



THE SECRETARY OF HEALTH AND HUMAN SERVICES

WASHINGTON, D.C. 20201

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I express my gratitude to Pulmonary Medicine, Infectious Disease and Critical Care Consultants Medical Group, Inc. of Sacramento, California (PMA) for submitting *The COPD and Asthma Monitoring Project (CAMP)* proposal to the Physician-Focused Payment Model Technical Advisory Committee (PTAC) for review and consideration as a proposed physician-focused payment model (PFPM). PMA's commitment to improving care for patients with chronic obstructive pulmonary disease (COPD), asthma, and other chronic lung conditions is evident in this proposal and in PMA's willingness to adopt CAMP in its clinical practice. I also thank the members of PTAC for the time and effort they invested in rigorous review of this proposal and providing their detailed comments and recommendation to me.

The Department of Health and Human Services (HHS) is keenly interested in ideas for how to improve specialty care for Medicare beneficiaries with complex chronic illnesses such as COPD and asthma. Reducing avoidable emergency department visits and inpatient admissions through approaches to more effective patient monitoring is a goal HHS shares with PMA. However, we agree with PTAC that this PFPM proposal should not be tested because of key areas of concern and uncertainty in the proposed model. In particular, while HHS is interested in broad models that address quality and payment, it does not plan to pursue models that mainly involve testing a particular form of proprietary technology or proposed models that are focused on implementation only by the submitter. As HHS develops potential models in this area, we will consider the input and insights from PMA's proposal. Supplemental information provided by the Centers for Medicare & Medicaid Services (CMS) about these and other issues is included in the attached appendix.

We all share a common goal of improving health care for all Americans. To do this, we must think creatively and leverage experience from across the nation. We must learn from health care providers in the field who have changed care delivery to encourage better outcomes and patient experience of care. We recognize the contributions of practicing physicians in driving this transformation.

I look forward to the continued engagement of all stakeholders in developing payment models and to future recommendations of PTAC regarding PFPMs that would reduce expenditures while preserving or enhancing the quality of care.

Thomas E. Price, M.D.  
Secretary

## **Appendix: Supplemental Information**

The following is additional information related to the Secretary's response to PTAC comments and recommendation on the *COPD and Asthma Monitoring Project (CAMP)* submitted by Pulmonary Medicine, Infectious Disease and Critical Care Consultants Medical Group, Inc. (PMA).

HHS would be interested in CMS testing an APM with more focus on COPD/Asthma, and is generally interested in APMs that address management of chronic conditions. However, HHS identified key issues with this proposal and is providing context for the policy areas the Secretary considered in crafting his response.

- **Payment Methodology**

The proposal does not include how payment amounts and the spending targets should be set for Medicare patients who are more likely to have multiple health problems and for whom additional time and resources may be needed to support both proactive outreach and coordination with other physicians. The payment methodology does not include PCPs, who do not bear any financial risk or incentive.

- **Care Coordination**

HHS is concerned that the model may not adequately support integration and care coordination with other disciplines relevant to the patient's care. It is uncertain whether the proposed technological approach for sharing information with PCPs will help facilitate coordination of care or pose additional information management burdens for the PCP. The proposal does not include a framework for incentivizing or ensuring participation by physicians or patients other than PMA.

- **Proprietary Components**

While the details of the technology included in the proposed PFPM are not clear from the proposal and supplemental materials, a potential limitation to broadening the scope of this PFPM to include other participants is that the model may rely on specific proprietary software, or be tailored to one specific EMR platform. HHS will not pursue models that only involve testing a particular device, app, or form of equipment; HHS is interested in models that involve a new payment structure.

- **Quality**

The proposal lacks information about how quality measures would affect payment, whether those measures are endorsed or validated, and how quality measures would be used to further the goals of the model. No patient-reported measures are included or described within the proposal, and while a measure is identified in supplemental communications to PTAC, it is only indicated that it would be monitored with no additional detail. HHS is concerned that some of the proposed measures would require reporting by referring PCPs, who are not included in the model and therefore do not have incentives to report.

- **Including Participants Other than the Submitter in the Proposed PFPM**

A new APM including pulmonologists would broaden CMS' portfolio of APMs; however, this proposal is focused on a model to be implemented by PMA and does not address what might be involved to incentivize other practices to deliver CAMP-type services.

- Savings Estimates

The proposal does not provide an estimate of potential cost savings from testing the proposed PFPM. Instead, the proposal estimates that \$14.76 billion could be saved if all Medicare beneficiaries with COPD received the proposed intervention, using aggregate costs of treating patients with COPD and a German study of a similar intervention. HHS' concerns about this estimate are that it does not estimate potential cost savings from the proposed PFPM, it relies on evidence from three per-protocol studies conducted in non-US health care systems, and it appears to inflate the baseline spending for the COPD population. The proposal fails to address how many patients with COPD and Asthma are likely to be referred by their physicians and would be willing to participate in CAMP. As such, estimates of potential cost savings are likely overstated and do not account for patient self-selection.