Preliminary Review Team Report to the Physician-Focused Payment Model Technical Advisory Committee (PTAC)

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In accordance with the Physician-Focused Payment Model Technical Advisory Committee's (PTAC's) ***Processes for Reviewing and Evaluating Proposed Physician-Focused Payment Models and Making Recommendations to the Secretary of the Department of Health and Human Services***, proposals for Physician-Focused Payment Models (PFPMs) that contain the information requested by PTAC's Request for Proposals will be assigned to a Preliminary Review Team (PRT). The PRT will draft a report containing findings regarding the proposal for discussion by the full PTAC. This PRT report is preparatory work for the full PTAC and is not binding on the PTAC. This report is provided by the PRT to the full Committee for the proposal identified below.

A. Proposal Information

1. **Proposal Name:** Comprehensive Colonoscopy Advanced Alternative Payment Model for Colorectal Cancer Screening, Diagnosis and Surveillance

2. **Submitting Organization or Individual:** Digestive Health Network, Inc.

3. **Submitter's Abstract:**

   "We are pleased to propose a comprehensive prospective bundled payment advanced alternative payment model to more effectively manage patients who require colonoscopy for colorectal cancer (CRC) screening and surveillance, for evaluation of a positive finding on other CRC screening modalities as recommended by the US Preventive Services Task Force , and for other diagnostic purposes. This prospective dual-risk model, built upon the knowledge gained from retrospective models with upside only risk and prospective 'day-of-procedure' fixed price models, will establish incentives to pay for higher-value care, will be flexible, and improve quality at a lower overall cost (42 CFR Sec. 414.1465)."

B. Summary of the PRT Review

Criteria Specified by the Secretary (at 42 CFR§414.1465)	PRT Conclusion	Unanimous or Majority Conclusion
1. Scope of Proposed PFPM (High Priority)	Does not meet criterion	Unanimous
2. Quality and Cost (High Priority)	Does not meet criterion	Unanimous
3. Payment Methodology (High Priority)	Does not meet criterion	Unanimous
4. Value over Volume	Does not meet criterion	Unanimous
5. Flexibility	Does not meet criterion	Majority
6. Ability to be Evaluated	Meets criterion	Unanimous
7. Integration and Care Coordination	Does not meet criterion	Unanimous
8. Patient Choice	Does not meet criterion	Unanimous
9. Patient Safety	Does not meet criterion	Unanimous
10. Health Information Technology	Does not meet criterion	Unanimous

PRT Recommendation (check one):

☒ Do not recommend proposed payment model to the Secretary.
☐ Recommend proposed payment model to the Secretary for:
- ☐ limited-scale testing of the proposed payment model;
- ☐ Implementation of the proposed payment model; or
- ☐ Implementation of the proposed payment model as a high priority.

C. Information Reviewed by the PRT

1. **Proposal** (Proposal available on the PTAC website)

   Proposal Overview: The proposal is for a bundled episode payment model for endoscopists performing colonoscopies for colorectal cancer screening, diagnosis, or surveillance.

   Included in the bundled payment are professional fees for colonoscopy, including pre- and post-procedure evaluation and management, anesthesia, pathology, radiology, and facility fees for the colonoscopy for a one-year period. The bundled payment also includes emergency room costs associated with post-procedure complications within seven days of the procedure. It is not entirely clear whether and how some of these services will be made separately payable if only some providers or facilities involved in the colonoscopy choose to participate.

   Clearly excluded from the bundled payment are hospitalization costs stemming from post-procedure complications and other colon cancer screening services such as CT

colonography, barium enema, and flexible sigmoidoscopy. Diagnostic and therapeutic services for colorectal neoplasms such as surgery, chemotherapy, radiation oncology, and/or molecular diagnostic testing also are not included in the bundled payment.

Physicians: Participating in the bundled payments are the endoscopists who are primarily gastroenterologists. The bundled payment goes to the endoscopist, who is responsible for allocating payment to "associated team members." To accomplish this, contractual arrangements will need to be executed between the endoscopist, pathologist, anesthesia professional, hospitals, and ambulatory surgical centers (ASCs). The proposal suggests that the endoscopist should pay associated team members on a fee-for-encounter basis, at least initially; later, they may enter a risk-sharing arrangement. Again, it is unclear whether and how payment will work if the endoscopist is unable to engage all related providers or facilities. Primary care physicians are not included in the bundled payment arrangement. The submitting organization, Digestive Health Network, represents 42 gastroenterology practices.

Patient Populations: A retrospective version of this model has been implemented by several commercial. A prospective version of this model has been implemented by self-funded employers and Taft-Hartley trusts. This proposal focuses on the Medicare population, which is older.

Health and Clinical Conditions of Focus: The proposal provides extensive information regarding colon cancer prevalence, incidence, and mortality rates. It describes the importance of improving the rate of appropriate colon cancer screening and decreasing the rate of repeat colonoscopies due to poor bowel preparation.

Proposed Interventions:

- Movement of colonoscopy services from hospital outpatient departments (HOPDs) to ambulatory surgical centers to reduce facility costs to achieve cost reductions.
- Capping the number of pathology specimens obtained during colonoscopy to achieve cost reductions.
- Interactive pre-procedure instructions provided online, over the phone, or in-person, based on patient needs.
- Culturally sensitive instructions in the patient's preferred language.
- 24/7 access to physicians or clinical staff to address urgent needs.
- Depression screening.

Clinical Practice Improvement: The proposal suggests that participation in this payment model combined with public reporting of quality measures on appropriateness of colonoscopy will reduce physicians performing inappropriately early procedures by 90%. A one-time payment for services including patient education prior to the procedure that is expected to result in a lower incidence of poor bowel preparation, which in turn would improve adenoma detection, is factored into the pricing of the bundled payment.

Clinical Quality Improvement: The proposal includes a plan to report on a subset of MIPS, ASC, and HOPD measures as well as PHQ-2. Payment is tied to the following metrics: reducing repeat procedures, increasing ASC utilization, and conducting follow-up at appropriate intervals.

Medicare Cost Savings Potential: Small cost savings are identified as occurring from practice improvements and the avoidance of complications. The PRT reviewed information in the proposal, subsequent information provided by the submitter, and other data described below. The submitter indicated in response to PRT questions that 1.1% of patients have an emergency room visit within seven days of the index colonoscopy.

PRT Review: The PRT met between January 30, 2017 and March 13, 2017. The submitter was sent and responded to two sets of questions from the PRT seeking additional information. The PRT reviewed 18 public comments regarding the proposal. The questions and answers and public comment letters are available on the PTAC website.

2. Data Analyses

The PRT sought additional information regarding colonoscopy costs and utilization as well as post-procedure emergency room visits. The Office of the Assistant Secretary for Planning and Evaluation (ASPE), through its contractor, produced data tables that are available on the PTAC website.

3. Literature Review and Environmental Scan

The submitter cites relevant literature in the proposal. ASPE, through its contractor, also conducted an abbreviated environmental scan that included a review of peer-reviewed literature as well as a search for relevant grey literature, such as research reports, white papers, conference proceedings, and government documents. The abbreviated environmental scan is available on the PTAC website.

Documents comprising the environmental scan were primarily identified using Google and PubMed search engines. Key words guiding the environmental scan and literature review were directly identified from the letter of intent (LOI). The key word and combination of key words were utilized to identify documents and material regarding the submitting organization, the proposed model in the LOI, features of the proposed model in the LOI or subject matter identified in the LOI. Key terms used included "colorectal cancer screening," "colorectal cancer screening guidelines," "colorectal cancer screening savings," "bundled payment colon cancer," "colonoscopy overuse," "colonoscopy repeat procedures," "colorectal cancer screening variations," "colonoscopy cost-effectiveness," "colon cancer alternative payment," "screening colonoscopy," "gastroenterology alternative payment," and "bowel preparation colonoscopy." This search produced two documents from the grey literature and eleven peer-reviewed articles. These documents are not intended to be comprehensive and are

limited to documents that meet predetermined research parameters including a five-year look back period, a primary focus on U.S. based literature and documents, and relevancy to the LOI.

D. Evaluation of Proposal Against Criteria

Criterion 1. Scope of Proposed PFPM (High Priority Criterion). The proposal aims to broaden or expand the CMS APM portfolio by either: (1) addressing an issue in payment policy in a new way, or (2) including APM Entities whose opportunities to participate in APMs have been limited.

The goal of this section of the proposal is to explain the scope of the PFPM by providing PTAC with a sense of the overall potential impact of the proposed model on physicians or other eligible professionals and beneficiary participation. Proposals should describe the scope and span of the payment model and discuss practice-level feasibility of implementing this model as well as clinical and financial risks.

PRT Qualitative Rating:	**Does Not Meet Criterion**

THE OVERAL POTENTIAL IMPACT OF THE PROPOSED MODEL ON PHYSICIANS AND MEDICARE BENEFICARIES

The proposed bundled payment model does not meet the Scope of the Proposed PFPM criterion for the following reasons:

Medicare Cost Savings

- The primary component of this proposal's plan for cost savings appears focused on facility pricing and the potential savings from moving colonoscopies from HOPDs to ASCs. However, the PRT is concerned about the impacts this may have on hospital-based physicians as well as beneficiaries, which is described in greater detail below.
- The relatively low post-procedure complication rates associated with colonoscopies and very low volumes of associated emergency department care do not suggest the potential for significant financial savings associated with the rationale for bundled episode payments.
- With respect to reductions in costs related to the avoidance of unnecessary repeat colonoscopies, the proposal inadequately describes the actual interventions to both achieve reduced volumes while ensuring appropriate patient care with respect to adenoma screening.
- Cost reductions associated with reducing the number of pathology specimens will need to also ensure input from pathologists on specimen adequacy and processes permitting exceptions if required for optimal patient care.

Impacts to Physicians

- The proposal's plan to incentivize endoscopists to change their site of service for colonoscopies does not address the impacts and logistical need of other physician specialties involved in the Medicare patient's care.
- The PRT is concerned about having the endoscopists alone manage the payment model and the distribution of funds to other physicians on a fee-for-encounter basis. The plan on how funds will be distributed and the formula determining such allocations is not clear. This may shift accountability and reduce the autonomy of other physician specialists with untold consequences.
- The PRT finds the absence of other specialties in governance, combined with those specialties' written concerns, problematic.
- It is not entirely clear how the model will work if only some physicians and facilities involved in the colonoscopy choose to participate.
- Hospital-employed physicians may find it difficult to change their site of service to ASCs. Some physicians, particularly those in rural settings, may not have access to ASCs. Evaluating patient geographic access in these communities is key to these discussions.

Clinical Practice Improvement

- While the need to improve screening colonoscopy rates is discussed in the proposal, the proposal does not propose interventions to address the 40% of Medicare beneficiaries who do not participate in appropriate screening.
- The proposal also does not adequately address interventions to improve bowel preparations. While improved pre-procedure evaluation and management was factored into the bundled payment, endoscopists are not required to make these improvements. Further, there is no mechanism to assure that the measured objective of reducing repeat procedures results from improved bowel preparations. Practices could achieve the target without successfully improving bowel preparation.
- There is the potential risk that incentivizing physicians not to perform the warranted repeat colonoscopies may have the unintended consequence of reducing adenoma detection.
- The one-year time frame proposed for this payment model is inadequate for achieving a significant reduction in avoidable and unnecessary colonoscopies.

Clinical Quality Improvement

- The quality measures proposed are not particularly different from what exists under current quality reporting programs. In addition, payment is only tied to the following metrics: reducing repeat procedures; increasing ASC utilization; and conducting follow-up at appropriate intervals.

Criterion 2. Quality and Cost (High Priority Criterion). The proposal is anticipated to (1) improve health care quality at no additional cost, (2) maintain health care quality while decreasing cost, or (3) both improve health care quality and decrease cost.

The goal of this section of the proposal is to better understand the "value proposition" that will be addressed by the proposed PFPM. The submitter was asked to describe how the components of the value proposition will be achieved. For example, how will clinical quality, health outcomes, patient experience, and health care cost management be addressed within the model and how will performance be measured? The submitter was also asked to describe any current barriers to achieving desired value/quality goals and how they would be overcome by the payment model. Finally, the submitter was asked to identify any novel clinical quality and health outcome measures included in the proposed model. In particular, measures related to outcomes and beneficiary experience were to be noted.

PRT Qualitative Rating: **Does Not Meet Criterion**

The proposal's value proposition is to improve quality and decrease costs. The primary component of this proposal's plan for cost savings appears focused on facility pricing and the potential savings from moving colonoscopies from HOPDs to ASCs. As stated in the proposal, "In a prospective episode payment model for a self-limited procedure such as colonoscopy, care delivery is expected to improve to achieve savings and improve quality. Medicare claims data indicates that approximately 52% of colonoscopy procedures are performed in the HOPD setting, while approximately 43% are performed in the ASC setting." Encouraging a change in site of service may be appropriate as a component of an alternative payment model in a few clinical circumstances. However, the PRT believes incentivizing a site of service change in this case would limit beneficiary choice, because it is unreasonable to expect hospital-based physicians to change their site of service for this procedure.

The proposal identifies important quality problems related to colonoscopy procedures including the overuse of routine colonoscopy in some Medicare beneficiaries, the absence of screening colonoscopy in others, and the failure to detect adenomas during colonoscopies because of inadequate bowel preparations in many beneficiaries. However, the payment model does not address the absence of screening colonoscopy and inadequately addresses the failure to detect adenomas. The proposal does include clinical quality measurement, mostly those that exist under current quality reporting programs. The submitters report their intent to act on them and anticipate public reporting of individual physician performance will reduce rates of inappropriate colonoscopy. Consumer experience measures are also listed. The proposal does not, however, include the methodology to maintain quality while reducing costs. In short, the envisioned improvement would derive more from assumed conscientious efforts by the participants sharing the bundled payment independent of the payment method, a collaborative commitment that cannot be assumed when the model is tested in diverse, unaffiliated practices nationally.
The proposal also describes including PHQ-2 screening for depression at the pre-procedure assessment. It does not describe plans for patient follow-up care or referral for management of care post screening.

Criterion 3. Payment Methodology (High Priority Criterion). Pay APM Entities with a payment methodology designed to achieve the goals of the PFPM Criteria. Addresses in detail through this methodology how Medicare, and other payers if applicable, pay APM Entities, how the payment methodology differs from current payment methodologies, and why the PFPM cannot be tested under current payment methodologies.

The goal of this section is to better understand the payment methodology for the proposed model, including how it differs from both existing payment methodologies and current alternative payment models. The submitter is asked to describe how the proposed PFPM will incorporate the performance results in the payment methodology and to describe the role of physicians or other eligible professionals in setting and achieving the PFPM objectives, as well as the financial risk that the entity/physicians will bear in the model. The submitter is asked to differentiate between how services will be reimbursed by Medicare versus how individual physicians or other eligible professionals might be compensated for being a part of this model. Finally, a goal of this section is to better understand any regulatory barriers at local, state, or federal levels that might affect implementation of the proposed model.

PRT Qualitative Rating: **Does Not Meet Criterion**

This proposal does not meet the Payment Methodology criterion because of the following:

- The primary component of this proposal's plan for cost savings appears focused on facility pricing and the potential savings from moving colonoscopies from HOPDs to ASCs. As noted above, the PRT believes incentivizing a site of service change in this case would limit beneficiary choice, because it is unreasonable to expect hospital-based physicians to change their site of service for this procedure.
- The governance of the bundled payment model is not adequately described. It does not include the plan to distribute funds to other physicians, the funding formula, or the process for recovering payments due to insufficient performance. It does not appear that many of the physicians in other specialties needed for successful care and coordination are included in the decision-making process for the bundled payment model.
- Again, while improved pre-procedure evaluation and management was factored into the bundled payment, endoscopists are not required to make these clinical practice improvements. Further, there is no mechanism to assure that the measured objective of reducing repeat procedures results from improved bowel preparations. Practices could achieve the target without successfully improving bowel preparation. In addition, Medicare already reduces payment for repeat colonoscopies.
- The proposal focuses bundled payment performance criteria on (a) site of service change to reduce facility fees, (b) achieving a reduction in the volume of colonoscopies performed, and (c) meeting specific surveillance interval targets. Cost savings from reductions in complication rates and associated emergency room visits were not included in the bundled payment methodology. Achievement of the other proposed cost savings ideas described were also not included in the bundled payment methodology.

- It is not entirely clear how the model will work if only some physicians and facilities involved in the colonoscopy choose to participate.

Criterion 4. Value over Volume. The proposal is anticipated to provide incentives to practitioners to deliver high-quality health care.

The goal of this section of the proposal is to better understand how the model is intended to affect practitioners' behavior to achieve higher value care through the use of payment and other incentives. PTAC acknowledges that a variety of incentives might be used to move care towards value, including financial and nonfinancial ones; the submitter is asked to describe any unique and innovative approaches to promote the pursuit of value including nonfinancial incentives such as unique staffing arrangements, patient incentives, etc.

PRT Qualitative Rating: **Does Not Meet Criterion**

The proposal does not meet the Value over Volume criterion because:

- As previously stated, the proposed bundled payment model does not include in the methodology performance criteria for those clinical practice improvements germane to the key issues: low colorectal cancer screening rates, poor bowel preparation necessitating repeat procedures, and reductions in complication rates.
- The proposed bundled payment model focuses on reducing facility fees by changing the site of service of the colonoscopies and incentivizing a reduction in the number of repeat procedures due to poor bowel preparation. The PRT is concerned this may not be adequate to encourage providers to offer higher value care.
- In addition, the PRT has concerns that the proposed plan to encourage changes to the site of service for the colonoscopy procedures may pose financial and logistical challenges for other physician specialties involved in the episode of care and may create access issues for physicians and patients in some communities without ASCs.

Criterion 5. Flexibility. Provide the flexibility needed for practitioners to deliver high-quality health care

The goal of this section is to better understand (1) how the proposed payment model could accommodate different types of practice settings and different patient populations, (2) the level of flexibility incorporated into the model to include novel therapies and technologies, and (3) any infrastructure changes that might be necessary for a physician or other eligible professionals to succeed in the proposed model.

PRT Qualitative Rating: **Does Not Meet Criterion**

The majority of the PRT finds that the proposal does not meet the Flexibility criterion because of the following:

- The model is focused on endoscopists changing their site of service. Hospital-employed physicians may not be able to participate if there is no affiliated ASC.

- Infrastructure changes would be necessary. Physicians participating in this bundled payment model would need the ability to transfer colonoscopies and related services to the ASC if they are currently hospital-based, and there are concerns whether that could be accomplished.
- Accommodating different populations is not addressed in the proposal.
- Novel therapies or technologies are not addressed in the proposal. CT services are excluded.

One PRT member viewed the proposed PFPM as attempting to stratify risk, and did not see the shift from HOPD to ASC as sufficient to characterize the overall proposal as not meeting the criterion.

Criterion 6. Ability to be Evaluated. Have evaluable goals for quality of care, cost, and any other goals of the PFPM.

The goal of this section is to describe the extent to which the proposed model or the care changes to be supported by the model can be evaluated and what, if any, evaluations are currently under way that identify evaluable goals for individuals or entities in the model. If there are inherent difficulties in conducting a full evaluation, the submitter is asked to identify such difficulties and how they are being addressed.

PRT Qualitative Rating:	**Meets Criterion**

The proposal does meet the Ability to be Evaluated criterion, although minimally.

The following can be assessed using billing, utilization, clinical quality and/or CMS data:
- Facility fee reductions IF physicians move to ASCs;
- Bundled payments to endoscopists for the defined list of codes included in the proposal; and
- MIPS, ASC, and HOPD quality metrics.

In addition, the following should also be evaluated:
- Performance metrics for any clinical practice improvements and intervention to address the key issues;
- Evaluation and monitoring of impacts on adenoma detection rates;
- Attribution models for evaluating performance-based compensation; and
- Savings proposed from limiting the number of pathology specimens will need to be first weighed against any risks to clinical care optimization and then the significance of any potential savings assessed.

Criterion 7. Integration and Care Coordination. Encourage greater integration and care coordination among practitioners and across settings where multiple practitioners or settings are relevant to delivering care to the population treated under the PFPM.

The goal of this section is to describe the full range of personnel and institutional resources that would need to be deployed to accomplish the proposed model's objectives. The submitter is asked to describe how such deployment might alter traditional relationships in the delivery system, enhance care integration, and improve care coordination for patients.

PRT Qualitative Rating: **Does Not Meet Criterion**

The proposal did not meet the Integration and Care Coordination criterion because of the following:

- While various physician specialties are involved in the episode of care defined in the bundled payment model, it is not clear they have an opportunity to provide input in the model. Financial and logistical impacts on physicians in other specialties related to the proposed site of service changes are not addressed in the proposal.
- The model does not address enhanced coordination with primary care physicians. As the proposal conveys, a significant problem is that some patients receive too many colonoscopies while others receive too few. Many patients learn about the need for colonoscopy from their primary care physician. Therefore, to address over and underutilization, involvement of primary care physicians seems necessary unless beneficiaries were somehow attributed to particular endoscopists for a lengthy period beyond one year.
- The payment model does not describe an attribution of beneficiaries to the endoscopists or attribute improvements in clinical practice behaviors to the other physicians engaged in the patient's care.

Criterion 8. Patient Choice. Encourage greater attention to the health of the population served while also supporting the unique needs and preferences of individual patients.

The goal of this section is to describe how patient choice and involvement will be integrated into the proposed PFPM. The submitter was asked to describe how differences among patient needs will be accommodated and how any current disparities in outcomes might be reduced. The submitter was asked to describe, as an example, how the demographics of the patient population and social determinants of care may be addressed.

PRT Qualitative Rating: **Does Not Meet Criterion**

The proposal fails to meet the Patient Choice criterion because of the following:

- The proposal indicates that patients are not required to participate in the model; the single co-payment for patients requiring diagnostic or procedural services would act as an incentive. However, it was unclear from the proposal what would happen if a patient did not want to participate or was willing to participate, but did not agree with the

procedure setting. The PRT was concerned that patients may have to find a new physician.
- The submitter does describe plans to seek consumer experience information, but not proactive patient engagement regarding choice.
- With the exception of the colorectal cancer demographic statistics included in the introduction of the proposal, little more is discussed in terms of patient demographics.
- Disparities in health care are not addressed.

Criterion 9. Patient Safety. How well does the proposal aim to maintain or improve standards of patient safety?

The goal of this section is to describe how patients would be protected from potential disruptions in health care delivery brought about by the changes in payment methodology and provider incentives. The submitter is asked to describe how disruptions in care transitions and care continuity will be addressed. Safety in this instance should be interpreted to be all-inclusive and not just facility-based.

PRT Qualitative Rating: Does Not Meet Criterion

The proposal does not meet the criterion for Patient Safety because of the following:
- Protections from potential disruptions in care are not addressed in the proposal.
- Changes in access for patients and the accessibility of ASCs to patients if the site of care is changed are not addressed. This would be particularly important in rural or smaller communities where ASCs are less prevalent or accessible to Medicare beneficiaries.
- There is the potential to encourage physicians to move higher risk patients from the hospital outpatient facility to an ASC, and it is not clear how patients are protected from this unintended consequence.
- Care transitions and care continuity are not specifically addressed.
- The PRT is concerned that the proposed interventions may not improve patient preparation significantly and/or may not sufficiently incentivize improved patient preparation and may instead create perverse incentives to not repeat procedures when necessary. While some measures of performance are tied to payment, none of them would seem to safeguard against these perverse incentives. The PRT was surprised that consideration of tying adenoma detection rate to payment was not discussed, for example.

Criterion 10. Health Information Technology. Encourage use of health information technology to inform care.

The goal of this section is to understand the role of information technology in the proposed payment model. In this section the submitter is asked to describe how information technology will be utilized to accomplish the model's objectives with an emphasis on any innovations that improve outcomes, improve the consumer experience and enhance the efficiency of the

care delivery process. The submitter is also asked to describe goals for better data sharing, reduced information blocking and overall improved interoperability to facilitate the goals of the payment model.

PRT Qualitative Rating:	**Does Not Meet Criterion**

The proposal does not meet the Health Information Technology criterion because of the following:

- The proposal mentions the use of electronic health records and the challenges other physicians may have accessing patient information. It does not propose strategies or solutions to assist them.
- Innovation to improve outcomes is not addressed.
- The submitter indicated in its response to questions from the PRT that "interactive web tools have been tested and hold promise in prep education." However, from the lack of specifics, the PRT's impression is that HIT innovation is only tangential to the model.
- No specific goals for better data are included in the model.
- Plans for reduced information blocking and improved interoperability are not specifically addressed.

E. PRT Recommendation

Do not recommend proposed payment model to the Secretary

F. PRT Comments

The proposal identifies important quality problems related to colonoscopy procedures. Overall, however, the proposal does not aim to directly affect many of these problems. Instead, the focus of the model is largely on improving pre-procedure patient preparation. The PRT is not convinced that improving pre-procedure preparation warrants the creation of a new payment model. The proposed bundled payment model does not provide the degree of clinical practice and quality improvement to offset the level of practice disruption for many of the physicians involved in the episode of care. The proposal also relies on an unrealistic expectation that physicians would change their site of service from HOPD to ASC. Other issues include:

- The proposal's plan to incentivize endoscopists to change their site of service for colonoscopies does not address the impacts and logistical needs of other physician specialties involved in the Medicare patient's care or hospital-employed endoscopists.
- Clinical practice improvements and interventions are not adequately described and are not directly tied to the bundle payment.
- There do not appear to be commitments in the proposal to either maintain or to set a quantifiable target for clinical quality improvement.

- The one-year time frame proposed for this payment model would not likely achieve a significant reduction in avoidable and unnecessary colonoscopies.

Therefore, the PRT concludes that the proposed PFPM should not be recommended.

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