COLLEGE of AMERICAN PATHOLOGISTS

January 5, 2016

Ann Page, Office of Health Policy, Assistant Secretary for Planning and Evaluation (ASPE)
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 Physician-Focused Payment Model (PFPM): ACS-Brandeis Advanced Alternative Payment Model (AAPM)

Dear Ms. Page:

The College of American Pathologists (CAP) appreciates the opportunity to comment on the Proposal for PFPM: ACS-Brandeis AAPM. 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.

Overview - The CAP appreciates the intended collaboration on which the success of the model is premised. The ACS-Brandeis AAPM provides an interesting conceptual model. Our general observation, though, is the level of detail, practical application, and certain rationale including specifics of the Episode Grouper for Medicare (EGM) such as triggers; organizational structure implications; and specifics regarding implementation were not sufficiently addressed in the proposal.

Furthermore, we do not understand how this proposal intends to meet one of the essential criteria set forth both legislatively and in CMS requirements: "Aim to either directly address an issue in payment policy that broadens and expands the CMS APM portfolio or include APM Entities whose opportunities to participate in APMs have been limited." First, it proposes a broad conceptual mechanism for "pushing down" risk and reward for overall costs of care to the level of practitioners. This mechanism could be applied (as it is in variations already applied) in any care setting that is already able to measure costs and outcomes of care, and that is sufficiently integrated to take on risks and give out rewards. Conversely, it is entirely unfeasible in any less integrated setting that is currently unable to handle the risks and rewards. We believe that a mechanism for allocation of financial risk applicable and available to healthcare delivery systems already organized to participate in existing alternative payment models but not in other settings does not broaden or expand the CMS APM portfolio. Second, and equally

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significantly, in proposing to allocate risks and rewards on generic example percentages, it does not address the core challenge for any allocation mechanism: to distinguish activities that increase the cost of care without improving its quality from those conducive to improved quality and/or efficiency of care. By not specifying operational parameters by which risks and rewards can be "pushed down" to practitioners, other than as preset generic percentages, we feel that this proposal does not extend meaningful opportunities for their participation.

Scope –The scope, at 54 procedural episodes involving as many as 75 specialties including pathology, seems a bit overbroad and challenging to effectively administer in its current form. The "core model" as proposed indicates it is "focused on procedure episodes," but the proposal indicates possible expansion to include acute and chronic conditions and has the potential to be a national model. With such a broad initial scope, expansion beyond the initial state gives cause for concern particularly without extensive testing prior to any contemplated expansion.

Implementation – While the breadth of the model presents complexities, our read of the proposal raises other implementation challenges as follows:

Quality – The quality adjustment payments, as proposed, seem a bit unclear particularly because the measures listed in the proposal do not apply to all specialties. The proposal's indication that the entity defines shared risk and applies a meaningful matrix of quality measures to realign incentives applies at a conceptual level, but lacks practical application. In addition, the proposal mentions quality measures attached to a registry, but is less clear on those participants who may not be reporting through a registry at the time of inception of the model.

Organizational Structure – Under the proposed ACS-Brandeis framework, MIPS-eligible clinicians would affiliate with an APM entity and use EGM episodes to define their practices. Absent an established organizational structure, it is not likely this will happen organically. This is why we believe the only organizations who could benefit from this proposal are the ones who have already integrated similar mechanisms. The proposal could benefit from specifics on what the APM entity that operates the model would be including examples of types of applicable organizations (e.g. profit or non-profit; hospital or non-hospital; local, regional, or national, etc.).

Similarly, under the proposal, the EGM is expected to deliver information necessary for multiple stakeholders to collaborate and make informed care decisions about the cost drivers in resource use and variation in care. Eligible clinicians and delivery system elements would receive predictive analytics from the episode grouper. The proposal, though, does not elaborate on how this will be done particularly without a specified

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convener responsible for the requirement with the ability to educate on resource use reports and associated clinical implications or when such analytics would be received.

Roles/Definitions – The proposal indicates clinical roles (primary, principal, episodic, supporting and ancillaries) borrow from the MACRA patient relationship categories. These categories, though, are not yet finalized. Additional feedback on patient relationship codes is not due to CMS until January 6, 2017 and will not be finalized until April 2017.

The proposed model includes an assignment of fiscal risk attribution for each condition or procedural episode to serve as a guide for payment to or from the APM entity. While intended to serve as a guide, the basis for these percentages and how they were derived is not readily apparent. More concerning, the proposal indicates these percentages could be applied across different APM entities and CMS could adopt this accountability rubric broadly across the portfolio of payment models.

An entity's share of the accountability for an episode is determined based on the qualifying participant's (QPs) clinical role in the episode and the number of other clinicians providing care to the patient for that episode. While in concept this is logical, participants will be unable to know with any precision or predictability in advance whether they are QPs particularly where volumes for roles outside of principals such as ancillaries are involved.

Episode Logic –Without being able to view the specifics of the EGM methodology, how the episodes would apply to pathology is unclear. In addition, with an objective of the EGM to frame spending patterns in ways that highlight opportunities for improvement seems to presume use by the ordering physician, when in fact the pathologist would need to be engaged with the ordering physician on appropriate laboratory testing. The focus on cost spending patterns and risk adjustment without taking into account new technologies could deter the ordering and use of novel and medically necessary laboratory testing, including molecular testing.

The proposal indicates an episode grouper which bundles all care for a condition into a single unit of analysis that is intended to serve as the basis for cost comparisons. As proposed, for clinicians to improve care, they need to understand processes of care, not just in the abstract, but also for their own patients. This requires not only formal analytics to support clinical judgment to identify areas for improvement. Involving all clinicians most suited to help interpret appropriateness of services in their specialty is necessary (e.g. pathologists involved with clinical colleagues on appropriate laboratory testing and pathology services).

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The proposal indicates the model is a multi-payer model yet the approach to developing episodes is well-defined diseases and illnesses that make up a significant percentage of Medicare spending. The application of the model in a multi-payer environment and/or where volume is relatively low is unclear.

Finally, the proposal indicates the model is based on an updated version of the EGM. While extensive information on the EGM is provided, the differences between it and the updated version not currently used by Medicare were not readily identifiable.

We thank you for the opportunity to comment on the proposed ACS-Brandeis AAPM. Should you have additional questions, please do not hesitate to contact Sharon West, JD, Director, Economic and Regulatory Affairs at swest@cap.org or 202-354-7112 or Mark Adelsberg, Manager, Economic and Regulatory Affairs at madelsb@cap.org or 202-354-7118.