an APM “provide for payment for covered professional services based on quality measures.” It does not require that the amounts of payment be a “factor” in determining the *amount* of payment. If a payment model is designed to achieve savings, the Affordable Care Act requires only that the payment model do so “without reducing the quality of care.” Consequently, an APM should be considered a qualified alternative payment model if it (1) measures quality and (2) requires a minimum standard of quality to be met in order for physicians to continue to participate in the APM.

## II. Defining “More Than Nominal Financial Risk” for Commercial Payers

**The criteria in Section 414.1420 should be revised to match those described above for Section 414.1415.**

MACRA uses a somewhat different definition of financial risk for payments coming from payers other than Medicare or Medicaid. In order for such payments to count toward the 50% threshold beginning in 2021 and the 75% threshold beginning in 2023, the physician or other eligible professional must participate in an entity that bears more than nominal financial risk “if actual aggregate expenditures exceeds expected aggregate expenditures.” The proper interpretation of the term “aggregate expenditures” depends on the structure of the payment model itself. For example,

- If the physician practice is receiving a fixed bundled payment under the APM to cover a range of services for patients, then the term “aggregate expenditures” would apply to the practice’s expenditures on those services for all patients covered by the APM. The amount of the bundled payment would typically be defined so that the aggregate revenues from the payments for all patients the practice cares for would be adequate to cover the practice’s expected aggregate expenditures for services to those patients. The *practice’s financial risk* would then be defined as the maximum amount it has to spend if its actual expenditures exceed the bundled payment revenues. The maximum will depend on

whether the payer agrees to an outlier payment, “stop loss,” or “risk corridor” limiting the amount by which the actual expenditures can exceed the payments.

- If the physician practice is being paid for individual services but the amounts of those payments are reduced if the aggregate amount of payments exceed a threshold (e.g., an episode budget), then the term “aggregate expenditures” would apply to the payer’s payments to the physician practice, and the practice’s financial risk would be defined as the amount by which its payments would be reduced if the total payments from the payer exceed the threshold.

The definition of “more than nominal” described in the previous section for Medicare payments can therefore also be applied to the risk under the commercial payments.

### III. Criteria for Physician Focused Payment Models

In contrast to the excessively narrow criteria defined for Alternative Payment Models, CMS is to be commended for creating simple, broad criteria for the Physician-Focused Payment Model Technical Advisory Committee (PTAC) to use in evaluating physician-focused payment models. However, **the following changes are needed to ensure that the most desirable and potentially successful models are submitted and approved:**

#### §414.1465 Physician-focused payment models.

- (a) **Definition.** A physician-focused payment model is an Alternative Payment Model wherein Medicare is a payer, which includes physician group practices or individual physicians as APM entities, and targets the quality and costs of ~~physician~~ physician services that the physicians participating in the payment model deliver, order, or can significantly influence.
- (b) **Criteria.** In carrying out its review of physician-focused payment model proposals, the PTAC shall assess whether the physician-focused payment model meets the following criteria for PFPMs sought by the Secretary. The Secretary seeks physician-focused payment models that:
  - (1) ~~Incentives~~ **Payment Structure:** Pay for higher-value care.
    - (i) **Value over volume:** provide ~~incentives~~ adequate resources to practitioners and other providers to deliver high-quality health care needed by patients.
    - (ii) **Flexibility:** provide the flexibility needed for practitioners and other providers to deliver high-quality health care.
    - (iii) **Quality and Cost:** are anticipated to improve health care quality at no additional cost, maintain health care quality while decreasing cost, or both improve health care quality and decrease cost.
    - (iv) **Payment methodology:** pay APM Entities with a payment methodology designed to achieve the goals of the PFPM Criteria. Addresses in detail through this methodology how Medicare, and other payers if applicable, pay APM Entities, how the payment methodology differs from current payment methodologies, and why the Physician-Focused Payment Model cannot be tested under current payment methodologies.

- (v) **Scope: aim to either directly address an issue in payment policy that broadens and expands the APM portfolio, address an issue in payment policy that is not effectively addressed by an existing APM, or include APM Entities whose opportunities to participate in APMs have been limited.**
  - (vi) **Ability to be evaluated: have evaluable goals for quality of care, cost, and any other goals of the Physician-focused Payment Model.**
- (2) **Care delivery improvements: Promote better care coordination, protect patient safety, and encourage patient engagement.**
- (i) **Integration and Care Coordination: encourage greater integration and care coordination among practitioners and across settings where multiple practitioners or settings are relevant to delivering care to the population treated under the Physician-focused Payment Model.**
  - (ii) **Patient Choice: encourage greater attention to the health of the population served while also supporting the unique needs and preferences of individual patients.**
  - (iii) **Patient Safety: aim to maintain or improve standards of patient safety.**
- (3) **Information Enhancements: Improving the availability of information to guide decision-making.**
- (i) **Health Information Technology: encourage use of health information technology to inform care.**
  - (ii) **[Reserved]**

In many cases, successful physician-focused Alternative Payment Models will be able to reduce spending on hospitalizations, drugs, post-acute care services, and other services that are ordered by but not delivered directly by physicians. The proposed definition inappropriately suggests that APMs that target these types of services would not qualify as a “physician-focused” payment model. On the other hand, one of the problems with many of the alternative payment models that CMS has been developing and implementing is that they put physicians at risk for the utilization or costs of services they cannot control or influence. The physicians in an APM may not be able to control the “physician services” that a patient receives from physicians not participating in the APM, particularly if those physician services are for health conditions or procedures unrelated to the condition(s) or procedure(s) for which the APM is designed. The recommended change to §414.1465(a) addresses both of these issues.

There is too much emphasis in the proposed criteria on “incentives” and not enough on paying adequately for the care that patients need. The biggest problem with the current payment system is not that it fails to “incent” high-quality care, but that it (a) fails to pay for many high-value services that physicians need to deliver in order to improve quality and reduce costs and/or (b) financially penalizes providers for delivering services that address patient needs at lower cost. Consequently, the most desirable physician-focused payment models will be those that pay adequately for lower volumes of services rather than those that simply try to “incent” higher quality. Moreover, in many cases, it is not just physicians that are negatively affected by these problems, but other providers, such as hospitals, post-acute care providers, etc. The changes recommended above to §414.1465(b)(1), §414.1465(b)(1)(i), and §414.1465(b)(1)(ii) address these problems.

Finally, the fact that CMS has an alternative payment model which was supposed to address a payment problem does not mean that that payment model addresses that problem effectively. Physicians and other stakeholders should not be discouraged from developing and submitting better payment models, and CMS should not give lower priority to such submissions, simply because some existing payment model ostensibly addresses the same issue. The change recommended above to §414.1465(b)(1)(v) corrects this problem.

## IV. CMS Process for Implementing APMs

MACRA stops short of requiring that HHS implement physician-focused payment models recommended by the PTAC. It would obviously be a tremendous waste of time and energy by both those proposing physician-focused payment models and the members of the PTAC if desirable payment models were reviewed and recommended by the PTAC but not implemented by HHS. Consequently, it will be essential that HHS create the necessary systems and processes so that it can implement physician-focused payment models recommended by the PTAC as well as alternative payment models involving other kinds of providers. **In the proposed rule, CMS is significantly increasing the accountability that physicians will need to accept in return for payment. CMS needs to make comparable commitments to greater accountability for improving its own efficiency and effectiveness in designing and implementing new payment models.**

It is clear that **CMS needs to establish a different approach to implementing alternative payment models than it has been using to date.** Although the Affordable Care Act created the Center for Medicare and Medicaid Innovation in 2010 in order to accelerate the development and implementation of innovative payment and delivery models, relatively little progress has been made in improving the ways most physicians and other providers are paid for their services. As the American Medical Association has stated, “Five years after CMS was authorized to implement ‘new patient care models’ ... Medicare still does not enable the majority of physicians to pursue ... opportunities to improve care in ways that could also reduce costs. Today, despite all of the demonstration projects and other initiatives that Medicare has implemented, most physicians – in primary care and other specialties – still do not have access to Medicare payment models that provide the resources and flexibility they need to improve care for their Medicare patients. Consequently, most Medicare patients still are not benefiting from regular access to a full range of care coordination services, coordinated treatment planning by primary care and specialist physicians, support for patient self-management of their chronic conditions, proactive outreach to ensure that high-risk patients get preventive care, or patient decision-support tools. As a result, the Medicare program is paying for hospitalizations and duplicative services that could have been avoided had physicians been able to deliver these high-value services.”

### 1. Creating a More Efficient Approach to Implementing APMs at HHS

One key reason for this slow progress is that the Center for Medicare and Medicaid Innovation (CMMI) has created a far more complex and resource-intensive process than is required or necessary to implement alternative payment models. Under most of the payment demonstrations that it has implemented to date, 18 months or more have elapsed from the time an initiative is first announced to the time when providers actually begin to receive different payments. Many proposals for alternative payment models have been submitted to CMMI that have not been implemented. This is not because the staff at CMMI are slow or incompetent, but because of the



complex, expensive, and time-intensive process they have created for designing the initiative, selecting participants, managing the payments, and evaluating the results as part of any payment model they test.

This process is extremely burdensome and expensive for CMMI to administer, it dramatically reduces the number of alternative payment models that can be tested, and it is also extremely burdensome for providers who are interested in participating in the initiatives that CMMI does attempt to implement. Many providers have decided not to even apply to participate in otherwise desirable CMMI programs and others have dropped out of the programs in the early phases solely or partly because of the cost and time burden of participating.

This burdensome process is not required by either the Affordable Care Act or MACRA. If HHS were to attempt to implement every new alternative payment model using the approaches that are currently being used by CMMI, it would take many years before even a fraction of the physicians in the country would have the ability meet the APM requirements under MACRA. This would mean relatively few Medicare beneficiaries could benefit from the higher quality care that would be possible under APMs and the Medicare program would not achieve the savings that APMs could generate.

**A complete re-engineering of the processes HHS uses to implement alternative payment models is needed. This re-engineering process should start with the goal that is implicit in MACRA – every physician should have the opportunity to receive at least 25% of their revenues from alternative payment models in 2019, 50% of revenues in 2021, and 75% in 2023. HHS should then work backward from those dates and design processes and timetables that will achieve the goals.**

Just as many physicians, hospitals, and other healthcare providers are now re-engineering their care delivery processes to eliminate steps that do not add significant value, HHS should use Lean design techniques and other approaches to identify and eliminate all steps and requirements in its implementation processes that do not add value or that impede achieving the goals that Congress has set. Moreover, since MACRA allows alternative payment models to be implemented using statutory authorizations other than Section 1115A (the enabling legislation for CMMI), HHS should use all of the options available under MACRA in order to implement desirable alternative payment models in the most efficient way possible.

In order for a physician to be participating in an APM during 2019, the processes for approving and implementing the APM and for approving the physician's participation in the APM will have to be completed no later than the end of 2018. However, in order for physicians to succeed under APMs, they will need to have sufficient lead time to form or join an alternative payment entity and to redesign the processes by which they deliver care with the flexibility provided by the APM, and so both the structure of the APM and the approval for a physician's participation will need to be completed long before the end of 2018. Some physician groups and medical specialty societies have already developed physician-focused alternative payment models that should be able to meet the criteria under MACRA; these could and should be implemented as soon as 2017.

**To ensure that the MACRA goals are achieved, HHS should establish specific milestones that are designed to implement as many alternative payment models as possible and as quickly as possible.** For example, the following timetable would allow payments under an

alternative payment model to begin flowing to a physician within one year after the model is recommended by the PTAC:

- When a physician-focused alternative payment model is recommended for implementation by PTAC, CMS should plan to implement it unless there is a compelling reason not to do so. The decision to implement the model should be made within 60 days after it is recommended by the PTAC.
- Once a physician-focused alternative payment model is recommended by the PTAC and approved by HHS, the applications that physician practices and alternative payment entities would need to complete in order to participate in the approved APM should be made available within 90 days.
- Physicians and alternative payment entities should be permitted to apply to participate in an approved APM no less frequently than twice per year.
- Applications to participate in an approved APM should be reviewed and approved or rejected within 60 days. Applications should only be rejected if an applicant cannot demonstrate that it has the ability to implement the model, not because of arbitrary limits on the size of the program or the locations where providers can be located. If an application is rejected, CMS should provide feedback to the applicant on the reasons for rejection and methods of correction. If a rejected application is revised and resubmitted, CMS should re-review it and approve or reject it within 30 days.
- CMS should implement an approved APM with the approved physician applicants no later than 90 days after the applications by physician practices to participate have been approved.
- Once a physician or other clinician begins to participate in an APM, they should be permitted to continue doing so as long as they wish to, unless CMS can demonstrate that Medicare spending under the payment model is higher than it would be under the standard physician fee schedule or that the quality of care for beneficiaries is being harmed.

## **2. Creating the Capability at HHS to Implement a Broad Range of Physician-Focused APMs**

A second key reason why only a small number of physicians are participating in alternative payment models under Medicare is the problematic structure of the current models that CMS and CMMI have been using. Most of the payment models that are currently being implemented or tested by CMS use a very similar approach – no changes in the current fee for service structure, holding individual physicians accountable for the costs of all services their patients receive from all providers, adjusting payment amounts based on shared savings calculations for attributed patients, etc. – and these approaches not only fail to solve the problems in the current payment systems, they can actually make them worse.

The components used in most CMS payment models are very problematic for physicians and therefore they are likely problematic for their patients as well. Although CMS may view some of these payment models as “physician-focused” because they are targeted at individual physicians or physician practices, the goal should be to create physician-focused payment models that are *successful* in improving care and improving costs in ways that are feasible for

physician practices, particularly small practices, to implement. To date, these payment models have not been successful in reducing costs because they do not provide the kinds of support that physicians need to redesign care. **New physician-focused payment models should not be required to use the same flawed approaches that are being used in current CMS payment demonstrations.**

At a minimum, HHS should create the administrative capabilities to implement seven different types of physician-focused APMs that can be used to address the most common types of opportunities and barriers that exist across all physician specialties. These are:

1. **Payment for a High-Value Service.** Under this APM, a physician practice could be paid for delivering one or more desirable services that are not currently billable, and the physician would take accountability for controlling the use of other, avoidable services for their patients.
2. **Condition-Based Payment for Physician Services.** Under this APM, a physician practice would have the flexibility to use the diagnostic or treatment options that address a patient's condition most efficiently and effectively without concern that using lower-cost options would harm the operating margins of the physician's practice.
3. **Multi-Physician Bundled Payment.** Under this APM, two or more physician practices that are providing complementary diagnostic or treatment services to a patient would have the flexibility to redesign those services in ways that would enable high-quality care to be delivered as efficiently as possible.
4. **Physician-Facility Procedure Bundle.** This APM would allow a physician who delivers a procedure at a hospital or other facility to choose the most appropriate facility for the treatment and to give the physician and facility the flexibility to deliver the procedure in the most efficient and high-quality way.
5. **Warranted Payment for Physician Services.** This APM would give a physician the flexibility and accountability to deliver care with as low a rate of complications as possible.
6. **Episode Payment for a Procedure.** This APM would enable a physician who is delivering a particular procedure to work collaboratively with the other providers delivering services related to the procedure (e.g., the facility where the procedure is performed, other physicians who are involved in the procedure, physicians and facilities who are involved in the patient's recovery or in treating complications of the procedure, etc.) in order to improve outcomes and control the total spending associated with the procedure.
7. **Condition-Based Payment.** Under this APM, a physician practice would have the flexibility to use the diagnosis or treatment options that address a particular health condition (or combination of conditions) most efficiently and effectively and to work collaboratively with other providers who deliver services for the patient's condition in order to improve outcomes and control the total spending associated with care for the condition.

More detail on each of these physician-focused Alternative Payment Models and examples of how they could be used to improve care for a wide range of patient conditions is available in a

report developed by CHQPR and the American Medical Association entitled *A Guide to Physician-Focused Alternative Payment Models* (available at [www.CHQPR.org](http://www.CHQPR.org)).

**HHS should begin immediately to implement the administrative systems needed to support all of these types of payment models.** This would not only ensure that the APMs can be implemented by 2019, but it would encourage physician groups and medical specialty societies to design payment models in a common framework, which will reduce implementation costs for HHS.

Re-engineering the processes for implementing alternative payment models as discussed above should dramatically increase the capacity of HHS to implement more payment models more quickly than it can today. However, **if there are insufficient staff or resources at HHS/CMS/CMMI to support implementation of a sufficient number of new alternative payment models to enable all physicians to participate, additional resources should be provided to achieve the necessary “bandwidth.”** Failing to allocate sufficient resources to implement alternative payment models that will save money for the Medicare program would be “penny wise and pound foolish.”

I would be happy to answer any questions you may have about these recommendations or to provide any additional information or assistance that would be helpful to you in implementing them.

Sincerely,

A handwritten signature in black ink, appearing to read 'H. Miller', written in a cursive style.

Harold D. Miller  
President and CEO