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December 22, 2016

Physician-Focused Payment Model Technical Advisory Committee
C/o U.S. DHHS Asst. Sec. of Planning and Evaluation Office of Health Policy
200 Independence Avenue S.W.
Washington, D.C. 20201

RE: American College of Surgeons, ACS-Brandeis Advanced Alternative Payment Model

Dear Committee Members:

On behalf of the more than 50,000 hospitalists now practicing in the US and the Society of Hospital Medicine (SHM), the medical professional association representing hospitalists, we would like to express our strong support for the proposal for a Physician-Focused Payment Model, which was submitted to the PTAC for review by the ACS and Brandeis. The ACS-Brandeis Advanced Alternative Payment Model (APM) seeks to provide novel incentives and tools for providing both efficient and effective care by improving the quality of care and reducing costs. The model is episode-based, built on an updated version of the Episode Grouper for Medicare (EGM) software, currently used by CMS for measuring resource use.

SHM and our hospitalist national thought leaders have been partners with ACS and Brandeis in the development and evolution of this unique approach to payment reform.

Financial risk is attributed to providers based on their individual role in providing care to the patient. Payments can be adjusted based upon the quality of care delivered. Unlike existing CMS episode-based payment models, the ACS-Brandeis model does not require a hospitalization, allowing inclusion of procedures performed in the outpatient setting as well as episodes for acute and chronic conditions cared for by medical specialties.

While this initial proposal is primarily for the surgical patient, we believe this patient-focused approach, based on the team-based nature of care for the surgical patient, can be expanded to be a format for more than just surgical care and could easily be translated to other forms of specialty care that hospitalists are managing every day.

If implemented, it is our sincere belief that this model will provide opportunities for participation in Advanced APMs to providers who have until now lacked options for meaningful participation. This will enhance the ability of many physicians to participate

in transformative delivery system reforms in a way that is designed to be clinically meaningful to them and to the patients they serve.

SHM is strongly in support of the ACS-Brandeis Advanced Alternative Payment Model and we hope that CMS will adopt this and as we move forward in designing the alternative payment models of the future that we will be able to build on this model and create innovative incentives to promote efficient and effective care by improving the quality of care and reducing costs.

Yours,

A handwritten signature in dark ink, appearing to read "Brian Harte".

Brian Harte, MD, SFHM
President, Society of Hospital Medicine

A handwritten signature in dark ink, appearing to read "Ron Greeno M.D.". The signature is written in a cursive style.

Ron Greeno, MD, MHM
President-Elect, Society of Hospital Medicine

January 3, 2017

Physician-Focused Payment Model Technical Advisory Committee
U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, D.C., 20201

Dear PTAC Members:

Remedy Partners currently acts as the APM Entity, through an Awardee Convener contract in the Medicare BPCI initiative, for over 100 health care organizations initiating bundled payment episodes at over 1,400 sites of care. We are also rolling-out bundled payment programs for managed care organizations, serving their employer, self-insured, Medicare Advantage and Medicaid programs. We offer these comments on the APM framework proposed by Brandeis and the American College of Surgeons from the perspective of coordinating tens of thousands of episodes daily.

We sincerely appreciate the efforts by Brandeis/ACS to propose a framework for APM entities to consider when assigning the risk/reward to Qualified Practitioners. We also applaud their efforts to suggest a framework that could be used to meet MACRA Advanced APM requirements.

Separately, we have made a wide range of recommendations to CMS for improving the BPCI initiative, in whatever form it takes next. Our recommendations are admittedly from the perspective of an organization serving hospitals, physician groups and post-acute providers. We therefore approach our advocacy from the perspective of accommodating a wide range of participants as what BPCI defined as an Episode Initiator.

Addressing Medicare's most pressing issues, our suggestions for improvements to Episode Payment Models covers the following goals:

1. Scale – achieving high levels of voluntary participation
2. Viability – creating the conditions for economic sustainability
3. Accuracy – refining attribution and pricing methodologies
4. Fairness – fostering trust and accountability
5. Impact – improving outcomes and lowering costs

We have not ventured into suggesting new episode definitions or recommendations for how each Awardee (to use a BPCI term) manage the details of their risk arrangements. Our presumption is that Medicare's more permanent episode APM needs to attract substantial voluntary participation and that mandatory bundles face insurmountable

political opposition. For that reason, we seek practical and administratively reasonable solutions to the already complex challenges inherent in bundled payments.

With that background, our summary comments and observations are as follows:

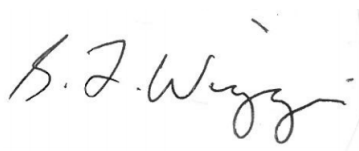
1. The proposed APM framework should only be a guide to APM entities accepting financial risk and should not be prescriptive about risk-sharing and responsibility. An entity's enrollment in Medicare, or a physician's Board certification, should not determine eligibility for, or the limit placed on, risk-sharing.
2. The proposed APM examples include an implicit assumption that allocation of risk and reward is appropriately tied to the physician's relative billings. We believe this is an erroneous methodology for attributing savings. Spending and quality outcomes are most often controlled by practitioners billing far less than surgeons; how much you bill is not proportionate with how much you drive cost and quality outcomes. There needs to be a recognition that rewards should also be made available to non-physicians who are in a position to significantly impact the key drivers of cost and quality.
3. In general, the APM framework proposed will increase the complexity of administering bundled payments and requires further refinement before being ready for use in a live bundled payment program. Triggering logic, grouping logic, closing rules, an opaque comorbidity/risk adjustment schema, and nesting are all in need of further refinement. This is a good starting place for considering refinements, but this APM framework is far from ready for prime time.

We strongly urge the Physician-Focused Payment Model Technical Advisory Committee to refrain from endorsing the Brandeis/ACS proposed episode APM as it is currently structured.

Again, we salute the effort and appreciate the contribution by Brandeis/ACS to the recommended ways that APM entities could allocate risk/reward and achieve Advanced APM status for MACRA. Efforts to refine their approach should be encouraged, but not recommended. There are easier and more pragmatic ways to achieve Medicare's goals.

Thank you for the opportunity to address comment on the Brandeis/ACS proposal for episode APMs.

Sincerely,



Steve Wiggins
Chairman

January 4, 2017

Physician-Focused Payment Model Technical Advisory Committee
C/o U.S. DHHS Asst. Sec. of Planning and Evaluation Office of Health Policy
200 Independence Avenue S.W.
Washington, D.C. 20201
PTAC@hhs.gov

RE: American Society of Anesthesiologists Support for the American College of Surgeons, ACS-Brandeis Advanced Alternative Payment Model

Dear Committee Members,

The American Society of Anesthesiologists (ASA) appreciates the opportunity to comment on the ACS-Brandeis Advanced Alternative Payment Model (APM). The ASA, along with other specialty societies, have been closely monitoring the development of this model and we offer our support for this model as an effective pathway into advanced APMs for those clinicians who are at the cornerstone of payment and patient care reform yet currently lack access to advanced APM practice opportunities. Specifically, many surgical, procedural and related clinicians should find new opportunities with the implementation of this payment model. The ACS-Brandeis model notably is designed to be applicable across diverse clinical care settings.

The application of the episode grouper application in this proposal is a highly valuable contribution to structuring an adaptable APM model. The proposed overlay of quality-based adjustments represents an important safety valve for an approach that must recognize quality, safety and value. ASA looks forward to contributing quality metrics that address anesthesia-related care in these episodes.

The ASA and the ACS-Brandeis model share a collective vision to recognize high quality surgical care as a team-based, multidisciplinary endeavor. The team-based approach recognizes the contributions of each critical member of a care team, including medical specialists, primary care and all other participants in the continuum of surgical and procedural care delivery. As part of this focus, the ASA has been organizing and partnering with other medical and surgical specialties to implement the Perioperative Surgical Home (PSH) care delivery model in dozens of healthcare organizations across America. The PSH is a system of coordinated patient care, which spans the entire experience from decision of the need for any invasive procedure—surgical, diagnostic, or therapeutic—to discharge from the acute-care facility and beyond. The PSH strives to achieve the triple aim of better patient experience, better healthcare, and reduced expenditures for all patients undergoing surgery and invasive procedures. Early experience with our PSH model shows very encouraging evidence of achieving these goals.

We understand that the composition of the team and the inputs of each member of the team will vary significantly from one setting to the next. For this reason, we take the attribution model described in the ACS-Brandeis submission as an illustrative example that may provide a starting point for individual APM entities to collaboratively develop their own risk-reward distribution model.

The ASA looks forward to having the opportunity to work with the necessary medical specialty society and regulatory stakeholders to further the goals of this payment model as well as the PTAC's broad goals of recommending models that promote quality and value and expanding the CMS APM portfolio to clinicians who currently have limited options to participate.

If you have any questions regarding our comments, please contact Roseanne Fischhoff, Economics and Practice Innovations Executive for the ASA, at r.fischhoff@asahq.org or (847) 268-9169.

Sincerely,

A handwritten signature in black ink, reading "J. Plagenhoef, M.D." with a stylized flourish at the end.

Jeffrey Plagenhoef, M.D.
President
American Society of Anesthesiologists



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 Tejada
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



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



COLLEGE of AMERICAN PATHOLOGISTS

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).



COLLEGE of AMERICAN PATHOLOGISTS

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.



The Society of Thoracic Surgeons

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January 11, 2017

(Submitted electronically via PTAC@hhs.gov)

Physician-Focused Payment Model Technical Advisory Committee (PTAC)
Department of Health and Human Services
Assistant Secretary of Planning and Evaluation
Office of Health Policy
200 Independence Avenue SW
Washington, D.C. 20201

RE: ACS-Brandeis Advanced APM submitted by the American College of Surgeons

Dear PTAC Members:

The Society of Thoracic Surgeons (STS) is pleased to provide comments in support of the ACS-Brandeis Advanced Alternative Payment Model (APM) submission. Founded in 1964, STS is a not-for-profit organization representing more than 7,400 surgeons, researchers, and allied health care professionals worldwide who are dedicated to ensuring the best possible outcomes for surgeries of the heart, lung, and esophagus, as well as other surgical procedures within the chest. The mission of the Society is to enhance the ability of cardiothoracic surgeons to provide the highest quality patient care through education, research, and advocacy.

STS requests that PTAC evaluate the submission with our support in mind and with the acknowledgement that currently-approved APMs do not provide meaningful participation options for surgeons. We believe that the ACS-Brandeis model provides the opportunity for surgeons to participate in an APM that supports patient care and improved outcomes by focusing on how patients receive care and the services that physicians directly influence.

We also support the ACS-Brandeis model because of how it can be applied across a variety of specialties. For example, we would like to direct your attention to *Appendix C: Society of Thoracic Surgeons Whitepaper on APM Collaboration*. We believe that STS is uniquely situated to complement the ACS-Brandeis submission in a way that reflects the clinical specificity needed in alternative-payment models while simultaneously acknowledging that the revenue and patient count thresholds finalized by the Centers for Medicare and Medicaid Services (CMS) to become a “qualified participant” (QP) in an Advanced APM will necessitate APM Entities taking on responsibility for multiple bundles in order to meet the QP thresholds. Bundles focused on specific procedures are not likely to afford cardiothoracic surgeons the opportunity to qualify as QPs. The inclusion of the STS National Database as

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PTAC

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part of the cardiothoracic episodes included in the model will allow for provider feedback to facilitate precisely the type of quality improvement and focus on resource use that PTAC seeks from APMs. We believe that the ACS-Brandeis model can be constructed in a way that allows specialties to bring resources, like the STS National Database, to the overall model without requiring CMS or the Center for Medicare and Medicaid Innovation (CMMI) to disassemble specialty episodes from the overall model.

We look forward to providing the Committee with more information on the STS quality/payment component and how it complements the model under consideration, and thank PTAC for the opportunity to support the ACS-Brandeis submission.

Sincerely,

A handwritten signature in black ink, appearing to read "Joe Bavaria", with a stylized flourish at the end.

Joseph E Bavaria, MD
President

January 11, 2016

Physician-Focused Payment Model Technical Advisory Committee
C/o U.S. DHHS Asst. Sec. of Planning and Evaluation Office of Health Policy
200 Independence Avenue S.W.
Washington, D.C. 20201
PTAC@hhs.gov

RE: Support for Consideration of the American College of Surgeons, ACS Advanced Alternative Payment Model

Dear Committee Members,

The undersigned organizations express their support for favorable consideration of the Physician-Focused Payment Model submitted for PTAC review by the American College of Surgeons on December 14, 2016.

The ACS-Brandeis Advanced Alternative Payment Model (APM) is an episode-based payment model built on an updated version of the Episode Grouper for Medicare (EGM) software which has been used by CMS for physician resource use reporting. The grouper processes Medicare claims data using clinical specifications to create condition-specific episodes to assess utilization and costs. The patient-focused philosophy of both the grouper and APM recognizes that surgical care is team-based, and that coordination with medical specialists, primary care and all the other segments of the delivery system involved plays an important role in improving outcomes.

Triggering an episode in this model does not require a hospitalization, meaning that the framework is applicable to multiple care settings. This flexibility is important because many specialties currently lack opportunities to meaningfully participate in voluntary Advanced APMs due to their geography, practice patterns or a lack of models covering their specific specialty or the specific type of care they provide. For surgical specialties and others that have developed or are developing models, these could be used in conjunction with the ACS proposal. While the current model focuses primarily on procedural episodes, its unique, physician-reviewed resource use methodology logically extends itself to other forms of specialty care including care for acute and chronic medical conditions.

The undersigned organizations, recognizing the potential of this model, have been closely monitoring or participating in its development and many have been actively involved in reviewing the clinical content of individual episodes, including trigger codes and relevant services. As the Committee moves forward with its review and evaluation of the ACS-Brandeis Advanced APM we urge you to keep in mind the model's flexibility and potential for expansion and future development. We thank you in advance for your consideration.

Sincerely,

American Academy of Orthopaedic Surgeons
American Academy of Otolaryngology—Head and Neck Surgery
American Medical Association
American Society of Anesthesiologists
American Society of Breast Surgeons
American Society of Plastic Surgeons
American Urological Association
Society for Vascular Surgery
Society of Hospital Medicine
The Society of Thoracic Surgeons

January 12, 2017

Physician-Focused Payment Model Technical Advisory Committee (PTAC),
C/o U.S. DHHS Asst. Sec. of Planning and Evaluation Office of Health Policy
200 Independence Avenue S.W. Washington, D.C. 20201
PTAC@hhs.gov

Public Comment – American College of Surgeons, ACS-Brandeis Advanced Alternative Payment Model

Dear Committee Members,

We reviewed the document “Proposal for a Physician-Focused Payment Model: ACS-Brandeis Advanced Alternative Payment Model” which is currently in exposure for comments through today. Our notes for your consideration are as follows:

- When designing the risk adjustment mechanism consider including an independent variable that identifies emergent vs elective surgery. For background see <https://www.ncbi.nlm.nih.gov/pubmed/25521669>.
- Consider including credibility standards in any shared risk / savings formula to help separate noise from degree of healthcare management. For example, a provider might need to participate in at least 30 surgeries under a given APM to be eligible for the full savings payment.
- When developing risk adjusted payment rates consider truncating claim costs for episodes costing more than a set amount, and then excluding these amounts when administering the shared savings / risk formula.
- Consider excluding components of medical utilization for which statistical evidence suggests that the service is not significantly impacted by care management protocols (e.g., distinguish between avoidable and non-avoidable ER visits).
- Per appendix page B2 (i.e., PDF page 130) consider model architectures other than those fit using simple linear regression models. For example, modern model architectures such as random forests often produce stronger fits to a given calibration dataset.

Thank you,



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American College of
RADIATION ONCOLOGY
Integrating Science and Technology into Patient Care

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January 12, 2017

Physician-Focused Payment Model Technical Advisory Committee
C/o U.S. DHHS Asst. Sec. of Planning and Evaluation Office of Health Policy
200 Independence Avenue S.W.
Washington, D.C. 20201
PTAC@hhs.gov

RE: American College of Surgeons, ACS Advanced Alternative Payment Model

Dear Committee Members,

The American College of Radiation Oncology (ACRO) is pleased to offer its comments to the PTAC regarding the Physician-Focused Payment Model submitted for PTAC review by the American College of Surgeons on December 14, 2016. With a current membership of over 1,200, ACRO is dedicated to fostering radiation oncology education and science; improving patient care services; studying the socioeconomic aspects of the practice of radiation oncology; and encouraging education in radiation oncology.

The ACS-Brandeis Advanced Alternative Payment Model (APM) is an episode-based payment model built on an updated version of the Episode Grouper for Medicare (EGM) software which has been used by CMS for physician resource use reporting. The grouper processes Medicare claims data using clinical specifications to create condition-specific episodes to assess utilization and costs. The patient-focused philosophy of both the grouper and APM recognizes that medical care is team-based, and that coordination with medical specialists, primary care and all the other segments of the delivery system involved plays an important role in improving outcomes.

Triggering an episode in this model does not require a hospitalization, meaning that the framework is applicable to multiple care settings. This flexibility is important because many specialties currently lack opportunities to meaningfully participate in voluntary Advanced APMs due to their geography, practice patterns or a lack of models covering their specific specialty or the specific type of care they provide. For radiation oncology and others that are developing models, these could be used in conjunction with the ACS proposal. While the current ACS model focuses primarily on procedural episodes, its unique, physician-reviewed resource use methodology logically extends itself to other forms of specialty care including care for acute and chronic medical conditions.

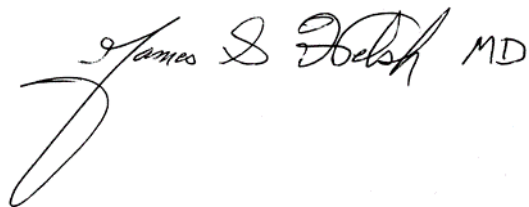
ACRO, recognizing the potential of this model, has been closely monitoring the development of the ACS model and would like to clarify two aspects of the model important to the practice of radiation

oncology. First, Exhibit 4 of the ACS proposal, notes that in some cases of palliative care, radiation oncology might be considered to be a “supporting provider.” While this may be the case in certain instances, ACRO strongly believes that in cases where radiation therapy is the primary provider or crucial in the adjuvant care intervention that the radiation oncologist should be considered the episodic provider. We believe ACRO’s perspective is consistent with the most recent CMS posting on “CMS Patient Relationship Categories and Codes.” Recent conversations with ACS staff also lead us to believe that the ACS proposal implicitly recognizes that in cases where radiation therapy is the primary or delivering crucial adjuvant care intervention that the radiation oncologist should be considered the episodic provider.

Second, while we applaud the ACS proposal’s efforts to develop a team-based approach, we wish to explicitly acknowledge that care of cancer patients is often multi-disciplinary in “focused episodes” (e.g. radiation oncology) with interval acute interventions as well as ongoing, broader episodic care. Such is often the case with radiation oncology interventions. Here again, we believe ACRO’s perspective is consistent with the most recent CMS posting on “CMS Patient Relationship Categories and Codes” and the ACS proposal.

Taking into account the aforementioned clarifications to the ACS proposal, ACRO would offer its support for favorable consideration by the PTAC of the ACS model. As the Committee moves forward with its review and evaluation of the ACS-Brandeis Advanced APM we also urge you to keep in mind the model’s flexibility and potential for expansion and future development. We thank you in advance for your consideration.

Sincerely,

A handwritten signature in black ink that reads "James S. Welsh MD". The signature is fluid and cursive, with the letters "J", "S", and "W" being particularly prominent.

James Welsh, M.D., FACRO
President
American College of Radiation Oncology
5272 River Road, Suite 630
Bethesda, Maryland 20816

Sincerely,

A handwritten signature in black ink that appears to read "Sheila Rege". The signature is stylized, starting with a large circle and followed by a series of loops and a long horizontal stroke.

Sheila Rege, M.D., FACRO
Chair, Economics Committee
American College of Radiation Oncology
5272 River Road, Suite 630
Bethesda, Maryland 20186

January 12, 2017

Members of the Physician-Focused Payment Model Technical Advisory Committee
c/o Angela Tejada
Office of the Assistant Secretary for Planning and Evaluation
Department of Health and Human Services
200 Independence Ave. SW
Washington, DC 20201

RE: ACS-Brandeis Advanced Alternative Payment Model proposal

Dear members of the Physician-Focused Payment Model Technical Advisory Committee (PTAC):

The Consumer-Purchaser Alliance is a collaboration of leading consumer, labor, and employer organizations committed to improving the quality and affordability of health care through the use of performance information to guide consumer choice, payment, and quality improvement.¹ We appreciate the opportunity to provide input on the proposed models for physician-focused payment models, including the ACS-Brandeis proposal for a payment model based on multiple procedural and condition episodes.

We encourage the PTAC to consider how physician-focused payment models will meet the needs of many stakeholders. Through the Health Care Payment Learning and Action Network (LAN) and Health Care Transformation Task Force (HCTTF), consumers and purchasers have laid out key principles for new payment and care delivery models.² The table below summarizes our analysis of how the ACS-Brandeis proposal addresses these key principles, and additional comments on select components of the model follow. Overall, we support the direction of the proposed model, particularly the design to promote coordinated and team-based care, and the concept of the Surgical Phases of Care measure set that brings the performance of various clinicians on multiple components of care into a cohesive picture of an episode of care.

¹ For brevity, we refer in various places in our comments to “patient” and “care,” given that many Medicare Part B programs are rooted in the medical model. People with disabilities frequently refer to themselves as “consumers” or merely “persons.” Choice of terminology is particularly important for purposes of care planning and care coordination, when the worlds of independent living and health care provider often intersect.

² The LAN consumer and patient principles are available here: <http://hcp-lan.org/workproducts/cpag-principles.pdf>. The HCTTF guiding principles and key questions for addressing consumer priorities are available here: <http://hcttf.org/resources-tools-archive/2016/8/30/addressing-consumer-priorities-in-value-based-care>. Purchaser principles are not finalized as of 1/12/17; our comments rely on draft principles developed by the LAN Purchaser Affinity Group.

Consumer/Purchaser Principle	Analysis of ACS-Brandeis proposal
Include patients/consumers as partners in decision-making at all levels of care	<ul style="list-style-type: none"> • We appreciate that ACS has proactively sought consumer input on the design of the model and on the approach to the Surgical Phases of Care (SPC) measure set, and the proposal reflects this input. • Little information is provided for how patients, consumers, families, and caregivers would be engaged in the implementation of this model on the ground, such as in the design of individual A-APM contracts or the establishment of new care workflows to support these episodes. • The SPC measure set includes multiple measures that could engage patients, families, and caregivers; it is not clear whether these measures will be weighted preferentially to encourage such engagement or meaningful shared decision-making.
Positive impact on patient care and health is paramount	<ul style="list-style-type: none"> • The SPC measure set emphasizes the central role of patient care and health through personalized risk assessment, care goal establishment and periodic assessment, and outcome measures.
Measures of performance and impact should be meaningful, actionable, and transparent	<ul style="list-style-type: none"> • We support the direction of the performance measurement strategy proposed here and have detailed questions and comments below.
Primary care services are foundational and must be effectively coordinated with other aspects of care	<ul style="list-style-type: none"> • The proposal emphasizes team-based care and appropriately incorporates the need for coordination and collaboration among a clinical team through model design, quality measures in the SPC set, and fiscal attribution. • The model includes post-discharge quality metrics and the episode grouper design allows for post-acute care to be included in the episodes. Without greater detail about the specific episodes proposed, it is unclear whether the episodes include the cost and quality of, thereby promoting coordination and integration with, post-acute care services, community services and supports, and other services delivered through non-traditional settings and modalities that meet patient needs.

Promote health equity for all	<ul style="list-style-type: none">• We support the risk adjustment described in Appendix D of the proposal. As we have noted in other settings, we strongly prefer that risk adjustment for sociodemographic factors not be built into quality measure calculations; instead, measures should be stratified to show performance for the various patient groups. ACS-Brandeis notes that sociodemographic factors can impact clinical performance and health outcomes; nonetheless, a complex patient population deserves high quality care that yields good outcomes. We support approaches to address sociodemographic factors via payment, and we would be glad to discuss possible approaches to modify an APM entity's or individual QP's fiscal incentives based on the sociodemographic factors of their patient population.
Accelerate use of person-centered health information technology	<ul style="list-style-type: none">• We urge ACS-Brandeis to describe how this model would accelerate the use of person-centered health information technology. Though interoperability between CEHRT and registries has many benefits, it does not advance information sharing between patients and their care teams.
Use transparent, meaningful, and aligned incentives that drive accountability for quality outcomes, patient experience, and total cost of care	<ul style="list-style-type: none">• We applaud ACS-Brandeis for developing a nuanced proposal that promotes team-based care and accountability for patient experience, patient outcomes, and episode cost. The combined use of the episode grouper for Medicare and the designated clinician roles and weights for procedural and condition episodes is innovative and well positioned to meet the goals of the MACRA A-APM track.• The proposal is well designed to facilitate multi-payer alignment. However, it may be more complex to implement this model in markets where population-based payment models such as ACOs are also in place.• We are eager to see how this model might evolve over time, including maturation of specific procedural and condition episodes and the exploration of a shift toward population-based risk models.• We recommend that ACS-Brandeis make clear whether the model includes any measures of appropriateness that would ensure patients are not receiving more intensive services than necessary, nor that case mix severity adjustments result in upcoding.

Additional comments on the proposed approach to quality measurement

- We acknowledge the need for transitional periods that allow clinicians to gain experience with a program and that support the maturation of measure sets. A measurement strategy that focuses on participation is appropriate for the initial implementation of this model. We commend ACS-Brandeis for including the requirement that an “Excellent” rating can only be achieved through top performance on at least one measure. We support the directional statements that in more mature phases of the program, assignment of quality tiers will be based on performance. At the same time, we acknowledge that this evolution may require different timelines for different types of measures; for example, the model may retain a pay-for-reporting approach for patient-reported outcomes or patient-reported outcome measures (PROs and PROMs, respectively) to support development and testing of de novo PROMs for some time even after quality tier assignment is based on composite performance.
- Transparency of measures and performance is a key requirement for alternative payment and care models that effectively serve consumers and purchasers. We support the proposal’s direction to rely on Qualified Registries and Qualified Clinical Data Registries that already have reporting mechanisms and requirements for sharing performance information with CMS. We encourage public reporting of performance information as a key component of any registry used for the quality components of an alternative payment model.
- We urge ACS-Brandeis to clarify the details of the measures available for the episodes already defined and the quality measurement approach, even in the early transition period of the model. Regarding the SPC measure set, some of the individual measures appear to be low value documentation and process measures (e.g., documentation of any single major co-morbid condition prior to surgery, with no assurance that all major co-morbid conditions are identified). However, the measure framework has the potential to promote highly patient-centered care with meaningful information to support quality improvement and accountability, if the individual measures are useful and appropriately prioritized. We are interested in more information about the weighting of various measures available in both the All Patient-based and Episode-based quality categories. We recommend that greater weight be given to higher value measures, such as unplanned readmissions and patient experience. The Consumer-Purchaser Alliance has published criteria for high value measures here:
http://www.consumerpurchaser.org/docs/files/CP%20Alliance_10_Measure_Criteria.pdf.
- The proposal notes that in the Episode-based quality category, any acceptable rating is only available to those clinicians or APM Entities who demonstrate their ability to collect PROMs in at least one episode for some percentage of patients. However, the details about the PROMs under consideration for the model are unclear. Are these established PROMs? Are these PRO tools in wide use that are good candidates for measure development? Would this requirement allow clinicians and APM entities to collect information about any PRO tool relevant to the episode at their discretion? We strongly support the use of PROMs in alternative payment models and also support any concerted effort to build the development and testing of new PROMs into an alternative payment model to improve care and outcomes in ways that matter to patients.
- We encourage ACS-Brandeis to consider opportunities to expand the All Patient-based quality category to include PROs and PROMs that are cross-cutting or address health-related quality of life, such as PROMIS-Global or VR-12. Alternatively, the category could offer some incentive for a clinician or APM Entity to use PRO tools that directly assess their primary area of practice.

Thank you again for the opportunity to comment on the proposed alternative payment model. Episode payment models present a significant opportunity to improve our nation's health care system through better quality, improved care coordination, lower costs, and greater transparency. If you have any questions about our comments, please contact Stephanie Glier, Senior Manager for the Consumer-Purchaser Alliance, at sglier@pbgh.org.

Sincerely,



Bill Kramer
Executive Director, National Health Policy
Pacific Business Group on Health
and
Co-Chair, Consumer-Purchaser Alliance



Debra Ness
President
National Partnership for Women & Families
and
Co-Chair, Consumer-Purchaser Alliance



LUGPA

Integrated Practices
Comprehensive Care

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January 12, 2017

BY ELECTRONIC SUBMISSION

Physician-Focused Payment Model Technical Advisory Committee
c/o Angela Tejada
Assistant Secretary for Planning and Evaluation
200 Independence Ave SW
Washington, DC 20201

RE: ACS-Brandeis Advanced Alternative Payment Model

Dear Ms. Tejada:

On behalf of LUGPA, we thank you for the opportunity to comment on the ACS-Brandeis Advanced Alternative Payment Model, which was submitted by the American College of Surgeons (ACS) to the Physician-Focused Payment Model Technical Advisory Committee (PTAC) for review on December 13, 2016. LUGPA wishes to thank the ACS for our inclusion in their webinars on the development of this APM and we support the efforts of the authors to design an alternative payment model (APM) which focuses on the contributions of specialty physicians to innovative care delivery. Although we applaud the authors for creating a generalized vehicle to maximize the number of physicians who are eligible to meet the stated requirements of an APM, LUGPA's focus is the development of APMs with value-based clinical innovation that enables specialty physicians to take true bidirectional risk, and as such we are providing comments in that regard. With respect to the ACS-Brandeis Proposal, while we commend the authors on creating a robust description of surgical episodes of care, we have concerns that the diffusion of economic accountability across such a wide variety of healthcare providers may limit full clinical integration and the development of full risk sharing among providers.

I. LUGPA

In 2008, when physician leaders of large urology group practices began to recognize the need for a formal association to help meet the challenges of the future, LUGPA was initially established with the purpose of enhancing communication between large urology groups, allowing for benchmarking of operations, promoting quality clinical outcomes, developing new business opportunities, and improving advocacy and communication in the legislative and regulatory arenas. Since that time, LUGPA has expanded its mission to include smaller group practices that are equally committed to providing integrated, comprehensive services to patients suffering from genitourinary disease. LUGPA currently represents 135 urology group practices in the United



States, with more than 2,000 physicians who, collectively, provide approximately 30% of the nation's urology services.

Integrated urology practices are able to monitor health care outcomes and seek out medical “best practice” in an era increasingly focused on medical quality and the cost-effective delivery of medical services, as well as better meet the economic and administrative obstacles to successful practice. LUGPA practices often include other specialists, such as pathologists and radiation oncologists, who work as teams with urologists to coordinate and deliver care through a convenient one-stop shop for the patient. LUGPA's mission is to provide urological surgeons committed to providing integrated, comprehensive care the means to access resources, technology, and management tools that will enable them to provide all services needed to care for patients with acute and chronic illnesses of the genitourinary system, including patients with prostate, bladder and kidney cancers, in an efficient, cost-effective, and clinically superior manner, while using data collection to create parameters that demonstrate quality and value to patients, vendors, third party payers, regulatory agencies, and legislative bodies.

As a specialty, urology is particularly well suited to the development of APMs, particularly those around specific episodes of care. Urology is relatively unique as a surgical discipline in that while urologists are not primary care physicians, we are the *principal* providers of care for the genitourinary tract. As such, patients are typically referred to urologists not with a diagnosis, but with clinical signs or symptoms – the urologist performs the cognitive evaluation (including the ordering of appropriate laboratory and /or imaging studies), makes the diagnosis, determines if medication or surgery is warranted, orders the medication or performs the necessary procedure and then is responsible for the longitudinal follow-up of the patient. While other physician specialties may be involved in the care of the patient, typically such involvement is temporally limited; as such, the creation of standardized clinical pathways and clinically integrated networks affords urology groups the opportunity to create genuine shared savings in the context of true improvement in outcomes. This opportunity has not gone unnoticed by regulatory bodies – as long ago as 2010, the Medicare Payment Advisory Committee (MedPAC) acknowledged that clinically integrated groups “could be well positioned to succeed under a new payment model.”¹

The ability for independent physician groups to be the most appropriate site for risk-sharing arrangements is supported by data in the literature. A landmark study on ACO expenditures² determined that quality was higher and costs were lower in ACOs managed by independent physician groups than those operated by hospital. Specifically, this study found that risk sharing arrangements operated by large physician groups performed better in 80% of quality parameters measured. Furthermore, while costs were lower in every Berenson-Eggers type of service (BETOS) category when such risk sharing arrangements were operated by independent physicians, the categories with the largest cost differential included items such as diagnostic imaging, laboratory, radiation therapy and Part B drug expenditures; importantly, these services are commonly incorporated into LUGPA member practices. The ability for integrated urology groups to control the utilization, cost and quality of these services dovetails perfectly with the stated goal of the triple aim.

¹ MedPAC report to the Congress, June 2010. Aligning Incentives in Medicare, p. 227.

² McWilliams JM, Chernew ME, Zaslavsky AM, et al. Delivery system integration and health care spending and quality for Medicare beneficiaries. (2013) JAMA internal medicine, 173(15), 1447-1456

II. Definition of Advanced APM entities

Perhaps due to submission restrictions on the length of the proposal, we were unable to precisely ascertain who would be assuming risk under this proposal. The proposal states that APM entities would be organizations that enter into risk-based contracts with Medicare, but the model does not provide any information on what type of organizations can achieve this role. The model also does not describe details regarding the relationship which providers will need to establish with the APM entity in order to be eligible to be Qualifying APM Participants, other than stating that such entities would include one or more Clinical Affinity Groups (CAG).

It is very important before adopting a specific methodology such as that proposed by the ACS, that there be clear definitions of the criteria used to define the APM entity and clinical affinity groups. Without these clear definitions, it is nearly impossible for physicians to be sure that they would be able to participate at these levels in the proposed APM. While we imagine that clinically integrated urology groups would meet these criteria, it is essential for groups to understand these proposed parameters for risk sharing.

It is LUGPA's position that fully integrated single- or multi-specialty groups are optimally positioned to create payment models to take the bidirectional risk needed to operate a truly innovative advanced APM.

III. Use of the episode grouper

The episode grouper used by the proposed ACS-Brandeis model is currently a "black box" model (without publicly available documentation of how claims are assigned and what conditions and procedures are included). We suggest that if this proposal were to be adopted, that the mechanics of the algorithm not only be publicly available, but available without cost to all clinicians for them to understand the risks inherent in their participation in this proposed APM. Even if such information was made available, the complexity at the core of any black box system is of concern – physician practices may lack the technical sophistication or resources to fully comprehend their risks. By contrast, BPCI, CJR, OCM and other programs have taken the approach of defined episodes that are readily understandable – the programs have also been publicly disseminated with all required documentation necessary to replicate the respective episodes of care.

While evaluation of historical data is clearly required to determine baselines for both cost and outcomes, LUGPA strongly supports a process that asks providers to collaboratively agree on prospective clinical "best practice" standards for their patients and evaluating practices on their ability to implement harmonized pathways with respect to either their own baseline or to the prevailing community standards, thereby optimizing value based care. By relying on changes in episode groupers without providing a framework for clinical integration within an APM entity, we are concerned that the detailed input of specialty healthcare providers who are best suited to achieve care pathway innovations of value may be marginalized.

The proposal states as one of its strengths that 'most clinicians in most specialties could practice as Qualified Participants (QPs) in an advanced APM environment' under the model's auspices. We concur that the model as presented could be a platform for broad participation in APMs by specialists who lack other vehicles for APM involvement. That said, it is LUGPA's belief that a more prospective model, in which providers agree on best practice and then are held accountable to it by taking risk, is a stronger model which will accelerate innovation within specialty practice more rapidly and effectively.

IV. The potential for diffused accountability in this proposal may reduce true risk-sharing

The proposed APM seems to inherently diffuse cost accountability, as is clear in the discussion of nested episodes-within-episodes. Collaboration among providers is clearly an admirable and necessary goal, but without specific accountability for clinical decisions that may deviate from best practice pathways, true risk-sharing may be diluted. LUGPA also sees challenges in attributing which percentage of episodes will go to which specialty providers. Without direct input from the specialists themselves, such assignments may be perceived as arbitrary. The incentive to develop pathway efficiency or avoid unnecessary procedures may be reduced without proper accountability for clinical decisions (and their inherent costs and consequences).

The diffusion of cost accountability that is given in example scenarios includes not only the physicians who are taking primary responsibility for managing certain conditions, but also those who provide ancillary services for the patient. Often, these ancillary providers are performing services that were ordered by the primary managing professional, and these services may be an expensive component of care. This does not demean the value or importance of these professionals to the care of the patient; however, ensuring that such services are utilized appropriately is a critical component of a clinical pathway and is largely under the purview of the managing professional. The proposal calls for identification of providers within an episode via billed services and distribution of such shared savings via pre-determined algorithm. Without further details, LUGPA is concerned that such a method may appear arbitrary to providers and not properly credit those that are actually making the decision to reduce utilization of these services. In addition, such a formula may not adequately attribute savings that result from use of clinically equivalent but less expensive pharmaceuticals or utilization of lower cost sites of service (such as performing a procedure in an ambulatory surgery centers as opposed to a hospital outpatient department).

V. Request for Action

The ACS-Brandeis proposal is to be commended as a vehicle for broad based applicability. While this model as written provides a good framework for physicians who do not have the capacity to create their own risk sharing entities, we believe that clinically integrated group practices have the capability to create even more tangible enhancements in outcomes and shared savings through the development of prospective best practice guidelines. Adoption of this model, if implemented, should be voluntary and not impede the development or adoption of other, potentially more robust options.

LUGPA stands ready to assist the PTAC and CMS as it continues its work to develop novel APMs. Please feel free to contact Dr. Kapoor at (516) 342-8170 or dkapoor@impplc.com if you have any questions or if LUGPA can provide additional information to assist CMS as it considers these issues.

Respectfully submitted,



Neal D. Shore, M.D.
President



Deepak A. Kapoor, M.D.
Chairman, Health Policy

cc: Celeste Kirschner, Chief Executive Officer, LUGPA

March 8, 2017

Submitted electronically via PTAC@hhs.gov

Physician Focused Payment Model Technical Advisory Committee
c/o United States Department of Health and Human Services
Assistant Secretary of Planning and Development Office of Health Policy
200 Independence Ave S.W.
Washington, DC 20201

RE: American College of Surgeons (ACS)–Brandeis Advanced Alternative Payment Model

Dear Committee Members:

The American Association of Nurse Anesthetists (AANA) welcomes the opportunity to comment on the proposed American College of Surgeons (ACS)–Brandeis advanced alternative payment model (APM). The AANA appreciates the shared accountability team-based model approach proposed by the ACS model. As the role of anesthesia and Certified Registered Nurse Anesthetists (CRNAs) are directly mentioned in the proposal, we seek further clarification about how CRNAs will be incorporated into this model. Specifically, the AANA makes the following comments and requests:

- Ensure equal treatment of CRNAs and anesthesiologists in the model and clarify that CRNAs are included in all three levels of aggregation.
- Confirm whether the application and meaning of the terms *nesting* and *clustering* and *bundles of bundles* provide flexibility whereby they do not reduce a CRNA's ability to participate at the same level of an anesthesiologist
- Clarify the patient relationship categories and their corresponding levels of financial risk attribution
- Identity the 54 proposed procedural episode groups used in this model
- Proposal makes mention of rural and small practices ability to participate but does not address barriers for participation

Background of the AANA and CRNAs

The AANA is the professional association for Certified Registered Nurse Anesthetists (CRNAs) and student nurse anesthetists, and AANA membership includes more than 50,000 CRNAs and student nurse anesthetists representing over 90 percent of the nurse anesthetists in the United States. CRNAs are advanced practice registered nurses (APRNs) who personally administer more than 43 million anesthetics to patients each year in the United States. Nurse anesthetists have provided anesthesia in the United States for 150 years, and high-quality, cost-effective CRNA services continue to be in high demand. CRNAs are Medicare Part B providers and since 1989, have billed Medicare directly for 100 percent of the physician fee schedule amount for services. CRNA provide every aspect of the delivery of anesthesia services including pre-anesthesia patient assessment, obtaining informed consent for anesthesia administration, developing a plan for anesthesia administration, administering the anesthetic, monitoring and interpreting the patient's vital signs, and managing the patient throughout the surgery. CRNAs also provide acute and chronic pain management services. CRNAs provide anesthesia for a wide variety of surgical cases and in some states are the sole

anesthesia providers in nearly 100 percent of rural hospitals, affording these medical facilities obstetrical, surgical, trauma stabilization, and pain management capabilities.

AANA Request: Ensure Equal Treatment of CRNAs and Anesthesiologists in the Model and Clarify that CRNAs are Included in All Three Levels of Aggregation

As the role of anesthesia and CRNAs are directly mentioned in the proposal, the AANA appreciates further clarification on how CRNAs will be incorporated into the model. CRNAs play an important role in the delivery of anesthesia care and post-operative pain management services and are critical in improving access to safe, cost-effective anesthesia care for all Americans. Furthermore, as CRNAs provide 43 million anesthetics per year, CRNAs practice with a high degree of autonomy. We also recognize that this model has the potential to drive value-based healthcare delivery, particularly in anesthesia care and related services, and meet the triple aims of improving patient experience of care, improving population health and reducing healthcare costs. The AANA expects that based on an anesthesia provider's clinical roles defined for each episode of care, CRNAs should automatically be included when anesthesiologists are mentioned. We urge the PTAC to ensure that CRNAs will not face professional discrimination based solely on licensure under the proposed APM.

The *ACS-Brandeis* model proposed three levels of aggregation above patient, episodes and clinicians, and our interpretation is that CRNAs are included in all three levels of aggregation. Specifically, the proposal uses the term "clinical teams" to mean individual clinicians will comprise a clinical team that furnishes care to a patient during a procedural episode. Clinicians in the team will have distinct roles and will share accountability for the cost and quality of that episode for an individual patient. The proposal also uses the term "*Clinical Affinity Groups (CAG)*," which is defined as a set of clinicians who participate together in episode groups to form the standards of care for the episode groups and who will be responsible for care redesign and improvement. Finally, the proposal uses the term "*Advanced APM Entity*," which is defined as organizations that enter into risk-based contracts with Medicare and other payers for the quality and cost of its contributions to episodes of care defined by the Episode Grouper for Medicare (EGM). If it is not the case that CRNAs are included among these three levels, we request clarification on how CRNAs will be incorporated into these three levels. We also request that the *ACS-Brandeis* model provide instruction regarding how an APM entity such as a medical home or ACO may participate in this proposed APM.

AANA Request: Confirm Whether the Application and Meaning of the Terms "Nesting," "Clustering," and "Bundles of Bundles" Provide Flexibility Whereby They do not Reduce a CRNA's Ability to Participate at the Same Level of an Anesthesiologist

We assume that the model is designed to be flexible whereby it does not reduce a CRNA's ability to participate at the same level of an anesthesiologist. We note that CRNAs and anesthesiologists both provide the same anesthesia services and use the same anesthesia CPT codes and HCPCs billing codes and are reimbursed 100 percent by Medicare, and therefore, should not be treated differently in this model. The proposal states the model was designed to be a "*bundle of bundles*" and "*clusters*" in a subspecialty with the

potential for procedural episode groups being “*nested*” in condition groups whereby grouper logic may accommodate “*nested*” episodes. Although these are interesting concepts, they are vague and do not provide detailed information and guidance on the group logic and their practical application and attribution to clinical practice by CRNAs and other members of the perioperative team. The ACS-Brandeis model acknowledges nurse anesthesia as one of the surgical subspecialties in procedural episodes, and we request confirmation as to whether the application and meaning of these terms provide flexibility whereby they do not reduce a CRNA’s ability to participate at the same level as that of an anesthesiologist.

AANA Request: Clarify the Patient Relationship Categories and their Corresponding Levels of Financial Risk Attribution

We request clarification of the patient relationship categories and their corresponding levels of financial risk attribution. We note that in the model, a clinician’s patient relationship category changes for each episode of care he or she furnishes as does his or her corresponding level of financial risk attribution. The *ACS-Brandeis* model classifies an anesthesia provider (e.g., anesthesiologist) as a *Supporting Provider* with financial risk at 30 percent for a procedural episode, but the methodology did not explain how they determined that this percentage was an appropriate level of risk. Furthermore, there is no data provided to substantiate these cost distributions relative to the clinical role. Given that resource use is a key factor in assessing a clinician’s performance in this model and is used in determining shared savings or shared risk, the AANA requests that ACS explain their attribution methodology so that it clearly reflects the cost of anesthesia care services provided by CRNAs and other anesthesia care providers. It is critical that the *ACS-Brandeis* model does not unfairly burden anesthesia care providers for costs that are unrelated to the services they provide particularly when it comes to issues such as readmissions and complications.

AANA Request: Identity the 54 Proposed Procedural Episode Groups used in this Model

We request that the proposal identify the 54 proposed procedural episode groups that are included in this model. It is critical that prior to implementation of this model, CRNAs are able to examine what procedures will be included so that they are aware of the level of services (i.e. simple or complex) they may be expected to provide as well as the potential costs associated these procedures. The current CMS bundled payment initiatives such as the Bundled Payments for Care Improvement (BPCI) and the Comprehensive Joint Replacement (CJR) programs list the procedures that are being tested and their respective diagnosis related groups (DRGs). The AANA requests that the *ACS Brandeis* model publish its list of procedural episodes, codes, grouper logic, and any corresponding documentation before PTAC makes any determinations.

AANA Comment: Proposal makes Mention of Rural and Small Practices’ Ability to Participate but Does Not Address Barriers for Participation

The *ACS-Brandeis* model makes mention of the ability of rural and small practices to participate in this model, but the proposal does not do enough to address barriers of participation for these practices. The *ACS-Brandeis* model recommends that small and rural providers consolidate their practices or convene as a group in order to be able to participate. This suggestion, however, does not deal with the challenges and barriers faced by small group practices. One challenge is the difficulty of implementing electronic health records (EHRs) into a solo or small surgical or anesthesia group practice. Using EHRs is a fundamental requirement for an advanced APM but many small and rural providers lack access to the capital and infrastructure needed. There is also a shortage of qualified personnel available to implement and maintain a practice's EHR system. If the intent of the model is to allow rural and small practices to participate, we request that the proposal address the barriers that these practices face.

The AANA appreciates this opportunity to comment and requests for additional occasions in which we may participate and provide input regarding the proposed *ACS-Brandeis* APM. Should you have any questions regarding this matter, please feel free to contact the AANA Senior Director of Federal Government Affairs, Ralph Kohl, at 202 741 9080 or rkohl@aanadc.com.

Sincerely,



Cheryl L. Nimmo, DNP, MSHSA, CRNA
AANA President

cc: Wanda O. Wilson, PhD, MSN, CRNA, AANA Executive Director
Ralph Kohl, AANA Senior Director of Federal Government Affairs
Romy Gelb-Zimmer, MPP, AANA Associate Director Federal Regulatory and Payment Policy



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February 3, 2017

Physician-Focused Payment Model Technical Advisory Committee
c/o U.S. DHHS Asst. Sec. of Planning and Evaluation Office of Health Policy 200 Independence Avenue
S.W. Washington, D.C. 20201

Letter of Support – Brandeis University, ACS-Brandeis Advanced Alternative Payment Model

We can imagine many scenarios in which various reforms under MACRA sputter, stall, or splinter, and ultimately disappoint. The “whole” may be less than the sum of the parts under scenarios of duplicative and misaligned efforts, with many working at cross-purposes. In contrast, we believe that the ACS-Brandeis model could help to establish and leverage an information and incentive platform that not only succeeds for its “part,” but also helps to shape and guide others’ efforts ultimately toward greater success.

Many small groups or even large companies have endeavored to create their own episode groupers, each representing one of a potentially infinite number of very different or slightly different ways to make inferences from claims data. That scenario can take us to the Tower of Babel, where multiple languages divide payers and providers into so many idiosyncratic conversations about how to measure cost and performance, but which fail to make reasonable, apples-to-apples comparisons and judgments.

A key aspect of the envisioned ACS-Brandeis platform is embodied in EGM, which is integral to our proposed strategy that calls upon CMS to lead national reforms via a “single-grouper solution.” EGM is a robust tool that recognizes every diagnosis and procedure code in relation to meaningful clinical concepts that can inform cost drivers and fiscal incentives. CMS can support EGM as a national resource that invites and rewards review and input from all medical and surgical specialties. Everybody benefits from others’ contributions within and across all clinical domains, so the benefits from all contributions are multiplied, rather than divided.

Historically, attempts at reform have tried carrots and sticks but few have succeeded in engaging the professionals with respect to their specific clinical work and the need for collaboration toward more excellent patient care. We believe that the ACS-Brandeis model will provide the missing hook, or impetus to engage, because it establishes a comprehensive yet clinically precise episode framework that is amenable to the merging of cost and clinical data, and to the most serious analysis in support of team-based care and shared accountability.

Brandeis University was the first-ever, and remains the most enduring external research and development partner for CMS. Our novel contributions to the field include diagnosis-based risk-adjustment for cost, the shared-savings payment model, hospital value-based purchasing, and the Episode Grouper for Medicare. We welcome opportunities to continue supporting CMS and the ACS-Brandeis model. At this point, we are uniquely qualified to configure, modify, and optimize the logic and specifications comprising the model, and to help educate others who can support and benefit from the model.

Sincerely,

A handwritten signature in cursive script, reading "Christopher P. Tompkins".

Christopher P. Tompkins, PhD
Associate Professor
Director, Institute on Healthcare Systems