COLLEGE of AMERICAN PATHOLOGISTS

January 25, 2017

Ann Page, Office of Health Policy, Assistant Secretary for Planning and Evaluation (ASPE) and Designated Federal Officer for PTAC
Physician-Focused Payment Model Technical Advisory Committee (PTAC)
c/o Angela Tejeda
ASPE
200 Independence Ave. SW
Washington, DC 2020
Via email to: PTAC@HHS.gov

RE: Proposal for a Physician-Focused Payment Model (PFPM): Comprehensive Colonoscopy Advanced Alternative Payment Model (AAPM) for Colorectal Cancer, Screening, Diagnosis, and Surveillance

Dear Ms. Page:

The College of American Pathologists (CAP) appreciates the opportunity to comment on the Proposal for a PFPM: Comprehensive Colonoscopy AAPM for Colorectal Cancer, Screening, Diagnosis, and Surveillance. The CAP is a national medical specialty society representing over 17,000 physicians who practice anatomic and/or clinical pathology. CAP members practice their specialty in clinical laboratories, academic medical centers, research laboratories, community hospitals, and federal and state health facilities.

Our review of the model raised significant concerns related both to some of its premises on patient protection and care coordination, and also to its handling of pathology services. As a result, the CAP's comments express opposition to the PTAC recommending the implementation of the model. Reasons for the CAP's opposition are provided below, but are in essence that this proposal fundamentally fails to balance financial incentives with patient protections, or to provide for meaningful coordination of care.

Care Coordination

The submission refers to team-based care for patients undergoing colorectal cancer screening, diagnosis, and surveillance using colonoscopy and indicates its comprehensive bundled payment model incorporates colonoscopy, anesthesia, moderate sedation, pathology, radiology, and evaluation and management services. It acknowledges that, unless physicians are already part of a multi-specialty group operating under a single tax identification number (TIN), there is no way to address care coordination across multiple providers and facilities with different TINs. The submission, however, provides neither guidance nor exposition on how care is to be coordinated or rendered in a team-based fashion as proposed. Instead, it blithely states that "a fixed price for the bundle will encourage physicians and other eligible professionals to deliver high-value health care." Without shared infrastructure, governance, or even a conceptual

description within the alternative payment model of how to provide care coordination, effective team-based care cannot simply be presumed to arise *sua sponte* because of a "fixed price for the bundle."

Under the proposal, the endoscopist alone would establish a prospective payment. While somewhat unclear, it appears the reconciliation and distribution of any share of savings would also be performed by the endoscopist. This approach is significantly different from an integrated model with a structure that sets targets for performance improvement and payment levels, and calculates and distributes earned incentives.

Patient Protection

The submission includes a brief section on patient safety, focused on the collection of rates of services from the initial physicians who indicated an interest in 2016 in the model, but lacks any tie to actual patient safety. In addition, patients are said to be "protected" against unintended consequences and less than optimal outcomes. It is actually these unintended but readily anticipated consequences which are of greatest concern.

The primary crux of the model is greatly reducing colonoscopy re-do rate over time. Strongly incentivizing reduction of the colonoscopy re-do rate does not itself translate into higher quality or patient protection. Reducing the colonoscopy re-do rate to (or below) the target to generate savings certainly does predispose to patients not getting a repeat procedure irrespective of medical indications. The submission acknowledges possible stinting of care and alludes to possible monitoring for this after implementation. No detail how this would be detected or monitored, however, is provided. The subsequent paragraph of the submission refers to "embedded monitoring" only as "under consideration."

Similarly, the model's other key focus, incentivizing movement of procedures to a lower cost setting, the ambulatory surgery center rather than the hospital, is also without either a conceptual model to guide implementation or a set of enunciated patient protections. In the absence of either, it fails to provide operational guidance to practitioners or safeguards to ensure that it is not detrimental to those patients for whom a hospital setting may be appropriate.

Finally in the area of patient protection and care improvement, several of the proposed quality metrics are not relevant for a model focused on colorectal screening, diagnosis, and surveillance. Some of the proposed measures are existing MIPS measures such as body mass index and tobacco use screening and cessation intervention, supporting the focus of the model being on cost reduction without an effective corresponding element of patient protection or care improvement.

Pathology Services

Specifically concerning for pathologists is their apparently gratuitous inclusion in the proposal by "establish[ing] a cap on the number of pathology specimens" with no meaningful mechanism for participation or alignment with the model's stated goals. As stated in the proposal, the overall anticipated impacts on Medicare spending is to limit repeat procedures, support performance of procedures in a lower cost setting, and cap the number of pathology specimens at the present average. Such a predetermined cap does not amount to "participation" in an alternative model of care by pathologists, but is rather a mere arrogation of additional services to the bundle. No quality or efficiency rationale is provided for the incorporation of this fixed cap nor is any opportunity provided for pathologists to effectively contribute.

As indicated above regarding patient protection, the model's stated focus is on reduction in the colonoscopy re-do rate and increase in ambulatory surgery center utilization. Pathologists are not involved in either of these goals. It seems then that pathologists are therefore "included" not to help coordinate care and achieve objectives, but to generate savings for the model based on caps on services that lack clinical justification or evidence for care improvement. Savings as a result of such caps, it appears, would be disseminated to those who truly are participants rather than to pathologists as further explained below.

Under the proposal, although pathologists are among the physicians included in the model, they are the only physicians whose services are preset at a fixed rate with an express cap on the number of services without incentives to generate savings or improve quality. Coupled with the inability to affect the model's primary objectives, reduction in the colonoscopy re-do rate and ambulatory surgery center utilization, this forces the CAP to question the legitimacy of the inclusion of pathology services at all.

"[P]ayment for pathology services are fixed" seems to affirm performance improvement incentives are inapplicable. The proposal establishes targets for the endoscopist colonoscopy re-do rate with savings distributed to the endoscopist and anesthesia professional. Similarly, an ambulatory surgery target applies to the endoscopist. Emergency department charges and claims for capsule and endoscopy and imaging procedures are paid and reconciled against the episode payment.

While payments for pathology services are not reconciled against the episode and the pathologist does not appear to be incentive-eligible, pathology services are capped at "2 bottles/procedure" and pathology special stains are "capped at 20% of procedures" where pathology specimens are obtained. Not only is this lacking in clinical justification, but the pathologist cannot practically fail to process and examine any specimens the endoscopist may submit, putting him or her in an untenable position with regard to "participating" in the proposed model.

The model's indication that "healthcare professionals are incented to provide high-quality, complete examination of the colon on the initial study" offers more confirmation of the lack of performance improvement incentive opportunity for pathologists. Regardless of the fixed payment and therefore lack of incentive for the pathologists, the submission's payment methodology section seems to apply downside risk to them under the following statement. "The penalties for failure are that all physicians and qualified health care professionals involved – endoscopist, anesthesia, pathologist, and facilities (HOPD, ASC) lose revenue if they are 1) not paid for potentially avoidable repeat procedures and 2) fail to achieve the financial goals of the model, result in downside adjustment."

This inconsistency demonstrates not only the lack of meaningful pathologist participation and failure to align with the model's objectives, but also the need to remove pathologists from express inclusion in the model.

In closing, we again urge you not to recommend the model for adoption. We appreciate your consideration. Any questions or requests for additional information may be directed to Sharon West, JD, Director, Economic and Regulatory Affairs at 202-354-7112 or swest@cap.org.