October 3, 2016

Andy Slavitt
Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS–5519–P
P.O. Box 8013
Baltimore, Maryland 21244–1850.

Submitted electronically

Re. Medicare Program; Advancing Care Coordination Through Episode Payment Models (EPMs); Cardiac Rehabilitation Incentive Payment Model; and Changes to the Comprehensive Care for Joint Replacement Model (CJR); Proposed Rule

Dear Acting Administrator Slavitt:

The American Gastroenterological Association (AGA) is pleased to provide comments on the Centers for Medicare and Medicaid Services’ (CMS) recent proposed rule expanding the Advanced Alternative Payment Model (Advanced APM) participation options available to physicians participating in Episode Payment Models (EPMs). Founded in 1897, AGA is the trusted voice of the gastroenterology community that has grown to include more than 16,000 members from around the globe who are involved in all aspects of the science, practice and advancement of gastroenterology. We appreciate the opportunity to provide feedback on the proposed rule and share your commitment to improving the value, quality, and delivery of health care for Medicare beneficiaries.

FUTURE DIRECTIONS FOR EPISODE PAYMENT MODELS

CMS Requests for Input
As part of the proposed rule, CMS requests feedback in several areas to facilitate potential development of EPMs related to care beyond those considered in the current EPM models (in which episodes are focused on inpatient care and are triggered by hospital inpatient MS-DRGs). As part of this feedback request, CMS shared the following:
In acknowledging that the current Bundled Payments for Care Improvement (BPCI) initiative does not meet the proposed Advanced APM criteria, CMS stated that the Center for Medicare and Medicaid Innovation (CMMI) will put forward a broad bundled payment model for calendar year 2018 that would be designed to meet the Advanced APM criteria.

CMS requested input on models for potential future condition-specific episode payment models that could focus on an acute event or procedure or longer-term care management, including feedback on:

- How to designate the accountable entity for the quality and cost of the episode (including the role of physician-led opportunities); and
- How to share responsibility of quality and spending between primary care providers, specialty physicians, and other health care professionals.

CMS also sought comment on model design features for episode payment models targeting procedures that could be inpatient or outpatient and for episode payment models for hospitalizations for acute medical conditions which could overlap, including input on:

- How to identify the accountable entity; and
- What potential opportunities there are for physician-led organizations.

**General Considerations**

The AGA appreciates that, under the Comprehensive Care for Joint Replacement (CJR) model and the currently proposed models related to Acute Myocardial Infarction (AMI), Coronary Artery Bypass Graft (CABG), and Surgical Hip/Femur Fracture Treatment (SHFFT), CMS has made the hospital the financially accountable entity. In selecting financially accountable entities responsible for assuming the financial risk related to care delivery, it is important that CMS ensure that such entities are in a position to actually influence the resources utilized and care delivered. In models where episodes are initiated by inpatient hospitalizations and participation is mandatory, we can appreciate CMS’ logic in determining that hospitals are the entities best-situated to assume this risk.

However, as CMS seeks to expand episode-based payment models (especially those intended to serve as true Alternative Payment Models and not just measures of resource utilization), purely hospital-based models are not sustainable. While a hospital-based model might lend itself well to episodes premised on the existence of a surgical procedure performed in a hospital setting, it will not translate well to other care environments as CMS seeks to expand episode-based payment models to encompass medical rather than surgical cases.

In addition, the AGA would be opposed to potential CMS proposals to make condition-based models or outpatient models mandatory. In some situations involving routine outpatient procedures (which are less commonly performed in a hospital setting), entities such as
ambulatory surgery centers (ASCs) may be better-situated to serve as the financially accountable entity. Depending on the procedures involved, ASCs may be in a better position to optimize care coordination to better achieve the goals envisioned by episode-based payment models. However, because procedures performed predominantly in ASCs are sometimes performed in the hospital outpatient setting, CMS must consider all care delivery settings in order to accurately create benchmark pricing. Therefore, a mandatory outpatient model where only ASCs serve as financially accountable entities would be flawed and would not accurately reflect the nuances of medical practice. Under a voluntary model, rather than a mandatory one, ASCs would be in a position to engage in new payment models designed to reward the delivery of efficient and high-value care in a way in which they have not previously been able.

The AGA supports CMS’ efforts to encourage models that provide participation opportunities for physician-led organizations. It is difficult to envision any episode-based payment model where physician-led organizations are mandatorily subjected to model requirements given the difference between the number of physicians that can be involved in patient care and the wide variation in the ways in which physician practices are organized. For example, it would be difficult to assign quality performance and resource utilization responsibility to a single physician group practice for all patient care related to a condition-based episode as some of that care will be provided by and under the control of physicians and entities outside of that physician group practice. Patients treated by gastroenterologists regularly suffer from conditions that require care coordination with other physicians, including additional specialists and primary care providers. However, under a voluntary outpatient or condition-based, episode-oriented APM, CMS can incentivize physicians to collaborate in partnerships that integrate the care delivery system in ways that can truly transform the way in which Medicare begins to pay for the value of care provided.

**Existing Gastroenterology Investments in Episode-Based Payment Models**

- **Colonoscopy Bundled Payment**: AGA launched a colonoscopy bundled payment framework in March 2014. Colonoscopy was selected for the bundle because the procedure has a predictable range of expected services, hence limiting variability in costs to both payers and providers. The goal of the bundle is to improve the value of health care by controlling costs, enhancing collaboration among providers, improving patient outcomes, and reducing the incidence of complications. Embedded in the colonoscopy bundle are quality measures and an incentive to perform a high quality procedure at the initial visit. We believe this bundle provides gastroenterologists with a significant opportunity to improve the quality of care at a lower cost to payers and purchasers, with the added potential of financial incentive rewarding high-value care. Since the colonoscopy bundled payment model was designed under a fee-for-service model, it is applicable to practices operating under fee-for-service but can also be used by practices piloting APMs, as it incentivizes physicians to coordinate care for patients.
undergoing screening and surveillance colonoscopy. AGA defined the bundle for colonoscopy services performed: (1) for colorectal cancer screening in asymptomatic patients, (2) for diagnosis in patients who have undergone colorectal cancer screening with a different type of screening modality (for example, stool-based testing) that suggested the need for a full colonoscopy, and (3) for surveillance in patients who have previously undergone a colonoscopy during which a pre-cancerous polyp was found and are returning for follow-up evaluation, in accordance with the recommendations of the U.S. Multi-Society Task Force on Colorectal Cancer. Since colorectal cancer screening is a mandated benefit under the Affordable Care Act and has been a benefit under the Medicare program since the Balanced Budget Act, AGA believes that both Medicare and private payers can benefit from this model. Additionally, GI practices across the country have been using the colonoscopy bundle framework when working with payers. For example, Horizon Blue Cross Blue Shield (BCBS) of New Jersey has implemented the colonoscopy bundle as part of its Episodes of Care (EOS) program, a shared savings program that has paid out $3 million to 51 specialty practices. These physicians were able to earn the payments by achieving quality, cost, efficiency, and patient satisfaction goals in 2014 while treating more than 8,000 Horizon BCBS patients.

• **Gastroesophageal Reflux Disease (GERD) Episode Payment.** AGA initiated a workgroup to develop an episode payment framework and care pathway for GERD that was published in the journal *Gastroenterology* in April 2016.¹ The GERD bundle framework encompasses both clinical management and surgical/endoscopic aspects of care for GERD, and includes input and perspectives from clinicians, pathologists, payers, patients, hospital representatives and reimbursement/policy experts. Like the colonoscopy bundle, the GERD bundle incorporates relevant quality measures to reinforce high quality, high value care.

• **Obesity Bundled Payment.** AGA also created an obesity bundled payment workgroup that includes obesity experts, reimbursement experts, advanced practice professionals, bariatric surgeons, endocrine experts, interventional endoscopists, community gastroenterologists, and a psychologist specializing in behavioral interventions for GI disorders. Given the complexity of obesity as a chronic disease of multi-faceted origin, management of this condition requires a multi-disciplinary approach including behavior modification, nutrition counseling, exercise, pharmaceuticals, and potentially minimally invasive endoscopically-placed devices. The obesity bundle framework will be patient-facing and encompass non-surgical management of obesity. AGA recognizes that obesity can impact health care system spending both directly and indirectly. The obesity bundle concept has the potential to improve the value of care for patients covered by both Medicare and private payers.

• **Project Sonar.** Project Sonar is a chronic disease management program for inflammatory bowel disease (IBD) patients that was piloted with BCBS of Illinois and is gaining interest from other BCBS plans across the country. The practices that participate in Project Sonar are paid a monthly care management fee per patient and take part in a retrospective shared savings arrangement. Project Sonar promotes increased and improved communication among patients, providers, and practices while empowering patients to seek treatment in IBD care before their condition requires more costly interventions. The model also is based on AGA’s IBD clinical service line, which contains evidence-based care guidelines and other clinical decision support tools for IBD to help engage both providers and patients to change behavior and improve outcomes. Project Sonar is an exciting APM for IBD care coordination that also effectively administers pharmaceuticals to patients in a cost-effective setting and empowers patients to be more engaged in managing their health. Project Sonar has already demonstrated improved care, decreased unnecessary emergency department visits, reduced hospitalizations, and overall savings.

**ADVANCED APM CONSIDERATIONS**

As previously mentioned, the AGA is appreciative CMS structured the EPM program to ensure that EPMs are able to meet the proposed requirements to be considered Advanced APMs, thus creating eligibility for the APM incentive payment created under the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA). As part of CMS’ proposed rule on the Merit-Based Incentive Payment System (MIPS) and the Advanced APM Incentive Payment, estimates for Advanced APM qualifying participation were extremely low, and the AGA remains concerned that the access to the Advanced APM incentive payment will be even more challenging for specialists. We remind CMS that the 5 percent Advanced APM incentive payment is time-limited under current law, and we believe that the goals of MACRA will be undermined unless APMs are an attractive option for specialty physicians, whose patients are often the most complex and costly Medicare beneficiaries. Providing avenues for specialty physicians to participate in APMs is the only way to address the underlying costs associated with these populations. We will continue to support CMS’ efforts to expand these participation opportunities and encourage CMS and CMMI implementation of models recommended by the Physician-Focused Payment Model (PFPM) Technical Advisory Committee (PTAC) as the PTAC begins its work.

At the same time, we encourage CMS to take into consideration the fact that models focused on a single condition or procedure type (as they are structured in this proposed rule) will likely provide little opportunity to achieve the thresholds required by MACRA and proposed by CMS to become an Advanced APM “Qualifying Participant” (QP), particularly in later years as those
thresholds necessitate that QPs derive 75 percent of their Medicare revenues from care delivered in the context of an Advanced APM or see 50 percent of their patients in the context of an Advanced APM. We understand that it was not necessarily CMS’ goal to design the four EPM models under consideration in order that hospitals would execute Sharing Arrangements with gastroenterology-based physician group practices (PGPs). However, as CMS expands EPMs in the future, the incentive for a hospital to engage with physician partners is diminished if these models are each considered *stand-alone* Advanced APMs. Rather, the proliferation of these models if considered in the *aggregate* will create greater incentives for hospitals to partner with physicians across many procedures and conditions, even in scenarios where a specialty might not be directly implicated in the main MS-DRG (or other eventual) triggers. Given the breadth of services that are considered to be a part of the proposed episodes once triggered, as these models expand we envision partnerships to treat patients for events such as GI hemorrhage or GI obstruction that encourage gastroenterology participation in a way that truly provides access for GI and others to the APM incentives mandated by MACRA.

Thank you for providing us the chance to comment on the EPM proposals and future episode-based APMs. We look forward to continuing these discussions with CMS in future program years. If you have any questions or concerns, please contact Michael Roberts, AGA’s Vice President of Public Policy, at (240) 482-3220 or mroberts@gastro.org.

Sincerely,

Michael Camilleri, MD, AGAF
Chair, AGA