



American Society of Hematology  
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American Society of Clinical Oncology  
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# **2016 American Society of Hematology / American Society of Clinical Oncology**

## **Hematology and Oncology Carrier Advisory Committee (CAC) Network Meeting**

**July 21 – 22, 2016**

American Society of Hematology  
2021 L Street, NW  
Suite 900  
Washington, DC 20036  
(202) 776-0544

10<sup>th</sup> Floor Conference Center

# 2016 ASH/ASCO Carrier Advisory Committee (CAC)

## Network Meeting Agenda

Friday, July 22, 2015

8:00 AM – 3:00 PM ET

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7:30 AM	<b>Breakfast</b>	12:00 PM	<b>Lunch</b> <i>Breakout session –Ways to Improve the CAC Process in Your Region</i>
8:00 AM	<b>Welcome and Introductions</b> Kenneth Adler, MD <i>ASH Co-Chair</i> Roscoe Morton, MD <i>ASCO Co-Chair</i>	12:45 PM	<i>Breakout session Report/Open Forum</i>
8:15 AM	<b>Part B ASP Demonstration Project – Phase I</b> Stephen Grubbs, MD <i>ASCO Clinical Affairs Department</i>	1:15 PM	<b>Palliative Care</b> Thomas Smith, MD <i>Johns Hopkin Medicine, Sidney Kimmel Cancer Center</i>
9:15 AM	<b>Part B ASP Demonstration Project – Phase II</b> Blase Polite, MD <i>The University of Chicago Medicine</i>	2:00 PM	<b>Coverage with Evidence Development</b> James Rollins, MD <i>Centers for Medicare and Medicaid Services, Office of Coverage</i>
10:15 AM	<b>Morning break</b>	2:45 PM	<b>Meeting Wrap-up</b> Kenneth Adler, MD Roscoe Morton, MD <i>CAC Meeting Co-Chairs</i>
10:30 AM	<b>Merit-Based Incentive Payment System (MIPS)</b> Koryn Rubin <i>American Medical Association</i>	3:00 PM	<b>Adjournment</b>
11:15 AM	<b>Alternative Payment Models</b> Harold Miller <i>Center for Healthcare Quality and Payment Reform</i>		

# **Welcome and Introductions**

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### Abbreviations

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COP = ASH Committee on Practice

CPC = ASCO Clinical Practice Committee  
RS = ASH Reimbursement Subcommittee

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CENTER FOR  
HEALTHCARE  
QUALITY &  
PAYMENT REFORM

# **IMPLEMENTING ALTERNATIVE PAYMENT MODELS UNDER MACRA**

***How the Federal Government  
Can Accelerate  
Successful Health Care  
Payment Reform***

**Harold D. Miller**

First Edition

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# Implementing Alternative Payment Models Under MACRA

## EXECUTIVE SUMMARY

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The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) creates two alternative paths by which Medicare payments to physicians will evolve over the next decade:

- Under the **Merit-Based Incentive Payment System (MIPS)**, Medicare payments to physicians for individual services will increase or decrease by 4%-9% based on the physician's performance on measures of quality of care, resource use, clinical improvement, and use of electronic health records.
- Physicians participating in one or more **Alternative Payment Models (APMs)** will be exempt from MIPS, receive a 5% bonus, and receive higher annual increases in their Medicare payments.

MACRA creates strong incentives for physicians to participate in Alternative Payment Models, and it specifically encourages the development of "Physician-Focused Payment Models," in order to address the many problems with current payment systems that MIPS cannot solve.

The success of MACRA in improving the quality and affordability of health care services will depend heavily on how the Department of Health and Human Services (HHS) implements the provisions of the law relating to Alternative Payment Models and Physician-Focused Payment Models. There are three key areas where administrative decisions and resources could either encourage rapid development and implementation of innovative and successful payment models, or deter innovation and impede the progress in payment reform that Congress wanted to support:

- The regulations defining Alternative Payment Models and alternative payment entities.
- The processes used for soliciting, reviewing, and approving Physician-Focused Payment Models.
- The systems and resources available to implement Physician-Focused Alternative Payment Models.

### 1. Implementing MACRA Requirements for Alternative Payment Models

MACRA contains only a small number of requirements for Alternative Payment Models, each of which is defined in simple, broad language. The regulations implementing MACRA should also be simple and flexible in order to encourage innovation in payment reforms. There are three sets of interrelated requirements regarding Alternative Payment Models (APMs): (1) the types of alternative payment models that can be used; (2) requirements for the alternative payment entity receiving payments under the APM, and (3) the minimum proportion of a physician's services or patients paid for through an APM.

### Eligible Types of Alternative Payment Models

MACRA requires that an Alternative Payment Model be either a model defined in Section 1115A of the Social Security Act (other than a health care innovation award); part of the shared savings program in section 1899 of the Social Security Act; a demonstration under section 1866C; or a demonstration required by federal law. Section 1115A authorizes the use of any Alternative Payment Model that "addresses a defined population for which there are deficits in care leading to poor clinical outcomes or potentially avoidable expenditures" and that is "expected to either (a) improve the quality of care without increasing spending, (b) reduce spending without reducing the quality of care, or (c) improve the quality of care and reduce spending." Imposing any additional or more restrictive requirements in regulations than this would unnecessarily limit innovation.

### Requirements for Alternative Payment Entities

MACRA appropriately recognizes that in many cases, special organizational arrangements will need to be created in order to receive and allocate payments under an Alternative Payment Model, and it defines these as "alternative payment entities." HHS should avoid creating unnecessarily detailed regulations specifying the way alternative payment entities should operate, so that physicians and other providers have as much flexibility as possible to create efficient organizational structures that address their specific needs. However, for physician-focused alternative payment models, it will be important to require that alternative payment entities are controlled by physicians in order to ensure that the payments are used to support the physician practices and the care they deliver to patients.

**Level of Financial Risk:** MACRA requires that for Medicare payments, an eligible alternative payment entity must bear "financial risk for monetary losses" under an alternative payment model that is "in excess of a nominal amount." An alternative payment entity's "financial risk for monetary losses" under an alternative payment model should be defined as the potential difference between the amount of costs the entity incurs or is obligated to pay as part of the alternative payment model and the amount of revenues that it could receive under the APM. "More than nominal" risk for APMs should be defined using the maximum reduction amounts that are used in MIPS. In 2019, since a physician's payments could be reduced by 4% under MIPS even with no change in the physician's costs, an alternative payment entity should be viewed as being at "more than nominal financial risk" if the amount of costs that it incurs under an alternative payment model could exceed the amount of revenue it receives under the model by at least 4%. That threshold would then increase to 5% in 2020, to 7%

in 2021, and to 9% in the year 2022, since these are the maximum percentage adjustments in payment under MIPS in those years.

**Use of Electronic Health Records:** MACRA also requires that participants in an alternative payment model “use” certified EHR technology. The regulations regarding use of EHRs in APMs should only require that clinical data about the patients receiving care supported by the alternative payment model should be stored in a certified electronic health record system.

**Use of Quality Measures:** Finally, MACRA requires that payments under an APM be based on quality measures “comparable” to the quality measures in the MIPS program. MACRA does not require the measures to be *identical* to those used in MIPS, nor should HHS require them to be the same, since the appropriate quality measures used in conjunction with alternative payment models will frequently be different than those used in MIPS. Since MACRA permits a physician practice to choose which quality measures are most appropriate to assess the practice’s performance under MIPS, HHS should give physician practices and alternative payment entities similar flexibility to choose which quality measures are most appropriate to use as part of an APM. Since MACRA does not specify the method in which quality measures should affect a physician’s payment under an APM, and in particular, it does not require that the standards of performance or the methods of adjusting payments be the same as the approaches used in MIPS, HHS should allow flexibility for APMs to use different approaches for adjusting payments based on quality than the methods used in MIPS.

### Calculating a Physician’s Revenues/Patients in Alternative Payment Models

The default requirement under MACRA is to evaluate the extent of participation by a physician or other clinician in APMs based on the proportion of that provider’s *revenues* that are associated with APMs. However, MACRA also authorizes the use of a “patient approach,” i.e., counting the *number of patients* receiving care under APMs and calculating the percentages on that basis instead of based on revenues. In order to encourage maximum participation in APMs, HHS should give all physicians the option to determine whether their participation in APMs should be measured through the percentage of their revenue that is coming from APMs or the percentage of their patients being cared for through APMs.

## 2. Soliciting, Reviewing and Approving Physician-Focused Payment Models

In order to be exempt from MIPS and to benefit from the incentives for APM participation under MACRA, physicians will need to have at least 25% of their Medicare payments or patients coming from an alternative payment model by 2019. Most physicians will not be able to achieve this goal unless more rapid progress is made in developing and implementing new physician-focused alternative payment models in Medicare than has occurred to date.

In order to accelerate the development and implementation of new physician-focused alternative payment models, MACRA established a process whereby individuals and stakeholders could submit proposals for physician-focused payment models for review by the federal government. This process has five components: (1) establishment of criteria for Physician-Focused Payment Models; (2) creation of the Physician-Focused Payment Model Technical Advisory Committee (PTAC); (3) authorization for submission of proposed models to the PTAC; (4) review of submitted proposals by the PTAC; and (5) review and response by HHS. The success of this process in developing an adequate number of physician-focused alternative payment models by 2019 will depend heavily on (1) the criteria that are established by HHS, (2) the information required for submission of proposals; (3) the timeliness of the review of submitted proposals, and (4) the willingness and ability of HHS to implement an adequate number of well-designed physician-focused alternative payment models.

### Criteria for Physician-Focused Payment Models

MACRA requires HHS to issue regulations specifying criteria for physician-focused payment models, including models for specialist physicians, by November 1, 2016. The goal of these criteria should be to enable as many physicians as possible to make improvements in care they have identified for as many of their patients as possible:

- Not every physician-focused payment model will be an alternative payment model and not every alternative payment model will be a physician-focused payment model. A Physician-Focused Payment Model should be defined as either (1) a method of paying physicians that meets the requirements for an alternative payment model under MACRA, or (2) a mechanism for compensating a physician for the physician’s services as an integral component of an alternative payment model being managed by an alternative payment entity as defined in MACRA.
- The criteria established by HHS for physician-focused alternative payment models should be kept as simple as possible in order to encourage as much innovation as possible. The only essential criteria are those needed to ensure that a proposed model meets the criteria for alternative payment models defined in MACRA.
- Although a key goal of alternative payment models should be to control Medicare spending, the criteria established by HHS for physician-focused payment models should not require that a proposal demonstrate immediate or significant savings, since that is not required by the law.
- The criteria established by HHS for physician-focused payment models should not require the use of particular payment systems, organizational structures, or processes for delivering care.
- Finally, the criteria established by HHS for physician-focused payment models should not include criteria that are designed primarily to limit the number of potential proposals.



## Information Required for Submission of Proposals for Physician-Focused Payment Models

MACRA authorizes submission of proposals for physician-focused payment models to the PTAC, but it does not specify the content of such proposals. The information required as part of proposals for physician-focused payment models should be kept to the minimum amount possible in order to encourage physician practices and specialty societies to develop and submit proposals, particularly small practices with limited resources. It is particularly important to avoid requiring submission of information that applicants cannot obtain or cannot obtain except at a very high cost. For example, it is usually impossible for physicians and other providers to obtain the type of data on Medicare spending needed to carry out simulations of the impact of payment models. HHS will need to provide data and technical assistance to those developing proposals in order for the PTAC to make a full evaluation and recommendation regarding the proposal.

## Timeliness of Reviews of Submitted Proposals

MACRA does not establish specific deadlines for review of payment proposals. Given the urgency of controlling healthcare costs and improving the quality of healthcare services, and given the widespread recognition that significant payment reforms are essential to delivering higher-value care, it is essential that HHS establish an aggressive timetable with clear deadlines for reviewing and approving proposals for Physician-Focused Alternative Payment Models.

## Implementing Physician-Focused Alternative Payment Models in Medicare

It would obviously be a tremendous waste of time and energy on everyone's part if desirable payment models were developed and recommended by the PTAC but not implemented by HHS. Consequently, it will be essential that HHS create the necessary systems and processes so that it can implement physician-focused payment models recommended by the PTAC.

HHS needs to establish a much different approach to implementing alternative payment models than it has been using to date. Although the Affordable Care Act created the Center for Medicare and Medicaid Innovation (CMMI) in 2010 in order to accelerate the development and implementation of innovative payment and delivery models, relatively little progress has been made in improving the ways most physicians and other providers are paid for their services due to the slow and burdensome process CMMI has used to implement new payment models. A complete re-engineering of the processes HHS uses to implement alternative payment models is needed to make them less burdensome for both CMMI and participants. This re-engineering process should start with the goal that is implicit in MACRA – every physician should have the opportunity to receive at least 25% of their revenues from alternative payment models in 2019, 50% of revenues in 2021, and 75% in 2023. HHS should then work backward from those dates and design processes and timetables that will

achieve the goals. To ensure that the MACRA goals are achieved, HHS should establish specific milestones that are designed to implement as many alternative payment models as possible and as quickly as possible.

Most of the payment models that are currently being implemented or tested by CMS use a very similar approach – no changes in the current fee for service structure, holding individual physicians accountable for the costs of all services their patients receive from all providers, adjusting payment amounts based on shared savings calculations for attributed patients, etc. – and these approaches not only fail to solve the problems in the current payment systems, they can actually make the problems worse. To date, these payment models have not been very successful in reducing costs because they do not provide the kinds of support that physicians need to redesign care. New physician-focused payment models should not be required to use the same flawed approaches that are being used in current CMS payment demonstrations.

It has been difficult for CMS to implement some types of new payment models because of the limitations of current coding and claims systems, but Congress has recognized this, and MACRA requires HHS to develop and implement new “patient condition groups,” “care episode groups,” and “patient relationship categories.” Codes for these new groups and categories are to be included on the claims that physicians submit for payment beginning in 2018. In order for these groups, categories, and codes to enable the implementation of better alternative payment models, they need to be designed to support a much broader range of APMs than CMS is using today. To achieve this, condition groups, care episode groups, and patient relationship categories should be developed in collaboration with physician groups and medical societies as MACRA explicitly requires.

There will need to be multiple types of APMs in order for physicians in all specialties to participate and in order for all patients to benefit. At a minimum, HHS should create the administrative capabilities to implement seven different types of physician-focused APMs that can be used to address the most common types of opportunities and barriers that exist across all physician specialties. These are:

1. **Payment for a High-Value Service.** Under this APM, a physician practice could be paid for delivering one or more desirable services that are not currently billable, and the physician would take accountability for controlling the use of other, avoidable services for their patients.
2. **Condition-Based Payment for Physician Services.** Under this APM, a physician practice would have the flexibility to use the diagnostic or treatment options that address a patient's condition most efficiently and effectively without concern that using lower-cost options would harm the operating margins of the physician's practice.
3. **Multi-Physician Bundled Payment.** Under this APM, two or more physician practices that are providing complementary diagnostic or treatment services to a patient would have the flexibility to redesign those services in ways that would enable high-quality care to be delivered as efficiently as possible.
4. **Physician-Facility Procedure Bundle.** This APM would allow a physician who delivers a procedure at a hospital

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tal or other facility to choose the most appropriate facility for the treatment and to give the physician and facility the flexibility to deliver the procedure in the most efficient and high-quality way.

5. **Warranted Payment for Physician Services.** This APM would give a physician the flexibility and accountability to deliver care with as low a rate of complications as possible.
6. **Episode Payment for a Procedure.** This APM would enable a physician who is delivering a particular procedure to work collaboratively with the other providers delivering services related to the procedure (e.g., the facility where the procedure is performed, other physicians who are involved in the procedure, physicians and facilities who are involved in the patient's recovery or in treating complications of the procedure, etc.) in order to improve outcomes and control the total spending associated with the procedure.
7. **Condition-Based Payment.** Under this APM, a physician practice would have the flexibility to use the diagnosis or treatment options that address a particular health condition (or combination of conditions) most efficiently and effectively and to work collaboratively with other providers who deliver services for the patient's condition in order to improve outcomes and control the total spending associated with care for the condition.

HHS should begin immediately to implement the administrative systems needed to support all of these types of payment models. This would not only ensure that the APMs can be implemented by 2019, but it would encourage physician groups and medical specialty societies to design payment models in a common framework, which will reduce implementation costs for HHS. If there are insufficient staff or resources at HHS to support implementation of a sufficient number of new alternative payment models to enable all physicians to participate, additional resources should be provided to achieve the necessary "bandwidth." Failing to allocate sufficient resources to implement alternative payment models that will save money for the Medicare program would be penny wise and pound foolish.

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# I. MACRA AND ALTERNATIVE PAYMENT MODELS

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## A. What is MACRA?

The Medicare Access and CHIP Reauthorization Act of 2015, commonly known as “MACRA,” was approved on a bipartisan basis by Congress<sup>1</sup> and signed into law by the President on April 16, 2015. In addition to repealing the Sustainable Growth Rate (SGR) formula, which had been annually threatening to make 25-30% cuts in physicians’ payments for services to Medicare beneficiaries, MACRA created two alternative paths by which Medicare payments to physicians would evolve over the next decade:

- **MIPS:** The default path is called the Merit-Based Incentive Payment System (MIPS). MIPS is a pay-for-performance system in which the standard amounts that a physician is paid for services provided to Medicare beneficiaries will be increased or decreased each year based on the physician’s performance compared to other physicians on a series of measures regarding quality of care, resource use, clinical improvement, and “meaningful use of certified EHR technology.”
- **APMs:** Alternatively, if a physician achieves a minimum threshold of participation in one or more Alternative Payment Models (APMs), the physician would (1) be exempt from MIPS, (2) receive a lump sum bonus equal to 5% of their total Medicare payments, and (3) receive a higher annual increase in the standard Medicare payment rates for all of their services than would physicians participating in MIPS.

## B. What are “Alternative Payment Models” and Why Do We Need Them?

The significant financial incentives MACRA awards to physicians who participate in Alternative Payment Models make it clear that Congress wanted to encourage physicians to participate in APMs rather than MIPS. However, these incentives are not the only reason for physicians to participate in APMs. Properly designed APMs can give physicians the ability to achieve far greater improvements in the quality and affordability of care for their patients than MIPS, because APMs can overcome the barriers to better care that exist in the current payment system in ways that MIPS cannot.

### 1. The Payment Barriers in Current Fee-for-Service Payments

The current fee-for-service payment system used by Medicare and most health plans to pay physicians and other providers has two serious weaknesses<sup>2</sup>:

- **Lack of payment or inadequate payment for high-value services.** Medicare and most health plans do not pay physicians and other providers for many services that would benefit patients and help reduce avoidable spending. For example, there is generally no payment or inadequate payment for:
  - ◆ responding to a patient’s phone call about a symptom or problem, which could help the patient avoid the need for far more expensive services, such as an emergency department visit;
  - ◆ communications between primary care physicians and specialists to coordinate care, or the time spent by a physician serving as the leader of a multi-physician care team, which can avoid ordering of duplicate tests and prescribing conflicting medications;
  - ◆ communications between community physicians and emergency physicians, and short-term treatment and discharge planning in emergency departments, which could enable patients to be safely discharged without admission;
  - ◆ providing proactive telephone outreach to high-risk patients to ensure they get preventive care, which could prevent serious health problems or identify them at earlier stages when they can be treated more successfully;
  - ◆ spending time in a shared decision-making process with patients and family members when there are multiple treatment options, which has been shown to reduce the frequency of invasive procedures and the use of low-value treatments;
  - ◆ hiring nurses and other staff to provide education and self-management support to patients and family members, which could help them manage their health problems more effectively and avoid hospitalizations for exacerbations;
  - ◆ providing palliative care for patients in conjunction with treatment, which can improve quality of life for patients and reduce the use of expensive treatments; and
  - ◆ providing non-health care services (such as transportation to help patients visit the physician’s office) which could avoid the need for more expensive medical services (such as the patient being taken by ambulance to an emergency department).
- **Financial penalties for delivering a different mix of services.** Under current fee-for-service (FFS) payment systems, physician practices and other providers lose revenue if they perform fewer procedures or lower-cost procedures, but the costs of operating physician practices, hospitals, etc. generally do not decrease proportionately (if at all), which can cause financial losses. For many types of procedures, most of the savings payers experience does not come from the payments that are made to physician practices, so significant savings for Medicare and other payers can still be achieved without financially penalizing physician practices. The most severe impact under FFS is that physician practices and other providers do not get paid at all if they suc-

ceed in keeping their patients healthy and the patients do not need health care services.

## 2. The Weaknesses of MIPS

The Merit-Based Incentive Payment System (MIPS) created under MACRA does not directly solve the major problems with the fee-for-service system for physicians:

- **MIPS does not change the services for which payments are made.** MIPS does not create any new Medicare payments for high-value services that are not currently covered by Medicare; it can only adjust the size of payments for the services that are currently paid for under the current fee schedule. Under MIPS, if a physician achieved improvements in quality or overall resource use by delivering one or more unpaid services, the physician could potentially receive higher payments for other services that are paid for under fee-for-service, but there would be no assurance that the increased revenues from the higher payments on other services would be sufficient to cover the costs of delivering the unpaid services that were needed to achieve those revenues. If the delivery of an *unpaid* service resulted in the need for fewer *paid* services, the physician practice could receive less total fee-for-service revenue, even with higher payments due to MIPS. Moreover, under MIPS, a physician can only receive higher payments if other physicians receive reductions in their fee-for-service payments, so if all physicians were to deliver the unpaid services and achieve similar improvements in quality or resource use, none of them would receive higher payments, and their practices would incur net financial losses even though they had delivered higher-value care for their patients and the Medicare program.
- **MIPS makes arbitrary changes in payment amounts.** The adjustments in the amounts of payments under MIPS are fixed in size and cannot be changed to ensure they cover the new costs incurred by a physician practice to deliver services differently or to offset the losses resulting from delivery of fewer services. Under MIPS, if a physician practice improved the health of its patients so much that 10% fewer services were needed by the patient, the practice's payments could not be increased by more than 4-9%. This could cause the practice to suffer financial problems even though the majority of the savings achieved by the Medicare program were likely due to reductions in services other than those delivered by the practice itself, such as fewer laboratory tests, imaging studies, and hospitalizations.

The bonuses and penalties under MIPS may provide an “incentive” for physicians to try to improve quality or reduce overall spending, but since the barriers in the underlying payment system remain unchanged, a physician may not have adequate resources to achieve improvements, and the financial losses the physician practice experiences if it *tries* to improve care could exceed the penalties it would face for not trying at all.

## 3. The Advantages of APMs

In contrast, a properly designed Alternative Payment Model (APM) can directly address the barriers under the current payment system that prevent delivery of higher quality, more affordable care. For example, an APM could pay the physician practice directly for the costs of a high-value service that is not paid under the current Medicare fee schedule if the physician accepted accountability for using that service to achieve improvements in quality or reductions in overall resource use. An APM could pay the physician practice based on its ability to address the patient's health problem rather than based on how many or what types of services the physician delivers; this could protect the physician practice against financial losses when it finds ways to treat a patient's health problem in ways that reduce overall spending for Medicare and other payers.

To achieve these advantages, however, an Alternative Payment Model must be *properly designed*. The fact that a payment system is *different* from the traditional fee-for-service payment system or MIPS does not automatically mean that it is *better*. As discussed in more detail in Section III-F, many of the alternative payment models currently being implemented in Medicare not only fail to address the problems in the current payment system, they can actually make things worse for physicians who want to improve care and reduce spending. Moreover, many of the Medicare payment models are not applicable to small physician practices or specialty practices. Consequently, as discussed in more detail in Section III, MACRA specifically encourages the development of *physician-focused* payment models.

*The fact that a payment system is different from the traditional fee-for-service payment system does not automatically mean that it is better. Many of the alternative payment models currently being implemented in Medicare not only fail to solve the problems in the current payment system, they can actually make things worse for physicians who want to improve care and reduce spending.*

In order to be successful in improving care for patients, reducing spending for Medicare and other payers, and maintaining financial viability for physician practices – a physician-focused alternative payment model must have three characteristics<sup>3</sup>:

- a. **Flexibility in Care Delivery.** To be successful, a physician-focused APM must be designed to give physicians sufficient flexibility to deliver the services patients need in the most efficient and effective way possible. If the current payment system does not pay for specific services needed to improve outcomes or reduce spending on other types of services, the APM must authorize payment for those services.
- b. **Adequacy and Predictability of Payment.** To be both successful and sustainable, a physician-focused APM must provide adequate and predictable resources to enable physician practices to cover the costs of delivering high-quality care to patients. Achieving savings for Medicare and other payers is only a desirable goal if it does not jeopardize access to care or the quality of care for patients. Moreover, it is impossible for physicians to make investments in facilities and equipment and to recruit, train, and retain high-quality personnel if they cannot predict how much they will be paid for their services. Payments must also be appropriately risk-adjusted based on characteristics of patients that increase their need for services, and limits must be placed on the total amount of financial risk that physicians face.
- c. **Accountability for Costs and Quality That Physicians Can Control.** In order to be successful and sustainable, a physician-focused APM must also be explicitly designed to assure patients and payers that spending will be controlled or reduced and that quality will be maintained or improved. However, individual physicians should only be held accountable for aspects of spending and quality they can control or influence.

*The goal of physician-focused APMs should not be to simply shift financial risk from payers to physician practices, but rather to give physician practices the resources and flexibility they need to take accountability for the aspects of costs and quality they can control or influence.*

The goal of physician-focused APMs should not be to simply shift financial risk from payers to physician practices, but rather to give physician practices the resources and flexibility they need to take accountability for the aspects of costs and quality they can control or influence. Similarly, the success of a payment model in improving care does not depend on the amount of financial risk in the payment model, but on whether the payment model provides sufficient payment to enable physicians to take accountability for costs and quality that the physicians can control. In some cases, a small change in the current payment system, such as payment for a specific type of service in addition to existing FFS payments, may be all that is needed to support better out-

comes and lower overall costs. In other cases, a more significant change may be needed, such as restructuring payments for many different services delivered by multiple providers.

## C. What is Needed for Successful Implementation of Physician-Focused APMs Under MACRA?

Although the passage of MACRA in 2015 provided a statutory framework for the development and implementation of Physician-Focused Alternative Payment Models that could significantly improve both the quality and affordability of care, success will depend on how the Department of Health and Human Services (HHS) implements the law. This report describes three key aspects of implementation where administrative decisions could either encourage rapid development and implementation of innovative and successful APMs, or deter innovation and impede the progress in payment reform that Congress wanted to support:

- **The regulatory interpretations of MACRA's requirements regarding Alternative Payment Models.** Section II of this report provides a detailed description of what MACRA requires and discusses how those requirements should be interpreted and implemented.
- **The processes used for soliciting, reviewing, and approving Physician-Focused Payment Models.** Sections III A, B, C, and D of the report describe the processes that MACRA establishes for reviewing proposals for Physician-Focused Payment Models and how they could be most effectively implemented.
- **The systems and resources HHS needs to put in place in order to implement a sufficient number of properly-designed Physician-Focused APMs by 2019.** The final section of the report (Section III-F) discusses how to ensure timely implementation of an adequate number and diversity of successful Physician-Focused Alternative Payment Models.

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# II. DEFINING ALTERNATIVE PAYMENT MODELS UNDER MACRA

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## A. What MACRA Requires

MACRA created three sets of interrelated requirements regarding Alternative Payment Models (APMs). (See the Appendix for the full text of the APM provisions under MACRA.) Because MACRA is focused on how physicians and other clinicians should be paid and creates two choices for payment (MIPS and APMs), the law both defines what *qualifies* as an APM for physicians and it also defines minimum thresholds for an individual physician's or other clinician's *participation* in APMs.

1. **Requirements for the physician or eligible professional.** Beginning in 2019, in order to be considered a *qualifying APM participant* ("QP") (and thereby exempt from MIPS and eligible for bonus payments and higher payment updates) a physician or other eligible professional must either:

- a. receive at least 25% of their total Medicare payments for the covered professional services they furnish through an *alternative payment entity* (see point 2 below), or
- b. in situations permitted by the Secretary of HHS, deliver services supported through an alternative payment entity to at least 25% of their patients.

In 2021, the minimum percentages increase to 50%, and in 2023, the minimum percentages increase to 75%. However, beginning in 2021, the percentages can be met either in terms of Medicare payments alone or through a combination of Medicare payments and payments from other payers, as long as at least 25% of Medicare payments or Medicare patients (if permitted by HHS) are in APMs, and as long as the payments from other payers meet the requirements for non-Medicare alternative payment models (see point 4 below).

The law also allows physicians to be classified as a *partial qualifying APM participant* ("partial QP") if the percentages of participation are no more than 5 percentage points lower than the requirements needed to be a qualifying APM participant (i.e., the threshold for partial QP status would be 20% of Medicare revenues or patients in APMs in 2019, 45% of Medicare or total payments in APMs beginning in 2021, and 70% of Medicare or total payments in APMs beginning in 2023).

2. **Requirements for the alternative payment entity.** An *alternative payment entity* must:

- a. be participating in an *alternative payment model* (see point 3 below); and
- b. either:
  - (i) bear financial risk for monetary losses under the alternative payment model in excess of a nominal amount; or
  - (ii) be designated as a medical home expanded under Section 1115A(c) of the Social Security Act.

3. **Requirements for an alternative payment model under Medicare.** An *alternative payment model* for Medicare payments must:

- a. be a model defined in Section 1115A of the Social Security Act (other than a health care innovation award), be part of the shared savings program in section 1899, be a demonstration under section 1866C, or be a demonstration required by federal law;
- b. require participants to use certified EHR technology; and
- c. provide for payment for covered professional services based on quality measures comparable to the quality measures in MIPS.

4. **Requirements for an alternative payment model from payers other than Medicare.** The requirements for an alternative payment model from other payers differ slightly from the requirements for Medicare payments. In order to be considered as part of an alternative payment model, payments from non-Medicare payers are required to be made under "arrangements" in which:

- a. quality measures comparable to the quality measures in MIPS apply;
- b. certified EHR technology is used;
- c. with respect to Medicaid beneficiaries, the physician or eligible professional participates in a medical home that meets criteria comparable to medical homes expanded under Section 1115A(c) of the Social Security Act; and
- d. with respect to individuals not on Medicaid, the physician or eligible professional participates in an entity that bears more than nominal financial risk if actual aggregate expenditures exceeds expected aggregate expenditures.

Note that MACRA does not in any fashion regulate or restrict the kinds of payment models that other payers can use to pay physicians or other providers. However, if a physician or other provider wants to count payments from non-Medicare payers toward the minimum proportion of revenues or patients needed to be considered a “qualifying APM participant” or “partial qualifying APM participant,” then those payments must meet the requirements in point 4 above. Other payment models from other payers may be beneficial for patients, payers, and the provider, but unless they meet the standards established in MACRA, they would not count toward the thresholds needed for physicians to be exempt from MIPS and to receive the payment bonuses and updates authorized under MACRA.

## B. How MACRA’s Requirements Should Be Implemented in Regulations

MACRA contains only a small number of requirements for Alternative Payment Models, each of which is defined in simple, broad language. If Congress had wished to create detailed requirements for the structure of APMs, it could have done so, since it created extremely detailed specifications for how the Merit-Based Incentive Payment System (MIPS) should be structured. Consequently, the small number of requirements for APMs in MACRA and the flexible language used to describe those requirements should not be seen as a void to be filled with extensive HHS regulations.

The following sections discuss how each of the requirements of MACRA should be defined in order to encourage as much innovation as possible in the development and use of APMs and to minimize the administrative burden on physicians and other providers in implementing APMs.

### 1. Eligible Types of Alternative Payment Models in Medicare

As noted above, MACRA requires that an Alternative Payment Model be either:

- a model defined in Section 1115A of the Social Security Act (other than a health care innovation award);
- part of the shared savings program in section 1899 of the Social Security Act;
- a demonstration under section 1866C; or
- a demonstration required by federal law.

#### a. Payment Models Under Section 1115A

Section 1115A was added to the Social Security Act in 2010 by the Patient Protection and Affordable Care Act. It established the Center for Medicare and Medicaid Innovation under HHS and defined a process for testing and expanding “innovative payment and service delivery models.” Section 1115A does not specifically discuss “alternative payment models,” so the provisions of that section only apply to APMs under MACRA to the extent that MACRA requires it.

What MACRA says is that a “model under section 1115A (other than a health care innovation award)” can be considered an “alternative payment model.” Section 1115A defines 24 different payment models (four of these were added by MACRA) but explicitly states that CMS is not limited to implementing only these models.<sup>6</sup> The only requirement in Section 1115A limiting which payment models CMS can select to implement is that “there is evidence that the model addresses a defined population for which there are deficits in care leading to poor clinical outcomes or potentially avoidable expenditures.” MACRA presumably excluded Health Care Innovation Awards because they are not payment models *per se*, but rather they are innovative service delivery models supported with time-limited grant funds. Many of these projects have been successful in improving care and reducing costs but they cannot continue unless an alternative payment model is created to support them on an ongoing basis because of the barriers that exist in the current payment system.

Importantly, MACRA does *not* require that a payment model described in Section 1115A had to have been tested and evaluated by the Center for Medicare and Medicaid Innovation (CMMI) or expanded nationally in order to qualify as an alternative payment model. If Congress had wished to limit APMs to models that CMMI had evaluated or the Secretary had expanded, it could easily have done so. Indeed, in defining an alternative payment entity, MACRA specifies that the entity must either (a) bear financial risk or (b) be a “medical home expanded under section 1115A(c).” The phrase “expanded under section 1115A(c)” is not used anywhere in MACRA to restrict APMs, but is only used to automatically designate medical homes that are expanded under section 1115A(c) as alternative payment entities.

In addition, Section 1115A(b)(3) explicitly states that HHS shall **not** require that a model be budget neutral initially in order to implement it. It further states that HHS can continue implementation of a model as long as the model is **expected** to either (a) improve the quality of care without increasing spending, (b) reduce spending without reducing the quality of care, or (c) improve the quality of care and reduce spending. If a payment model is not expected to achieve one of these goals, HHS is authorized to *modify* it as well as terminate it. There is no statutory limit on how long a payment model may be continued or how many times it may be modified before a final determination is made that it cannot achieve the statutory goals and that it must be terminated.

**MACRA does not require that a payment model has to have been tested and evaluated by the Center for Medicare and Medicaid Innovation (CMMI) or expanded nationally in order to qualify as an alternative payment model.**

Consequently, any APM that “addresses a defined population for which there are deficits in care leading to poor clinical outcomes or potentially avoidable expenditures” and that is “expected to either (a) improve the quality of care without increasing spending, (b) reduce spending without reducing the quality of care, or (c) improve the quality of care and reduce spending” should be viewed as an alternative payment model that meets the requirements of MACRA. Imposing any additional or more restrictive requirements in regulations would unnecessarily limit innovation.

#### b. Payment Models Under Section 1899

Section 1899 was also added to the Social Security Act in 2010 by the Patient Protection and Affordable Care Act.<sup>7</sup> It created a new Medicare payment program titled the “Shared Savings Program.” This is the statutory authorization that CMS has used to implement the Medicare Shared Savings Program (MSSP) for Accountable Care Organizations (ACOs). Consequently, the Medicare Shared Savings Program would qualify as an APM under MACRA.

Although the title of Section 1899 is “Shared Savings Program,” subsection 1899(i) allows HHS and CMS to use payment models other than shared savings to support ACOs. To date, CMS has not used this authority to implement any other payment models, but MACRA creates a new reason to do so.

Section 1899(i)(2) explicitly authorizes the use of “partial capitation” in addition to shared savings. The law states that under partial capitation payment, an ACO would be “at financial risk for some, but not all, of the items and services covered under parts A and B, such as some or all physicians’ services or all items and services under part B.” The law states that payments to an ACO for items and services for beneficiaries for a year under the partial capitation model should be established in a manner that does not result in spending more for such ACO for such beneficiaries than would otherwise be expended for such ACO for such beneficiaries for such year if the model were not implemented, as estimated by HHS. Finally, the law permits, but does not require, HHS to limit a partial capitation model to ACOs that are highly integrated systems of care and to ACOs capable of bearing risk.

More significantly, Section 1899(i)(3) authorizes the use of “any payment model that the Secretary determines will improve the quality and efficiency of items and services furnished” to Medicare beneficiaries. The only restriction is that payments must be designed in a way that does not result in Medicare spending more for the services covered by the payment model than would have been spent in the absence of the payment model.

Consequently, a wide range of payment models would be eligible to be considered as APMs under MACRA if appropriate changes are made to the CMS regulations that are currently used to implement Section 1899.

#### c. Payment Models Under Section 1866C

Section 1866C of the Social Security Act was added by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003. Titled the Health Care Quality Demonstration Program, it was originally intended to last for a period of 5 years, but the time limit was removed by the Patient Protection and Affordable Care Act in 2010.

The Health Care Quality Demonstration Program authorizes the use of “alternative payment systems” for “health care groups.” There is no restriction on the nature of the alternative payment system, other than that the aggregate expenditures during the entire demonstration period must be no greater than what would have been expended otherwise.

A “health care group” can be either:

- a group of physicians
- an integrated health care delivery system; or
- an organization representing regional coalitions of physician groups or integrated delivery systems

Significantly, in addition to changes in payment, the Health Care Quality Demonstration Project authorizes modifications to the benefits available to Medicare beneficiaries under Medicare Parts A and B or to the benefits available through a Medicare Advantage plan. It also authorizes the Secretary of HHS to waive other requirements of the Medicare program.

CMS only implemented 3 demonstration projects under the law.<sup>8</sup> However, the authorization to implement additional projects remains in effect. Consequently, **Section 1866C could potentially be used to authorize APMs that cannot meet the criteria under Section 1115A or Section 1199.**

#### d. Payment Models Under Demonstrations Required by Federal Law

Congress has mandated a number of demonstrations over time. For example, the Affordable Care Act mandated a National Pilot Program on Payment Bundling. Payment models established under these demonstrations would qualify as APMs under MACRA. In some cases, there are time limits on the authorization of payment models under these demonstrations.



## 2. Requirements for Alternative Payment Entities

### a. Defining an Alternative Payment Entity

MACRA appropriately recognizes that in many cases, special organizational entities will need to be created to receive payments under an Alternative Payment Model. For example:

- Two different specialists in separate practices may want to share a bundled payment in order to support a collaborative effort to care for patients with specific kinds of health problems or combinations of health problems. To do so, they will likely want to create a new corporate entity (such as a limited liability corporation) to accept the bundled payments and then divide the revenues between the two practices.
- An independent physician practice and community hospital that want to jointly manage a bundled payment for all of the care delivered during a hospitalization may want to create a Physician-Hospital Organization (PHO) or other entity to receive and allocate the bundled payment.
- Multiple small physician practices who want to work together to manage an alternative payment model for a population of patients could create or use an Independent Practice Association (IPA) to accept the payment and allocate it among the practices.

HHS should avoid creating unnecessarily detailed regulations specifying the way alternative payment entities should operate, so that physicians and other providers have as much flexibility as possible to create efficient organizational structures that address their specific needs. However, for physician-focused alternative payment models (which are discussed in more detail in Section III below), it will be important to require that alternative payment entities are controlled by physicians in order to ensure that the payments are used to support the physician practices and the care they deliver to patients.

### b. Defining “More Than Nominal Financial Risk” for Medicare Payments

MACRA requires that for Medicare payments, an eligible alternative payment entity must bear “financial risk for monetary losses” under an alternative payment model that is “in excess of a nominal amount.”

#### How Should “Financial Risk?” Be Defined?

The term “financial risk for monetary losses” in MACRA clearly refers to *losses in the operations of the alternative payment entity*, not to losses or increased spending in the Medicare program. The gains or losses of the alternative payment entity are a function of both the *costs that the alternative payment entity incurs* to implement the model and the *revenues it receives under the model*. If the alternative payment entity hires or pays for new staff to deliver services to patients under the alternative payment model, if it acquires new or different equipment to deliver services, or if it incurs other kinds of expenses to implement the alternative payment model, and if

those expenses are not automatically or directly reimbursed by Medicare, then the alternative payment entity is accepting financial risk for monetary losses.

Although many people seem to think that “financial risk” is only associated with alternative payment models, there is financial risk involved in any payment system other than one which reimburses physicians or other providers for their actual costs. Today, physician practices incur financial risk for monetary losses under the fee-for-service payment system because the costs they incur for office space, equipment, and staff are not directly reimbursed by Medicare, and if the practice does not deliver enough services to generate fee-for-service payment revenues in excess of those costs, it could be forced to declare bankruptcy. **The measure of a good alternative payment model should not be how much it increases financial risk for physician practices and other providers, but rather how effectively it realigns their financial risk so that financial losses result from delivering lower quality care rather than fewer services.**

Financial risk cannot be defined simply in terms of the potential reduction in revenues the alternative payment entity could receive from Medicare. The alternative payment entity could easily incur monetary losses under an alternative payment model even if the entity has no obligation to repay losses that the Medicare program has incurred, as long as the entity could incur costs that exceed its payments. **For example, even under an “upside only” shared savings model, a physician practice or other provider incurs financial risk if it incurs costs to implement programs that are designed to reduce Medicare spending, since the provider could fail to qualify for the shared savings payment it needs to pay for those costs.**

It is also not appropriate to measure the amount of risk accepted by a physician practice or other provider in terms of the percentage change in total Medicare spending for which the provider is responsible. A small percentage change in Medicare spending could represent a very large percentage of a provider’s revenues, particularly the revenues of a small provider, and it would represent an even larger percentage of that provider’s *profit margin*. **Because the payments to a physician practice generally represent only a small percentage of total Medicare spending on a patient’s care, a physician practice could be forced out of business if it is held responsible for paying for even a very small percentage change in the total Medicare spending for the practice’s patients.**

*The measure of a good alternative payment model should not be how much it increases financial risk for physician practices and other providers, but rather how effectively it realigns their financial risk so that financial losses result from delivering lower quality care rather than fewer services.*

Consequently, an alternative payment entity's "financial risk for monetary losses" under an alternative payment model should be defined as the potential difference between the amount of costs the entity incurs or is obligated to pay as part of the alternative payment model and the amount of revenues that it could receive under the APM. The greater the costs it incurs or the lower the revenue it could potentially receive, the greater the financial risk it will face under the APM.

### **How Should "More than Nominal" Financial Risk Be Defined?**

If Congress had wanted alternative payment entities to accept *substantial* financial risk, it could easily have explicitly required that, so it is clear that in using the term "more than nominal financial risk," Congress did not mean "substantial" financial risk. Logically, "more than nominal" risk should also be significantly less than what would be considered "substantial" risk.

For 20 years, CMS has defined "substantial financial risk" for physician practices receiving payments from Medicare Advantage plans. Section 422.208 of the Code of Federal Regulations<sup>10</sup> defines "substantial financial risk" as a situation in which more than 25% of a physician practice's payment is at risk based on services that the physician practice does not deliver itself, or a situation in which capitation payments could vary by more than 25%. Consequently, the threshold for "more than nominal" risk in MACRA would need to be set well below a 25% variation in an alternative payment entity's revenues relative to its costs.

In MACRA, Congress has placed all physicians' payments "at risk" under the Merit-Based Incentive Payment System (MIPS). In the initial year of the program (2019), physician payments could be reduced by 4%, and the maximum reduction increases to 9% in 2022. These amounts are presumably "more than nominal" if Congress expected them to influence physician performance on the measures defined in MIPS, which includes resource measures.

Consequently, "more than nominal" risk for APMs should be defined using the maximum reduction amounts that are used in MIPS. In 2019, since a physician's payments could be reduced by 4% under MIPS even with no change in the physician's costs, an alternative payment entity should be viewed as being at "more than nominal financial risk" if the amount of costs that it incurs under an alternative payment model could exceed the amount of revenue it receives under the model by at least 4%. That threshold would then increase to 5% in 2020, to 7% in 2021, and to 9% in the year 2022, since these are the maximum percentage adjustments in payment under MIPS in those years.

### **c. Defining "More Than Nominal Financial Risk" for Commercial Payers**

As noted earlier, MACRA uses a somewhat different definition of financial risk for payments coming from payers other than Medicare or Medicaid. In order for such payments to count toward the 50% threshold beginning in 2021 and the 75% threshold beginning in 2023, the physician or other eligible professional must participate in an

entity that bears more than nominal financial risk "if actual aggregate expenditures exceeds expected aggregate expenditures." The proper interpretation of the term "aggregate expenditures" depends on the structure of the payment model itself. For example,

- If the physician practice is receiving a fixed bundled payment under the APM to cover a range of services for patients, then the term "aggregate expenditures" would apply to the practice's expenditures on those services for all patients covered by the APM. The amount of the bundled payment would typically be defined so that the aggregate revenues from the payments for all patients the practice cares for would be adequate to cover the practice's expected aggregate expenditures for services to those patients. **The practice's financial risk would then be defined as the maximum amount it has to spend if its actual expenditures exceed the bundled payment revenues.** The maximum will depend on whether the payer agrees to an outlier payment, "stop loss," or "risk corridor" limiting the amount by which the actual expenditures can exceed the payments.
- If the physician practice is being paid for individual services but the amounts of those payments are reduced if the aggregate amount of payments exceeds a threshold (e.g., an episode budget), then the term "aggregate expenditures" would apply to the payer's payments to the physician practice, and **the practice's financial risk would be defined as the amount by which its payments would be reduced if the total payments from the payer exceed the threshold.**

Once the method of calculating risk is defined for a commercial payment model, the same definition of "more than nominal" described in the previous section for Medicare payments can be applied to the risk under the commercial payments.

### **d. Use of EHR Technology**

MACRA requires that participants in an alternative payment model "use" certified EHR technology. After several years of HHS trying to define "meaningful use" of EHRs, there is widespread agreement that detailed requirements regarding how clinicians should use EHRs have increased costs and harmed quality rather than improving it. Since MACRA simply requires "use" of the EHR, **regulations regarding use of EHRs in APMs should only require that clinical data about the patients receiving care as part of the alternative payment model be stored in a certified electronic health record system.** It is impossible to prescribe how a physician or other provider should "use" the technology beyond this without potentially interfering with the provider's flexibility to deliver services in the most effective way or imposing unnecessary costs and administrative burdens on the provider. A physician practice participating in the APM will have a strong incentive to use the EHR if the EHR has capabilities that will improve the practice's success, regardless of any specific requirements imposed by HHS. Any specific requirements for "use" of EHRs that are imposed in regulations should be treated as a cost that increases the financial risk for a physician practice to participate in the APM if the cost is not explicitly supported by the APM itself.

### e. Use of Quality Measures

MACRA requires that payments under an APM be based on quality measures “comparable” to the quality measures in the MIPS program. **MACRA does not require the measures to be identical to those used in MIPS, nor should HHS require them to be the same;** indeed, the appropriate quality measures used in conjunction with alternative payment models should be expected to be different than those used in MIPS for two reasons:

- To the extent that quality measures are intended to protect patients against receiving low quality care, there will be different incentives for underuse, overuse, and misuse of services by physicians and other providers in an alternative payment model than under the current fee-for-service system. For example, more quality measures designed to protect against *underuse* of services may be needed in an APM that holds providers accountable for spending, whereas *fewer* quality measures designed to protect against *overuse* of services would be needed in the APM.
- To the extent that quality measures are intended to encourage improvements in care, physicians may be able to achieve improvements in different aspects of care using the flexibility and resources under an APM than they could under the standard physician fee schedule. As noted in Section I, many high-value services are not paid for today; the bonuses and penalties created under MIPS would not solve this problem, whereas an APM could enable one or more of these high-value services to be delivered, so different quality measures may be appropriate.

Not only should quality measures for APMs differ from those under MIPS, quality measures will differ for different APMs. Since different alternative payment models will focus on different types of patients and health conditions and will address different barriers in the current payment system, the appropriate quality measures for those APMs will also differ. **Since MACRA permits a physician practice to choose which quality measures are most appropriate to assess the practice’s performance under MIPS, HHS should give physician practices and alternative payment entities similar flexibility to choose which quality measures are most appropriate to use as part of an APM.**

If there are not evidence-based measures that are directly relevant to the aspect of quality that is of concern, HHS should not attempt to substitute for this by requiring the use of *irrelevant* quality measures, since this could jeopardize the success of the model. Instead, efforts should be made to develop appropriate measures as part of the measure development process created under MACRA. **If HHS requires the physicians or other providers in an APM to collect or report on quality measures in addition to those that are part of the design of the APM, the costs of collecting and reporting those measures should be treated as increasing the financial risk for a physician practice to participate in the APM.**

MACRA does not specify the method by which quality measures should affect a physician’s payment under an APM, and in particular, it does not require that the stand-

ards of performance or the methods of adjusting payments be the same as the approaches used in MIPS. **HHS should allow flexibility for APMs to use different approaches for adjusting payments based on quality than the methods used in MIPS.**

### 3. Calculating a Physician’s Revenues/Patients in Alternative Payment Models

The default requirement under MACRA is that the extent of participation by a physician or other clinician in APMs be evaluated by calculating the proportion of that provider’s *revenues* that are associated with APMs. However, MACRA also authorizes the use of a “patient approach,” i.e., counting the *number of patients* receiving care under APMs and calculating the percentages on that basis instead of based on revenues.

MACRA gives the Secretary of HHS the discretion as to whether and when to permit this approach. **In order to encourage maximum participation in APMs, HHS should give all physicians the option to determine whether their participation in APMs should be measured through the percentage of their revenue that is coming from APMs or the percentage of their patients being cared for through APMs.** In general, Medicare payments that are made directly to physicians represent only a small proportion of the total Medicare spending on the physicians’ patients. In some cases, the biggest opportunity for savings to Medicare may be associated with patients who represent only a small proportion of a physician practice’s revenues, and so it would be inappropriate to discourage a physician from participating in an APM for those patients simply because it affects only a small proportion of the physician’s own revenue.

In order to make the process as simple as possible for physicians and other eligible professionals, the thresholds could be defined as follows:

#### a. Threshold Based on Percentage of Revenue

- Any payment that the physician or clinician receives directly from an alternative payment entity that is specifically related to the care of a Medicare beneficiary (or a patient of another payer, when calculating percentages of total revenues under APMs) should be counted toward the threshold. For example, if the physician or clinician is paid by the alternative payment entity based on the number or types of services delivered or the number of patients cared for, those payments would be counted toward the threshold.
- Any payment or portion of payment that the physician or other clinician receives from Medicare under traditional fee-for-service payment systems (or from another payer, when calculating percentages of total revenues under APMs) should also be counted toward the threshold if that payment, or the service or patient for which that payment was made, is part of an alternative payment model managed by an alternative payment entity. In addition, if the physician is eligible to receive a separate payment from the alternative payment entity and/or required to make a payment to the alternative payment entity based on the physician’s performance or the entity’s performance, any such

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payments made to the physician would be counted toward the threshold and any payments made by the physician to the entity would be deducted from the payments counted toward the threshold. For example, if the physician is part of a Medicare Shared Savings Program ACO or a retrospectively reconciled episode payment model as part of the CMS Bundled Payments for Care Improvement (BPCI) demonstration, the physician would be paid directly by CMS for his or her services, not by the ACO or BPCI episode initiator. If the physician shares financially in the reconciliation of any gains or losses under the payment model, then those shares should be counted as payments from an alternative payment model.

- If payments from the alternative payment entity are made to the physician's or clinician's practice and the practice then compensates the physician/clinician on a different basis than the way the payment to the practice is made, the practice would need to establish a method for calculating the proportion of the physician's/clinician's compensation that is derived from the payments made by the alternative payment entity. For example, if the physicians in the practice are paid a salary, then the fraction of their salary that is treated as coming from the Alternative Payment Entity could be calculated based on the proportion of the practice's revenues coming from the Alternative Payment Entity.
- The sum of all of these payments received during a period of time should then be divided by the total payments the physician or eligible professional received during that same period of time to determine whether that physician/clinician meets the threshold defined in the law. The physician/clinician should have the option of computing the payment thresholds on a cash or accrual basis, whichever is simpler for them.

#### **b. Threshold Based on Patient Counts**

- If all of the services the physician/clinician delivers to a particular patient are compensated through an alternative payment entity (or through the physician's/clinician's practice using payments made to the practice by the alternative payment entity), that patient should be counted 100% toward the threshold.
- If only a portion of the services the physician/clinician delivers to the patient are compensated through an alternative payment entity, then the physician/clinician should be able to partially count that patient toward the threshold. The fraction of the patient to be counted should be defined using a methodology established and approved as part of the alternative payment model.
- The sum of all of these "total patient equivalents" should then be compared to the total number of unique patients receiving services from the physician/clinician during the relevant period of time to determine whether that individual meets the threshold established in the law.

# III. DEVELOPING AND IMPLEMENTING PHYSICIAN-FOCUSED PAYMENT MODELS UNDER MACRA

In addition to the provisions defining APMs and participation thresholds that are described in Section II, MACRA contains provisions specifically designed to encourage the development and use of “Physician-Focused Payment Models.”

## A. What is a Physician-Focused Payment Model?

Some people have found the wording in MACRA confusing because it does not explicitly state that “physician-focused payment models” should be alternative payment models, nor does it require alternative payment models to be physician-focused payment models. It is unlikely that Congress was trying to define two completely different types of payment models in MACRA, but rather it was acknowledging the simple fact that not every physician-focused payment model will be an alternative payment model and not every alternative payment model will be a physician-focused payment model for the reasons described below. Moreover, it seems clear that MACRA intended that physician-focused payment models should be integrally related to alternative payment models, since the provisions governing physician-focused payment models are part of the section of MACRA titled “Promoting Alternative Payment Models.”

### Many, But Not All APMs Will Be Physician-Focused Payment Models

Not every alternative payment model will be “physician-focused” simply because many types of care will be delivered jointly by physicians and other providers. For example, in its Acute Care Episode Demonstration, CMS made a bundled payment to physicians and hospitals for inpatient orthopedic and cardiovascular procedures. The payment could only be paid to a Physician-Hospital Organization controlled jointly by the physicians and hospitals. This would easily meet the criteria for an alternative payment model with the PHO serving as the alternative payment entity, but the payment and the accountability for success were *shared* by the physicians and hospitals, they were not focused solely or primarily on physicians. In contrast, many types of care are delivered solely or primarily by physicians, and for these types of care, alternative payment models can and should be “physician focused.” For example, payments made to support primary care medical homes can be defined in ways that meet the criteria for alternative payment models, and the principal focus of these models will be on enabling primary care physicians to deliver better care to their patients and reduce spending by Medicare and other payers in the process, so they should clearly be considered “physician-focused.” Similarly, many specialists provide

all or most of their services in their offices, not in hospitals or other facilities; they need alternative payment models to give them the flexibility and resources to improve care for their patients, and those payment models would also clearly be “physician-focused” APMs.

### Physician-Focused Payment Models Are Also Needed Within Larger APMs

In addition, there is a need for methods of changing the ways that physicians are paid as part of larger alternative payment models. For example, in alternative payment models that involve bundled or global payments for services delivered by both physicians and other providers such as hospitals or home health agencies, there needs to be a way of compensating the physicians differently in order to overcome the barriers created by traditional fee-for-service approaches. This is particularly true when payment models are implemented with “retrospective reconciliation” approaches such as those used by CMS in its Shared Savings (MSSP) and Bundled Payments for Care Improvement (BPCI) programs. Under these models, the physicians and other providers delivering services as part of the Accountable Care Organization or the BPCI episode continue to be paid under existing CMS fee for service systems; the total spending relevant to the payment model is compared to a budget and then a reconciliation payment is made to the ACO or BPCI entity which it can then allocate among participating physicians and other providers. However, the individual physicians may not be able to change care in ways that will make the ACO or BPCI episode team successful if there is no fee-for-service payment (or inadequate payment) for one or more high-value services. A physician-focused payment model could involve making adequate Medicare payments for the currently unpaid or underpaid services in order to support the success of the overall ACO or BPCI episode team. These would certainly be “physician-focused payment models,” but they would not need to directly meet the criteria for an alternative payment model.<sup>9</sup>

### Defining Physician-Focused Payment Models

In light of the above, the following two-part definition for a Physician-Focused Payment Model could be used:

**A Physician-Focused Payment Model is either:**

- (1) a method of paying physicians that meets the requirements for an alternative payment model under Section 1833(z)(3) of the Social Security Act, or**
- (2) a mechanism for compensating a physician for the physician’s services as an integral component of an alternative payment model being managed by an alternative payment entity as defined in Section 1833(z)(3).**

A payment model in sub-category (1) can be termed a “Physician-Focused Alternative Payment Model,” and a payment model in sub-category (2) can be termed an “APM Physician Compensation System.”

## B. Processes Created by MACRA to Encourage Physician-Focused Payment Models

In order to be exempt from MIPS and to benefit from the incentives for APM participation under MACRA, physicians will need to have at least 25% of their Medicare payments or patients coming from an alternative payment model by 2019. Most physicians will not be able to achieve this goal unless more rapid progress is made in developing and implementing new physician-focused alternative payment models in Medicare.

In order to accelerate the development and implementation of new physician-focused alternative payment models, MACRA established a process whereby individuals and stakeholders could submit proposals for physician-focused payment models for review by the federal government. This process has five components:

- (1) **Establishment of Criteria for Physician-Focused Payment Models.** MACRA requires HHS to issue regulations specifying criteria for physician-focused payment models, including models for specialist physicians. These must be issued no later than November 1, 2016, after two efforts to obtain public input – a request for information<sup>12</sup>, and a notice of proposed rulemaking. HHS is also authorized by MACRA to update the initial criteria through subsequent rulemaking.
- (2) **Creation of the Physician-Focused Payment Model Technical Advisory Committee.** MACRA establishes a permanent and independent Physician-Focused Payment Model Technical Advisory Committee (PTAC) to review proposals for physician-focused payment models. The Assistant Secretary for Planning and Evaluation (ASPE) at HHS is required to provide technical and operational support for the Committee, and the CMS Office of the Actuary is required to provide actuarial assistance as needed to the Committee. The eleven members of the PTAC were appointed by the Comptroller General in September 2015, and they began their work in 2016.<sup>13</sup>
- (3) **Authorization for Submission of Proposed Models.** MACRA authorizes “individuals and stakeholder entities” to submit proposals for physician-focused payment models to the Committee “on an ongoing basis” if the individuals and entities believe the proposals meet the criteria established in the HHS regulations.
- (4) **Review of Submitted Proposals.** MACRA requires the PTAC to periodically review models that are submitted, prepare comments and recommendations regarding whether the models meet the criteria established under regulations, and submit the comments and recommendations to the Secretary of HHS.
- (5) **Review and Response by HHS.** MACRA requires the Secretary of HHS to review the comments and recom-

mendations submitted by the PTAC and post a detailed response on the CMS website.

**How successful the process established under MACRA will be in developing an adequate number of physician-focused alternative payment models by 2019 will depend heavily on (1) the criteria that are established by HHS, (2) the information required for submission of proposals; (3) the timeliness of the review of submitted proposals, and (4) the willingness and ability of HHS to implement an adequate number of well-designed physician-focused alternative payment models.**

## C. Criteria for Approval of Physician-Focused Payment Models

As noted above, MACRA requires HHS to issue regulations specifying criteria for physician-focused payment models, including models for specialist physicians, by November 1, 2016. **The goal of these criteria should be to enable as many physicians as possible to make improvements in care they have identified for as many of their patients as possible.** This will maximize savings for Medicare as well as maximize the number of Medicare beneficiaries receiving better care. **In order to achieve this goal:**

- **The criteria established by HHS for physician-focused payment models should be kept as simple as possible** in order to encourage as much innovation as possible. The only essential criteria are those needed to ensure that a proposed model meets the criteria defined in MACRA. Section II-B above describes how the criteria for an alternative payment model can be defined in ways that meet the requirements of the law without creating unreasonable burdens on physicians or precluding small practices from participating.
- Although a key goal of alternative payment models should be to control Medicare spending, **the criteria established by HHS for physician-focused payment models should not require that a proposal demonstrate immediate or significant savings.** In fact, for payment models authorized under Section 1115A, the law states that HHS shall **not** require that a model be budget neutral initially and that models can be implemented as long as they are **expected** to either (a) improve the quality of care without increasing spending, (b) reduce spending without reducing the quality of care, or (c) improve the quality of care and reduce spending. While Section 1115A requires HHS to *focus* on models “expected to reduce program costs ... while preserving or enhancing the quality of care received by individuals receiving benefits...”, CMS is not prohibited from implementing models which will improve quality without increasing spending, and the criteria established by HHS should not preclude such models from being proposed.
- **The criteria established by HHS for physician-focused payment models should not require the use of particular payment systems, organizational structures, or processes for delivering care.** In particular, payment models should *not* be required to follow the formula CMS has been using in most of its payment initiatives to date, i.e., making no changes in the fee-for-service system, holding individual physicians accountable for the costs of all services their patients receive from all pro-

viders, and adjusting payment amounts based on shared savings calculations for attributed patients. As discussed in more detail in Section III-F, these approaches are extremely problematic for physicians and patients, and they are contributing to the poor results that have been achieved so far under these payment models, so new proposals should not be forced to follow these same approaches.

- Finally, **the criteria established by HHS for physician-focused payment models should not include criteria that are designed primarily to limit the number of potential proposals.** To the extent that priorities need to be established in implementing proposed models, they should be established *after* the proposals are reviewed, not before they are even submitted. For example, the Request for Information (RFI) issued by CMS in September 2015 indicated that it was considering requiring that proposed payment models be “primarily focused on the inclusion of participants ... who have not had the opportunity to participate in another physician-focused payment model with CMS because such a model has not been designed to include their specialty” and that payment models “aim to directly solve a current issue in payment policy that CMS is not already addressing in another model or program.” Although it should be a *priority* for HHS to ensure that there is at least *one* alternative payment model in which every specialist can participate, the fact that CMS has designed one model that it believes includes that specialty does not mean that model will work for every physician in that specialty or that a new APM proposed by physicians in that specialty would not achieve better results. Similarly, the fact that CMS is attempting to address a payment issue in an existing model or program does not mean that it is doing so as successfully as possible for all types of physician practices, and a new APM proposed by physicians may well be able to achieve far better results.

## D. Information Required for Submission of Proposed Models

MACRA authorizes submission of proposals for physician-focused payment models to the PTAC, but it does not specify the content of such proposals. Although it will be impossible for the PTAC to review and make recommendations regarding models without adequate information, **the information that proposals for physician-focused payment models should be required to contain should be kept to the minimum amount possible** in order to encourage physician practices and specialty societies to develop and submit proposals, particularly small practices with limited resources. Anecdotal information indicates that many physician practices do not even attempt to participate in some CMS payment programs because of the burdensome amount of information required to submit an application and the limited timeframes established to do so. Similarly, the 19 factors that the Center for Medicare and Medicaid Innovation currently uses to evaluate payment models<sup>14</sup> go far beyond what is necessary to determine whether a payment model would be likely to meet the requirements of MACRA, and requiring

submission of information relevant to all of these criteria would make it extremely difficult for small physician practices or medical societies to propose physician-focused alternative payment models.

**It is particularly important to avoid requiring submission of information that physicians and other developing proposals cannot obtain or cannot obtain except at a very high cost.** For example, although it would obviously be desirable for the PTAC to see financial simulations of the impact of a payment model on Medicare spending, it is usually impossible for physicians and other providers to obtain the type of data on Medicare spending needed to carry out such simulations. Although HHS has made considerable progress in making a broader array of Medicare data available on a more timely basis, most of the available data are fragmented, limited in detail, and several years old, and they generally cannot be used to support an adequate analysis of alternative payment models.

To enable the PTAC to effectively evaluate payment model proposals without making it too difficult for groups to submit them, it would be desirable if the PTAC and HHS could establish a two-step process for evaluation. If a proposal meets an initial set of criteria, HHS could provide the group submitting the proposal with the data or technical assistance needed in order for the PTAC to make a full evaluation and recommendation regarding the proposal.

## E. Process and Timetable for Reviewing and Recommending Proposals

MACRA does not establish specific deadlines for review of payment proposals. It merely authorizes proposals to be submitted to the PTAC “on an ongoing basis,” it requires the PTAC to “periodically” review proposals and submit comments and recommendations to the Secretary of HHS, and it requires the Secretary of HHS to post a detailed response on the CMS website with no deadline for doing so.

Given the urgency of controlling healthcare costs and improving the quality of healthcare services, and given the widespread recognition that significant payment reforms are essential to delivering higher-value care, **it is essential that HHS establish an aggressive timetable with clear deadlines for carrying out all of the steps defined in MACRA. It is important that proposals for physician-focused payment models be reviewed quickly, that prompt feedback be provided to those proposing the models, and that timely guidance be provided to other groups that are developing proposals.** The following would be an appropriate timetable to follow:

- The PTAC should accept proposals for physician-focused payment models no less often than quarterly.
- If a proposal does not include all of the necessary information for a complete review, the PTAC should make a determination within 90 days as to whether the proposal has the potential to meet the criteria for a physician-focused alternative payment model, and if so, the PTAC should request the additional information from the individual or entity that submitted the proposal. If the proposing entity needs information from

HHS to complete the application, the PTAC and HHS should attempt to provide that information and assistance within 60 days.

- If a proposal is submitted with all of the required information, it should be reviewed by the PTAC and a determination made as to whether it meets the criteria for a physician-focused payment model within 90 days.
  - ◆ If the proposal *does not* meet the criteria, the PTAC should provide feedback to the proposer as to why it does not, along with advice on what could be done to revise the proposal.
  - ◆ If the proposal *does* meet the criteria, the PTAC should inform the proposer and submit a recommendation to that effect to the Secretary of HHS.
- HHS staff should review each proposal submitted to the PTAC and provide its comments on the proposal to the PTAC before the PTAC makes its decision about whether to recommend the proposal for implementation. If the PTAC recommends implementation, the Secretary of HHS should post her comments on the proposal on the HHS website as required by MACRA, and the comments should explicitly indicate any reasons why HHS would not be able to implement the model by 2019.
- If a rejected proposal is revised and resubmitted, PTAC should re-review it within 60 days and either approve it or reject it.

## F. Ensuring Implementation of Well-Designed Physician-Focused APMs in Medicare

MACRA stops short of requiring that HHS implement physician-focused payment models recommended by the PTAC. It would obviously be a tremendous waste of time and energy by both those proposing physician-focused payment models and the members of the PTAC if desirable payment models were reviewed and recommended by the PTAC but not implemented by HHS. Consequently, **it will be essential that HHS create the necessary systems and processes so that it can implement physician-focused payment models recommended by the PTAC as well as alternative payment models involving other kinds of providers.**

It is clear that **HHS needs to establish a different approach to implementing alternative payment models than it has been using to date.** Although the Affordable Care Act created the Center for Medicare and Medicaid Innovation in 2010 in order to accelerate the development and implementation of innovative payment and delivery models, relatively little progress has been made in improving the ways most physicians and other providers are paid for their services. As the American Medical Association has stated, “Five years after CMS was authorized to implement ‘new patient care models’... Medicare still does not enable the majority of physicians to pursue ...opportunities to improve care in ways that could also reduce costs. Today, despite all of the demonstration projects and other initiatives that Medicare has implemented, most physicians – in primary care and other specialties – still do not have access to

Medicare payment models that provide the resources and flexibility they need to improve care for their Medicare patients. Consequently, most Medicare patients still are not benefiting from regular access to a full range of care coordination services, coordinated treatment planning by primary care and specialist physicians, support for patient self-management of their chronic conditions, proactive outreach to ensure that high-risk patients get preventive care, or patient decision-support tools. As a result, the Medicare program is paying for hospitalizations and duplicative services that could have been avoided had physicians been able to deliver these high-value services.”<sup>15</sup>

### 1. Creating a More Efficient Approach to Implementing APMs at HHS

One key reason for this slow progress is that the Center for Medicare and Medicaid Innovation (CMMI) has created a far more complex and resource-intensive process than is required or necessary to implement alternative payment models. Under most of the payment demonstrations that it has implemented to date, 18 months or more have elapsed from the time an initiative is first announced to the time when providers actually begin to receive different payments. Many proposals for alternative payment models have been submitted to CMMI that have not been implemented. This is not because the staff at CMMI are slow or incompetent, but because of the complex, expensive, and time-intensive process they have created for designing the initiative, selecting participants, managing the payments, and evaluating the results as part of any payment model they test.

This process is extremely burdensome and expensive for CMMI to administer, it dramatically reduces the number of alternative payment models that can be implemented, and it is also extremely burdensome for providers who are interested in participating in the initiatives that CMMI does attempt to implement. Many providers have decided not to even apply to participate in otherwise desirable CMMI programs and others have dropped out of the programs in the early phases solely or partly because of the cost and time burden of participating.

These burdensome processes are not required by either the Affordable Care Act or MACRA. If HHS were to attempt to implement every new alternative payment model using the approaches that are currently being used by

*The Center for Medicare and Medicaid Innovation (CMMI) has created a far more complex and resource-intensive process than is required or necessary to implement alternative payment models. This process dramatically reduces the number of alternative payment models that can be implemented, and it discourages physicians and other providers from participating.*



CMMI, it would take many years before even a fraction of the physicians in the country would have the ability to meet the APM requirements under MACRA. This would mean relatively few Medicare beneficiaries could benefit from the higher quality care that would be possible under APMs and the Medicare program would not achieve the savings that APMs could generate.

**A complete re-engineering of the processes HHS uses to implement alternative payment models is needed. This re-engineering process should start with the goal that is implicit in MACRA – every physician should have the opportunity to receive at least 25% of their revenues from alternative payment models in 2019, 50% of their revenues in 2021, and 75% in 2023. HHS should then work backward from those dates and design processes and timetables that will achieve the goals.**

*HHS should use Lean design techniques and other approaches to identify and eliminate all steps and requirements in its implementation processes that do not add value or that impede achieving the goals that Congress has set.*

Just as many physicians, hospitals, and other healthcare providers are now re-engineering their care delivery processes to eliminate steps that do not add significant value, HHS should use Lean design techniques and other approaches to identify and eliminate all steps and requirements in its implementation processes

that do not add value or that impede achieving the goals that Congress has set. Moreover, since MACRA allows alternative payment models to be implemented using statutory authorizations other than Section 1115A (the enabling legislation for CMMI), HHS should use all of the options available under MACRA in order to implement desirable alternative payment models in the most efficient way possible.

In order for a physician to be participating in an APM during 2019, the processes for approving and implementing the APM and for approving the physician's participation in the APM will have to be completed no later than the end of 2018. However, **in order for physicians to succeed under APMs, they will need to have sufficient lead time to form or join an alternative payment entity and to redesign the processes by which they deliver care with the flexibility provided by the APM, and so both the structure of the APM and the approval for a physician's participation will need to be completed long before the end of 2018.** Some physician groups and medical specialty societies have already developed physician-focused alternative payment models that should be able to meet the criteria under MACRA; these could and should be implemented as soon as 2017.

To ensure that the MACRA goals are achieved, **HHS should establish specific milestones that are designed to implement as many alternative payment models as possible and as quickly as possible.** For example, the following timetable would allow payments under an alternative payment model to begin flowing to a physician

within one year after the model is recommended by the PTAC:

- Once a physician-focused alternative payment model is recommended by the PTAC and approved by HHS, the applications that physician practices and alternative payment entities would need to complete in order to participate in the approved APM should be made available within 90 days.
- Physicians and alternative payment entities should be permitted to apply to participate in an approved APM no less frequently than twice per year.
- Applications to participate in an approved APM should be reviewed and approved or rejected within 60 days. Applications should only be rejected if an applicant cannot demonstrate that it has the ability to implement the model, not because of arbitrary limits on the size of the program. If an application is rejected, CMS should provide feedback to the applicant on the reasons for rejection and methods of correction. If a rejected application is revised and resubmitted, CMS should re-review it and approve or reject it within 30 days.
- CMS should implement an approved APM with the approved physician applicants no later than 90 days after the applications by physician practices to participate have been approved.
- Once a physician or other clinician begins to participate in an APM, they should be permitted to continue doing so as long as they wish to, unless CMS can demonstrate that Medicare spending under the payment model is higher than it would be under the standard physician fee schedule or that the quality of care for beneficiaries is being harmed.<sup>16</sup>

## 2. Creating the Capability at HHS to Implement a Broad Range of Physician-Focused APMs

A second key reason why only a small number of physicians are participating in alternative payment models under Medicare is the problematic structure of the current models that CMS and CMMI have been using. Most of the payment models that are currently being implemented or tested by CMS use a very similar approach – no changes in the current fee for service structure, holding individual physicians accountable for the costs of all services their patients receive from all providers, adjusting payment amounts based on shared savings calculations for attributed patients, etc. – and these approaches not only fail to solve the problems in the current payment systems, they can actually make them worse.

### a. Correcting the Problems With Current CMS Payment Models

As shown in the table on page 16, the components used in most CMS payment models are very problematic for physicians and therefore they are likely problematic for their patients as well. Although CMS may view some of these payment models as “physician-focused” because they are targeted at individual physicians or physician practices, the goal should be to create physician-focused payment models that are *successful* in improving care

# IMPROVEMENTS NEEDED IN CMS ALTERNATIVE PAYMENT MODELS

ELEMENTS FREQUENTLY USED IN CMS ALTERNATIVE PAYMENT MODELS	PROBLEMS FOR PHYSICIANS WITH THE CMS APPROACH	TYPES OF APPROACHES NEEDED FOR SUCCESSFUL PHYSICIAN-FOCUSED ALTERNATIVE PAYMENT MDOELS
<b>No changes are made to the underlying Medicare physician fee schedule</b>	<ul style="list-style-type: none"> <li>Physicians may not be able to afford to deliver new services needed to improve quality or reduce spending</li> <li>Improved outcomes may reduce physician revenues because patients need fewer billable services</li> </ul>	<ul style="list-style-type: none"> <li>Authorize payments for new types of high-value services</li> <li>Make payments based on patient conditions or outcomes rather than the number and types of services delivered</li> </ul>
<b>Individual physicians are held accountable for spending on all services their patients receive from all providers for all of the patients' health problems</b>	<ul style="list-style-type: none"> <li>Physicians cannot control all services their patients receive</li> <li>Physicians cannot control the prices of services delivered by other providers</li> <li>The payment model may only be designed to affect a subset of services</li> <li>Patients receive services for conditions other than those treated by the physician</li> <li>Physicians and other providers are forced to consolidate</li> </ul>	<ul style="list-style-type: none"> <li>Hold physicians accountable for the specific services related to the patient's condition that the physician can control or significantly influence</li> <li>Hold physicians accountable for utilization of services rather than spending, or adjust spending measures to exclude spending changes due to price changes</li> <li>Provide condition-based payments designed to support the care delivered by small teams of providers</li> </ul>
<b>Physicians are held accountable for large numbers of quality measures</b>	<ul style="list-style-type: none"> <li>Physicians may not be able to control all of the factors driving the quality measures or may not have adequate resources to do so</li> <li>Some quality measures may have little or nothing to do with the type of care or the patient condition that is being addressed</li> </ul>	<ul style="list-style-type: none"> <li>Hold physicians accountable for the specific types of quality measures likely to be affected by the change in payment</li> <li>Provide sufficient additional payment to cover the costs of improving quality in all of the desired areas</li> </ul>
<b>Payments and accountability measures are not risk adjusted based on characteristics of patients that affect costs and outcomes</b>	<ul style="list-style-type: none"> <li>Physicians are financially penalized for caring for sicker or higher-risk patients</li> <li>Physicians are forced to avoid serving higher-risk patients</li> </ul>	<ul style="list-style-type: none"> <li>Risk adjust or stratify payments based on the specific factors affecting costs and outcomes for the types of health conditions and services addressed by the payment model</li> <li>Allow physicians to assign patients to appropriate payment categories based on relevant clinical and non-clinical factors</li> </ul>
<b>Additional payments to the physician are dependent on shared savings calculations</b>	<ul style="list-style-type: none"> <li>Physicians who already have high levels of performance receive no additional resources</li> <li>Physicians who have overused expensive services in the past can receive large wind-fall bonuses</li> <li>Physicians receive larger shared savings bonuses for avoiding necessary care</li> <li>Payments to small physician practices are subject to uncontrollable random variation in spending</li> <li>Physicians experience cash flow problems waiting for shared savings payments</li> </ul>	<ul style="list-style-type: none"> <li>Provide adequate payment for the services physicians will need to deliver high quality care as long as physicians achieve or maintain good levels of performance</li> <li>Adjust payments only for physicians whose performance is better or worse than pre-defined good performance levels by statistically significant margins</li> <li>Base performance measures on avoidable spending rather than total spending</li> </ul>
<b>Additional payments and accountability measures are based on patients assigned using statistical attribution methods based on office visits</b>	<ul style="list-style-type: none"> <li>Patients who are healthy may not be attributed to the physician, making spending and quality measures look worse</li> <li>Physicians who use non-visit-based payments to improve care may lose the payments if patients make fewer visits</li> <li>Physicians may be attributed patients for whom they no longer provide care or who only see the physician for services unrelated to the payment model</li> <li>Hospitals are forced to acquire physician practices in order to share in payments</li> </ul>	<ul style="list-style-type: none"> <li>Allow physicians to designate which patients are having their care managed by the physician based on an agreement with the patient, not based on the number of office visits</li> <li>Provide bundled payments to physicians and other providers such as hospitals that allow them to jointly manage the care of patients and provide adequate financial support for their respective costs</li> </ul>

*Most of the payment models that are currently being implemented or tested by CMS use a very similar approach – no changes in the current fee for service structure, holding individual physicians accountable for the costs of all services their patients receive from all providers, adjusting payment amounts based on shared savings calculations for attributed patients, etc. – and these approaches not only fail to solve the problems in the current payment systems, they can actually make them worse.*

and improving costs in ways that are feasible for physician practices, particularly small practices, to implement. To date, these payment models have not been successful in reducing costs because they do not provide the kinds of support that physicians need to redesign care as discussed in Section I. **New physician-focused payment models should not be required to use the same flawed approaches that are being used in current CMS payment demonstrations.**

#### **b. Creating Coding Systems to Support Successful Physician-Focused Payment Models**

The table on page 16 also shows the kinds of approaches that should be used instead of the CMS approaches in order to design physician-focused APMs that enable physicians to successfully reduce spending by supporting better care to their patients in ways that are financially feasible for the physicians' practices. Some of these approaches have been difficult for CMS to implement in the past because of the limitations of current coding and claims systems, but Congress recognized this and MACRA requires HHS to develop and implement solutions. Specifically:

- **Patient Condition Groups.** MACRA requires the creation of “patient condition groups” based on a patient’s chronic conditions, current health status, and recent significant history, such as hospitalization or surgery. If properly designed, these groups will enable far better risk adjustment and acuity stratification than the methods used in Medicare payment programs today.
- **Care Episode Groups.** MACRA requires the creation of “care episode groups” that define the types of procedures or services furnished for particular clinical conditions or diagnoses. If properly designed, these groups will enable far better measures of the kinds of services and costs physicians can control or influence than the total cost measures used in Medicare payment programs today.
- **Patient Relationship Categories.** MACRA requires the creation of “patient relationship categories” and associated codes that define and distinguish the relationship and responsibility of a physician or applicable practitioner with a patient at the time of furnishing an item or service. If properly designed, these categories and codes will enable payments and accountability for

spending and quality to be far more accurate than the retrospective statistical attribution methodologies used in Medicare payment programs today.

MACRA establishes an aggressive timetable for developing and implementing these groups, categories, and codes. Beginning on January 1, 2018, appropriate codes are to be included on the claims that physicians submit for payment.

In order for these groups, categories, and codes to enable the implementation of better alternative payment models, they need to be designed with those payment models in mind. MACRA explicitly indicates that these groups, categories, and codes should be designed to support both MIPS and APMs, but in order for them to properly support successful APMs, **HHS will need to develop patient condition groups, care episode groups, and patient relationship categories in ways that support a much broader range of APMs than CMS is using today.** At a minimum, this should include all of the payment models described in the next subsection. **Condition groups, care episode groups, and patient relationship categories should be developed in collaboration with physician groups and medical societies as MACRA explicitly requires.<sup>17</sup>**

#### **c. Implementing Systems to Support Multiple Types of Physician-Focused Payment Models**

There is no single Physician-Focused Alternative Payment Model that will work for all physicians or their patients. Different medical specialties treat different kinds of health problems, and the opportunities to improve quality and reduce costs will differ for the different types of health problems addressed by physicians within each specialty and subspecialty. Moreover, the care delivery changes that are needed to address these opportunities will also differ by specialty, as will the barriers in the current payment system that need to be overcome in order for physicians to redesign care delivery for their patients.

This means there will need to be multiple types of APMs in order for physicians in all specialties to participate and in order for all patients to benefit. A good APM will overcome the *specific* payment system barriers a physician practice faces in pursuing the *specific* kinds of improvement opportunities available for the *specific* types of patient conditions the physicians in that practice treat. There is no need for complex and expensive changes in payment structures if simple changes will address the barriers. If paying for a new service code could enable a physician practice to deliver significantly better care at lower overall cost, there is no need to force the practice to find ways to manage a complex bundled payment. Conversely, if services need to be completely redesigned or if multiple types of physicians need to work closely together in order to deliver high-value care for a particular condition, a bundled condition-based payment may be essential, and physicians should not be forced to use shared savings or other payment models that do not provide the necessary flexibility.

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At a minimum, HHS should create the administrative capabilities to implement seven different types of physician-focused APMs that can be used to address the most common types of opportunities and barriers that exist across all physician specialties. These are:

1. **Payment for a High-Value Service.** Under this APM, a physician practice could be paid for delivering one or more desirable services that are not currently billable, and the physician would take accountability for controlling the use of other, avoidable services for their patients.
2. **Condition-Based Payment for Physician Services.** Under this APM, a physician practice would have the flexibility to use the diagnostic or treatment options that address a patient's condition most efficiently and effectively without concern that using lower-cost options would harm the operating margins of the physician's practice.
3. **Multi-Physician Bundled Payment.** Under this APM, two or more physician practices that are providing complementary diagnostic or treatment services to a patient would have the flexibility to redesign those services in ways that would enable high-quality care to be delivered as efficiently as possible.
4. **Physician-Facility Procedure Bundle.** This APM would allow a physician who delivers a procedure at a hospital or other facility to choose the most appropriate facility for the treatment and to give the physician and facility the flexibility to deliver the procedure in the most efficient and high-quality way.
5. **Warranted Payment for Physician Services.** This APM would give a physician the flexibility and accountability to deliver care with as low a rate of complications as possible.
6. **Episode Payment for a Procedure.** This APM would enable a physician who is delivering a particular procedure to work collaboratively with the other providers delivering services related to the procedure (e.g., the facility where the procedure is performed, other physicians who are involved in the procedure, physicians and facilities who are involved in the patient's recovery or in treating complications of the procedure, etc.) in order to improve outcomes and control the total spending associated with the procedure.
7. **Condition-Based Payment.** Under this APM, a physician practice would have the flexibility to use the diagnosis or treatment options that address a particular health condition (or combination of conditions) most efficiently and effectively and to work collaboratively with other providers who deliver services for the patient's condition in order to improve outcomes and control the total spending associated with care for the condition.

More detail on each of these physician-focused Alternative Payment Models and examples of how they could be used to improve care for a wide range of patient conditions is available in a report developed by the American Medical Association and CHQPR entitled *A Guide to Physician-Focused Alternative Payment Models*.<sup>18</sup>

HHS should begin immediately to implement the administrative systems needed to support all of these types of alternative payment models. This would not only ensure that the APMs can be implemented by 2018, but it would encourage physician groups and medical specialty societies to design payment models in a common framework, which will reduce implementation costs for HHS.

Re-engineering the processes for implementing alternative payment models as discussed in Section III-F-1 above should dramatically increase the capacity of HHS to implement more payment models more quickly than it can today. However, **if there are insufficient staff or resources at HHS/CMS/CMMI to support implementation of a sufficient number of new alternative payment models to enable all physicians to participate, additional resources should be provided to achieve the necessary "bandwidth."** Failing to allocate sufficient resources to implement alternative payment models that will save money for the Medicare program would be penny wise and pound foolish.

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# ENDNOTES

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1. H.R. 2 (the Medicare Access and CHIP Reauthorization Act of 2015) passed the House of Representatives by a vote of 392-37 on March 26, 2015 and it passed the Senate by a vote of 92-8 on April 14, 2015.
2. Miller HD, Marks S. *A Guide to Physician-Focused Alternative Payment Models*. American Medical Association and Center for Healthcare Quality and Payment Reform, November 2015. Available at: <http://www.chqpr.org/downloads/Physician-FocusedAlternativePaymentModels.pdf>
3. For a more detailed discussion of the components needed for a successful Alternative Payment Model, see Miller HD. *The Building Blocks of Payment Reform: Designing Payment Systems that Support Higher-Value Health Care*, Network for Regional Healthcare Improvement, Center for Healthcare Quality and Payment Reform, and Robert Wood Johnson Foundation. April 2015. Available at <http://www.chqpr.org/downloads/BuildingBlocksofSuccessfulPaymentReform.pdf>.
4. An “eligible professional” can be a physician; a physician assistant; a nurse practitioner; a clinical nurse specialist; a certified registered nurse anesthetist; a certified nurse-midwife; a clinical social worker; a clinical psychologist; a registered dietitian or nutrition professional; a physical or occupational therapist; a qualified speech-language pathologist; or a qualified audiologist.
5. The law defines the denominator of the percentage as the sum of Medicare payments (or patients) and payments (or patients) from all other payers except for the Department of Defense, the Veterans Affairs Administration, and state Medicaid programs that have no medical home program or alternative payment models available.
6. The full set of provisions of Section 1115A is available at [https://www.ssa.gov/OP\\_Home/ssact/title11/1115A.htm](https://www.ssa.gov/OP_Home/ssact/title11/1115A.htm)
7. The full set of provisions of Section 1899 is available at [https://www.ssa.gov/OP\\_Home/ssact/title18/1899.htm](https://www.ssa.gov/OP_Home/ssact/title18/1899.htm)
8. Information on the demonstrations implemented under Section 1866C are available at <https://innovation.cms.gov/initiatives/Medicare-Health-Care-Quality/>
9. This approach was required in the successful Acute Care Episode (ACE) Demonstration conducted by CMS. More information on the ACE Demonstration is available at <https://innovation.cms.gov/initiatives/ACE/>
10. The provisions of CFR 422.208 can be found at <https://www.gpo.gov/fdsys/pkg/CFR-2002-title42-vol2/pdf/CFR-2002-title42-vol2-sec422-208.pdf>
11. For a more detailed discussion of how alternative payment models can be used for compensation of providers within larger alternative payment models, see Miller HD. *The Building Blocks of Successful Payment Reform: Designing Payment Systems that Support Higher-Value Health Care*. Available at <http://www.chqpr.org/downloads/BuildingBlocksofSuccessfulPaymentReform.pdf> .
12. The Request for Information was issued in September 2015 and the deadline for comments was later extended to November 17, 2015. The comments that were submitted can be found at [www.regulations.gov](http://www.regulations.gov).
13. Information about the PTAC is available at <https://aspe.hhs.gov/medicare-access-and-chip-reauthorization-act-2015>
14. These criteria are posted on the CMS website at <https://innovation.cms.gov/Files/x/rfi-websitepreamble.pdf>
15. Letter from James L. Madara, MD, Executive Vice President and CEO, American Medical Association to Andrew M. Slavitt, Acting Administrator, Centers for Medicare and Medicaid Services, November 17, 2015, pages 3-4.
16. Section 1115A of the Social Security Act explicitly permits the Secretary of HHS to continue a payment model as long as the model is expected to improve the quality of care without increasing spending, reduce spending without reducing the quality of care, or improve the quality of care and reduce spending. Moreover, if a payment model is not achieving these goals, the law gives the Secretary of HHS the power to modify the payment model rather than terminate it. Decisions to continue or modify a model can be made before an evaluation of the model is completed.
17. Section 1848(r) of the Social Security Act, which requires the development of patient condition groups, care episode groups, and patient relationship categories, is titled “Collaborating with the Physician, Practitioner, and Other Stakeholder Communities to Improve Resource Use Measurement” and specifies detailed processes and timetables that HHS must follow to obtain input from physician specialty societies, practitioner organizations, and other stakeholders.
18. Miller HD, Marks S. *A Guide to Physician-Focused Alternative Payment Models*. American Medical Association and Center for Healthcare Quality and Payment Reform, November 2015. Available at: <http://www.chqpr.org/downloads/Physician-FocusedAlternativePaymentModels.pdf>

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# APPENDIX

## PROVISIONS OF MACRA REGARDING ALTERNATIVE PAYMENT MODELS

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### MEDICARE ACCESS AND CHIP REAUTHORIZATION ACT OF 2015

#### TITLE I—SGR REPEAL AND MEDICARE PROVIDER PAYMENT MODERNIZATION

#### SEC. 101. REPEALING THE SUSTAINABLE GROWTH RATE (SGR) AND IMPROVING MEDICARE PAYMENT FOR PHYSICIANS' SERVICES.

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#### (e) PROMOTING ALTERNATIVE PAYMENT MODELS.

#### (1) INCREASING TRANSPARENCY OF PHYSICIAN-FOCUSED PAYMENT MODELS.

Section 1868 of the Social Security Act (42 U.S.C. 1395ee) is amended by adding at the end the following new subsection:

#### Section 1868 (c) PHYSICIAN-FOCUSED PAYMENT MODELS.

#### (1) TECHNICAL ADVISORY COMMITTEE.

#### (A) ESTABLISHMENT.

There is established an ad hoc committee to be known as the 'Physician-Focused Payment Model Technical Advisory Committee' (referred to in this subsection as the 'Committee').

#### (B) MEMBERSHIP.

#### (i) NUMBER AND APPOINTMENT.

The Committee shall be composed of 11 members appointed by the Comptroller General of the United States.

#### (ii) QUALIFICATIONS.

The membership of the Committee shall include individuals with national recognition for their expertise in physician-focused payment models and related delivery of care. No more than 5 members of the Committee shall be providers of services or suppliers, or representatives of providers of services or suppliers.

#### (iii) PROHIBITION ON FEDERAL EMPLOYMENT.

A member of the Committee shall not be an employee of the Federal Government.

#### (iv) ETHICS DISCLOSURE.

The Comptroller General shall establish a system for public disclosure by members of the Committee of financial and other potential conflicts of interest relating to such members. Members of the Committee shall be treated as employees of Congress for purposes of applying title I of the Ethics in Government Act of 1978 (Public Law 95-521).

#### (v) DATE OF INITIAL APPOINTMENTS.

The initial appointments of members of the Committee shall be made by not later than 180 days after the date of enactment of this subsection.

#### (C) TERM; VACANCIES.

#### (i) TERM.

The terms of members of the Committee shall be for 3 years except that the Comptroller General shall designate staggered terms for the members first appointed.

#### (ii) VACANCIES.

Any member appointed to fill a vacancy occurring before the expiration of the term for which the member's predecessor was appointed shall be appointed only for the remainder of that term. A member may serve after the expiration of that member's term until a successor has taken office. A vacancy in the Committee shall be filled in the manner in which the original appointment was made.

#### (D) DUTIES.

The Committee shall meet, as needed, to provide comments and recommendations to the Secretary, as described in paragraph (2)(C), on physician-focused payment models.

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(E) COMPENSATION OF MEMBERS.

(i) IN GENERAL.

Except as provided in clause (ii), a member of the Committee shall serve without compensation.

(ii) TRAVEL EXPENSES.

A member of the Committee shall be allowed travel expenses, including per diem in lieu of subsistence, at rates authorized for an employee of an agency under subchapter I of chapter 57 of title 5, United States Code, while away from the home or regular place of business of the member in the performance of the duties of the Committee.

(F) OPERATIONAL AND TECHNICAL SUPPORT.

(i) IN GENERAL.

The Assistant Secretary for Planning and Evaluation shall provide technical and operational support for the Committee, which may be by use of a contractor. The Office of the Actuary of the Centers for Medicare & Medicaid Services shall provide to the Committee actuarial assistance as needed.

(ii) FUNDING.

The Secretary shall provide for the transfer, from the Federal Supplementary Medical Insurance Trust Fund under section 1841, such amounts as are necessary to carry out this paragraph (not to exceed \$5,000,000) for fiscal year 2015 and each subsequent fiscal year. Any amounts transferred under the preceding sentence for a fiscal year shall remain available until expended.

(G) APPLICATION.

Section 14 of the Federal Advisory Committee Act (5 U.S.C. App.) shall not apply to the Committee.

**(2) CRITERIA AND PROCESS FOR SUBMISSION AND REVIEW OF PHYSICIAN-FOCUSED PAYMENT MODELS.**

(A) CRITERIA FOR ASSESSING PHYSICIAN-FOCUSED PAYMENT MODELS.

(i) RULEMAKING.

Not later than November 1, 2016, the Secretary shall, through notice and comment rulemaking, following a request for information, establish criteria for physician-focused payment models, including models for specialist physicians, that could be used by the Committee for making comments and recommendations pursuant to paragraph (1)(D).

(ii) MEDPAC SUBMISSION OF COMMENTS.

During the comment period for the proposed rule described in clause (i), the Medicare Payment Advisory Commission may submit comments to the Secretary on the proposed criteria under such clause.

(iii) UPDATING.

The Secretary may update the criteria established under this subparagraph through rulemaking.

(B) STAKEHOLDER SUBMISSION OF PHYSICIAN-FOCUSED PAYMENT MODELS.

On an ongoing basis, individuals and stakeholder entities may submit to the Committee proposals for physician-focused payment models that such individuals and entities believe meet the criteria described in subparagraph (A).

(C) COMMITTEE REVIEW OF MODELS SUBMITTED.

The Committee shall, on a periodic basis, review models submitted under subparagraph (B), prepare comments and recommendations regarding whether such models meet the criteria described in subparagraph (A), and submit such comments and recommendations to the Secretary.

(D) SECRETARY REVIEW AND RESPONSE.

The Secretary shall review the comments and recommendations submitted by the Committee under subparagraph (C) and post a detailed response to such comments and recommendations on the Internet website of the Centers for Medicare & Medicaid Services.

**(3) RULE OF CONSTRUCTION.**

Nothing in this subsection shall be construed to impact the development or testing of models under this title or titles XI, XIX, or XXI.

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## (2) INCENTIVE PAYMENTS FOR PARTICIPATION IN ELIGIBLE ALTERNATIVE PAYMENT MODELS.

Section 1833 of the Social Security Act (42 U.S.C. 1395l) is amended by adding at the end the following new subsection:

### Section 1833 (z) INCENTIVE PAYMENTS FOR PARTICIPATION IN ELIGIBLE ALTERNATIVE PAYMENT MODELS.

#### (1) PAYMENT INCENTIVE.

##### (A) IN GENERAL.

In the case of covered professional services furnished by an eligible professional during a year that is in the period beginning with 2019 and ending with 2024 and for which the professional is a qualifying APM participant with respect to such year, in addition to the amount of payment that would otherwise be made for such covered professional services under this part for such year, there also shall be paid to such professional an amount equal to 5 percent of the estimated aggregate payment amounts for such covered professional services under this part for the preceding year. For purposes of the previous sentence, the payment amount for the preceding year may be an estimation for the full preceding year based on a period of such preceding year that is less than the full year. The Secretary shall establish policies to implement this subparagraph in cases in which payment for covered professional services furnished by a qualifying APM participant in an alternative payment model –

- (i) is made to an eligible alternative payment entity rather than directly to the qualifying APM participant; or
- (ii) is made on a basis other than a fee-for-service basis (such as payment on a capitated basis).

##### (B) FORM OF PAYMENT.

Payments under this subsection shall be made in a lump sum, on an annual basis, as soon as practicable.

##### (C) TREATMENT OF PAYMENT INCENTIVE.

Payments under this subsection shall not be taken into account for purposes of determining actual expenditures under an alternative payment model and for purposes of determining or rebasing any benchmarks used under the alternative payment model.

##### (D) COORDINATION.

The amount of the additional payment under this subsection or subsection (m) shall be determined without regard to any additional payment under subsection (m) and this subsection, respectively. The amount of the additional payment under this subsection or subsection (x) shall be determined without regard to any additional payment under subsection (x) and this subsection, respectively. The amount of the additional payment under this subsection or subsection (y) shall be determined without regard to any additional payment under subsection (y) and this subsection, respectively.

#### (2) QUALIFYING APM PARTICIPANT.

For purposes of this subsection, the term ‘qualifying APM participant’ means the following:

##### (A) 2019 AND 2020.

With respect to 2019 and 2020, an eligible professional for whom the Secretary determines that at least 25 percent of payments under this part for covered professional services furnished by such professional during the most recent period for which data are available (which may be less than a year) were attributable to such services furnished under this part through an eligible alternative payment entity.

##### (B) 2021 AND 2022.

With respect to 2021 and 2022, an eligible professional described in either of the following clauses:

###### (i) MEDICARE PAYMENT THRESHOLD OPTION.

An eligible professional for whom the Secretary determines that at least 50 percent of payments under this part for covered professional services furnished by such professional during the most recent period for which data are available (which may be less than a year) were attributable to such services furnished under this part through an eligible alternative payment entity.

###### (ii) COMBINATION ALL-PAYER AND MEDICARE PAYMENT THRESHOLD OPTION.

An eligible professional—

(I) for whom the Secretary determines, with respect to items and services furnished by such professional during the most recent period for which data are available (which may be less than a year), that at least 50 percent of the sum of—

(aa) payments described in clause (i); and

(bb) all other payments, regardless of payer (other than payments made by the Secretary of Defense or the Secretary of Veterans Affairs and other than payments made under title XIX in a State in which no medical home or alternative payment model is available under the State program under that title), meet the requirement described in clause (iii)(I) with respect to payments described in item (aa) and



- meet the requirement described in clause (iii)(II) with respect to payments described in item (bb);
- (II) for whom the Secretary determines at least 25 percent of payments under this part for covered professional services furnished by such professional during the most recent period for which data are available (which may be less than a year) were attributable to such services furnished under this part through an eligible alternative payment entity; and
- (III) who provides to the Secretary such information as is necessary for the Secretary to make a determination under subclause (I), with respect to such professional.

(iii) REQUIREMENT.

For purposes of clause (ii)(I)—

- (I) the requirement described in this subclause, with respect to payments described in item (aa) of such clause, is that such payments are made to an eligible alternative payment entity; and
- (II) the requirement described in this subclause, with respect to payments described in item (bb) of such clause, is that such payments are made under arrangements in which—
  - (aa) quality measures comparable to measures under the performance category described in section 1848(q)(2)(B)(i) apply;
  - (bb) certified EHR technology is used; and
  - (cc) the eligible professional participates in an entity that—
    - (AA) bears more than nominal financial risk if actual aggregate expenditures exceeds expected aggregate expenditures; or
    - (BB) with respect to beneficiaries under title XIX, is a medical home that meets criteria comparable to medical homes expanded under section 1115A(c).

(C) BEGINNING IN 2023.

With respect to 2023 and each subsequent year, an eligible professional described in either of the following clauses:

(i) MEDICARE PAYMENT THRESHOLD OPTION.

An eligible professional for whom the Secretary determines that at least 75 percent of payments under this part for covered professional services furnished by such professional during the most recent period for which data are available (which may be less than a year) were attributable to such services furnished under this part through an eligible alternative payment entity.

(ii) COMBINATION ALL-PAYER AND MEDICARE PAYMENT THRESHOLD OPTION.

An eligible professional—

- (I) for whom the Secretary determines, with respect to items and services furnished by such professional during the most recent period for which data are available (which may be less than a year), that at least 75 percent of the sum of—
  - (aa) payments described in clause (i); and
  - (bb) all other payments, regardless of payer (other than payments made by the Secretary of Defense or the Secretary of Veterans Affairs and other than payments made under title XIX in a State in which no medical home or alternative payment model is available under the State program under that title), meet the requirement described in clause (iii)(I) with respect to payments described in item (aa) and meet the requirement described in clause (iii)(II) with respect to payments described in item (bb);
- (II) for whom the Secretary determines at least 25 percent of payments under this part for covered professional services furnished by such professional during the most recent period for which data are available (which may be less than a year) were attributable to such services furnished under this part through an eligible alternative payment entity; and
- (III) who provides to the Secretary such information as is necessary for the Secretary to make a determination under subclause (I), with respect to such professional.

(iii) REQUIREMENT.

For purposes of clause (ii)(I)—

- (I) the requirement described in this subclause, with respect to payments described in item (aa) of such clause, is that such payments are made to an eligible alternative payment entity; and
- (II) the requirement described in this subclause, with respect to payments described in item (bb) of such clause, is that such payments are made under arrangements in which—
  - (aa) quality measures comparable to measures under the performance category described in section 1848(q)(2)(B)(i) apply;
  - (bb) certified EHR technology is used; and
  - (cc) the eligible professional participates in an entity that—

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(AA) bears more than nominal financial risk if actual aggregate expenditures exceeds expected aggregate expenditures; or

(BB) with respect to beneficiaries under title XIX, is a medical home that meets criteria comparable to medical homes expanded under section 1115A(c).

**(D) USE OF PATIENT APPROACH.**

The Secretary may base the determination of whether an eligible professional is a qualifying APM participant under this subsection and the determination of whether an eligible professional is a partial qualifying APM participant under section 1848(q)(1)(C)(iii) by using counts of patients in lieu of using payments and using the same or similar percentage criteria (as specified in this subsection and such section, respectively), as the Secretary determines appropriate.

**(3) ADDITIONAL DEFINITIONS.**

In this subsection:

**(A) COVERED PROFESSIONAL SERVICES.**

The term ‘covered professional services’ has the meaning given that term in section 1848(k)(3)(A).

**(B) ELIGIBLE PROFESSIONAL.**

The term ‘eligible professional’ has the meaning given that term in section 1848(k)(3)(B) and includes a group that includes such professionals.

**(C) ALTERNATIVE PAYMENT MODEL (APM).**

The term ‘alternative payment model’ means, other than for purposes of subparagraphs (B)(ii)(I)(bb) and (C)(ii)(I)(bb) of paragraph (2), any of the following:

- (i) A model under section 1115A (other than a health care innovation award).
- (ii) The shared savings program under section 1899.
- (iii) A demonstration under section 1866C.
- (iv) A demonstration required by Federal law.

**(D) ELIGIBLE ALTERNATIVE PAYMENT ENTITY.**

The term ‘eligible alternative payment entity’ means, with respect to a year, an entity that—

- (i) participates in an alternative payment model that—

- (I) requires participants in such model to use certified EHR technology (as defined in subsection (o)(4));
  - and

- (II) provides for payment for covered professional services based on quality measures comparable to measures under the performance category described in section 1848(q)(2)(B)(i);

and (ii)

- (I) bears financial risk for monetary losses under such alternative payment model that are in excess of a nominal amount; or

- (II) is a medical home expanded under section 1115A(c).

**(4) LIMITATION.**

There shall be no administrative or judicial review under section 1869, 1878, or otherwise, of the following:

(A) The determination that an eligible professional is a qualifying APM participant under paragraph (2) and the determination that an entity is an eligible alternative payment entity under paragraph (3)(D).

(B) The determination of the amount of the 5 percent payment incentive under paragraph (1)(A), including any estimation as part of such determination.

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### **(3) COORDINATION CONFORMING AMENDMENTS.**

Section 1833 of the Social Security Act (42 U.S.C. 1395l) is further amended

(A) in subsection (x)(3), by adding at the end the following new sentence: “The amount of the additional payment for a service under this subsection and subsection (z) shall be determined without regard to any additional payment for the service under subsection (z) and this subsection, respectively.”; and

(B) in subsection (y)(3), by adding at the end the following new sentence: “The amount of the additional payment for a service under this subsection and subsection (z) shall be determined without regard to any additional payment for the service under subsection (z) and this subsection, respectively.”.

### **(4) ENCOURAGING DEVELOPMENT AND TESTING OF CERTAIN MODELS.**

Section 1115A(b)(2) of the Social Security Act (42 U.S.C. 1315a(b)(2)) is amended—

(A) in subparagraph (B), by adding at the end the following new clauses:

(xxi) Focusing primarily on physicians’ services (as defined in section 1848(j)(3)) furnished by physicians who are not primary care practitioners.

(xxii) Focusing on practices of 15 or fewer professionals.

(xxiii) Focusing on risk-based models for small physician practices which may involve two-sided risk and prospective patient assignment, and which examine risk-adjusted decreases in mortality rates, hospital readmissions rates, and other relevant and appropriate clinical measures.

(xxiv) Focusing primarily on title XIX, working in conjunction with the Center for Medicaid and CHIP Services; and

(B) in subparagraph (C)(viii), by striking “other public sector or private sector payers” and inserting “other public sector payers, private sector payers, or statewide payment models”.

### **(5) CONSTRUCTION REGARDING TELEHEALTH SERVICES.**

Nothing in the provisions of, or amendments made by, this title shall be construed as precluding an alternative payment model or a qualifying APM participant (as those terms are defined in section 1833(z) of the Social Security Act, as added by paragraph (1)) from furnishing a telehealth service for which payment is not made under section 1834(m) of the Social Security Act (42 U.S.C. 1395m(m)).

### **(6) INTEGRATING MEDICARE ADVANTAGE ALTERNATIVE PAYMENT MODELS.**

Not later than July 1, 2016, the Secretary of Health and Human Services shall submit to Congress a study that examines the feasibility of integrating alternative payment models in the Medicare Advantage payment system. The study shall include the feasibility of including a value-based modifier and whether such modifier should be budget neutral.

### **(7) STUDY AND REPORT ON FRAUD RELATED TO ALTERNATIVE PAYMENT MODELS UNDER THE MEDICARE PROGRAM.**

(A) STUDY.

The Secretary of Health and Human Services, in consultation with the Inspector General of the Department of Health and Human Services, shall conduct a study that—

(i) examines the applicability of the Federal fraud prevention laws to items and services furnished under title XVIII of the Social Security Act for which payment is made under an alternative payment model (as defined in section 1833(z)(3)(C) of such Act (42 U.S.C. 1395l(z)(3)(C)));

(ii) identifies aspects of such alternative payment models that are vulnerable to fraudulent activity; and

(iii) examines the implications of waivers to such laws granted in support of such alternative payment models, including under any potential expansion of such models.

(B) REPORT.

Not later than 2 years after the date of the enactment of this Act, the Secretary shall submit to Congress a report containing the results of the study conducted under subparagraph (A). Such report shall include recommendations for actions to be taken to reduce the vulnerability of such alternative payment models to fraudulent activity. Such report also shall include, as appropriate, recommendations of the Inspector General for changes in Federal fraud prevention laws to reduce such vulnerability.



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# **IMPROVING RESOURCE USE MEASUREMENT UNDER MACRA**

***Creating Better Methods  
of Accountability for  
Healthcare Spending in  
Value-Based Purchasing and  
Alternative Payment Models***

**Harold D. Miller**

February 2016

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# Improving Resource Use Measurement Under MACRA

## EXECUTIVE SUMMARY

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The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) creates two alternative paths by which Medicare payments to physicians will evolve over the next decade – the Merit-Based Incentive Payment System (MIPS) and Alternative Payment Models (APMs). Both MIPS and APMs require physicians to take accountability for utilization and spending on healthcare services. However, the current methodologies used by the Centers for Medicare and Medicaid Services (CMS) and private health plans for measuring spending during episodes of care, for attributing spending to physicians, and for risk adjusting spending measures have many serious weaknesses that have the potential to harm patients and to bankrupt healthcare providers, particularly small physician practices and hospitals. For example:

- Physicians cannot control all of the services and spending assigned to them under typical resource use measures.
- Physicians are not attributed the spending for many services they do provide.
- Many patients are not assigned to the physicians who are helping them manage their health problems.
- Risk adjustment systems do not adequately adjust for differences in patient needs.

Fortunately, Congress has recognized these problems, and MACRA requires the Department of Health and Human Services to develop and implement solutions. MACRA requires creation of three new ways of classifying services and patients:

- **Care Episode Groups.** MACRA requires the creation of “care episode groups” that define the types of procedures or services furnished for particular clinical conditions or diagnoses. If properly designed, Care Episode Groups will enable far better measures of the kinds of services and costs physicians can control or influence than the total cost of care and episode spending measures used in Medicare payment programs today.
- **Patient Relationship Categories.** MACRA requires the creation of “patient relationship categories” that define and distinguish the relationship and responsibility of a physician or applicable practitioner with a patient at the time of furnishing a service. If properly designed, Patient Relationship Categories will enable payments and accountability for spending and quality to be far more accurate than the retrospective statistical attribution methodologies used in Medicare payment programs today.
- **Patient Condition Groups.** MACRA requires the creation of “patient condition groups” based on a patient’s chronic conditions, current health status, and recent significant history, such as hospitalization or surgery.

If properly designed, Patient Condition Groups will enable far better risk adjustment and acuity stratification than the methods used in Medicare payment programs today.

Each of these new groups and categories will have an associated code that physicians will record on the claims they submit for payment beginning on January 1, 2018.

Congress explicitly directed the Department of Health and Human Services (HHS) and the Centers for Medicare and Medicaid Services (CMS) to develop the details of these new groups and categories in a collaborative way with physicians and other stakeholders. MACRA requires HHS to undertake two separate rounds of input, each lasting 4 months, before finalizing the definitions of the Care Episode Groups and the Patient Condition Groups, and it requires a four-month period for obtaining input on the Patient Relationship Categories before they are finalized.

### DEFINING CARE EPISODE GROUPS AND CODES

The Care Episode Groups and codes that MACRA requires represent a fundamentally different and significantly better approach to defining and measuring episodes of care than the “episode groupers” that CMS has been developing and that many private health plans currently use. Episode groupers are complex and highly error-prone because they try to determine the relationship between the services a patient receives long after those services have been delivered, using information from claims forms that were designed for billing purposes, not for defining clinical episodes. MACRA requires a *concurrent* approach that enables physicians to determine, at the time a service is rendered, the care episode or episodes to which the service should be assigned based on the goal of the service and its relationship to other services that the patient is receiving.

In order for the Care Episode Groups to solve the serious weaknesses with current episode groupers, they should be defined in the following ways:

- Care Episode Groups should be defined based on the patient’s underlying health condition that is being treated, not just a procedure chosen for treatment.
- Separate Care Episode Groups should be defined for the same procedure for patients with significantly different needs.
- Care Episode Groups should be defined around sub-episodes within larger episodes of care.
- Care Episode Groups should include diagnostic episodes as well as treatment episodes.

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## DEFINING PATIENT CONDITION GROUPS AND CODES

The resources required to achieve appropriate outcomes for a patient during a particular episode of care will depend heavily on the specific needs of that patient and their ability to access and use different treatment options. Unfortunately, the risk adjustment systems that CMS and other payers are using today for both resource use measurement and payment have many serious weaknesses that can inappropriately penalize physicians who care for sicker patients and reward physicians who do not, and use of these flawed systems as part of MIPS and APMs could make it harder for higher-need patients to access appropriate care. In MACRA, Congress recognized that effective adjustment could not be done effectively using the data currently being collected, and so it required the creation of Patient Condition Groups.

In order for the Patient Condition Groups required under MACRA to solve the serious weaknesses with current methods of risk adjustment, they should be defined in the following ways:

- Patient Condition Groups should be defined based on differences in patient needs rather than ability to predict current spending levels.
- Patient Condition Groups should be defined using diagnostic information not captured in current diagnosis codes.
- Patient Condition Groups should be defined based on all of a patient's health problems that could affect costs and outcomes.
- Patient Condition Groups should be defined using patients' functional limitations as well as their medical conditions.
- Patient Condition Groups should be defined to consider the barriers patients face in accessing healthcare services.
- Patient Condition Groups should be defined so they complement Care Episode Groups.

## DEFINING PATIENT RELATIONSHIP CATEGORIES AND CODES

There are serious weaknesses in the methods that CMS and other payers are using today to “attribute” patients to physicians and other healthcare providers. Congress wisely recognized that the current *retrospective* and *prospective* methods of attributing patients to physicians are fundamentally flawed and need to be improved. MACRA requires creation of a *concurrent* approach that enables physicians to state their relationship with the patient at the time a service is rendered using Patient Relationship Categories.

Congress provided a detailed starting point for defining Patient Relationship Categories by requiring they include the following types of relationships between patients and the physicians and other practitioners who provide their care:

- (i) a physician (or other practitioner) who considers themselves to have the primary responsibility for the general and ongoing care for the patient over extended periods of time;
- (ii) a physician (or other practitioner) who considers themselves to be the lead physician or practitioner and who furnishes items and services and coordinates care furnished by other physicians or practitioners for the patient during an acute episode;
- (iii) a physician (or other practitioner) who furnishes items and services to the patient on a continuing basis during an acute episode of care, but in a supportive rather than a lead role;
- (iv) a physician (or other practitioner) who furnishes items and services to the patient on an occasional basis, usually at the request of another physician or practitioner; or
- (v) a physician (or other practitioner) who furnishes items and services only as ordered by another physician or practitioner.

In order to more accurately define the full range of relationships between physicians and patients, CMS should add the following three categories to the five Patient Relationship Categories already defined by Congress:

- (vi) a physician (or other practitioner) who considers themselves to have the primary responsibility for managing the care of a particular health condition (such as cancer) or a combination of health conditions (such as diabetes and coronary artery disease) over a period of one month or more.
- (vii) a physician (or other practitioner) who works in close coordination with one or more other physicians to jointly manage the care of a particular health condition or combination of conditions over a period of one month or more.
- (viii) a physician (or other practitioner) who takes the lead responsibility for determining a diagnosis for a patient's symptoms, or for verifying the accuracy of an existing diagnosis, utilizing the services of other physicians, practitioners, and providers as necessary.

## MEASURING AND REPORTING ON RESOURCE USE

In addition to Care Episode Groups, Patient Condition Groups, and Patient Relationship Categories, a fourth piece of information is essential to effective resource use measurement – identifying the physician who *ordered* a service, not just the physician who *delivered* the service. MACRA requires that the National Provider Identifier of the ordering physician or practitioner be included on the claims form if the service was ordered by a different physician or practitioner than the individual who delivered the service.

Information on the providers who ordered and delivered services should be used to divide measures of resource use within Care Episode Groups into four categories for each physician or other practitioner who indicates (through use of a Patient Relationship Category code)



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that they are playing a lead or supportive role in a patient's care:

1. Services both *ordered and delivered* directly by the physician/practitioner playing the designated role in the patient's care.
2. Services delivered by *other physicians or providers* that are *integrally related* to the services delivered by the physician/practitioner playing the designated role.
3. Services delivered by other physicians or providers that resulted from orders or referrals from the physician/practitioner playing the designated role.
4. Services delivered by other providers that were related to services delivered or ordered by the physician/practitioner playing the designated role, but not directly delivered or ordered by that individual.

In addition, many physicians are providing a variety of high-value services to patients for which there is no direct payment under Medicare. Because resource use measures are being used to make or modify payments to physicians for their services, it is important to know all of the services that are being delivered as part of a patient's care. A calculation that does not include the time spent or costs incurred on these unpaid services is not a true measure of the resources used in delivering health care.

The only way to know what is really being done to achieve better value when a physician or other provider redesigns care and what resources will be needed to sustain that is to allow the provider to record the services that are being delivered without direct compensation. CMS needs to permit physicians and other providers to voluntarily submit claims forms describing *all services they deliver* even if those services are not currently eligible for payment under Medicare.

## SUPPORTING THE DEVELOPMENT AND IMPLEMENTATION OF SUCCESSFUL ALTERNATIVE PAYMENT MODELS

MACRA explicitly indicates that one of the purposes of creating Care Episode Groups, Patient Condition Groups, and Patient Relationship Categories is to support the development and implementation of Alternative Payment Models. The ability to bill for services using codes defining Care Episode Groups, Patient Condition Groups, and Patient Relationship Categories could facilitate and dramatically accelerate the development of more innovative and effective approaches to Alternative Payment Models. However, these new codes could only be used to facilitate billing and payment under Alternative Payment Models if the codes are defined in ways that complement and support those Alternative Payment Models. Consequently, it is essential that CMS specifically seek input from physician groups, medical specialty societies, and others that are developing Alternative Payment Models (APMs), particularly the Physician-Focused Alternative Payment Models required under MACRA, as it works to define the Care Episode Groups, Patient Condition Groups, and Patient Relationship Categories required under MACRA.

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# I. THE NEED FOR BETTER MEASURES OF RESOURCE USE

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## A. Accountability for Resource Use in MIPS and APMs

The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) creates two alternative paths by which Medicare payments to physicians will evolve over the next decade – the Merit-Based Incentive Payment System (MIPS) and Alternative Payment Models (APMs). Physicians will be required to participate in MIPS unless they achieve a minimum threshold of participation in one or more APMs.<sup>1</sup>

A key goal of MACRA is to slow the growth in healthcare spending in more effective ways than the deeply flawed Sustainable Growth Rate (SGR) formula. To do this, both MIPS and APMs require physicians to take accountability for utilization and spending on healthcare services:

- Under MIPS, the standard amount that a physician is paid for each individual service provided to a Medicare beneficiary will be increased or decreased each year based on a “performance score” created from measures of the physician’s quality of care, resource use, clinical improvement activities, and meaningful use of certified EHR technology. Resource use measures will represent 30% of the performance score beginning in 2021, and will represent up to 10-15% of the performance score in 2019 and 2020.
- MACRA requires that APMs either (a) improve the quality of care without increasing spending, (b) reduce spending without reducing the quality of care, or (c) improve the quality of care and reduce spending. In contrast to MIPS, APMs can be structured to give physicians additional resources or greater flexibility in using existing resources so that they can redesign care in ways that reduce total spending without harming patients or jeopardizing the financial viability of their practices.

## B. Problems with Current Resource Use Measures

In their “value-based purchasing” and pay-for-performance systems, the Centers for Medicare and Medicaid Services (CMS) and private health plans currently use similar approaches to measure resource use and to hold physicians accountable for resource use. In general, the spending and resource use measures are being used to assign accountability to a *single* physician for *all* of the spending on *all* of the health care services received by a patient during a particular period of time, regardless of which physicians or other providers actually delivered those services. Statistical rules are used to *retrospectively attribute* responsibility to an individual

physician for the spending on all of the services that a patient received during either an “episode of care” or a calendar year. Statistical formulas are also used to risk-adjust the spending amount attributed to each physician based on *health problems the patient had in previous years*, not the current problems the patient had when they received the services for which resource use is being measured.

The current methodologies for measuring spending during episodes of care, for attributing spending to physicians, and for risk adjusting spending measures have many serious weaknesses that have the potential to harm patients and to bankrupt healthcare providers, particularly small physician practices and hospitals. For example:<sup>2</sup>

- **Physicians cannot control all of the services and spending assigned to them under typical resource use measures.** In fact, *most* of the spending that is attributed to physicians in typical methodologies results from services delivered by *other* physicians.
- **Physicians are not attributed the spending for many services they do provide.** Most attribution systems fail to assign physicians the majority of services they delivered. Spending on complications and preventable conditions may be assigned to the physicians who *treated* the problems rather than those who may have *caused* them.
- **Many patients are not assigned to the physicians who are helping them address their health care needs.** In most attribution methodologies, a patient is only assigned to a physician if the patient has actually seen the physician for an office visit during the previous year, so patients whose healthcare problems are being well-managed by their physician may not be assigned to their own physician or to any physician at all.
- **Risk adjustment systems do not adequately adjust for differences in patient needs.** The risk adjustment methods used in most resource measurement systems do not effectively separate differences in patient needs from differences in the way providers deliver care. The risk adjustment systems also use *historical* information on patient health problems, not the most current information on health problems that affect the services patients need, which can penalize physicians and other providers who care for patients with many acute healthcare problems. Most risk adjustment systems give little or no consideration to factors other than health status that can affect patient needs, such as functional limitations and ability to access healthcare services.

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## C. Tools for Improving Resource Use Measurement Required by MACRA

Fortunately, Congress has recognized the serious problems described above, and MACRA requires the Department of Health and Human Services to develop and implement solutions. Section 101(f) of MACRA adds a new Section 1848(r) to the Social Security Act that requires creation of three new ways of classifying services and patients:

- **Care Episode Groups.** MACRA requires the creation of “care episode groups” that define the types of procedures or services furnished for particular clinical conditions or diagnoses. If properly designed, Care Episode Groups will enable far better measures of the kinds of services and costs physicians can control or influence than the total cost measures used in Medicare payment programs today.
- **Patient Relationship Categories.** MACRA requires the creation of “patient relationship categories” that define and distinguish the relationship and responsibility of a physician or applicable practitioner with a patient at the time of furnishing an item or service. If properly designed, Patient Relationship Categories will enable payments and accountability for spending and quality to be far more accurate than the retrospective statistical attribution methodologies used in Medicare payment programs today.
- **Patient Condition Groups.** MACRA requires the creation of “patient condition groups” based on a patient’s chronic conditions, current health status, and recent significant history, such as hospitalization or surgery. If properly designed, Patient Condition Groups will enable far better risk adjustment and acuity stratification than the methods used in Medicare payment programs today.

Each of these new groups and categories will have an associated code that physicians will record on the claims they submit for payment beginning on January 1, 2018.

## D. Input Required from Physicians and Other Stakeholders

The section of MACRA requiring the new codes is entitled “Collaborating With the Physician, Practitioner, and Other Stakeholder Communities to Improve Resource Use Measurement,” and Congress was clearly serious about trying to ensure that the Department of Health and Human Services (HHS) and the Centers for Medicare and Medicaid Services (CMS) developed the details of these new groups, categories, and codes in a collaborative way with physicians and other stakeholders. MACRA requires HHS to undertake two separate rounds of input, each lasting 4 months, before finalizing the definitions of the Care Episode Groups and the Patient Condition Groups, and it requires a four-month period for obtaining input on the Patient Relationship Categories before they are finalized. The law explicitly requires HHS to use mechanisms other than traditional notice-and-comment rule-making to obtain input, such as open door forums, town

hall meetings, and web-based forums.

As shown in the table on page 3, this input process began in the fall of 2015 and is scheduled to continue through the spring of 2017. The first round of input was solicited at the end of 2015 and beginning of 2016. Input on a draft list of Patient Relationship Categories will be solicited in the spring and summer of 2016, and input on a draft list of Care Episode Groups and Patient Condition Groups will be solicited at the end of 2016 and beginning of 2017, so that operational sets of codes can be finalized in 2017 in time for physicians to begin recording them on claims forms beginning on January 1, 2018.

## E. Ensuring the Goals of MACRA Are Achieved

If Care Episode Groups, Patient Condition Groups, Patient Relationship Categories and the associated codes are designed appropriately, they can:

- solve decades-old problems both providers and payers have experienced in using healthcare claims data for performance measurement;
- eliminate the need to use problematic episode groupers, attribution systems, and risk adjustment methodologies in value-based payment programs; and
- dramatically improve the ability of both physicians and CMS to use healthcare claims data to design and implement Alternative Payment Models as well as to implement the Merit-Based Incentive Payment System.

However, the devil is in the details. The remainder of this report explains the requirements of MACRA in more detail and describes how these requirements should be implemented in the most effective ways.

- Section II describes how Care Episode Groups and codes should be defined;
- Section III describes how Patient Condition Groups and codes should be defined;
- Section IV describes how Patient Relationship Categories and codes should be defined;
- Section V describes additional improvements needed in measuring and reporting on resource use; and
- Section VI describes how to ensure that Care Episode Groups, Patient Condition Groups, and Patient Relationship Categories support the development and implementation of successful Alternative Payment Models.

# TIMETABLE FOR IMPLEMENTATION OF IMPROVED RESOURCE USE MEASUREMENT

Deadline Under MACRA	Estimated Date(s)	HHS Actions Related to Care Episode Groups and Codes	HHS Actions Related to Patient Condition Groups and Codes	HHS Actions Related to Patient Relationship Categories and Codes
≤180 days after MACRA enactment	October 16, 2015	Post list of episode groups developed by CMS under Affordable Care Act on CMS website		
≥120 days after posting episode groups	October 16, 2015 to March 1, 2016	Accept suggestions from stakeholders on definitions of care episode groups	Accept suggestions from stakeholders on definitions of patient condition groups	
≤1 year after MACRA enactment	April 16, 2016			Post draft list of patient relationship categories and codes on CMS website
≥120 days after posting patient relationship categories and codes	April 16, 2016 to August 13, 2016			Actively seek comments on draft patient relationship categories and codes
≤270 days after end of comment period on care episode groups and patient condition groups	November 25, 2016	Post draft list of care episode codes on CMS website	Post draft list of patient condition codes on CMS website	
≥120 days after posting care episode and patient condition codes	November 25, 2016 to March 25, 2017	Actively seek input on draft care episode codes and definitions	Actively seek input on draft patient condition codes and definitions	
≤240 days after end of comment period on patient relationship categories	April 20, 2017			Post operational list of patient relationship categories and codes
≤270 days after end of second comment period on care episode and patient condition codes	December 20, 2017	Post operational list of care episode codes and definitions	Post operational list of patient condition codes and definitions	
January 1, 2018	January 1, 2018	Include care episode codes on claim forms	Include patient condition codes on claim forms	Include patient relationship category codes on claim forms
≤November 1 of each year	November 1, 2018	Issue revised list of care episode codes and definitions	Issue revised list of patient condition codes and definitions	Issue revised list of patient relationship categories and codes
	November 1, 2019	Issue revised list of care episode codes and definitions	Issue revised list of patient condition codes and definitions	Issue revised list of patient relationship categories and codes

# II.

## DEFINING CARE EPISODE GROUPS AND CODES

### A. The Problems With Episode Groupers

The Care Episode Groups and codes that MACRA requires in Section 1848(r) represent a fundamentally different and significantly better approach to defining and measuring episodes of care than the “episode grouper” that Congress had previously required CMS to develop when the Affordable Care Act added Section 1848(n)(9)(A) to the Social Security law. An episode grouper is a method of using the diagnosis codes and procedure codes that are recorded on claims forms in an attempt to retrospectively group claims into clinically-related episodes. Episode groupers are complex and highly error-prone because they try to determine the relationship between the services a patient has received long after those services have been delivered, using information from claims forms that were designed for billing purposes, not for defining clinical episodes.

A number of studies, including research commissioned by CMS, have identified the serious problems with episode groupers that use this approach. For example, a 2006 study by the Medicare Payment Advisory Commission found that two commonly used episode groupers, when applied to the same population of Medicare patients, calculated significantly different amounts of spending in episodes with similar names.<sup>3</sup> A 2008 study conducted by Acumen, LLC for the Centers for Medicare and Medicaid Services found that one of these episode groupers assigned the majority of a sample patient’s spending to a Pneumonia episode, whereas the other grouper assigned the majority of the patient’s spending to an Alzheimer’s Disease episode.<sup>4</sup> A 2012 study conducted for the U.S. Bureau of Economic Analysis found that those same two episode groupers, when applied to a group of commercially insured patients, produced very different classifications of spending into episodes.<sup>5</sup>

In response to Section 1848(n)(9)(A), CMS developed two new episode grouper methodologies – the Episode Grouper for Medicare (EGM), which CMS is also referring to as “Method A,” and a second methodology which CMS is describing as “Method B.”<sup>6</sup> Both of these methodologies have been used to create reports for physicians as part of the 2014 Supplemental Quality and Resource Use Reports (QRURs). Although CMS has made available all of the codes and logic used to define the episodes, it has not released any information to enable an assessment of the validity or reliability of these methodologies and how they perform relative to other groupers.

However, no matter how carefully the new episode groupers have been constructed, the results they produce will inherently have errors – potentially serious errors – because they are based on procedure codes and diagnosis codes that do not contain sufficient infor-

mation to accurately determine the episode to which an individual service should be assigned, particularly for patients with multiple health problems and patients receiving multiple procedures during a short period of time.

Although resource use measures calculated using these imperfect grouper methodologies may provide helpful information to physicians in some cases, they will never be sufficiently accurate or reliable to use for defining Alternative Payment Models or for holding physicians accountable for resource use under the Merit-Based Incentive Payment System (MIPS). It would be inappropriate to use flawed grouper methodologies to determine that a physician is “inefficient” because the grouper erroneously assigns unrelated services to an episode of care the physician is managing, and it would be inappropriate to determine that a physician is “efficient” because services they deliver or order are erroneously assigned to episodes being managed by other physicians.

**Resource use measures calculated using episode grouper methodologies will never be sufficiently accurate or reliable to use for defining Alternative Payment Models or for resource use measurement under the Merit-Based Incentive Payment System (MIPS)**

### B. Using Care Episode Groups and Codes to Improve Episode Measures

Congress wisely recognized that the current *retrospective* approach to measuring resource use using episode groupers is fundamentally flawed and needs to be improved. What MACRA requires is a *concurrent* approach that enables physicians to determine, at the time a service is rendered, the care episode or episodes to which the service should be assigned based on the goal of the service and its relationship to other services that the patient is receiving. MACRA requires that Care Episode Groups be established taking into account “the patient’s clinical problems *at the time items and services are furnished* during an episode of care, such as the clinical conditions or diagnoses, whether or not inpatient hospitalization occurs, and the principal procedures or services furnished” [emphasis added].

Although the definitions of episodes and the rules for assigning services to episodes that CMS has developed

for its current grouper methodologies could be used as starting points for the definitions and logic for the Care Episode Groups required under MACRA, revisions are both desirable and appropriate because the episode definitions no longer need to be constrained by the limits of current procedural and diagnostic coding on claims forms. A physician should be able to assign a Care Episode Group code to a patient based on whatever criteria are appropriate for defining the Care Episode Group, rather than just what can be determined using CPT® and ICD codes. For example:

- Today, it is impossible to accurately define separate treatment episodes for different stages of cancer in an episode grouper because there is no way to accurately determine the stage of a patient's cancer from either procedure codes or diagnosis codes. However, if separate Care Episode Groups are defined based on stage of cancer, it would be a simple matter for the oncologist treating the cancer to choose the correct Care Episode Group code based on the stage of cancer.
- Today, it is impossible to accurately determine whether one patient is receiving more services than another patient for the same condition because the two patients responded differently to their initial treatment or for other reasons. However, Care Episode Group codes could be defined so that a physician could identify when a second line of therapy was given following the patient's failure to respond to initial treatment.
- Today, because of the uncertainty about the accuracy of diagnosis codes on claims forms for ambulatory services, the CMS groupers require the presence of the same diagnosis code on two separate outpatient Evaluation and Management Service claims for all but very basic health problems. However, Care Episode Group codes can enable physicians to assign a patient to the correct episode group based on a single visit or other outpatient service.

## C. How Care Episode Groups Should Be Defined

In order for the Care Episode Groups required under MACRA to solve the serious weaknesses with current episode groupers, they should be defined in the following ways:

- **Care Episode Groups Should Be Defined Based on the Patient's Underlying Health Condition That is Being Treated, Not Just a Procedure Chosen for Treatment.** The vast majority of the episodes CMS has developed to date are defined around specific procedures, primarily hospital-based procedures, not the patient's underlying health problem that is being treated or managed. Although it is clearly important to ensure that all of the care during and following a hospital-based procedure is delivered as efficiently and effectively as possible, measuring episode spending only for specific procedures ignores the opportunity to reduce costs and improve outcomes by using different procedures and treatments and by performing procedures in lower-cost settings. For example, a knee or

hip arthroplasty is one way to treat knee or hip osteoarthritis, but many patients can achieve pain relief and improved mobility using non-surgical approaches while avoiding the inherent risks of surgery. Measuring resource use solely for the patients who receive surgery can unintentionally make physicians who do more surgeries on lower-risk patients look "more efficient" than those who only use surgery for patients for whom other alternatives have failed.

- **Separate Care Episode Groups Should Be Defined for the Same Procedure for Patients with Significantly Different Needs.** In the episodes that have been developed by CMS to date, there is only one episode definition for each type of procedure, despite the fact that in many cases, different combinations of services beyond the procedure itself will be needed for patients with different characteristics. The Inpatient Prospective Payment System used for Medicare payments to hospitals recognizes that the number and types of services needed to manage a patient's care during a hospitalization for a particular procedure will depend not only on the procedure itself, but on the number and severity of the patient's health

*Measuring episode spending only for specific procedures ignores the opportunity to reduce costs and improve outcomes by using different procedures and treatments and by performing procedures in lower-cost settings.*

problems, and so there are several levels of MS-DRGs for each type of procedure, with differing payments for each of the levels.<sup>7</sup> Since episodes of care are intended to define a more complete range of services than just the inpatient stay, and since differences in patient needs will result in greater differences in services during episodes that extend beyond a hospital stay, it does not make sense to have only one episode definition for major procedures.

Although Patient Condition Groups could also be used to signal differences in patient needs instead of creating separate Care Episode Groups based on patient needs, it would be better to use the two types of codes in complementary ways. For patient characteristics that predictably result in very different service needs, separate Care Episode Groups and codes should be defined; then Patient Condition Groups and codes can be used to enable better risk adjustment within episodes based on patient characteristics that have smaller or less certain impacts on service needs.

- **Care Episode Groups Should Be Defined Around Sub-Episodes Within Larger Episodes of Care.** Although it is appropriate and desirable to examine resource use and outcomes for the full range of services a patient receives as part of their treatment for a condition, in many cases there is no one physician or health provider who delivers all of the services in the full episode of care, and there may be no physician who is able to

supervise or coordinate all of those services. It would be much easier to improve overall efficiency in a care episode if the sources of inefficiencies can be effectively localized and if the impacts of changes in different areas can be measured separately.

- ◆ For example, many patients who are treated in a hospital will receive their post-acute care services not only in a different facility, but in a different community or different state. Although the inpatient and post-acute care services should be better coordinated and managed than they are today in order to improve resource use and outcomes across the full episode, services must also be effectively managed and coordinated within each portion of the episode by those who are delivering those services in order to achieve the best outcomes for the patient.
- ◆ Similarly, an overall episode of care should encompass both the initial procedure and the treatment of any complications of that procedure (e.g., a surgery and a readmission to treat a surgical site infection), and improvements to the overall episode can come from both reducing the number of complications and from improving the treatment of the complications when they occur. Since different physicians and hospitals may be involved in the initial procedure and the treatment of complications, those two portions of the overall episode should be measured separately as well as jointly.

While coordinated care across a full episode is certainly preferable to uncoordinated care, the mere fact that care is being coordinated does not make it good care if the individual components are of poor quality, so it is essential to improve the quality and value of each sub-episode in order to ensure the best overall value in an entire episode of care.

The need for better ways of breaking down large episodes into clinically meaningful sub-episodes can be seen in the 2014 Supplemental Quality and Resource Use Reports (QRURs) that CMS has been distributing based on data generated by the current episode groupers. The episode spending reports are only disaggregated using traditional payment categories – hospital stays, physician services, DME, etc. – and it is impossible to determine when in the course of an episode those services were delivered or why they were delivered, making the reports of relatively little use to physicians who want to improve the quality and reduce the cost of care.

In addition, MACRA indicates that the purpose of developing Care Episode Groups is to support Alternative Payment Models (APMs) as well as the Merit-Based Incentive Payment System (MIPS). In many cases, separate Alternative Payment Models will need to be defined for individual sub-episodes so that providers can have the flexibility needed to improve care within the sub-episode they are managing as well as work together effectively with other physicians and providers as part of a payment model focused on the overall episode. CMS has recognized the value of this approach in its Bundled Payments for Care Improvement Initiative by defining one payment model focused solely on the inpatient stay, one focused solely on the post-acute care services, and one model encompassing the full episode of care surrounding a hospitalization. Defining Care Episode Groups representing sub-episodes within larger episodes will facilitate the development of the kinds of Physician-Focused Alternative Payment Models that MACRA encourages.

- **Care Episode Groups Should Include Diagnostic Episodes as Well As Treatment Episodes.** All of the current condition-based episode definitions used in episode groupers implicitly presume that the patient's condition or need has been accurately diagnosed, and the procedural episodes also implicitly presume that the treatment is appropriate based on an accurate diagnosis of the patient's underlying condition. However, there is growing recognition that many treatments are unnecessary, inappropriate, or ineffective because the underlying diagnosis is inaccurate.<sup>9</sup> Inadequate payment to support the time and effort needed to develop a good diagnosis is one of the major culprits in erroneous diagnoses.<sup>10</sup> At the same time, it is well known that there is considerable overuse of testing and imaging in many aspects of the diagnostic process. Consequently, it will be important to define Care Episode Groups for the services used to establish a diagnosis in response to a patient's symptoms, not just Care Episode Groups based on the treatments delivered after a diagnosis has ostensibly been established.

# III.

# DEFINING PATIENT CONDITION GROUPS AND CODES

## A. Problems With Current Risk Adjustment Methodologies

The resources required to achieve appropriate outcomes for a patient during a particular episode of care will depend heavily on the specific needs of that patient and their ability to access and use different treatment options. Consequently, measures of resource use, quality, and outcomes need to be adjusted for differences in these factors.

Unfortunately, the risk adjustment systems that CMS and other payers are using today for both resource use measurement and payment have many serious weaknesses that can inappropriately penalize physicians who care for sicker patients and reward physicians who do not, and use of these flawed systems as part of MIPS and APMs could make it harder for higher-need patients to access appropriate care.<sup>11</sup>

- Most risk adjustment systems are designed to predict *spending* on patient care, not adjust for differences in patient *needs*. This can reinforce inappropriate spending, penalize efforts to reduce underuse, and cause providers to focus spending reduction efforts on the wrong patients.
- Most risk adjustment systems use *historical* information on patient characteristics, not the most current information on health problems that affect the services patients need. This can penalize providers who care for patients with many acute healthcare problems.
- The *same* risk score can be assigned to patients who need very *different* kinds of services from physicians in different specialties; this can distort spending comparisons and give physicians too few resources to adequately care for higher-need patients.
- Most risk adjustment systems only use diagnosis information currently recorded in claims data that does not completely or accurately measure *differences in the severity of patient health problems*.
- Most risk adjustment systems give little or no consideration to factors *other than health status* that can affect patient needs. For example, patients who have functional limitations are more likely to have higher healthcare spending, but measures of functional limitations are not included in typical risk adjustment systems.

In Section 1848(n)(6) of the Social Security Act, Congress required that reports on resource use be adjusted based on patient health status and patient characteristics “to the extent practicable.” In MACRA, Congress recognized that effective adjustment could not be done effectively using the data currently being collected, and so it required the creation of Patient Condition Groups.

## B. How Patient Condition Groups Should Be Defined

In order for the Patient Condition Groups required under MACRA to solve the serious weaknesses with current methods of risk adjustment, they should be defined in the following ways:

- **Patient Condition Groups Should Be Defined Based on Differences in Patient Needs Rather Than Their Ability to Predict Current Spending Levels.** Most current risk adjustment systems, such as Medicare’s Hierarchical Condition Category (HCC) system, were designed to predict how much will be *spent on healthcare services* for a particular patient population, not to measure differences in the *extent of patient needs* or to predict differences in the outcomes of treatment. These risk adjustment systems

use statistical regression analyses to assign a higher risk score to a patient if the amount that is *typically spent* on similar patients is higher, even if those patients did not actually *need* all of the services they received. Conversely, these statistical analyses inherently assign lower risk scores to patients who received fewer billable services, even if the patient needed more services or if the services that were delivered were not billable. Moreover, because these analyses are performed using claims data, they cannot consider patient characteristics that are not recorded in diagnosis codes or differences in services

other than those described in procedure codes. As a result, using risk scores calculated as is done today can actually reinforce inappropriate spending, penalize efforts to reduce underuse, and cause providers to focus spending reduction efforts on the wrong patients. Patient Condition Groups should be defined based on input from physicians and other health care providers regarding the characteristics of patients that affect their need for healthcare services.

*The risk adjustment systems that CMS and other payers are using today for both resource use measurement and payment have many serious weaknesses that can inappropriately penalize physicians who care for sicker patients and reward physicians who do not, and use of these flawed systems as part of MIPS and APMs could make it harder for higher-need patients to access appropriate care.*



- Patient Condition Groups Should be Defined Using Diagnostic Information Not Captured in Current Diagnosis Codes.** One reason that Patient Condition Group codes are needed in addition to diagnosis codes is that current diagnosis codes do not adequately distinguish aspects of some health conditions that can significantly affect the resources needed to treat or manage those conditions and/or the outcomes that can be achieved. For example, in addition to the *type* of cancer a patient has (e.g., breast, colon, lung, etc.), the *stage* of cancer (i.e., whether it has metastasized to other parts of the body) has a significant impact on how it is treated by oncologists and the outcomes that can be achieved for the patient. However, neither the ICD-9 nor ICD-10 diagnostic coding system has a method for recording the stage of cancer, only the type of cancer. Similarly, the ICD-10 coding system has no codes to distinguish the severity of a patient's heart failure, even though the severity of the condition has a significant impact on treatment costs and outcomes for heart failure patients. Patient Condition Groups should be defined so that physicians can distinguish differences in patient needs, such as the severity of health conditions, that go beyond what is possible using diagnosis codes.
  - Patient Condition Groups Should Be Defined Based on All of a Patient's Health Problems That Could Affect Costs and Outcomes.** Medicare's Hierarchical Condition Category (HCC) system is a *prospective* risk adjustment system that is based primarily or exclusively on whether a patient had *chronic* health conditions in the previous year, and it completely ignores the potential impact of any newly diagnosed health problems or recent acute conditions or treatments. Not surprisingly, *concurrent* risk adjustment systems that consider new health problems are better able to predict service utilization. Patient Condition Groups should be defined with consideration for all of a patient's current and past health problems that could affect the number and type of services they need during a particular time period or episode of care.
  - Patient Condition Groups Should Be Defined Using Patient Functional Limitations as Well as Medical Conditions.** A patient's functional limitations (e.g., inability to walk) can have an equal or greater effect on costs and outcomes as do their medical conditions. Patients who are unable to walk or drive or are unable to carry out activities of daily living will have greater difficulty caring for themselves and greater difficulty obtaining traditional office-based ambulatory care services, which can lead to increased use of more expensive healthcare services. For example, one analysis found that there were hospital admissions for 34% of Medicare beneficiaries who had functional limitations as well as chronic diseases, but there were admissions for only 20% of the Medicare beneficiaries who had 3 or more chronic conditions but no functional limitations. The researchers also found that the majority of the beneficiaries on whom Medicare spent the most had both chronic conditions and functional limitations.<sup>12</sup> However, since information about functional limitations is not captured effectively by stand-
- ard diagnosis coding in claims data, it is not incorporated into most risk adjustment models. Another study found that the Medicare HCC risk adjustment model significantly under-predicted actual spending on the subset of patients with functional disabilities.<sup>13</sup> All of Medicare's current payment systems for post-acute care differentiate payments based on patients' functional status as well as their health problems, so it would be inappropriate to ignore functional status in measuring resource use around episodes that could potentially include the need for post-acute care services. Patient Condition Groups should be defined with consideration of patients' functional limitations as well as their medical diagnoses.
- Patient Condition Groups Should Be Defined to Consider the Barriers Patients Face in Accessing Healthcare Services.** Having health insurance does not automatically assure that a patient can access the care they need. High deductibles or high cost-sharing levels may discourage individuals from seeking needed care or taking prescribed medications, which can result in avoidable complications and higher overall expenses that are outside the control of their physicians and other healthcare providers. For patients who live in rural areas, long distances to provider locations, lack of public transportation, etc. can also make it difficult for patients to obtain needed care regardless of the benefit design in their health insurance plan. Patient Condition Groups should be defined with consideration of the barriers patients face in obtaining the most appropriate care for their health problems.
  - Patient Condition Groups Should Be Defined So They Complement Care Episode Groups.** Patient Condition Groups should be defined in ways that complement rather than conflict with or duplicate Care Episode Groups. A patient characteristic that will have an important impact on the cost of treating one type of health condition may have little or no impact on the cost of treating other conditions. One of the many weaknesses with the Hierarchical Condition Category (HCC) system currently used by CMS for risk adjustment is that its categories are too aggregated for some types of episodes.<sup>14</sup> Patient Condition Groups should be defined so that they can be disaggregated or aggregated based on the types of patient characteristics that will affect resource use in specific types of care episode groups.

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# IV. DEFINING PATIENT RELATIONSHIP CATEGORIES AND CODES

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## A. Problems with Current Methods of Attributing Patients to Physicians

There are serious weaknesses in the methods that CMS and other payers are using today to “attribute” patients to physicians and other healthcare providers:<sup>15</sup>

- Many patients and the spending on their care are not attributed to any physician or other provider.
- Physicians are attributed the spending for many services that they did not provide or order. In fact, *most* of the spending that is attributed to physicians in typical attribution methodologies results from services delivered by *other* physicians.
- Physicians are not attributed the spending for many of the services they provide. Most attribution systems fail to assign physicians the majority of patients they did care for or the majority of services they delivered.

These problems arise because the attribution methodologies attempt to assign patients to physicians *retrospectively*, i.e., after the care has already been provided, using statistical calculations based on relative frequencies of office visits and other services, rather than based on the actual nature of the relationship between the physician and patient. So-called “prospective” attribution methodologies do not solve this problem; they simply make the retrospective calculation based on services delivered prior to the period being measured, and then assume that relationships between patients and physicians during the prior period will continue into the current period, even though that is frequently not true.

## B. How Patient Relationship Categories Should Be Defined

Congress wisely recognized that the current *retrospective* and *prospective* methods of attributing patients to physicians are fundamentally flawed and need to be improved. MACRA requires creation of a *concurrent* approach that enables physicians to state their relationship with the patient at the time a service is rendered using Patient Relationship Categories. Once these Categories are defined and codes for them are recorded on claims forms, there will no longer be a need for either the problematic retrospective or prospective attribution methodologies that CMS and other payers are currently using. In Section 1848(r)(3)(B), Congress provided a detailed starting point for defining Patient Relationship Categories by requiring they include the following types of relationships between patients and the physicians and other practitioners who provide their care:

- (i) a physician (or other practitioner) who considers themselves to have the primary responsibility for the general and ongoing care for the patient over extended periods of time;
- (ii) a physician (or other practitioner) who considers themselves to be the lead physician or practitioner and who furnishes items and services and coordinates care furnished by other physicians or practitioners for the patient during an acute episode;
- (iii) a physician (or other practitioner) who furnishes items and services to the patient on a continuing basis during an acute episode of care, but in a supportive rather than a lead role;
- (iv) a physician (or other practitioner) who furnishes items and services to the patient on an occasional basis, usually at the request of another physician or practitioner; or
- (v) a physician (or other practitioner) who furnishes items and services only as ordered by another physician or practitioner.

In order to more accurately define the full range of relationships between physicians and patients, **CMS should add the following three categories to the five Patient Relationship Categories already defined by Congress:**

- (vi) a physician (or other practitioner) who considers themselves to have the primary responsibility for managing the care of a particular health condition (such as cancer) or a combination of health conditions (such as diabetes and coronary artery disease) over a period of one month or more.
- (vii) a physician (or other practitioner) who works in close coordination with one or more other physicians to jointly manage the care of a particular health condition or combination of conditions over a period of one month or more.
- (viii) a physician (or other practitioner) who takes the lead responsibility for determining a diagnosis for a patient’s symptoms, or for verifying the accuracy of an existing diagnosis, utilizing the services of other physicians, practitioners, and providers as necessary.

# V.

## MEASURING AND REPORTING ON RESOURCE USE

### A. Distinguishing the Providers Who Order and Deliver Services

In addition to Care Episode Groups, Patient Condition Groups, and Patient Relationship Categories, a fourth piece of information is essential to effective resource use measurement – identifying the physician who *ordered* a service, not just the physician who *delivered* the service. The current measures of resource use that are used by CMS are seriously flawed because they may assign accountability for a service to a physician who delivered the service even if they did not order it, and current resource use measures may fail to assign accountability for a service to the physician who ordered the service if it was delivered by a different physician or provider.

In the 2012 Quality and Resource Use Reports (QRURs) that CMS provided to physicians, it included “Drill Down Tables” as part of the Supplemental Exhibits that enabled a physician practice to distinguish between services that were ordered or referred by physicians outside of the practice from services that were ordered by physicians inside the practice.<sup>16</sup> However, this information is no longer being provided by CMS in the QRUR Supplemental Exhibits.

Congress recognized the importance of knowing which physician ordered a service as well as which physician delivered the service, and so in addition to the requirements in Section 1848(r)(4)(A) that claims forms include codes for Care Episode Groups, Patient Condition Groups, and Patient Relationship Categories, Section 1848(r)(4)(B) requires that the National Provider Identifier of the ordering physician or practitioner be included on the claims form if the service was ordered by a different physician or practitioner than the individual who delivered the service. Although Medicare regulations already require this information, the statutory requirement in MACRA will ensure that this information is consistently available.

**Information on the providers who ordered and delivered services should be used to divide measures of resource use within Care Episode Groups into four categories for each physician or other practitioner who indicates (through use of a Patient Relationship Category code) that they are playing a lead or supportive role in a patient’s care (other than merely delivering a service in response to orders from other physicians or practitioners):<sup>17</sup>**

1. **Services both *ordered and delivered* directly by the physician/practitioner playing the designated role in the patient’s care.**
2. **Services delivered by *other physicians or providers* that are *integrally related* to the services delivered by**

**the physician/practitioner playing the designated role.** For example, if a physician performs surgery on a patient in a hospital, then the payment to the hospital for the surgery and the payment to the anesthesiologist for the anesthesia services are integrally related to the payment to the surgeon for performing the surgery, since the surgery could not have been performed without the other services.

3. **Services delivered by other physicians or providers that resulted from orders or referrals from the physician/practitioner playing the designated role.** Resource use measures need to measure these services separately from the services that are ordered and delivered by a physician/practitioner because the physician/practitioner who orders a service generally has only limited control over how the service is actually performed and what resources may be used by the physician/practitioner who delivers it.

4. **Services delivered by other providers that were related to services delivered or ordered by the physician/practitioner playing the designated role, but not directly delivered or ordered by that individual.** For example, if a patient develops a surgical site infection after discharge from a hospital and is admitted to a different hospital for treatment of that infection, the surgeon who performed the surgery did not deliver or order the treatment for the infection, but the treatment for the infection is clearly related to the procedure that the surgeon performed. However, the responsibility for the fact that the related services were needed may have been shared between the physician/practitioner playing the designated role and other physicians or providers (e.g., a surgical site infection may develop because of poor wound care by a post-acute care provider), so it is appropriate to measure this aspect of resource use separately from the services that were directly delivered or ordered by the physician/practitioner playing the designated role.

*Current measures of resource use are seriously flawed because they may assign accountability for a service to a physician who delivered the service even if they did not order it, and current resource use measures may fail to assign accountability for a service to the physician who ordered the service if it was delivered by a different physician or provider.*

## B. Measuring Resource Use for Unpaid Services

Many physicians are providing a variety of high-value services to patients for which there is no direct payment under Medicare. For example, when a physician responds to a patient concern through a phone call, there is no payment to the physician for the time they spent on the phone call. That physician may have used fewer resources to successfully address the patient's need than a physician who would ask a similar patient to come in to the office for a visit or a physician who would tell the patient to go to a hospital emergency department, but the fact that the physician was not paid by Medicare does not mean that no resources at all were expended on the patient's care. A calculation that does not include the time spent or costs incurred on these unpaid services is not a true measure of the resources used in delivering health care.

*The fact that a physician was not paid by Medicare does not mean that no resources at all were expended on the patient's care. A calculation that does not include the time spent or costs incurred on unpaid services is not a true measure of the resources used in delivering health care.*

Moreover, because CMS is using the resource use measures to make or modify payments to physicians for their services, it is important to know all of the services that are being delivered as part of a patient's care. For example, in its Comprehensive Care for Joint Replacement (CJR) Program, CMS is planning to adjust the annual payment budgets based on the spending levels achieved by all participating providers. If a physician, hospital, or post-acute care provider develops a new type of service (e.g., a new type

of home-based rehabilitation service) that is not currently billable to Medicare and uses that service to reduce spending on billable services, the surplus under the CJR program would enable the provider to cover the costs of the new type of service. However, it is inappropriate for CMS to then reduce the payment budget for the episode to the amount that the provider is spending on *billable* services as it is planning to do in the CJR program; that would mean the provider would no longer be able to afford to deliver the *unbillable* service, even though that was what allowed the overall spending to be reduced in the first place.<sup>18</sup>

The only way to know what is really being done to achieve better value when a physician or other provider redesigns care and the only way to know what level of resources will be needed to sustain the improved services is to allow the provider to record how many and what types of services are being delivered without direct compensation. **CMS should permit physicians and other providers to voluntarily submit claims forms describing all services they deliver even if those services are not currently eligible for payment under Medicare.** In many cases, there are CPT codes available to describe these services even though Medicare does not pay for them, so it would be feasible for physicians to record when these services were provided. However, submission of this information should be voluntary, not required, since there would be an administrative cost to the physician for which he or she would receive no compensation except as part of an appropriately-designed Alternative Payment Model.

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# VI. SUPPORTING DEVELOPMENT AND IMPLEMENTATION OF SUCCESSFUL ALTERNATIVE PAYMENT MODELS

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MACRA explicitly indicates that one of the purposes of creating Care Episode Groups, Patient Condition Groups, and Patient Relationship Categories is to support the development and implementation of Alternative Payment Models.

Just as most current resource use measurement systems are based on problematic retrospective episode grouper and attribution methodologies, most current Alternative Payment Models being implemented by CMS and other payers are based on problematic retrospective attribution and reconciliation methodologies because there are not adequate ways for physicians to signal that a patient is receiving services that are to be supported by a specific payment model. The ability to bill for services using codes defining Care Episode Groups, Patient Condition Groups, and Patient Relationship Categories could facilitate and dramatically accelerate the development of more innovative and effective approaches to Alternative Payment Models. For example, a physician who is willing to accept a bundled payment for all of the services included in a Care Episode Group could bill Medicare for that bundled payment (or trigger the calculation of an episode budget for the services) using the code defined for that Care Episode Group, and the physician could indicate that they are managing all of the care during that episode by recording the appropriate Patient Relationship Category code. The amount of the payment could be adjusted based on the patient's needs using one or more Patient Condition Group codes that the physician records in conjunction with the Care Episode Group code.

However, these new codes could only be used to facilitate billing and payment under Alternative Payment Models if the codes are defined in ways that complement and support those Alternative Payment Models. Consequently, it is essential that CMS specifically seek input from physician groups, medical specialty societies, and others that are developing Alternative Payment Models (APMs), particularly the Physician-Focused Alternative Payment Models required under MACRA, as it works to define the Care Episode Groups, Patient Condition Groups, and Patient Relationship Categories required under MACRA.

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# ENDNOTES

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1. For a more detailed description of the requirements in MACRA related to MIPS and APMs, see Miller H. *Implementing Alternative Payment Models Under MACRA: How the Federal Government Can Accelerate Successful Health Care Payment Reform*. Center for Healthcare Quality and Payment Reform. January 2016. Available at <http://www.chqpr.org/downloads/ImplementingAPMsUnderMACRA.pdf>
2. For a more detailed explanation of these problems with current episode groupers, attribution systems, and risk adjustment methodologies, see Miller H. *Measuring and Assigning Accountability for Healthcare Spending*. Center for Healthcare Quality and Payment Reform. August 2014. Available at <http://www.chqpr.org/downloads/AccountabilityforHealthcareSpending.pdf>.
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6. More information on the CMS episode groupers is available at <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/MACRA-MIPS-and-APMs/MACRA-Feedback.html>
7. CMS has stated in the past that defining clinically meaningful groupings of patients in DRGs has been essential for helping providers manage costs effectively without harming patients. "Because the DRGs were developed to group clinically similar patients, an extremely important means of communication between the clinical and financial aspects of care was created. DRGs provided administrators and physicians with a meaningful basis for evaluating both the process of providing care and the associated financial impacts. Development of care pathways by DRG and profit-and-loss reports by DRG product lines became commonplace. With the adoption of these new management methods, length of stay and the use of ancillary services dropped dramatically...The vast majority of modifications to the DRGs since the inception of the Medicare inpatient hospital prospective payment system ... have almost always been the result of clinicians identifying specific types of patients with unique needs...Central to the success of the Medicare inpatient hospital prospective payment system is that DRGs have remained a clinical description of why the patient required hospitalization." 66 Federal Register 22668, May 4, 2001.
8. Information on the Quality and Resource Use Reports (QRURs) is available at <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/2014-QRUR.html>
9. Balogh EP, Miller BT, Ball JR. *Improving Diagnosis in Health Care*. Institute of Medicine; The National Academies of Sciences, Engineering, and Medicine. 2015.
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11. For a more detailed discussion of the problems with current risk adjustment systems, see Miller H. *Measuring and Assigning Accountability for Healthcare Spending*. Center for Healthcare Quality and Payment Reform. August 2014. Available at: <http://www.chqpr.org/downloads/AccountabilityforHealthcareSpending.pdf>.
12. Komisar HL, Feder J. Transforming care for Medicare beneficiaries with chronic conditions and long-term care needs: coordinating care across all services. Scan Foundation and Georgetown University. October 2011. Available at: [http://www.thescanfoundation.org/sites/default/files/Georgetown\\_Trnsfrming\\_Care.pdf](http://www.thescanfoundation.org/sites/default/files/Georgetown_Trnsfrming_Care.pdf).
13. Noyes K, Liu H, Temkin-Greener H. Medicare capitation model, functional status, and multiple comorbidities: model accuracy. *Am J Manag Care*. 2008 October; 14 (10): 679-690.
14. For example, in the 2014 version of the Medicare HCC risk adjustment system, a patient with colon cancer would have the same risk score as a patient who had a stroke, but one would not expect a patient with colon cancer to receive the same types of services from neurologists, cardiologists, and physiatrists as would a patient with a stroke.
15. For a more detailed discussion of the problems with current attribution systems, see Miller H. *Measuring and Assigning Accountability for Healthcare Spending*. Center for Healthcare Quality and Payment Reform. August 2014. Available at <http://www.chqpr.org/downloads/AccountabilityforHealthcareSpending.pdf>.
16. A sample of the Drill Down Tables in the 2012 Supplemental QRURs is available at <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/Episode-Costs-and-Medicare-Episode-Grouper.html>
17. A more detailed discussion of how to structure resource use measures is available in Miller H. *Measuring and Assigning Accountability for Healthcare Spending*. Center for Healthcare Quality and Payment Reform. August 2014. Available at <http://www.chqpr.org/downloads/AccountabilityforHealthcareSpending.pdf>.
18. For a more detailed discussion of this problem, see Miller H. *Bundling Badly: The Problems With Medicare's Proposal for Comprehensive Care for Joint Replacement*. Center for Healthcare Quality and Payment Reform. 2015. Available at: <http://www.chqpr.org/downloads/BundlingBadly.pdf>

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# APPENDIX

## PROVISIONS OF MACRA REGARDING RESOURCE USE MEASUREMENT

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### MEDICARE ACCESS AND CHIP REAUTHORIZATION ACT OF 2015

#### TITLE I—SGR REPEAL AND MEDICARE PROVIDER PAYMENT MODERNIZATION

#### SEC. 101. REPEALING THE SUSTAINABLE GROWTH RATE (SGR) AND IMPROVING MEDICARE PAYMENT FOR PHYSICIANS' SERVICES.

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#### (f) COLLABORATING WITH THE PHYSICIAN, PRACTITIONER, AND OTHER STAKEHOLDER COMMUNITIES TO IMPROVE RESOURCE USE MEASUREMENT

Section 1848 of the Social Security Act (42 U.S.C. 1395w-4), as amended by subsection (c), is further amended by adding at the end the following new subsection:

#### Section 1848 (r) COLLABORATING WITH THE PHYSICIAN, PRACTITIONER, AND OTHER STAKEHOLDER COMMUNITIES TO IMPROVE RESOURCE USE MEASUREMENT.—

(1) IN GENERAL.—In order to involve the physician, practitioner, and other stakeholder communities in enhancing the infrastructure for resource use measurement, including for purposes of the Merit-based Incentive Payment System under subsection (q) and alternative payment models under section 1833(z), the Secretary shall undertake the steps described in the succeeding provisions of this subsection.

#### (2) DEVELOPMENT OF CARE EPISODE AND PATIENT CONDITION GROUPS AND CLASSIFICATION CODES.—

(A) IN GENERAL.—In order to classify similar patients into care episode groups and patient condition groups, the Secretary shall undertake the steps described in the succeeding provisions of this paragraph.

(B) PUBLIC AVAILABILITY OF EXISTING EFFORTS TO DESIGN AN EPISODE GROUPER.—Not later than 180 days after the date of the enactment of this subsection, the Secretary shall post on the Internet website of the Centers for Medicare & Medicaid Services a list of the episode groups developed pursuant to subsection (n)(9)(A) and related descriptive information.

(C) STAKEHOLDER INPUT.—The Secretary shall accept, through the date that is 120 days after the day the Secretary posts the list pursuant to subparagraph (B), suggestions from physician specialty societies, applicable practitioner organizations, and other stakeholders for episode groups in addition to those posted pursuant to such subparagraph, and specific clinical criteria and patient characteristics to classify patients into—

- (i) care episode groups; and
- (ii) patient condition groups.

#### (D) DEVELOPMENT OF PROPOSED CLASSIFICATION CODES.—

(i) IN GENERAL.—Taking into account the information described in subparagraph (B) and the information received under subparagraph (C), the Secretary shall—

- (I) establish care episode groups and patient condition groups, which account for a target of an estimated 1/2 of expenditures under parts A and B (with such target increasing over time as appropriate); and
- (II) assign codes to such groups.

(ii) CARE EPISODE GROUPS.—In establishing the care episode groups under clause (i), the Secretary shall take into account—

- (I) the patient's clinical problems at the time items and services are furnished during an episode of care, such as the clinical conditions or diagnoses, whether or not inpatient hospitalization occurs, and the principal procedures or services furnished; and
- (II) other factors determined appropriate by the Secretary.

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(iii) PATIENT CONDITION GROUPS.—In establishing the patient condition groups under clause (i), the Secretary shall take into account—

(I) the patient's clinical history at the time of a medical visit, such as the patient's combination of chronic conditions, current health status, and recent significant history (such as hospitalization and major surgery during a previous period, such as 3 months); and

(II) other factors determined appropriate by the Secretary, such as eligibility status under this title (including eligibility under section 226(a), 226(b), or 226A, and dual eligibility under this title and title XIX).

(E) DRAFT CARE EPISODE AND PATIENT CONDITION GROUPS AND CLASSIFICATION CODES.—Not later than 270 days after the end of the comment period described in subparagraph (C), the Secretary shall post on the Internet website of the Centers for Medicare & Medicaid Services a draft list of the care episode and patient condition codes established under subparagraph (D) (and the criteria and characteristics assigned to such code).

(F) SOLICITATION OF INPUT.—The Secretary shall seek, through the date that is 120 days after the Secretary posts the list pursuant to subparagraph (E), comments from physician specialty societies, applicable practitioner organizations, and other stakeholders, including representatives of individuals entitled to benefits under part A or enrolled under this part, regarding the care episode and patient condition groups (and codes) posted under subparagraph (E). In seeking such comments, the Secretary shall use one or more mechanisms (other than notice and comment rulemaking) that may include use of open door forums, town hall meetings, or other appropriate mechanisms.

(G) OPERATIONAL LIST OF CARE EPISODE AND PATIENT CONDITION GROUPS AND CODES.—Not later than 270 days after the end of the comment period described in subparagraph (F), taking into account the comments received under such subparagraph, the Secretary shall post on the Internet website of the Centers for Medicare & Medicaid Services an operational list of care episode and patient condition codes (and the criteria and characteristics assigned to such code).

(H) SUBSEQUENT REVISIONS.—Not later than November 1 of each year (beginning with 2018), the Secretary shall, through rulemaking, make revisions to the operational lists of care episode and patient condition codes as the Secretary determines may be appropriate. Such revisions may be based on experience, new information developed pursuant to subsection (n)(9)(A), and input from the physician specialty societies, applicable practitioner organizations, and other stakeholders, including representatives of individuals entitled to benefits under part A or enrolled under this part.

(3) ATTRIBUTION OF PATIENTS TO PHYSICIANS OR PRACTITIONERS.—

(A) IN GENERAL.—In order to facilitate the attribution of patients and episodes (in whole or in part) to one or more physicians or applicable practitioners furnishing items and services, the Secretary shall undertake the steps described in the succeeding provisions of this paragraph.

(B) DEVELOPMENT OF PATIENT RELATIONSHIP CATEGORIES AND CODES.—The Secretary shall develop patient relationship categories and codes that define and distinguish the relationship and responsibility of a physician or applicable practitioner with a patient at the time of furnishing an item or service. Such patient relationship categories shall include different relationships of the physician or applicable practitioner to the patient (and the codes may reflect combinations of such categories), such as a physician or applicable practitioner who—

(i) considers himself to have the primary responsibility for the general and ongoing care for the patient over extended periods of time;

(ii) considers himself to be the lead physician or practitioner and who furnishes items and services and coordinates care furnished by other physicians or practitioners for the patient during an acute episode;

(iii) furnishes items and services to the patient on a continuing basis during an acute episode of care, but in a supportive rather than a lead role;

(iv) furnishes items and services to the patient on an occasional basis, usually at the request of another physician or practitioner; or

(v) furnishes items and services only as ordered by another physician or practitioner.

(C) DRAFT LIST OF PATIENT RELATIONSHIP CATEGORIES AND CODES.—Not later than one year after the date of the enactment of this subsection, the Secretary shall post on the Internet website of the Centers for Medicare & Medicaid Services a draft list of the patient relationship categories and codes developed under subparagraph (B).

(D) STAKEHOLDER INPUT.—The Secretary shall seek, through the date that is 120 days after the Secretary posts the list pursuant to subparagraph (C), comments from physician specialty societies, applicable practitioner organizations, and other stakeholders, including representatives of individuals entitled to benefits under part A or enrolled under this part, regarding the patient relationship categories and codes posted under subparagraph (C). In seeking such comments, the Secretary shall use one or more mechanisms (other than notice and comment rulemaking) that may include open door



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forums, town hall meetings, web-based forums, or other appropriate mechanisms.

(E) OPERATIONAL LIST OF PATIENT RELATIONSHIP CATEGORIES AND CODES.—Not later than 240 days after the end of the comment period described in subparagraph (D), taking into account the comments received under such subparagraph, the Secretary shall post on the Internet website of the Centers for Medicare & Medicaid Services an operational list of patient relationship categories and codes.

(F) SUBSEQUENT REVISIONS.—Not later than November 1 of each year (beginning with 2018), the Secretary shall, through rulemaking, make revisions to the operational list of patient relationship categories and codes as the Secretary determines appropriate. Such revisions may be based on experience, new information developed pursuant to subsection (n)(9)(A), and input from the physician specialty societies, applicable practitioner organizations, and other stakeholders, including representatives of individuals entitled to benefits under part A or enrolled under this part.

(4) REPORTING OF INFORMATION FOR RESOURCE USE MEASUREMENT.—Claims submitted for items and services furnished by a physician or applicable practitioner on or after January 1, 2018, shall, as determined appropriate by the Secretary, include—

(A) applicable codes established under paragraphs (2) and (3); and

(B) the national provider identifier of the ordering physician or applicable practitioner (if different from the billing physician or applicable practitioner).

(5) METHODOLOGY FOR RESOURCE USE ANALYSIS.—

(A) IN GENERAL.—In order to evaluate the resources used to treat patients (with respect to care episode and patient condition groups), the Secretary shall, as the Secretary determines appropriate—

(i) use the patient relationship codes reported on claims pursuant to paragraph (4) to attribute patients (in whole or in part) to one or more physicians and applicable practitioners;

(ii) use the care episode and patient condition codes reported on claims pursuant to paragraph (4) as a basis to compare similar patients and care episodes and patient condition groups; and

(iii) conduct an analysis of resource use (with respect to care episodes and patient condition groups of such patients).

(B) ANALYSIS OF PATIENTS OF PHYSICIANS AND PRACTITIONERS.— In conducting the analysis described in subparagraph (A)(iii) with respect to patients attributed to physicians and applicable practitioners, the Secretary shall, as feasible—

(i) use the claims data experience of such patients by patient condition codes during a common period, such as 12 months; and

(ii) use the claims data experience of such patients by care episode codes—

(I) in the case of episodes without a hospitalization, during periods of time (such as the number of days) determined appropriate by the Secretary; and

(II) in the case of episodes with a hospitalization, during periods of time (such as the number of days) before, during, and after the hospitalization.

(C) MEASUREMENT OF RESOURCE USE.—In measuring such resource use, the Secretary—

(i) shall use per patient total allowed charges for all services under part A and this part (and, if the Secretary determines appropriate, part D) for the analysis of patient resource use, by care episode codes and by patient condition codes; and

(ii) may, as determined appropriate, use other measures of allowed charges (such as subtotals for categories of items and services) and measures of utilization of items and services (such as frequency of specific items and services and the ratio of specific items and services among attributed patients or episodes).

(D) STAKEHOLDER INPUT.—The Secretary shall seek comments from the physician specialty societies, applicable practitioner organizations, and other stakeholders, including representatives of individuals entitled to benefits under part A or enrolled under this part, regarding the resource use methodology established pursuant to this paragraph. In seeking comments the Secretary shall use one or more mechanisms (other than notice and comment rulemaking) that may include open door forums, town hall meetings, web-based forums, or other appropriate mechanisms.

(6) IMPLEMENTATION.—To the extent that the Secretary contracts with an entity to carry out any part of the provisions of this subsection, the Secretary may not contract with an entity or an entity with a subcontract if the entity or subcontracting entity currently makes recommendations to the Secretary on relative values for services under the fee schedule for physicians' services under this section.

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- (7) LIMITATION.—There shall be no administrative or judicial review under section 1869, section 1878, or otherwise of—
- (A) care episode and patient condition groups and codes established under paragraph (2);
  - (B) patient relationship categories and codes established under paragraph (3); and
  - (C) measurement of, and analyses of resource use with respect to, care episode and patient condition codes and patient relationship codes pursuant to paragraph (5).
- (8) ADMINISTRATION.—Chapter 35 of title 44, United States Code, shall not apply to this section.
- (9) DEFINITIONS.—In this subsection:
- (A) PHYSICIAN.—The term ‘physician’ has the meaning given such term in section 1861(r)(1).
  - (B) APPLICABLE PRACTITIONER.—The term ‘applicable practitioner’ means—
    - (i) a physician assistant, nurse practitioner, and clinical nurse specialist (as such terms are defined in section 1861(aa)(5)), and a certified registered nurse anesthetist (as defined in section 1861(bb)(2)); and
    - (ii) beginning January 1, 2019, such other eligible professionals (as defined in subsection (k)(3)(B)) as specified by the Secretary.
- (10) CLARIFICATION.—The provisions of sections 1890(b)(7) and 1890A shall not apply to this subsection.



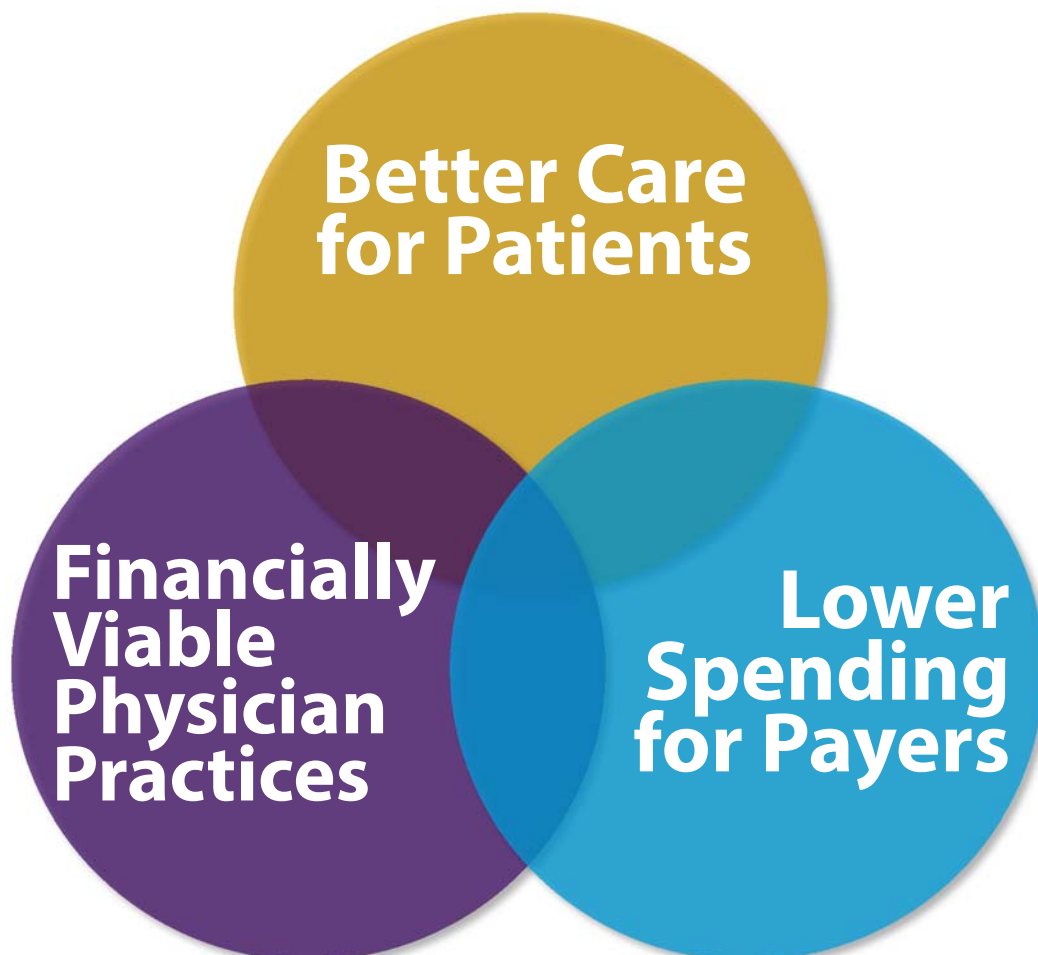
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# A GUIDE TO PHYSICIAN-FOCUSED ALTERNATIVE PAYMENT MODELS



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# A Guide to Physician-Focused Alternative Payment Models

## EXECUTIVE SUMMARY



### The Barriers in Current Payment Systems to Higher-Value Healthcare

All too often, when physicians try to redesign the ways they deliver services in order to provide higher quality patient care at a lower cost, they find that barriers in current payment systems prevent them from doing so. The two most common barriers are:

- **Lack of payment or inadequate payment for high-value services.** Medicare and most health plans do not pay physicians for many services that would benefit patients and help reduce avoidable spending.
- **Financial penalties for delivering a different mix of services.** Under fee for service (FFS), practices lose revenue if physicians perform fewer or lower-cost services, but their practice costs do not decrease proportionately (if at all), which can cause operating losses.

### Alternative Payment Models Can Enable Higher Quality and Lower Costs

Alternative Payment Models (APMs) can provide a way of overcoming the barriers in current payment systems so that physicians can deliver higher-quality care for patients at lower costs for purchasers in ways that are financially feasible for physician practices. To be successful, an APM must have three characteristics:

- 1. Flexibility in Care Delivery.** An APM must be designed to give physicians sufficient flexibility to deliver the services patients need in the most efficient and effective way possible.
- 2. Adequacy and Predictability of Payment.** An APM must provide adequate and predictable resources to enable physician practices to cover the costs of delivering high-quality care to patients. Payments must be appropriately risk-adjusted based on characteristics of patients that increase their need for services, and limits must be placed on the total amount of financial risk that physicians face.
- 3. Accountability for Costs and Quality That Physicians Can Control.** An APM must also be explicitly designed to assure patients and payers that spending will be controlled or reduced and that quality will be maintained or improved. However, individual physicians should only be held accountable for aspects of spending and quality they can control or influence.

The Medicare Access and CHIP Reauthorization Act (MACRA) encourages the creation of APMs and provides incentives for physicians to participate in them. MACRA explicitly encourages the development of “Physician-Focused Payment Models,” and the law provides considerable flexibility in

defining APMs so that they can support the wide range of health problems physicians treat.

### A Menu of Physician-Focused Alternative Payment Models

There is no single approach to APMs that will work for all physicians or their patients. Different medical specialties treat different kinds of health problems, and the opportunities to improve quality and reduce costs differ by the different types of health problems addressed by physicians within each specialty and subspecialty. Moreover, the care delivery changes that are needed to address these opportunities also differ by specialty, as do the barriers in the current payment system that need to be overcome for physicians to redesign care delivery for their patients.

This report describes seven ways of structuring APMs that can be used to address the most common types of opportunities and barriers that physicians face:

- APM #1. Payment for a High-Value Service.** A physician practice would be paid for delivering one or more desirable services that are not currently billable, and the physician would take accountability for controlling the use of other, avoidable services for their patients.
- APM #2. Condition-Based Payment for Physician Services.** A physician practice would have the flexibility to use the diagnostic or treatment options that address a patient’s condition most efficiently and effectively without concern that using lower-cost options would harm the operating margins of the physician’s practice.
- APM #3. Multi-Physician Bundled Payment.** Two or more physician practices that are providing complementary diagnostic or treatment services to a patient would have the flexibility to redesign those services in ways that would enable high-quality care to be delivered as efficiently as possible.
- APM #4. Physician-Facility Procedure Bundle.** A physician who delivers a procedure at a hospital or other facility would have the flexibility to choose the most appropriate facility for the treatment and to work with the facility to deliver the procedure in the most efficient and high-quality way.
- APM #5. Warrantied Payment for Physician Services.** A physician would have the flexibility and accountability to deliver care with as few complications as possible.
- APM #6. Episode Payment for a Procedure.** A physician who is delivering a particular procedure could work collaboratively with the other providers delivering services related to the procedure (e.g., the facility where

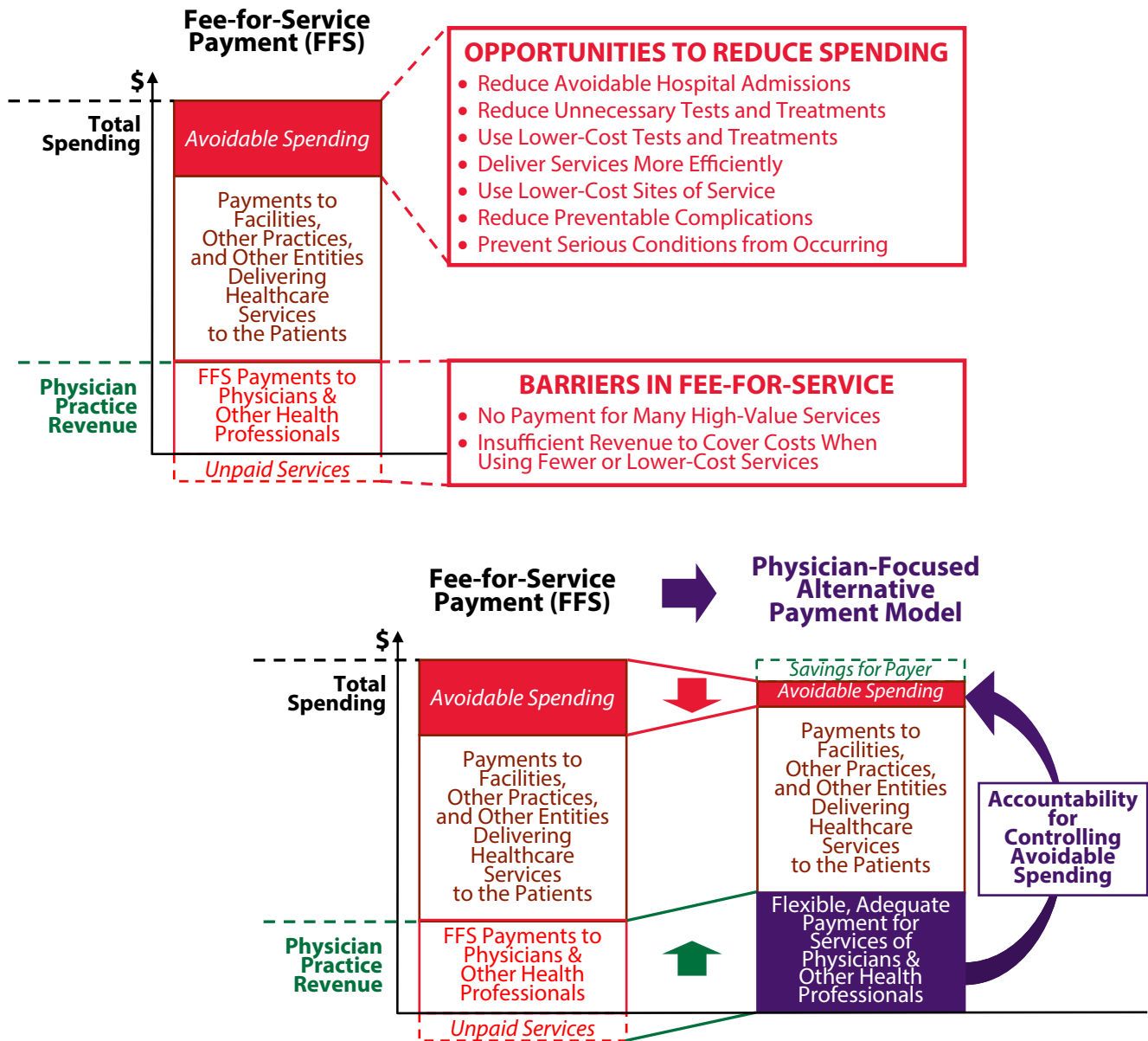
the procedure is performed, other physicians who are involved in the procedure, physicians and facilities who are involved in the patient's recovery or in treating complications of the procedure, etc.) to improve outcomes and control the total spending associated with the procedure.

**APM#7. Condition-Based Payment.** A physician practice would have the flexibility to use the diagnosis or treatment options that address a particular health condition (or combination of conditions) most efficiently and effectively and to work collaboratively with other providers that deliver services for the patient's condition in order to improve outcomes and control the total spending associated with care for the condition.

The "right" APM for a particular specialty or a particular physician practice in that specialty will depend on the types of patients and conditions that specialty cares for, the opportunities that exist for improving their care, the barriers the

physicians face under the current payment system, and any barriers that exist that are unrelated to payment (e.g., restrictions in laws or regulations). In some cases, two or more APMs could potentially be used to address a particular combination of opportunities and barriers, but one of the models may be more feasible for a particular physician practice given its size or relationships with other providers.

The fastest progress in improving the quality and controlling the cost of healthcare will be achieved if each of the physicians and other providers who deliver care to patients can receive the resources and flexibility they need to improve the aspects of care quality and costs that they can control or influence. Consequently, it is important that Medicare and other payers make all of these APMs available so that every physician practice in every specialty can contribute effectively to the nation's efforts to achieve higher quality, more affordable healthcare.



# I. THE NEED FOR PHYSICIAN-FOCUSED ALTERNATIVE PAYMENT MODELS



## A. Barriers to Better Care and Lower Costs in Current Payment Systems

There are many significant opportunities to improve the quality and reduce the costs of healthcare. Many patients develop health problems that could have been prevented, receive tests and procedures that are not needed, are hospitalized because their health problems were not effectively managed, or experience complications and infections that could have been avoided. Other patients could receive different types of treatment than they do today that would be equally effective but cost less. If these unnecessary and avoidable health problems, services, and costs could be eliminated, tens of billions of dollars could be saved and the quality of life for the patients would be improved.<sup>1</sup>

Helping people stay healthy, improving quality, and reducing health care spending will require changes in care delivery. New types of services, innovative ways of delivering existing services, less costly settings for service delivery, and different combinations of services and providers will likely be needed. Only physicians can ensure that these new approaches to delivering services will safely and appropriately address patient needs.

Many physicians are actively working to redesign the ways they deliver and order services in order to provide higher quality care for patients while lowering spending by payers. However, all too often, these desirable changes in care delivery cannot be successfully implemented because of barriers in current payment systems. The two most common barriers are:

**1. Lack of payment or inadequate payment for high-value services.** Medicare and most health plans do not pay physicians for many services that would benefit patients and help reduce avoidable spending. For example, there is generally no payment or inadequate payment for:

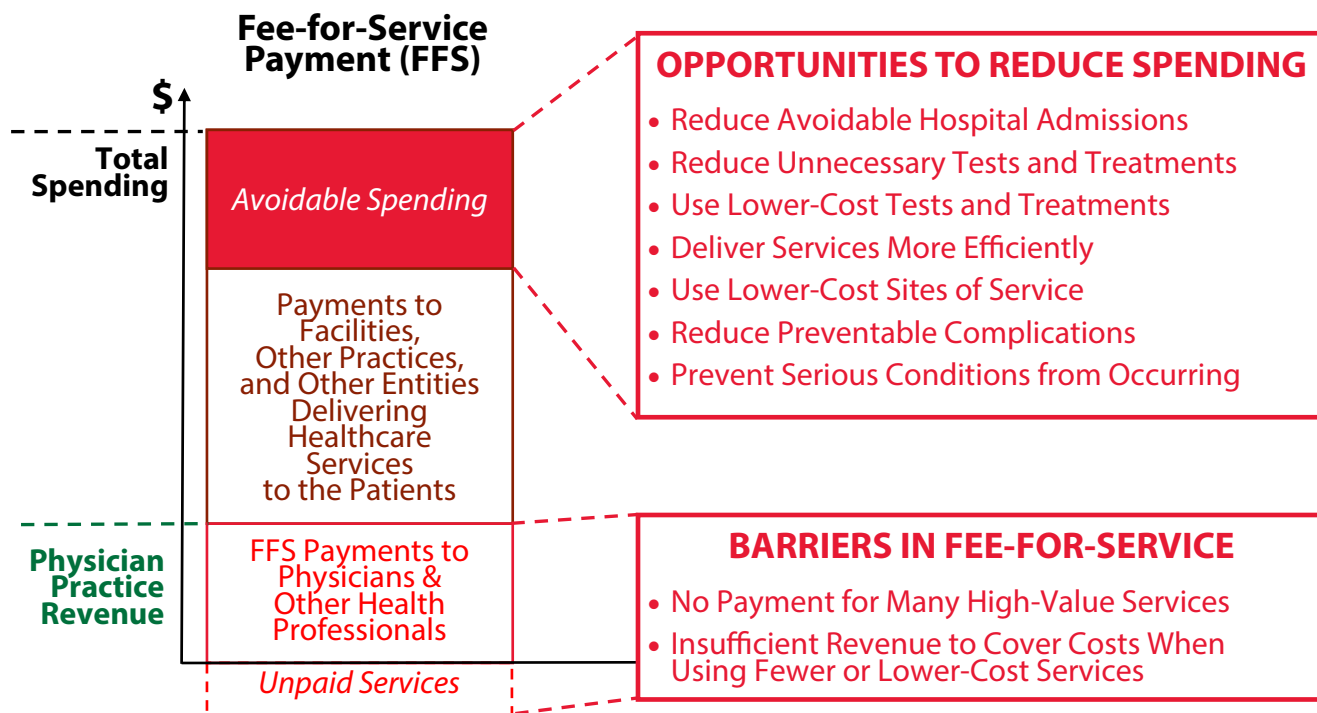
- ◆ responding to a patient's phone call about a symptom or problem, which could help the patient avoid the need for far more expensive services, such as an emergency department visit;
- ◆ communications between primary care physicians and specialists to coordinate care, or the time spent by a physician serving as the leader of a multi-physician care team, which can avoid ordering of duplicate tests and prescribing conflicting medications;
- ◆ communications between community physicians and emergency physicians, and short-term treatment and discharge planning in emergency departments, which could enable patients to be safely discharged without admission;

- ◆ providing proactive telephone outreach to high-risk patients to ensure they get preventive care, which could prevent serious health problems or identify them at earlier stages when they can be treated more successfully;
- ◆ spending time in a shared decision-making process with patients and family members when there are multiple treatment options, which has been shown to reduce the frequency of invasive procedures and the use of low-value treatments;
- ◆ hiring nurses and other staff to provide education and self-management support to patients and family members, which could help them manage their health problems more effectively and avoid hospitalizations for exacerbations;
- ◆ providing palliative care for patients in conjunction with treatment, which can improve quality of life for patients and reduce the use of expensive treatments; and
- ◆ providing non-health care services (such as transportation to help patients visit the physician's office) which could avoid the need for more expensive medical services (such as the patient being taken by ambulance to an emergency department).

**2. Financial penalties for delivering a different mix of services.** Under fee for service (FFS) payment, physician practices lose revenue if physicians perform fewer procedures or lower-cost procedures, but the costs of running the practices generally do not decrease proportionately (if at all), which can cause operating losses. For many types of procedures, most of the savings payers experience does not come from the payments that are made to the physician practice, so savings can still be achieved without financially penalizing the physician practice. The most severe impact under FFS is that physician practices do not get paid at all when their patients stay healthy and do not need health care services.

Some physician practices have received special funding from the federal government, private foundations, health plans, and/or provider organizations for demonstration projects to overcome these payment barriers. These projects have enabled physicians to show that with the right financial support, they can deliver better care for patients at lower costs and with greater professional satisfaction than is possible in the typical delivery system today. Unfortunately, despite positive results, many of these demonstration projects have had to be terminated because they cannot be sustained on a long-term basis under the current FFS payment system.





## B. Characteristics of Successful Alternative Payment Models

It is unrealistic to expect physicians to improve quality or reduce spending without adequate financial support for their efforts. On the other hand, it is also unrealistic to expect that patients or payers will be willing to pay more or differently without assurances that the quality of care will be improved, spending will be lower, or both. *Alternative Payment Models (APMs)* are needed that support the delivery of higher-quality care for patients at lower costs for purchasers in ways that are financially feasible for physician practices.

The fact that a payment system is *different* from traditional fee-for-service payment does not automatically mean that it is *better*. In order to be successful in achieving all three of these goals – better care for patients, lower spending for payers, and financial viability for physician practices – an APM must have three characteristics:<sup>2</sup>

- 1. Flexibility in Care Delivery.** To be successful, an APM must be designed to give physicians sufficient flexibility to deliver the services patients need in the most efficient and effective way possible. If the current payment system does not pay for specific services that physicians need to deliver in order to improve outcomes or reduce spending on other types of services, the APM must authorize payment for additional services, broaden the definition of the services that can be provided using existing payments, or both.
- 2. Adequacy and Predictability of Payment.** To be both successful and sustainable, an APM must provide adequate and predictable resources to enable physician practices to cover the costs of delivering high-quality care to patients. Achieving savings is only a desirable goal if it does not jeopardize access or quality. Moreover, it is impossible for physicians to make investments in facilities and equipment and to recruit, train, and retain high-quality personnel if they cannot predict how much they

will be paid for their services or if there are frequent, significant changes in payments. Payments must also be appropriately risk-adjusted based on characteristics of patients that increase their need for services, and limits must be placed on the total amount of financial risk that physicians face.

- 3. Accountability for Costs and Quality That Physicians Can Control.** In order to be successful and sustainable, an APM must also be explicitly designed to assure patients and payers that spending will be controlled or reduced and that quality will be maintained or improved. However, individual physicians should only be held accountable for aspects of spending and quality they can control or influence.

The goal of APMs should not be to simply shift financial risk from payers to physician practices, but rather to give physician practices the resources and flexibility they need to take accountability for the aspects of costs and quality they can control or influence. In some cases, a small change in the current payment system, such as payment for a specific type of service in addition to existing FFS payments, may be all that is needed to support better outcomes and lower overall costs. In other cases, a more significant change may be needed, such as restructuring payments for many different services delivered by multiple providers.

In most cases, traditional pay-for-performance and “value-based purchasing” systems that simply modify current FFS payment rates based on measures of quality or total spending will not be sufficient to serve as a successful APM, since they do not remove the barriers in the current payment system. The problem to be solved is not a lack of “incentives” for physicians to deliver care in a different way, but the failure of the current payment system to adequately support the better and more efficient approaches to care delivery that physicians want to use.<sup>3</sup>

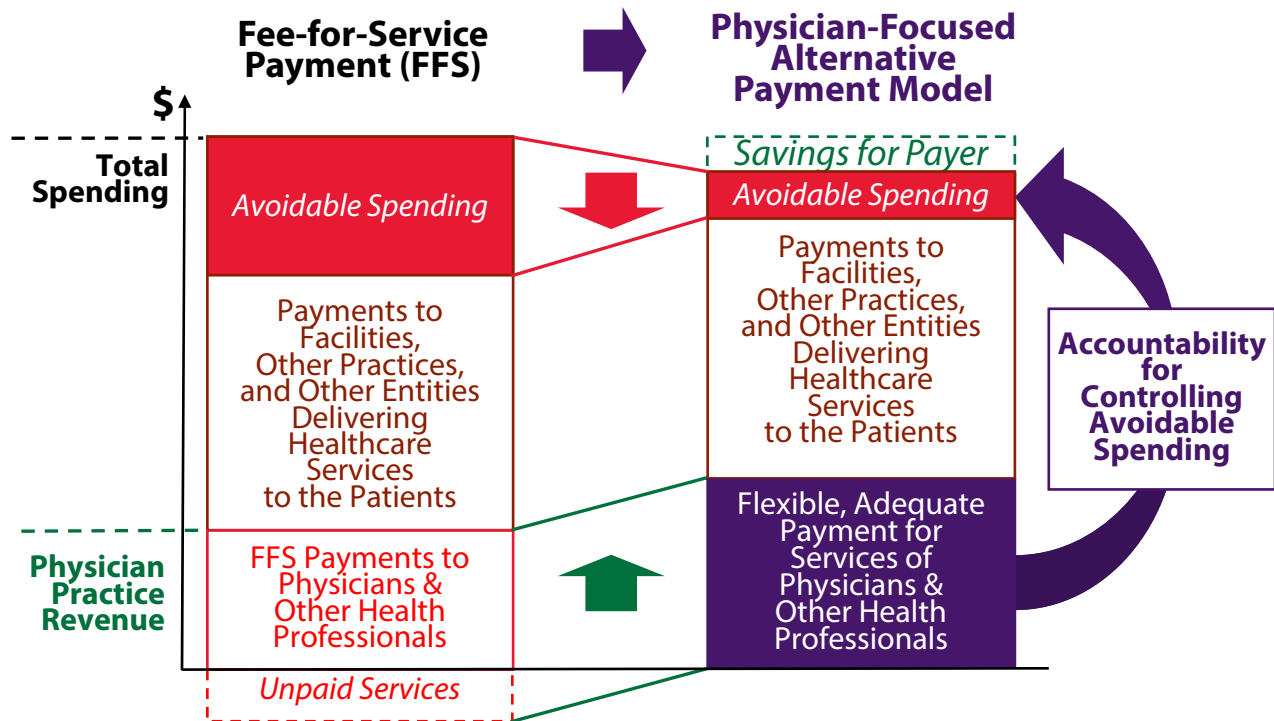
### C. Creating Physician-Focused APMs in Medicare

The Medicare Access and CHIP Reauthorization Act (MACRA) that was enacted by Congress in April 2015 encourages the creation of APMs and provides incentives for physicians to participate in them. Physicians who have a minimum percentage of their revenues or patients in APMs will receive supplemental payments beginning in 2019 and they will receive higher updates to their payments under the Physician Fee Schedule (PFS) beginning in 2026, in addition to the benefits of participating in the APMs.

MACRA specifically designates Accountable Care Organizations (ACOs) within the Medicare Shared Savings Program as a qualifying APM. However, many physicians do not view the current design of this program as providing the flexibility in care delivery or the adequacy and predictability in payment that they need to successfully improve patient care while reducing costs. In addition, the program tries to hold

the providers in the ACO accountable for the costs of healthcare services that the providers cannot control or influence. These weaknesses have discouraged many physicians from participating and have made it difficult for the ACOs that have been created to be successful.

Fortunately, MACRA explicitly encourages the development of “Physician-Focused Payment Models,” and the law provides considerable flexibility in defining APMs so that they can support the wide range of health problems physicians treat. This provides an unprecedented opportunity for physician organizations to work with the Department of Health and Human Services and the Centers for Medicare and Medicaid Services to develop APMs that can support better care for patients, at lower costs for Medicare and other payers, in ways that are financially sustainable for physician practices and other providers.



# II. A MENU OF PHYSICIAN-FOCUSED ALTERNATIVE PAYMENT MODELS



There is no single Alternative Payment Model that will work for all physicians or their patients. Different medical specialties treat different kinds of health problems, and the opportunities to improve quality and reduce costs will differ for the different types of health problems addressed by physicians within each specialty and subspecialty. Moreover, the care delivery changes that are needed to address these opportunities will also differ by specialty, as will the barriers in the current payment system that need to be overcome if physicians are to redesign care delivery for their patients.

This means there will need to be multiple types of APMs in order for physicians in all specialties to participate and in order for all patients to benefit. A good APM will overcome the *specific* payment system barriers a physician practice faces in pursuing the *specific* kinds of improvement opportunities available for the types of patient conditions the physicians in that practice treat.

There is no need for complex and expensive changes in payment structures if simple changes will address the barriers. If paying for a new service code could enable a physician practice to deliver significantly better care at lower overall cost, there is no need to force the practice to find ways to manage a complex bundled payment. On the other hand, if much more extensive changes in care delivery are needed that involve multiple providers, an entirely new type of bundled payment may be needed to provide sufficient flexibility and accountability to support those changes in care, and a physician practice may need to work collaboratively with other physician practices and other types of providers to manage that payment in order to deliver the improved care.

This report describes seven different types of APMs that can be used to address the most common types of opportunities and barriers:

**APM #1. Payment for a High-Value Service.** A physician practice would be paid for delivering one or more desirable services that are not currently billable, and the practice would take accountability for controlling the use of other, avoidable services for their patients.

**APM #2. Condition-Based Payment for Physician Services.** A physician practice would have the flexibility to use the diagnostic or treatment options that address a patient's condition most efficiently and effectively without concern that using lower-cost options would harm the operating margins of the physician practice.

**APM #3. Multi-Physician Bundled Payment.** Two or more physician practices that are providing complementary diagnostic or treatment services to a patient would have the flexibility to redesign those services in ways that would enable high-quality care to be delivered as efficiently as possible.

**APM #4. Physician-Facility Procedure Bundle.** A physician who delivers a procedure at a hospital or other facility would have the flexibility to choose the most appropriate facility for the treatment and to work with the facility to deliver the procedure in the most efficient and high-quality way.

**APM #5. Warranted Payment for Physician Services.** A physician would have the flexibility and accountability to deliver care with as few complications as possible.

**APM #6. Episode Payment for a Procedure.** A physician who is delivering a particular procedure would be able to work collaboratively with the other providers delivering services related to the procedure (e.g., the facility where the procedure is performed, other physicians who are involved in the procedure, physicians and facilities who are involved in the patient's recovery or in treating complications of the procedure, etc.) in order to improve outcomes and control the total spending associated with the procedure.

**APM #7. Condition-Based Payment.** A physician practice would have the flexibility to use the diagnosis or treatment options that address a particular health condition (or combination of conditions) most efficiently and effectively and to work collaboratively with other providers that deliver services for the patient's condition in order to improve outcomes and control the total spending associated with care for the condition.

Each of these APMs addresses a different type of opportunity for savings and/or a different barrier in the current payment system. Although each APM design would need to be adapted to the unique services and outcomes associated with a specific health problem or treatment, the basic structure of the APM would be similar across the different specialties and patient conditions to which it is applied. This means that the billing and claims payment system changes made to support one of the APM designs in one specialty could be used for physician practices in other specialties that are using the same basic APM structure.

Some of the APMs could be implemented easily by single specialty physician practices of any size, while other APMs would likely only be feasible for larger physician practices, for multi-specialty practices, or for practices working collaboratively with other physician practices or other providers, such as hospitals. For those APMs that are involve services delivered by multiple specialties or multiple types of providers, an "Alternative Payment Entity" may be needed to accept and distribute payments among the participating providers.<sup>4</sup>

**TABLE 1**

<b>CHANGE FROM CURRENT FEE FOR SERVICE SYSTEM</b>					
	<b>Payment Made for Services Not Covered by Current Fee-for-Service Payment</b>	<b>Payment is Based on the Patient's Condition, Not the Treatment Delivered</b>	<b>One Payment is Made for Related Services Delivered by Multiple Physicians</b>	<b>One Payment is Made for Related Services Delivered by Physicians and Facilities</b>	<b>One Payment is Made for Both Planned &amp; Unplanned Services Related to Treatment</b>
<b>APM #1 Payment for a High-Value Service</b>	<b>YES</b>	<b>NO</b>	<b>NO</b>	<b>NO</b>	<b>NO</b>
<b>APM #2 Condition-Based Payment for a Physician's Services</b>	<b>YES</b>	<b>YES</b>	<b>NO</b>	<b>NO</b>	<b>NO</b>
<b>APM #3 Multi-Physician Bundled Payment</b>	<b>YES</b>	<b>YES</b>	<b>YES</b>	<b>NO</b>	<b>NO</b>
<b>APM #4 Physician-Facility Procedure Bundle</b>	<b>YES</b>	<b>NO</b>	<b>NO</b>	<b>YES</b>	<b>NO</b>
<b>APM #5 Warranted Payment for Physician Services</b>	<b>YES</b>	<b>NO</b>	<b>NO</b>	<b>NO</b>	<b>YES</b>
<b>APM #6 Episode Payment for a Procedure</b>	<b>YES</b>	<b>NO</b>	<b>YES</b>	<b>YES</b>	<b>YES</b>
<b>APM #7 Condition-Based Payment</b>	<b>YES</b>	<b>YES</b>	<b>YES</b>	<b>YES</b>	<b>YES</b>

# APM #1: PAYMENT FOR A HIGH-VALUE SERVICE



## Goal of the APM:

Pay physicians for delivering desirable services that are not currently billable in order to avoid the need for patients to receive other, more expensive services.

## Components of the APM:

- 1. Continuation of Existing FFS Payments.** The physician practice can continue to bill and be paid the standard amounts for all CPT® codes that are currently eligible for payment under the Physician Fee Schedule.
- 2. Payment for Additional Services.** The practice can also be paid for one or more specific services or combinations of services that are not currently eligible for FFS payment. To receive payment, the practice bills the payer using a code indicating that the service or combination of services was delivered. This may be an existing CPT® code that is not currently billable or a newly-developed code to describe the service or a combination of services. A payment amount is defined for the code based on the cost of delivering the service or combination of services.
- 3. Measurement of Avoidable Utilization.** One or more other services are identified that the practice agrees can be avoided or controlled by delivering the newly-payable services. Utilization of these services by the practice's patients is measured to determine the rate of avoidable utilization. A target level of avoidable utilization is defined based on what is known to be achievable by practices that have the resources to deliver appropriate services. The practice's rate of avoidable utilization is compared to the target level to determine whether the physician practice is above or below the target level. The rate is risk-adjusted to reflect patient characteristics that affect utilization but are outside the physician's control.
- 4. Measurement of Quality/Outcomes.** If the services to be avoided are undesirable (e.g., treatment of infections or complications following a procedure), the measure of avoidable utilization also represents a measure of quality. However, if the services are sometimes necessary or desirable and sometimes undesirable or unnecessary, then there may also need to be one or more additional measures of quality, outcomes, or appropriateness, in order to ensure that only the undesirable/unnecessary services are being reduced. A target level for the quality/outcome measures or consistency with appropriateness criteria would be defined based on what is known to be achievable by physician practices with similar patients and similar resources.
- 5. Adjustment of Payment Amounts Based on Performance.** If the practice's rate of avoidable utilization and quality is within normal statistical variation around the target levels, it receives the standard payment amount for the new code. If the practice's rate of avoidable utilization is significantly higher than the target level or if quality is significantly lower, the payment amount for the new service would be reduced. If utilization is significantly lower or quality is significantly higher, the payment amount would be increased. If the rate of avoidable utilization

is much higher than the target level, the physician practice could be ineligible to bill for the new code.

- 6. Updating Payments Over Time.** The payment amount for the new service code would be increased each year based on inflation, and the payment amount would be periodically adjusted based on an assessment of the costs of delivering the service in order to ensure that the payment is adequate but no higher than necessary.

## Benefits of the APM:

- The patient would benefit by receiving services that cannot currently be provided due to lack of payment.
- The payer would benefit because the expected savings from low levels of avoidable utilization would be greater than the payments made for additional services.
- The physician practice would benefit by receiving the resources needed to deliver desirable services to patients that will avoid complications or the need for the patients to receive less effective services.

## Examples:

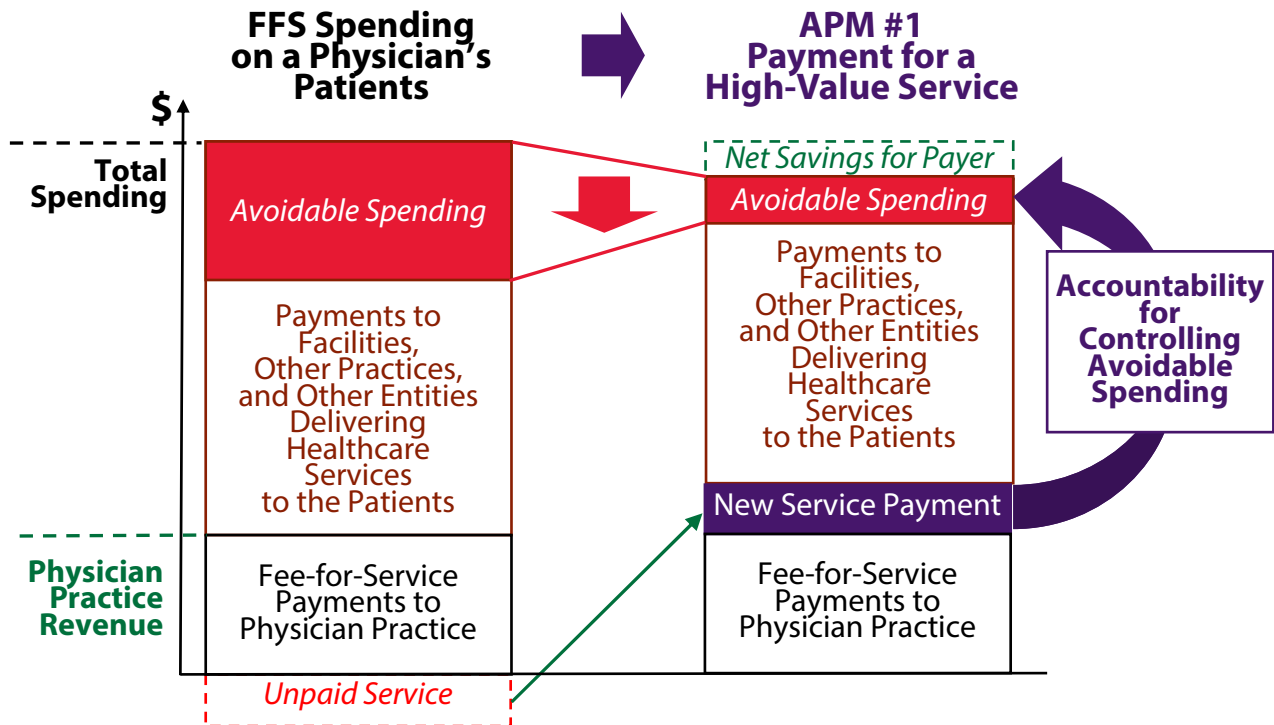
- **Payment for Services to Reduce Avoidable Emergency Room Visits and Hospitalizations of Cancer Patients.** Under this APM, in addition to current E&M services payments, an oncology practice would be able to bill and be paid for delivering care management services to patient undergoing chemotherapy treatment. A bill would be submitted to the payer for each month of services using a newly-defined service code to indicate that care management services were delivered in that month. The practice would have the flexibility to use the payment for whatever combination of specific care management services it deemed appropriate. The rate at which the oncology practice's patients visited an emergency department or were admitted to the hospital for conditions related to cancer treatment (such as dehydration or fever) would be measured and compared to a target level, and the practice's monthly payment for care management would be adjusted up or down based on that performance measure. The practice's visit/admission rate would be risk-adjusted based on the types of cancers treated and the toxicity levels of the treatments used. (This is one of the elements of the American Society of Clinical Oncology's proposal for Patient-Centered Oncology Payment.<sup>5</sup>)
- **Payment for Services to Support Safely Discharging Emergency Room Patients without Hospital Admission.** Under this APM, in addition to current E&M services payments, emergency physicians could bill and be paid for discharge planning and coordination services for patients seen in the emergency department. The emergency physician would have the flexibility to use this additional payment to support additional physician time or additional staff to help appropriate patients

return home (or return to the facility where they resided) rather than being admitted to the hospital. The rate at which the patients of the emergency medicine practice or emergency department are admitted to the hospital would be measured and compared to a target level, and a quality indicator, such as the rate of returns to the ED, would also be measured, with both rates risk-adjusted based on clinical and other characteristics of the patients. The amounts paid to the emergency physicians for discharge planning and coordination would be adjusted up or down based on performance on these measures.

- Payment to Support Implementation of Appropriate Use Criteria for Diagnostic Testing.** Under this APM, in addition to current CPT codes for E&M visits, a physician practice would bill and be paid for the time and resources needed to apply appropriate use criteria and engage in an education/shared decision-making process with patients in order to determine the most appropriate diagnostic tests to use when the patient has symptoms (e.g., chest pain) or is at high risk of developing a disease or a recurrence (e.g., cancer). The proportion of tests ordered that were consistent with the appropriate use criteria would be measured and compared to expected rates based on registry data, and the amounts paid to the physician practice for the application of the criteria would be adjusted up or down based on performance. Since performance would be based on appropriate use, not absolute rates of utilization, no separate measures of quality would be needed. (This is also an element of the American Society of Clinical Oncology’s proposal for Patient-Centered Oncology Payment.)

**Difference from Other Payment Models:**

- In contrast to typical pay-for-performance programs, the physician practice would be paid for the additional services it needs to deliver in order to improve quality or reduce total costs.
- In contrast to a typical shared savings program, an individual physician practice’s payments would not be explicitly tied to how much money that practice saved the payer. Instead, the physician practice would be paid adequately to deliver appropriate services, and the payer would save money by spending less on avoidable services (for the patients in all participating practices) than the additional payments made to all practices participating in the APM. A physician practice that already had achieved low rates of avoidable utilization by delivering services without adequate payment would be able to receive additional payment in order to sustain that performance without having to further reduce avoidable utilization, and a physician practice that had an unusually high rate of avoidable utilization would need to make significant reductions in order to receive the additional payment.



# APM #2: CONDITION-BASED PAYMENT FOR A PHYSICIAN'S SERVICES



## Goal of the APM:

Give a physician the flexibility to use the most appropriate diagnostic or treatment option for a patient's condition without reducing the operating margins of the physician's practice, including diagnosis or treatment options not supported through the current payment system.<sup>6</sup>

## Components of the APM:

- 1. Payment Based on the Patient's Health Condition Rather Than Services Delivered.** The physician practice can bill and be paid for treating or managing the care of patients with a specific health condition (or combination of conditions), rather than having payment tied to the delivery of specific services or treatments. The physician practice has the flexibility to use the payment to support both services that are currently billable as well as new services that are not currently billable. The bundle could be defined to include services delivered on a single day or over a longer period of time, such as a month.
- 2. Condition-Based Payment Replaces Some Current Fee-for-Service Payments to the Physician Practice.** For patients who have the relevant health condition(s) and are eligible for services through the Condition-Based Payment, the physician practice no longer bills for individual CPT<sup>®</sup> codes for services that are included in the Condition-Based Payment.<sup>7</sup> The practice continues to bill and be paid for individual services to the patients that are *not* related to the condition (such as treatment for an unrelated acute episode or accident) using the appropriate CPT<sup>®</sup> codes. If the practice unintentionally submitted a separate bill for one of the services included in the Condition-Based Payment, the payer would simply not pay the bill for that individual service.<sup>8</sup> Payments to other providers that deliver services for the condition (e.g., payment to a hospital for services the physician performs at the hospital, or payments to a laboratory for tests the physician orders) would still be made separately by the payer to those providers. (See APM #3 - Multi-Physician Bundled Payment and APM #4 - Physician-Facility Procedure Bundle for discussions of bundled payments that involve services delivered by multiple providers, rather than just by one physician practice.)
- 3. Payment Amounts Stratified Based on Patient Needs.** The physician practice would bill for an eligible patient by choosing a code from a new family of bundled service codes (these would be "condition-based" codes rather than procedure codes). Each of these condition-based codes would be defined based on patient characteristics that are expected to result in a mix of services from the physician practice with similar costs, similar to the way hospital Diagnosis Related Groups define a range of patients who are expected to require similar amounts of hospital resources during an inpatient stay. Different codes would be assigned different amounts of payment based on differences in the expected costs of services for the patients.

- 4. Measurement of Appropriateness/Outcomes.** In order to ensure that patients continue to receive the most appropriate services through the Condition-Based Payment, the physician practice would either agree to document the application of appropriate use criteria (if such criteria exist) or to measure quality or outcomes for treatment of the patient's condition and compare the quality/outcome measures to benchmarks.
- 5. Adjustment of Payment Amounts Based on Performance.** The payment amounts for the condition-based codes would be reduced if the physicians in the practice failed to apply appropriate use criteria or if the quality/outcome measures were significantly below benchmark levels.
- 6. Updating Payments Over Time.** The Condition-Based Payment amounts would be increased each year based on inflation, and the payment amounts would be periodically adjusted based on an assessment of the costs of delivering care to the patients who have the condition in order to ensure that the payments are adequate but no higher than necessary.

## Benefits of the APM:

- The patient would benefit because the flexibility under the Condition-Based Payment would allow the physician practice to deliver different types or combinations of services to patients that cannot currently be provided due to lack of payment, and to deliver care for the patient's condition more effectively at a lower total cost.
- The payer would benefit because either (1) the new combination of services enables the physician to order fewer or lower-cost services from other providers or results in fewer health problems or complications for the patient, so the payer would spend less overall, or (2) the practice can accept a lower payment for the Condition-Based Payment than the payer would have expected to pay for the individual services that would have been provided under the current payment system.
- The physician practice would benefit by having the flexibility to deliver the most appropriate services to patients without concern about which service will generate more revenue for the practice.

## Examples:

- **Monthly Payments for Chronic Disease Management.** Under this APM, a primary care practice or specialty practice that is helping a patient manage a chronic disease such as asthma, COPD, diabetes, heart failure, or inflammatory bowel disease (or a combination of such conditions) would bill for a single payment amount each month. The practice would no longer bill for Evaluation & Management payments for these patients. (The practice *could* continue to bill for E&M services for patients without chronic diseases and it could continue to bill for any individual procedures performed on all patients, including chronic disease patients.<sup>9</sup>) The

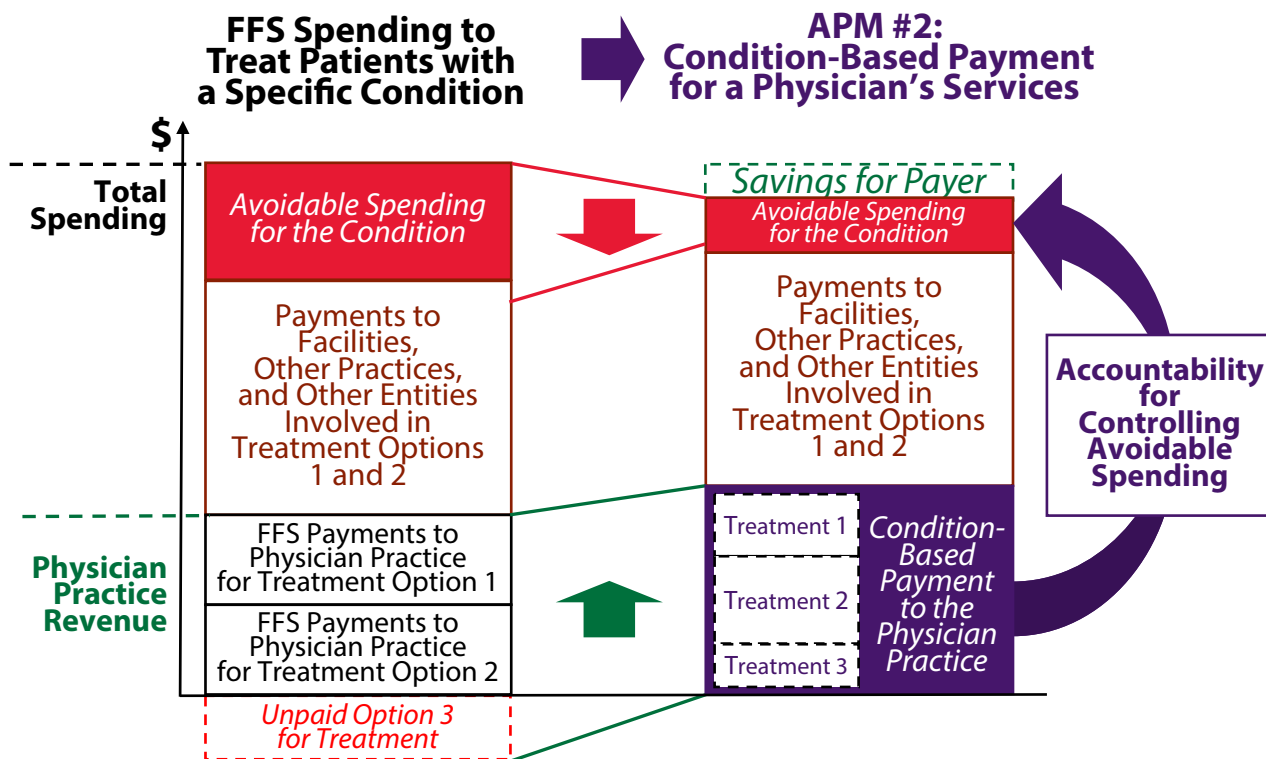
practice would have the flexibility to use the payments for whatever combination of services were most effective – office visits, phone calls, emails, support from non-physician staff, etc. Monthly payments would be higher for patients with multiple chronic diseases or more severe chronic diseases, since the patients would be expected to need more contacts with physicians or practice staff. Quality measures and rates of hospitalization would be calculated and compared to benchmarks to ensure patients were receiving necessary care.<sup>10</sup>

- Case Rates for Radiation Therapy for Cancer.** Under this APM, a radiation oncology practice would bill for a single payment amount for an entire course of radiation therapy for a patient. The amount of payment would not be based on the specific type of treatment used, but it would be based on the type of cancer and on patient-specific factors affecting the appropriate radiation therapy. The amount of payment for a particular category of patients would be based on the average spending on the different treatment modalities used for similar patients in the past. The radiation oncologist would have the flexibility to use whichever type of treatment was most appropriate for the patient. (The American Society of Radiation Oncology is developing this type of payment model for breast cancer treatment and palliative care of bone metastases; some radiation oncology practices have implemented this approach with commercial health plans.<sup>11</sup>)

- Monthly Payments for Chemotherapy Treatment.** Under this APM, a medical oncology practice would bill for a single payment amount for each month that a patient is undergoing chemotherapy. The monthly payment would replace E&M services payments and payments for about 50 different CPT codes describing different types of infusions and injections (drugs and diagnostic tests would still be billed for and paid separately). The oncology practice would have the flexibility to use the monthly payment to provide the combination of services that best met the patient’s needs without concern for which services generated more revenue. The amount of payment would differ depending on patient characteristics such as comorbidities and the toxicity and complexity of the treatment regimen, instead of being based on the number of office visits or on whether infused or oral therapy was used. (This is similar to the proposal for Consolidated Payments for Oncology Care developed by the American Society of Clinical Oncology.<sup>12</sup>)

**Difference from Other Payment Models:**

In contrast to typical pay-for-performance programs and shared savings programs, the physician practice would have the flexibility to deliver new types of services and different combinations of services rather than being limited to what can be billed under the current fee-for-service payment system.





# APM #3: MULTI-PHYSICIAN BUNDLED PAYMENT



## Goal of the APM:

Give multiple physicians who are providing services to the same patient the flexibility and resources needed to redesign their services in coordinated ways that will improve quality and reduce the costs of diagnosis or treatment.

## Components of the APM:

- 1. Single Bundled Payment for Services Delivered by Two or More Physicians.** A single payment is made that covers the services delivered by two or more physicians in order to diagnose a patient's condition or to deliver a specific treatment for a diagnosed health problem. The physicians would have the flexibility to use the bundled payment for services that are not currently eligible for payment as well as for services for which they can currently bill the payer, and they would also have the flexibility to divide the payment differently than what they would receive under the current payment system.
- 2. Bundled Payment May Supplement and/or Replace Current Fee-for-Service Payments to the Physicians.** The bundled payment could be designed to increase revenue to the physician practices in order to support delivery of one or more specific services or combinations of services that are not currently eligible for payment under the Physician Fee Schedule or that do not currently receive adequate payment. The bundled payment could also be designed to replace payment for some existing services, i.e., the physicians delivering those services would no longer bill for individual CPT® codes for the services but would instead use the bundled payment to cover the costs of those services. The exact structure of the bundle will depend on the nature of the barriers in the current payment system.
- 3. Patient Agreement to Use the Multi-Physician Team for the Services.** In order to receive the benefits of the more coordinated and flexible care, the patient would need to agree to use only the physicians on the team for all services covered by the Bundled Payment.
- 4. Bundled Payment Paid to an Alternative Payment Entity Designated by the Participating Physicians.** The participating physician practices would designate an organizational entity to receive the bundled payment. This "Alternative Payment Entity" could either be one of the physician practices (which would agree to pay the other physician practices their shares of the bundled payment for the components of services they provide) or it could be a new organization (e.g., a limited liability corporation that is jointly owned by the participating practices) that would receive the payment and allocate it among the participating practices based on rules the practices adopt.
- 5. Payment Amounts Stratified Based on Patient Needs.** The designated Alternative Payment Entity bills the payer for services to an eligible patient using a new service code. If some patients need significantly more services than others, a family of new bundled service codes would be used, with each code defined based on patient characteristics that are expected to need combinations of ser-

vices from the participating practices with similar total costs.

- 6. Measurement of Avoidable Utilization of Other Services.** If the bundled payment is designed to increase total payments to the physician practices, one or more other services are identified that the physician practices agree can be reduced or controlled by delivering the newly-payable services using the bundled payment. The utilization of these services for the physician practices' patients is measured to determine the rate of avoidable utilization, and a target level of avoidable utilization is defined based on what is known to be achievable by physician practices that have the resources to deliver appropriate services. The rate of avoidable utilization for the practices' patients is compared to the target level to determine whether the practices are above or below the target level. The rate is risk-adjusted to reflect patient characteristics that affect utilization but are outside the physician practices' control.
- 7. Measurement of Appropriateness/Quality/Outcomes.** If the bundled payment replaces payments for two or more existing services, then in order to ensure that patients continue to receive appropriate and high quality services under the bundled payment arrangement, the participating physicians would either agree to document the application of appropriate use criteria (if such criteria exist) or to measure quality and/or outcomes for the patients and compare the measures to benchmarks.
- 8. Adjustment of Payment Amounts Based on Performance.** The amounts paid for the bundled service codes would be reduced if the avoidable utilization was not reduced, if physicians failed to apply appropriate use criteria, or if quality or outcome measures were significantly below benchmark levels.
- 9. Updating Payments Over Time.** The bundled payment amounts would be increased each year based on inflation, and the payment amounts would be periodically adjusted based on an assessment of the costs of delivering the services to patients to ensure that the payments are adequate but no higher than necessary.

## Benefits of the APM:

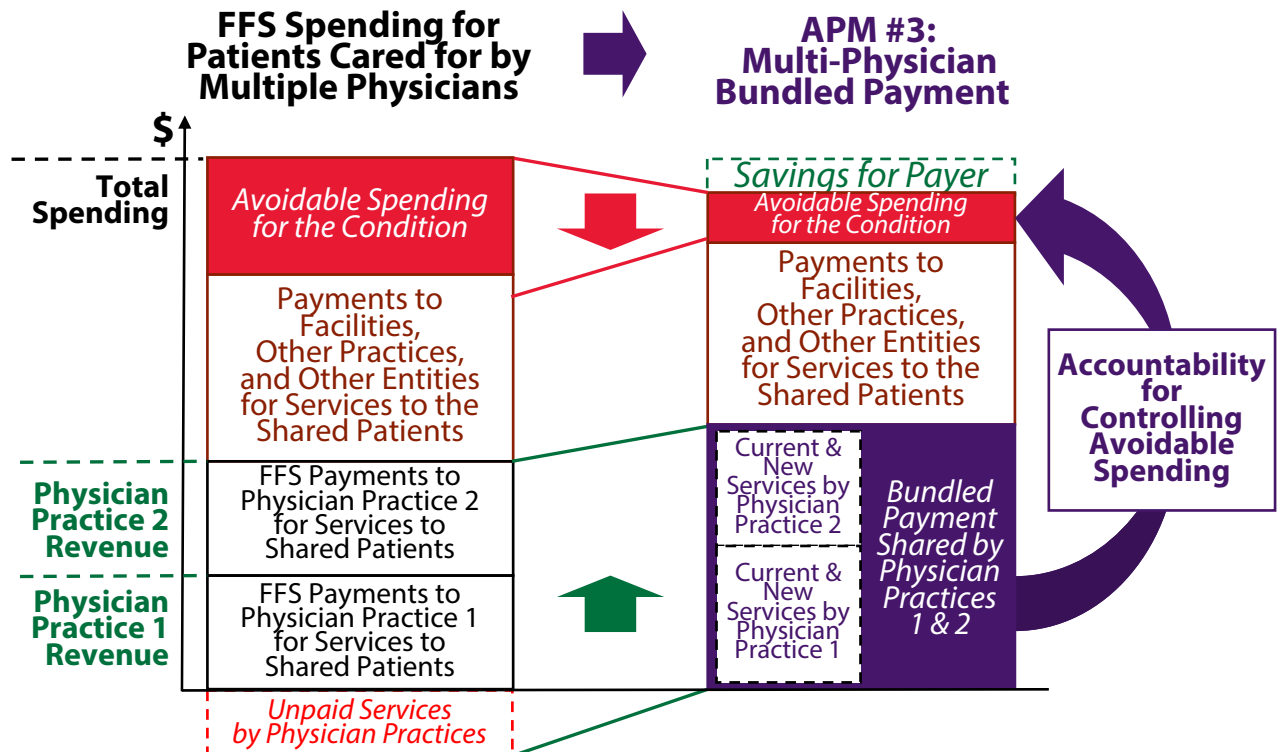
- Patients would benefit because the physicians delivering their care could work together in a more coordinated way and use the additional resources and/or flexibility under the bundled payment to deliver different types or combinations of services that cannot currently be provided.
- The payer would benefit because the new payment would enable the physicians to deliver care more efficiently, order fewer or lower-cost services from other providers, and/or reduce the number of complications for their patients.
- The physician practices would benefit by having the resources and flexibility to deliver the most appropriate services to patients in a coordinated way without con-

cern about which services will generate more revenue for the individual practices.

**Examples:**

• **Bundled Payment for Diagnosis of Non-Urgent Chest Pain.** Under this APM, primary care practices and cardiologists would work together to accurately diagnose individuals with newly reported mild chest pain that does not warrant emergency treatment. A group of primary care practices and a cardiology practice would receive a monthly payment to support use of the American College of Cardiology appropriate use criteria for determining the most appropriate tests to order when patients report new chest pain. The cardiologists would help the primary care physicians implement the criteria and the primary care physicians would contact the cardiologists by telephone or email for assistance in determining what to do for “gray area” cases. The monthly payment would cover the cost of any electronic decision support system incorporating the appropriate use criteria, the primary care physicians’ time in applying the criteria, and the cardiologists’ time in consulting with the PCPs. Primary care practices and cardiology practices would continue to receive standard E&M payments for office visits with patients in addition to the new bundled payment. The monthly payments would be increased or decreased based on the rate of adherence to the criteria in ordering tests and/or the rate of utilization of high-cost diagnostic tests. (This is a type of payment model being considered to support the SMARTCare project developed by the American College of Cardiology.<sup>13</sup>)

- **Bundled Payment for Collaborative Treatment of Allergic Asthma.** Under this APM, primary care practices and allergy specialists would work together to develop and implement a treatment plan for patients with allergic asthma. The primary care and allergy practices would bill payers for a payment for each patient with diagnosed allergic asthma. The payment would support the development of appropriate immunotherapy treatment by the allergy practice and administration of the treatments by the primary care practice with telephone support from the allergy practice. The rate at which asthma control medications are used and the frequency of exacerbations would be measured to assess whether patient outcomes had improved and total costs had been reduced.
- **Bundled Payment for Integrated Behavioral and Physical Health Care.** Under this APM, primary care practices and psychiatry practices would jointly receive a payment to support (1) screening of patients for behavioral health problems in the primary care practice office and (2) either brief interventions in the primary care practice office or referral for treatment by the psychiatrist when appropriate. The bundled payments would support the additional time spent by primary care providers to screen patients for behavioral health needs, the hiring of behavioral health specialists to work in the primary practice (or to be available through a tele-health link) to provide immediate brief interventions for patients with a positive screening, and training, phone consultations, and supervision by psychiatrists.



# APM #4: PHYSICIAN-FACILITY PROCEDURE BUNDLE



## Goal of the APM:

Give a physician greater ability to choose the most appropriate hospital or other facility to deliver a particular procedure and to work with the facility to improve efficiency and quality in delivering that procedure.

## Components of the APM:

- 1. Single Bundled Payment for the Physician and Facility Services.** A single payment is made for the physician services and the services of the hospital or other facility where the physician performs services as part of a particular treatment for a patient's health problem. The physician practice and the facility have the flexibility to use the bundled payment for services that are not currently eligible for payment as well as for services for which they can currently bill. The physician practice and the facility can divide the bundled payment in ways that are different from what they would have received for the same services under current payment systems.
- 2. Bundled Payment Replaces Current Fee-for-Service Payments to the Physician and Facility.** The physician practice no longer bills for individual CPT® codes for the services covered by the bundled payment, and the facility no longer bills for the relevant services under the applicable payment system (e.g., a hospital would not bill under the Inpatient Prospective Payment System if the bundle applied to inpatient care, and it would not bill under the Outpatient Prospective Payment System if the bundle applied to outpatient care.)
- 3. Payment Made to an Alternative Payment Entity Designated by the Participating Providers.** An "Alternative Payment Entity" is designated to receive the bundled payment and allocate it between the physician practice and facility. This entity could be the physician practice, the hospital or other facility where the procedure is performed, a Physician-Hospital Organization that is jointly owned by physicians and the hospital, or a newly formed entity.
- 4. Facility-Independent Payment or Facility-Specific Payment.** Since many treatments can be delivered in multiple types of facilities (e.g., in a hospital inpatient unit, a hospital outpatient department, an ambulatory surgery center, a physician office, etc.), the bundle could be "facility-independent," i.e., the payment would be the same regardless of which type of facility is used for the treatment. Alternatively the bundled payment could be "facility-specific," with the payment amount differing depending on the specific facility where the treatment is delivered.
- 5. Payment Amounts Stratified Based on Patient Needs.** The Alternative Payment Entity submits a bill to a payer for payment for services delivered to an eligible patient using a code from a family of new bundled codes that designate the service provided. Payment amounts are assigned to codes based on differences in the expected costs of the services delivered by both the physician and the facility. If the codes are facility-specific, each code is

defined based on patient characteristics that are expected to affect the types of services performed by the physician and the facility, but the code is not based explicitly on the actual services delivered. If the codes are facility-independent, then the codes are also defined based on patient characteristics that are expected to affect the type of facility used for a patient, but the payment is not based explicitly on which facility was actually used.

- 6. Outlier Payments for Patients with Unusually High Needs.** A supplemental payment would be made for patients who need an unusually large number of services or unusually expensive services as part of the treatment.
- 7. Measurement of Appropriateness/Quality/Outcomes.** In order to ensure that patients continue to receive appropriate, high quality services under the bundled payment, the physician and facility agree to document the application of appropriate use criteria (if such criteria exist) or to measure quality and/or outcomes for the patients and compare those measures to benchmarks.
- 8. Adjustment of Payment Amounts Based on Performance.** The amounts paid for the bundled codes are reduced if the providers fail to apply appropriate use criteria or if quality or outcome measures are significantly below benchmark levels.
- 9. Updating Payments Over Time.** The bundled payment amounts would be increased each year based on inflation, and the payment amounts would be periodically adjusted based on an assessment of the costs of delivering the procedure to ensure that the bundled payments are adequate but no higher than necessary.

## Benefits of the APM:

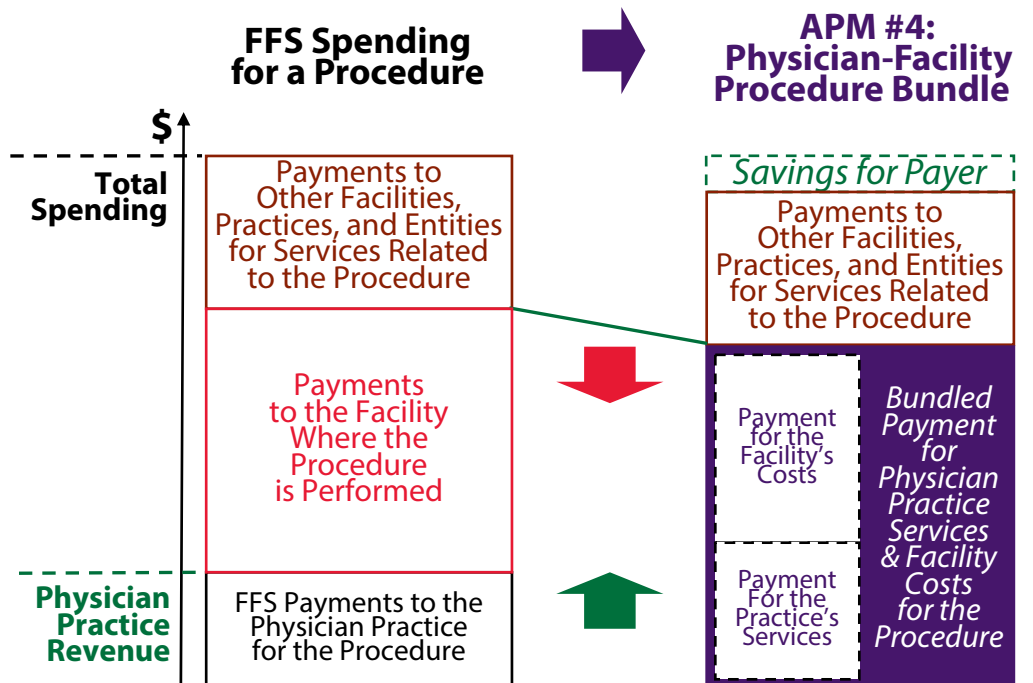
- The patient would benefit by being able to receive high quality care at the lowest-cost facility and to receive coordinated and efficient care from the physician and facility staff.
- The payer would benefit because the Alternative Payment Entity could accept a lower payment for the bundle than the total amounts that would have been paid separately to the physician and facility under current payment systems.
- The physician practice could benefit by using the bundled payment to cover the costs of services that are not current billable or do not receive adequate compensation, and by receiving compensation for changes in the physician's services that reduce the costs of the services delivered by the facility.

**Examples:**

- Bundled Payments for Hospital Admissions.** Under this APM, a single payment would be made to a Physician-Hospital Organization (PHO) to cover both the physician services and the hospital services during a hospital admission. The physician practice and the hospital involved in the bundle would not bill separately for their services for any patient who was eligible for the bundled payment. (This payment model was successfully implemented by CMS for orthopedic and cardiac procedures as part of the Medicare Acute Care Episode Demonstration.<sup>14)</sup>
- Facility-Independent Bundled Payment for Surgery.** Under this APM, a surgery practice would receive a single, bundled payment to cover both the surgeon's costs for performing the surgical procedure and the costs of the facility used to perform the surgery. The bundled payment would be the same regardless of where the surgery was performed, so if patients could safely receive surgery in an outpatient setting or ambulatory surgery center rather than an inpatient setting (or in the physician's office rather than an outpatient hospital setting), the payer could pay less for the bundle while the surgery practice would earn more for performing the procedures. The surgery practice or the entity managing the payment would have the flexibility to pay more for services in the

outpatient setting than the standard amount paid under the current payment system if that would enable a patient to be safely treated at a lower overall cost. The bundled payment would be higher for patients who have characteristics that would increase the likelihood that the patient would need to receive surgery in a higher-cost setting. Complication rates and patient-reported outcomes (such as pain and level of function) would be measured and reported, and payments would be reduced if patients were experiencing more complications or if outcomes worsened.

- Facility-Independent Bundled Payment for Normal Vaginal Delivery.** Under this APM, an obstetrics practice would receive a single, bundled payment to cover both the obstetrician's time for labor and delivery and the payment to the facility where the delivery occurs. The bundled payment would be the same regardless of where the delivery occurred, so if a subset of mothers could safely deliver in a birth center rather than a hospital, the obstetrics practice could charge less for the bundled payment while earning more for performing deliveries. The obstetrics practice would have the flexibility to pay the birth center more than the standard amount it would have received under the current payment system if that would enable more babies to be safely delivered at the birth center at a lower overall cost.



# APM #5: WARRANTIED PAYMENT FOR PHYSICIAN SERVICES



## Goal of the APM:

Give physicians adequate payment and flexibility to redesign care in a way that will prevent complications and reduce the spending needed to treat them.

## Components of the APM:

This APM differs from the previous APMs by using a single bundled payment to cover the costs of *unplanned* physician services to treat complications in addition to the costs of services that are planned as part of a patient's treatment. (If the procedure resulting in a complication was delivered in a facility, APM #5 could be combined with APM #4 - Physician-Facility Treatment Bundle to include the costs of facility services associated with treatment of complications as well as the physician services.)

- 1. A Single Payment for Both a Planned Service and Treatment of Avoidable Complications.** The physician practice can bill and be paid for a warrantied version of a service the physician performs, and the physician practice receives a higher payment than what is currently paid under the current payment system for delivering the same type of service without a warranty. The physician practice is responsible both for delivering the initial service and for providing or paying for the additional physician services needed to treat specific types of complications arising from the initial service. The physician practice no longer bills separately for the services delivered to treat the complications covered by the warranty. If the treatment for the complication is delivered by a physician practice other than the physician practice that delivered the initial service, the payer reduces the payment to the physician practice that delivered the initial service by the amount paid to the physician who treated the complication.
- 2. Payment Amounts Stratified Based on the Risk of Complications.** The physician practice bills for the warrantied service by choosing a code from a family of new service codes. Each code is defined based on patient characteristics that are expected to result in a significantly higher or lower rate of complications.
- 3. Measurement of Quality/Outcomes.** The rate of complications covered by the warranty would be reported so that patients could choose physician practices with lower rates of complications. (There is no need to explicitly adjust the payment amount based on the rate of complications; the physician practice's operating margins would automatically be lower if complication rates are higher, because the cost of treating the complications would increase but the warrantied payment would remain the same.)
- 4. Updating Payments Over Time.** The warrantied payment amounts would be increased each year based on inflation, and the payment amounts would be periodically adjusted based on an assessment of (1) the costs of delivering care to the patients and (2) the achievable rate of complications, in order to ensure that the payments are adequate but no higher than necessary.

## Benefits of the APM:

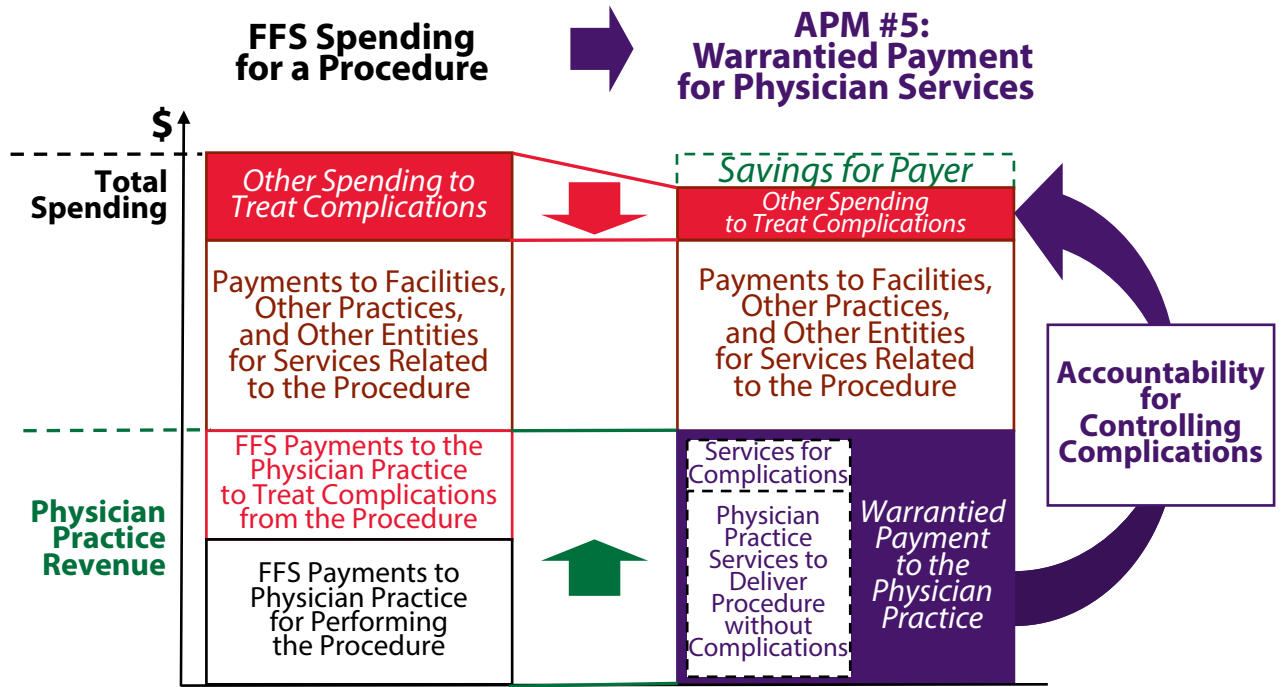
- The patient would benefit by being able to receive care with fewer complications and lower overall costs.
- The payer would benefit by paying less for the warrantied service than it would have paid for the combination of the planned services and treatment of complications at current complication rates.
- The physician practice would benefit by having the flexibility to deliver care differently if it would reduce complication rates, and to be paid more for delivering higher-quality care.

## Examples:

- **Warranty for Surgery.** Under this APM, a surgery practice would bill for a warrantied payment for surgery. The payment would be higher than the standard surgical fee, but the surgery practice would not bill for a separate fee if the patient required a second surgery to address a complication. If specific types of patient characteristics are known to significantly increase the risk of complications, a higher level of payment would be made for patients with those characteristics. The types of complications covered by the warranty would be specified, and if a different type of complication or problem occurred that required a second surgery, the surgery practice could bill separately for that surgery. If a different surgeon performed the surgery for a complication covered by the warranty, the payment to that surgeon would be deducted from the payment to the surgery practice of the surgeon who delivered the initial warrantied surgery. (A warrantied payment focused solely on the physician practice would not be expected to cover the payment to the hospital if a second surgery was needed; however, a multi-provider bundled payment could be defined that included both the payment to the surgeon and the hospital, as described in APM#4.)
- **Warranty for Repeat Colonoscopy.** Under this APM, a gastroenterology practice would bill for a warrantied payment for colonoscopy. The payment would be higher than the standard colonoscopy fee, but the gastroenterology practice would not bill for an additional fee if a repeat colonoscopy was needed due to an incomplete procedure or to address post-polypectomy bleeding.

## Difference from Other Payment Models:

In contrast to penalties that reduce payments when complications occur, the warranty approach provides greater upfront resources so that care can be redesigned to reduce complications. In addition, although no additional payment is made when complications occur, the cost of treating some complications is built into the warrantied payment amount, so the physician practice is not financially penalized when a small number of complications occur, but it is rewarded if it can eliminate most or all complications.



# APM #6: EPISODE PAYMENT FOR A PROCEDURE



## Goal of the APM:

Give physicians and other providers the ability to deliver all of the care during and after delivery of a particular procedure or treatment in a coordinated, efficient way.

## Components of the APM:

This APM involves a single bundled payment for multiple services delivered by multiple providers over a period of time, including services needed to address complications that patients may experience as a result of treatment.

- 1. Payment for a Complete “Episode of Care” Associated With a Procedure or Treatment.** An “episode of care” would be defined based on the time needed to deliver a particular procedure or treatment and any follow-up services needed, as well as a period of time in which most complications would be expected to occur. For example, the episode of care for a procedure or treatment delivered during an inpatient hospital admission is typically defined as the length of the hospitalization (and potentially a period of time before the hospital admission occurs) plus a fixed period of time after discharge (e.g., 30 days or 90 days). This means that the length of the episode can vary from patient to patient depending on the number of days involved in delivering the treatment. (Although payments for management of chronic conditions are also sometimes labeled “episode payments,” these are more appropriately called Condition-Based Payments and are described under APM #7.)
- 2. Bundled Payment For All Related Services Delivered During the Episode By All Providers.** The episode payment is a bundled payment that covers all services delivered by all providers during the episode that are related to the procedure or treatment, including services delivered by all physicians to the patient as part of the treatment or procedure, the services delivered by the hospital or other facility where the physician services are performed, and any services delivered by physicians or other providers after completion of the treatment that are needed for recovery from the treatment (e.g., post-acute care services after discharge from the hospital).
- 3. Warranted Payment for Treatment of Complications Occurring During the Episode.** The episode payment also covers any services delivered to treat specific types of complications related to the treatment or procedure, such as hospital readmissions for complications related to the treatment.
- 4. Patient Agreement to Use the Provider Team for the Episode Services.** In order to receive the benefits of the more coordinated and flexible care, the patient would need to agree to only use the providers on the team participating in the Episode Payment for all services related to the procedure or treatment.
- 5. Bundled Payment Paid to an Alternative Payment Entity.** An Alternative Payment Entity would be designated or created to serve as the recipient of the episode payment. Depending on the type of procedure or treatment, this could be a physician practice, a hospital,

a Physician-Hospital Organization, or some other organizational entity governed by physicians.

- ◆ **Prospective Payment:** If the episode payment is paid “prospectively,” the providers would no longer bill the payer for the services they deliver that are covered by the episode payment, but they would instead be paid by the Alternative Payment Entity using the revenues that entity receives from the payer via the episode payment.
  - ◆ **Retrospective Reconciliation:** An alternative approach to implementing the episode payment is “retrospective reconciliation.” The episode payment is treated as a budget, the providers continue to bill the payer for their individual services and they are paid by the payer under the existing payment systems, and those payments are totaled by the payer and compared to the budget. Then, if the fee-for-service billings are less than the budget, the payer pays the difference between the billings and the budget to the Alternative Payment Entity; if the fee-for-service billings total more than the budget, the Alternative Payment Entity must return the difference to the payer.
  - ◆ **Hybrid Prospective/Retrospective Payment.** A third alternative is for a subset of the providers to be paid by the payer under the current payment systems; these payments would be deducted by the payer from the episode payment and then the balance would be paid to the Alternative Payment Entity. The remaining providers would no longer bill directly for their individual services but would be paid through the Alternative Payment Entity using the revenues from the episode payments.
- 6. Payment Amounts Stratified Based on Patient Needs.** The designated Alternative Payment Entity bills the payer for services to an eligible patient by choosing a code from a family of new bundled service codes. Each code would be defined based on patient characteristics that are expected to need combinations of services with similar total costs.<sup>15</sup>
  - 7. Outlier Payments and Risk Corridors for Patients with Unusually High Needs.** A supplemental payment (an outlier payment) would be made by the payer to the Alternative Payment Entity for patients who need an unusually large number of services during an episode. In addition, a supplemental payment (a risk corridor payment) would be made if an unusually large number of patients had above average needs for services during episodes.<sup>16</sup>
  - 8. Measurement of Appropriateness/Quality/Outcomes.** In order to ensure that patients continue to receive appropriate and high quality services under the episode payment arrangement, the participating providers would agree to document the application of appropriate use criteria (if such criteria exist) and/or to measure quality and/or outcomes for the patients and compare the measures to benchmarks.

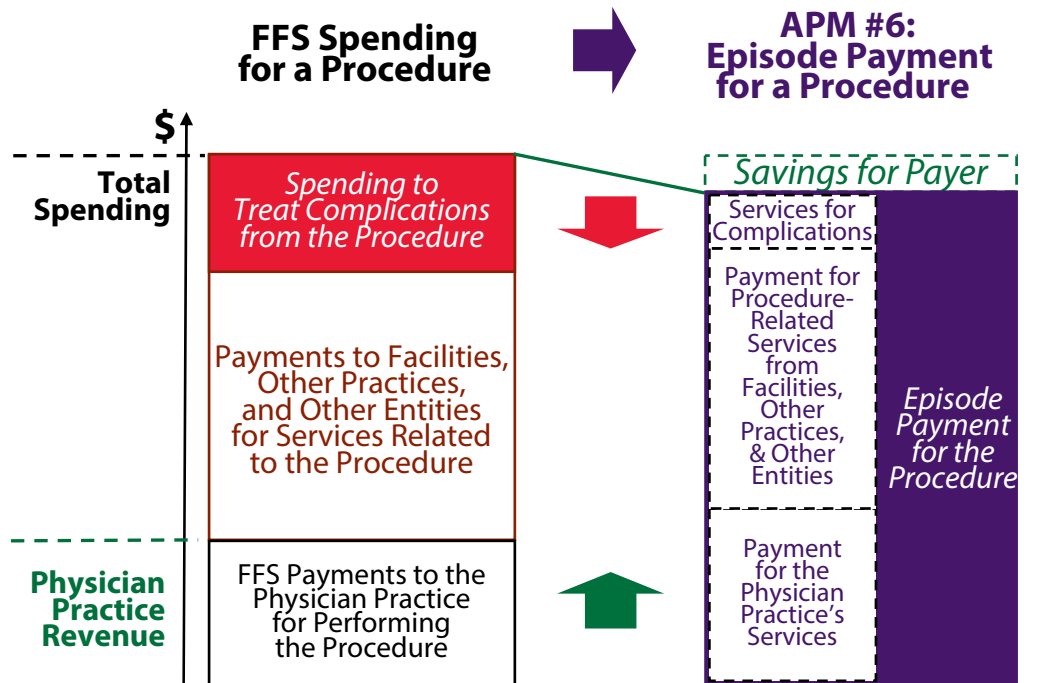
- 9. Adjustment of Payment Amounts Based on Performance.** The amounts paid for the episodes would be reduced if the providers failed to apply appropriate use criteria or if quality or outcome measures were significantly below benchmark levels.
- 10. Updating Payments Over Time.** The episode payment amounts would be increased each year based on inflation, and the payment amounts would be periodically adjusted based on an assessment of the costs of delivering the procedure or treatment to ensure that the payments are adequate but no higher than necessary.

**Benefits of the APM:**

- The patient would benefit by receiving more coordinated care and by the ability to receive different types or amounts of services than are possible under the current payment system.
- The payer would benefit by paying less for the episode payment than it would have expected to spend in total for all of the services delivered during the episode under the current payment and delivery system.
- The physician practice and other providers would benefit by having the flexibility to deliver care differently if it would reduce costs and complication rates and they could be paid more for delivering higher-quality, lower-cost care.

**Examples:**

- **Bundled Payment for Colonoscopy.** Under this APM, a gastroenterology practice would receive a single payment to cover all of the services associated with delivery of a screening colonoscopy – the services of the gastroenterologist performing the colonoscopy, the services of an anesthesiologist or nurse anesthetist if one was used, and the facility fee for the facility where the colonoscopy was performed. The payment would be the same regardless of which facility is used to perform the colonoscopy. The payment would also cover any repeat colonoscopies performed due to incomplete procedures or polypectomy bleeding. (The colonoscopy bundle developed by the American Gastroenterological Association includes all of these costs.<sup>17</sup>)
- **Episode Payment for Joint Surgery.** Under this APM, a surgery practice, Physician-Hospital Organization, or health system would receive a single payment (or a defined budget) for all of the costs involved in performing hip or knee surgery during an inpatient hospital admission, delivering rehabilitation services after surgery, and treating any post-operative complications. The payment amount would be higher for patients with comorbidities and functional limitations that would require more inpatient or post-acute care. The payment amount would be adjusted based on measures of quality and outcomes for the patients.<sup>18</sup>





# APM #7: CONDITION-BASED PAYMENT



## Goal of the APM:

Give physicians and other providers who are delivering care to patients for an acute or chronic condition the flexibility and accountability to deliver the most appropriate treatment for the patient's condition in a coordinated, efficient, high-quality manner.

## Components of the APM:

- 1. Payment Based on the Patient's Health Condition.** The physician practice (or an Alternative Payment Entity designated by the practice) can bill and be paid for managing the care of a specific health condition (or combination of conditions), rather than having payment tied to the delivery of specific procedures or treatments.
- 2. Payment Covering Multiple Treatment Options Delivered by the Physician and Other Providers.** The Condition-Based Payment covers all services delivered by the physician or by other providers that are related to the condition during a defined period of time. For an acute condition, the time period would end when the acute condition is resolved; for a chronic condition, a fixed time period could be defined (e.g., a month or a year) or the time period could end when the nature or severity of the patient's condition changes (e.g., the chronic condition becomes significantly more severe). The physician practice (or the Alternative Payment Entity receiving the payment) has the flexibility to use the payment for services that are currently eligible for fee-for-service payments, for services that are not currently eligible for payment, and for services delivered by individuals or organizations that are not currently eligible to be paid directly.
- 3. Patient Agreement to Use the Provider Team for Services Related to the Condition(s).** In order to receive the benefits of the more coordinated and flexible care, the patient would need to agree to only use the providers on the team participating in the Condition-Based Payment for all services related to their condition.
- 4. Payment Paid to an Alternative Payment Entity**
  - ◆ **Prospective Payment:** If the condition-based payment is paid "prospectively," the physician practice and other providers would no longer bill the payer for the services they deliver that are covered by the Condition-Based Payment, but they would instead be paid by the Alternative Payment Entity using the revenues that entity receives from the payer via the episode payment.
  - ◆ **Retrospective Reconciliation:** An alternative approach to implementing the Condition-Based Payment is "retrospective reconciliation." The Condition-Based Payment is treated as a budget, the providers continue to bill the payer for their individual services and they are paid by the payer under the existing payment systems, and those payments are totaled by the payer and compared to the budget. Then, if the fee-for-service billings are less than the budget, the payer pays the difference between the billings and the budget to the Alternative Payment Entity; if the fee-for-service billings
- total more than the budget, the Alternative Payment Entity must return the difference to the payer.
- ◆ **Hybrid Prospective/Retrospective Payment.** A third alternative is for a subset of the providers to be paid by the payer under the current payment systems; these payments would be deducted by the payer from the Condition-Based Payment and then the balance would be paid to the Alternative Payment Entity. The remaining providers would no longer bill directly for their individual services but would be paid through the Alternative Payment Entity using the revenues from the Condition-Based Payments.
- 5. Payment Amounts Stratified Based on Patient Needs.** The designated Alternative Payment Entity bills a payer for services to an eligible patient by choosing a code from a family of new "condition-based" codes. Each code would be defined to describe patients with characteristics who would be expected to need combinations of services with similar total costs, and the payment for each code would be based on the expected costs of services for patients with the characteristics associated with that code.
- 6. Outlier Payments and Risk Corridors for Patients with Unusually High Needs.** A supplemental payment (an outlier payment) would be made by the payer to the Alternative Payment Entity for patients who need an unusually large number of services to address the condition(s). In addition, a supplemental payment (a risk corridor payment) would be made if an unusually large number of patients had above average needs for services.
- 7. Measurement of Appropriateness/Quality/Outcomes.** In order to ensure that patients continue to receive appropriate and high quality services under the Condition-Based Payment arrangement, the Alternative Payment Entity would agree to document the application of appropriate use criteria (if such criteria exist) and/or to measure quality and/or outcomes for the patients and compare the measures to benchmarks.
- 8. Adjustment of Payment Amounts Based on Performance.** The Condition-Based Payment amounts would be reduced if the providers failed to apply appropriate use criteria or if quality or outcome measures were significantly below benchmark levels.
- 9. Updating Payments Over Time.** The Condition-Based Payment amounts would be increased each year based on inflation, and the payment amounts would be periodically adjusted based on an assessment of the costs of delivering care to the patients with the condition to ensure that the payments are adequate but no higher than necessary.

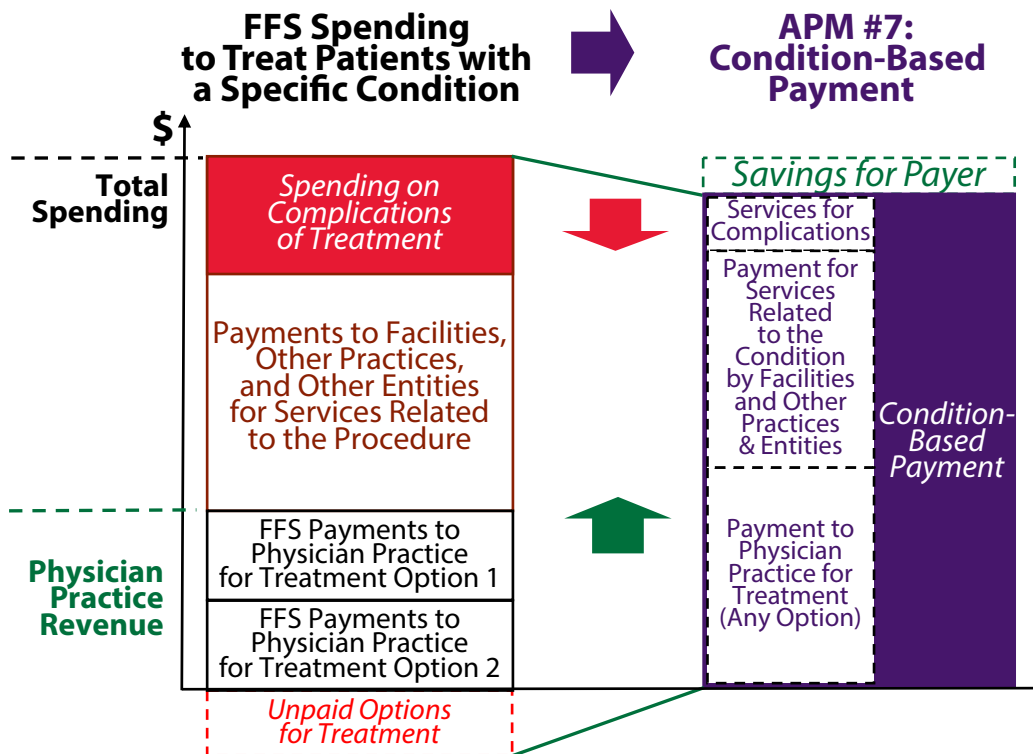
**Benefits of the APM:**

- The patient would benefit by receiving more coordinated care for their health problem and by the ability to receive different types or amounts of services than are possible under the current payment system.
- The payer would benefit by paying less for care of the patient’s condition than the payer would have expected to spend in total for all of the services delivered for the condition under the current payment system.
- The physician practice and other providers would benefit by having the flexibility to deliver care in ways that would reduce costs and complication rates and they could be paid more for delivering higher-quality, lower-cost care.

**Examples:**

• **Condition-Based Payment for Joint Osteoarthritis.** Under this APM, a physician practice (or an entity designated by the physician practice) would bill for and receive a payment for patients with serious osteoarthritis of the hip or knee. The physician practice would have the flexibility to use the payment for whatever types of service would achieve the greatest benefit for the patient, including physical therapy or surgery, and the practice would also have the flexibility to pay more or less for services than under existing payment systems. The amount of the payment would be higher for patients with more severe osteoarthritis, comorbidities, or other characteristics that would increase the likelihood that the patient would need more extensive or expensive services, but the payment would not be higher simply based on the type of services delivered, whether surgery was used, or the facilities used for services. Complication rates and patient-reported outcomes would be measured and reported, and payments would be reduced if these measures indicated poor quality of care.

- **Condition-Based Payment for Chronic Disease Management.** Under this APM, a primary care practice or a partnership between a primary care practice and specialty practice would bill for a monthly payment for management of a patient’s chronic disease, such as asthma, COPD, diabetes, or heart failure. The payment would cover all of the physicians’ services related to the chronic disease, including office visits, all tests and therapies ordered for treatment of the disease, and the costs of ED visits or hospital admissions for exacerbations of the disease. Payments would be risk-stratified based on the severity of the patient’s condition and other patient characteristics that would increase their need for services and the risk of exacerbations.<sup>19</sup>
- **Condition-Based Payment for Post-Acute Care Following a Hospitalization.** Under this APM, one payment would cover all of the post-acute care services needed following a hospitalization (e.g., for back surgery). Higher payments would be made for patients with characteristics that increase their need for more post-acute care services or higher-cost post-acute care settings, but the payment would not be higher simply based on the type of services delivered. The physician would have the flexibility to order different types of post-acute care than are available under the current payment system, e.g., if patients could safely be discharged to home with some short-term home care services, the physician and other providers who were managing the payment would have the flexibility to deliver and pay for those services even if they were not eligible for payment under current payment systems. Post-acute care providers could be paid more or less than current payment rates based on the actual costs of services for specific patients. Readmission rates and patient outcomes would be measured and payments would be reduced if these measures indicated a deterioration in the quality of care.<sup>20</sup>



# III. CHOOSING AN APPROPRIATE ALTERNATIVE PAYMENT MODEL



## A. Matching the APM to the Opportunities, Barriers, and Capabilities of Physician Practices

The “right” APM for a particular specialty or a particular physician practice in that specialty will depend on the types of patients and conditions that specialty cares for, the opportunities that exist for improving their care, the barriers the physicians face under the current payment system, and any barriers that exist that are unrelated to payment (e.g., restrictions in laws or regulations). Table 2 shows which APMs address specific improvement opportunities and payment barriers. In general, several different APMs could be used to address the same combination of opportunities and barriers, but one of the models may be more feasible for a particular physician practice given its size or relationships with other providers.

If simply paying for a service that is not currently paid for under the fee-for-service payment system could enable a physician practice to deliver significantly better care at lower overall cost, then APM #1 would be a sufficient payment reform to overcome the barriers that exist, and there would be no need to force the practice to find ways to manage a larger or more complex bundled payment. There are many ways in which the quality of healthcare can be improved and spending can be reduced through the actions of individual physician practices, and it is important that Medicare and other payers create both small and large APMs that enable all types of physician practices to improve care in ways that are feasible for those practices.

## B. Combining Multiple APMs

The seven APMs listed in this report can not only be used as individual payment models, but they can also be used as “building blocks” to create additional APMs. For example:

- if physicians from two different specialty practices are involved in delivering a procedure at a facility (e.g. a surgery practice and an anesthesiology practice that deliver surgeries at a hospital), a bundled payment could be created involving the two practices and the hospital; this Alternative Payment Model would combine the elements of both APM #3 (Multi-Physician Bundled Payment) and APM #4 (Physician-Facility Procedure Bundle).
- if a physician practice and hospital wanted to redesign an inpatient procedure in ways that would both reduce the costs of delivering the procedure and reduce the complication rate, they could create a bundled and warranted payment for the hospital procedure. This APM would combine the elements of APM #4 (Physician-Facility Procedure Bundle) and APM #5 (Warranted Payment for Physician Services). This might be more feasible for the physi-

cian practice and hospital to implement than the full Episode Payment defined in APM #6, since the latter would also require taking accountability for the costs of post-acute care services after discharge.

The biggest Alternative Payment Model of all – a risk-adjusted global payment – can be created by combining Condition-Based Payments (APM #7) for each type of patient health problem into a single overall structure. This enables using the most appropriate risk adjustment structures for each type of patient condition, rather than trying to create one single risk adjustment system that addresses all of the differences in needs for patients with diverse conditions.

## C. Using APMs for Provider Compensation Inside of Other APMs

Finally, the seven APMs in this report can also be used to help allocate payments in larger bundles among the participating providers in an appropriate way.<sup>21</sup> For example:

- If a physician practice or an Alternative Payment Entity accepts a Condition-Based Payment (APM #7) to manage care for a particular health problem, and if there is a choice of multiple procedures for treating the patient’s condition, the Alternative Payment Entity will need a way to pay the specific providers who deliver the specific procedure that the physician and patient choose to use. The Alternative Payment Entity could do this by defining Episode Payments for each procedure using APM #6, and using those Episode Payments to pay the providers who deliver the procedure the patient chooses.
- If a physician practice or an Alternative Payment Entity accepts an Episode Payment for a Procedure (APM #6), it could use the other APMs to pay individual providers (other physician practices or facilities) for the components of the episode that they deliver. For example, if an Episode Payment is defined for a hospital procedure that includes post-acute care services, a Physician-Facility Procedure Bundle (APM #4) could be used to pay the physician practice and the facility for the portion of the episode that is delivered in the hospital, and a Condition-Based Payment (APM #7) could be used to pay for the post-acute care portion of the episode.

If a physician practice or other provider organization is accepting a risk-adjusted global payment for a population of patients, it could use the revenues from that payment to make Condition-Based Payments to the physicians and other providers involved in managing the care of patients with different types of health problems. In this way, Physician-Focused Payment Models could help multiple physician practices work together to successfully form and manage Accountable Care Organizations.

**TABLE 2**

<b>Opportunity to Improve Care and Reduce Total Spending</b>	<b>Barrier(s) in the Current Payment System</b>	<b>Potential Solutions Through Alternative Payment Models</b>
Help patients better manage health problems and risk factors in ways that avoid the need for hospitalizations	Lack of payment or inadequate payment for proactive outreach, care management, rapid response to problems, and non-hospital treatment options	APM #1: Payment for a High-Value Service APM #2: Condition-Based Payment for Physician Services APM #3: Multi-Physician Bundled Payment APM #7: Condition-Based Payment
Reduce unnecessary testing and visits to specialists	Insufficient payment to allow time for good diagnosis  No payment to support phone or email contacts between physicians to develop good diagnoses and treatment plans	APM #1: Payment for a High-Value Service APM #2: Condition-Based Payment for Physician Services APM #3: Multi-Physician Bundled Payment
Use lower-cost procedures and services to treat patient conditions	Loss of physician revenue when fewer services or less-expensive services are performed, even though most costs and savings are associated with the corresponding payments to hospitals or other providers, not the physician practice	APM #2: Condition-Based Payment for Physician Services APM #7: Condition-Based Payment
Reduce the total cost of delivering a specific procedure or treatment in a hospital or other facility	Separate payments to the physician and hospital (or other facility) prevent compensating physicians for additional time or costs needed to reduce costs for the hospital/facility	APM #4: Physician-Facility Procedure Bundle
Use lower-cost providers or facilities for services ordered as part of treatment	Lack of payment or inadequate payment for use of lower-cost facilities or providers in conjunction with the physician’s treatment services	APM #4: Physician-Facility Procedure Bundle APM #6: Episode Payment for a Procedure APM #7: Condition-Based Payment
Reduce the number of avoidable complications and the cost of treating avoidable complications	Inadequate payment for services needed to prevent complications or reduce the cost of treating complications	APM #1: Payment for a High-Value Service APM #5: Warranted Payment for Physician Services APM #6: Episode Payment for a Procedure APM #7: Condition-Based Payment

# ENDNOTES



1. Yong PL, Saunders RS, Olsen L. The Healthcare Imperative: Lowering Costs and Improving Outcomes: Workshop Series Summary. Institute of Medicine. 2010. Available at <http://iom.nationalacademies.org/Reports/2011/The-Healthcare-Imperative-Lowering-Costs-and-Improving-Outcomes.aspx>.
2. For a more detailed discussion of the components needed for a successful Alternative Payment Model, see Miller HD. *The Building Blocks of Payment Reform: Designing Payment Systems that Support Higher-Value Health Care*, available at <http://www.chqpr.org/downloads/BuildingBlocksofSuccessfulPaymentReform.pdf>.
3. For a more detailed discussion of the problems with pay-for-performance, value-based purchasing, and shared savings programs, see Miller HD, *Measuring and Assigning Accountability for Healthcare Spending*, available at <http://www.chqpr.org/downloads/AccountabilityforHealthcareSpending.pdf>.
4. Under the Medicare Access and CHIP Reauthorization Act (MACRA), physicians' participation in Alternative Payment Models is measured based on the proportion of their revenues or patients associated with services furnished through an "Alternative Payment Entity." An Alternative Payment Entity is an entity that participates in an Alternative Payment Model and either (1) bears financial risk for monetary losses under the alternative payment model that are in excess of a nominal amount, or (2) is a medical home expanded under the statutory authority granted to the Center for Medicare and Medicaid Innovation.
5. American Society of Clinical Oncology, *Patient-Centered Oncology Payment: Payment Reform to Support Higher Quality, More Affordable Cancer Care*, May 2015. Available at: [http://www.asco.org/sites/www.asco.org/files/asco\\_patient-centered\\_oncology\\_payment\\_final\\_2.pdf](http://www.asco.org/sites/www.asco.org/files/asco_patient-centered_oncology_payment_final_2.pdf).
6. Although a payment model could be defined that bundles two or more services that are always delivered as part of a patient's treatment, this would not create any real flexibility or cost savings, since the combined payment would presumably be the same as the sum of the individual payments if the same combination of services is always provided.
7. If the out-of-pocket costs to the physician practice differed significantly for the different services (e.g., some used more expensive supplies or drugs than others), the Condition-Based Payment could be designed to cover only the physician's time for the different services, and smaller fee-for-service payments could continue to be made to cover the out-of-pocket costs the physician practice incurs to deliver the services. This would avoid financially penalizing the physician practice for choosing a service that would be less expensive for the payer but cost the practice more to deliver.
8. This is similar to what payers do today in paying a global surgical fee instead of paying separately for the surgical procedure and the surgeon's visits with patients after surgery.
9. This is different from traditional primary care capitation, which replaces all E&M payments for all patients and is not risk-adjusted or limited to chronic disease patients.
10. A more detailed description of how this APM could be structured to better support the work of primary care practices is included in *Patient-Centered Primary Care Payment*, which is available from the Center for Healthcare Quality and Payment Reform.
11. Falit BP, Chernew ME, Mantz, CA. Design and Implementation of Bundled Payment Systems for Cancer Care and Radiation Therapy. *International Journal of Radiation Oncology, Biology, and Physics* 89(5): 950-953, 2014.
12. See pages 15-16 of *Patient-Centered Oncology Payment: Payment Reform to Support Higher Quality, More Affordable Cancer Care*, *op cit*.
13. More detail on how this APM could be structured is included in *Provider Payment and Patient Benefits to Support SMART-Care*, which is available from the Center for Healthcare Quality and Payment Reform. More information on SMARTCare is available at <http://www.betterheartcare.org>
14. See Impaq International, *Evaluation of the Medicare Acute Care Episode (ACE) Demonstration*, May 31, 2013. Available at <https://downloads.cms.gov/files/cmmti/ACE-EvaluationReport-Final-5-2-14.pdf>.
15. The categories would be defined differently from the way Diagnosis Related Groups are defined, since they would need to capture differences in the types of post-acute care needed and in the risk of readmission as well as differences in the costs of inpatient care.
16. For a more detailed discussion of outlier payments and risk corridors in Alternative Payment Models, see *The Building Blocks of Payment Reform: Designing Payment Systems that Support Higher-Value Health Care*, available at <http://www.chqpr.org/downloads/BuildingBlocksofSuccessfulPaymentReform.pdf>
17. Brill JV et al. A Bundled Payment Framework for Colonoscopy Performed for Colorectal Cancer Screening or Surveillance. *Gastroenterology* 2014; 146:849-853.
18. For a detailed discussion of how to structure an Episode Payment for joint surgery, see *Bundling Better: How Medicare Should Pay for Comprehensive Care (for Hip and Knee Surgery and Other Healthcare Needs)*, available at <http://www.chqpr.org/downloads/BundlingBetter.pdf>.
19. More detail on how this APM could be structured to better support care of heart failure patients by cardiology practices and primary care practices is available in *Better Payment for Cardiovascular Care*, which is available from the Center for Healthcare Quality and Payment Reform.
20. Model 3 of the CMS Bundled Payments for Care Improvement (BPCI) program creates a virtual bundle for post-acute care costs and readmissions after discharge from an inpatient stay in a hospital. For more detail, see <https://innovation.cms.gov/initiatives/BPCI-Model-3/>.
21. Additional detail on how smaller bundled payments can be used as compensation structures for providers within larger Alternative Payment Models is available in *The Building Blocks of Payment Reform: Designing Payment Systems that Support Higher-Value Health Care*, available at <http://www.chqpr.org/downloads/BuildingBlocksofSuccessfulPaymentReform.pdf>.

## ABOUT THE AUTHORS:

**Harold D. Miller** is President and CEO of the Center for Healthcare Quality and Payment Reform. He also serves as Adjunct Professor of Public Policy and Management at Carnegie Mellon University and is a member of the U.S. Department of Health and Human Services Physician-Focused Payment Models Technical Advisory Committee. In previous positions, he served as CEO of the Network for Regional Healthcare Improvement, Associate Dean of the Heinz School of Public Policy and Management at Carnegie-Mellon University, and Director of the Pennsylvania Governor's Office of Policy Development.

**Sandra S. Marks** is Assistant Director of Federal Affairs at the American Medical Association. She previously served as Director of Physician Payment Systems at the AMA and Assistant Director of the Center for Health Services and Policy Research at Northwestern University.

# **Lunch/Breakout Session**

### **Breakout Session Instructions**

- Attendees will breakout into their MAC regions and the group lists can be found in the meeting binder. All groups will meet in the current meeting room. As you can see, you have already been arranged to sit with your region. Tables are marked by region and MAC.
- Each group will need to identify and appoint a facilitator. There will be a forty-five minute discussion period.
- Groups are asked to consider the below during their breakout discussion:
  - Ways to improve the CAC process and/or how communication can be improved in your region
- After forty-five minutes, the identified facilitator will be asked to provide a brief summary of his/her group's discussion.

**Region E (Noridian)**

Dr. Sabina Wallach  
Dr. Joseph Alvarnas  
Dr. Daniel Mirda  
Jose Gonzalez  
Dr. Warren Fong  
Dr. Heather Allen  
Dr. Arthur Lurvey

**Region F (Noridian)**

Dr. James Gajewski  
Dr. Latha Subramanian  
Tammy Thiel  
Liz Cleland  
Rise Cleland  
Dr. Xylina Gregg  
Dr. Gary Oakes

**Jurisdiction 5 (WPS)**

Dr. Roscoe Morton  
Dr. Mary Klir

**Jurisdiction 6 (WPS)**

Dr. Gary MacVicar  
Dr. Paul Fishkin

**Region H (Novitas)**

Dr. Debra Patt  
Dr. John Cox  
Dr. Debra Patterson  
Dr. Ray Page  
Dr. Todd Kliewer  
Mary Jo Richards  
Dr. Jose Najera  
Dr. Annette Fontaine

**Jurisdiction 8 (WPS)**

Dr. Samuel Silver  
Carol Christner  
Dr. Barry Whites

**Jurisdiction 15 (CGS)**

Dave Dillahunt  
Dr. Joel Saltzman  
Dr. Alan Lichtin  
Dr. Taral Patel

**Region J (Cahaba)**

Dr. Leonard Heffner  
Karen Beard  
Dr. Thom Mitchell

**Region K (NGS)**

Nathan Strunk  
Dr. Steve Allen  
Dr. Joseph DiBenedetto, Jr.  
Dr. Tracey Weisberg  
Dr. Michael Willen  
Dr. Eric Wong  
Dawn Holcombe  
Dr. Laurence Clark

**Region L (Novitas)**

Dr. Kenneth Adler  
Dr. Mark Pascal  
Dr. Eric Seifter  
Dr. Arturo Loaiza-Bonilla  
Dr. Paul Celano  
Dr. Sunil Lalla

**Region M (Palmetto)**

Dr. Kashyap Patel  
Dr. Quillin Davis  
Dr. Elaine Jeter  
Dr. Donald Fleming  
Dr. Steven Grubbs

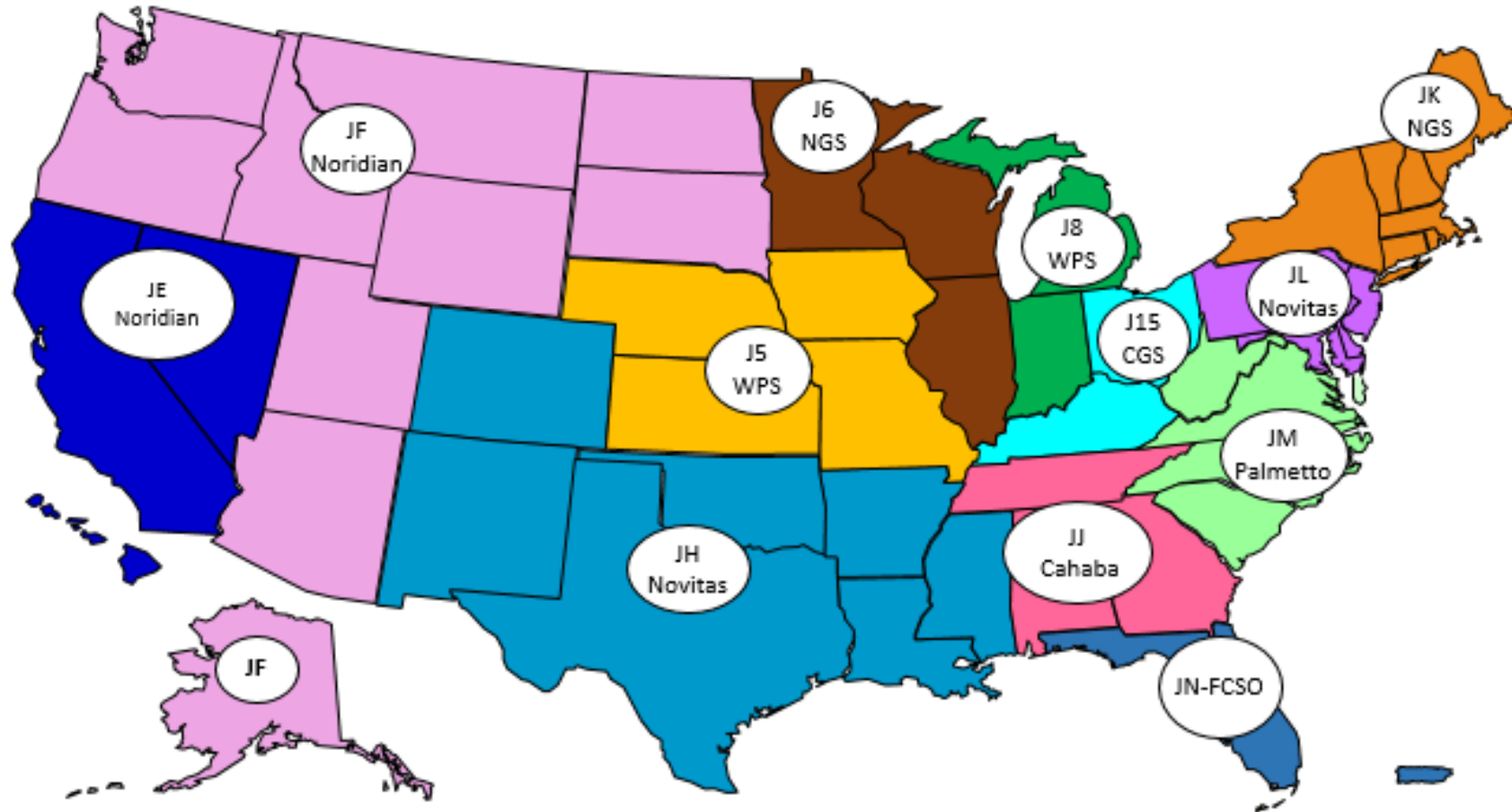
**Region N (FCSO)**

Dorothy Green Phillips  
Dr. Juan L. Schaening  
Dr. Tom Marsland

*Marci Cali (J5, J6, E, H, M)*  
*Nicole Dreabit (J5, J6, E, H, M)*  
*Mary Jo Richards (E, F, H, I)*  
*Dr. Matthew Cheung*



# A/B Jurisdiction Map as of December 2015



# Palliative Care

**Thomas J. Smith MD FACP, FASCO, FAAHPM**

Harry J. Duffey Family Professor of Palliative Medicine and  
Director of Palliative Medicine, Johns Hopkins Medical Institutions  
Professor of Oncology, Sidney Kimmel Comprehensive Cancer Center  
600 N. Wolfe Street, Blalock 369  
Baltimore, MD 21287-0005  
Phone 410-955-2091; Fax 410-955-2098; Cell 443-742-5978  
[tsmit136@jhmi.edu](mailto:tsmit136@jhmi.edu)

Training:

University of Akron, B.S., summa cum laude 1971-74  
Yale University School of Medicine, M.D. cum laude 1974-79  
Yale University School of Organization and Management (core curriculum, one year) 1977-78  
Special Visiting Fellow, National Cancer Center Biological Response Modifiers Program, Frederick, MD  
1986  
Virginia Commonwealth University Fellowship in Hematology/Oncology 1982-87  
Project on Death in America Faculty Scholar, 1995-98

Current position: Professor of Oncology, Sidney Kimmel Comprehensive Cancer Center of Johns Hopkins, and the Harry J. Duffey Family Professor of Palliative Medicine, and Director of Palliative Medicine, Johns Hopkins Medical Institutions, Baltimore, MD

Dr. Smith is a medical oncologist and palliative care specialist with a lifelong interest in better symptom management, open and accurate communication, and improving access to high quality affordable care. He is the Director of Palliative Medicine for Johns Hopkins Medicine, charged with integrating palliative care into all the Johns Hopkins venues, including a consult service, inpatient unit, clinics, home visiting program, and research. He attends on the Longcope Service of the Osler Medical Program.

Dr. Smith has a long track record of starting innovative programs with concurrent evaluation of their impact on quality and costs, including the Virginia Rural Cancer Outreach Program, the Thomas Palliative Care Program, the Virginia Initiative on Palliative Care, and the Rural Palliative Care Program, among others.

Dr. Smith received the national Humanism in Medicine Award in 2000, and in 2000 and 2006 was voted the Distinguished Clinician on the VCU-MCV Faculty. He has been recognized in "Best Doctors in America" for many years and is now a Baltimore "Top Doc". He is a Fellow in the American College of Physicians, the American Society of Clinical Oncology and the American Academy of Hospice and Palliative Medicine. In 2012 Bruce Hillner and he received the ABIM "Professionalism" Prize for their NEJM article "Bending the Cost Curve in Cancer Care" and leading the "Choosing Wisely" initiatives for AAHPM and ASCO. In 2015 he received the American Cancer Society Trish Greene Award for those "... who have accomplished outstanding research that benefits cancer patients and their families."

His current funded research includes an RO1 for a randomized trial of PC versus usual care for Phase I cancer patients (Betty Ferrell PI), PC for caregivers of those with HIV-AIDS, patient-decision aids that give truthful information, and "Scrambler Therapy" for chemotherapy-induced neuropathic pain.

# **Coverage with Evidence Development**



# Medicare Coverage and Evidence Development

James A. Rollins, M.D., M.S.H.A., Ph.D.  
Coverage Analysis Group  
Center for Medicare and Medicaid Services

## Disclosure Statement of Financial Interest

I, Jim Rollins, DO NOT have a financial interest/arrangement or affiliation with one or more organizations that could be perceived as a real or apparent conflict of interest in the context of the subject of this presentation.

## Medicare Construct

- Established by the Social Security Act of 1965, Title XVIII
  - §1862(a)(1) Notwithstanding any other provision of this title, no payment may be made under part A or part B for any expenses incurred for items or services—
  - (A) which, except for items and services described in a succeeding subparagraph or additional preventive services (as described in section 1395x(ddd)(1) of this title), are not **reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member**
  - (E) in the case of research conducted pursuant to §1142, which is not reasonable and necessary
- Defined benefit program
  - Beneficiaries
  - Providers
  - Settings

3

## FDA and CMS

### FDA

Safety: There is reasonable assurance that a device is safe when it can be determined, based upon valid scientific evidence, that the probable benefits to health from use of the device for its intended uses and conditions of use, when accompanied by adequate directions and warnings against unsafe use, outweigh any probable risks.

Effectiveness: There is reasonable assurance that a device is effective when it can be determined, based upon valid scientific evidence, that in a significant portion of the target population, the use of the device for its intended uses and conditions of use, when accompanied by adequate directions for use and warnings against unsafe use, will provide clinically significant results.

FDA regulation 21 CFR 860.7

### CMS

1862(a)(1)(A) Reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member.

Evidence-based Medicare coverage - clinically meaningful health outcomes, benefits and risks.

Diagnostic laboratory and imaging tests such as molecular biomarkers and PET scans – FDA approved, analytic validity, clinical validity, clinical utility.

4

## Reasonable & Necessary

- Sufficient level of confidence that the evidence is adequate to conclude that the item or service:
  - Improves health outcomes
  - Is generalizable to the Medicare population
  - Is generalizable to general provider community

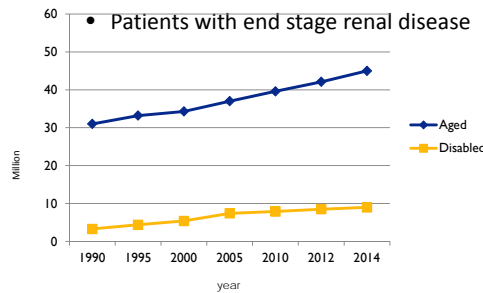
## Evidence Deficits

- No evidence
- Standard measures missing
- Short term follow-up to studies
- Lack of comparative effectiveness
- Generalizability for Medicare beneficiaries

# Evidence-based Medicare Coverage

- Coverage determinations address whether the evidence is sufficient to conclude that the item or service improves clinically meaningful health outcomes for the Medicare population

- Age ≥ 65 years
- Disabled individuals
- Patients with end stage renal disease



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# Value in Health Care



01/26/2015 Sylvia Mathews Burwell, HHS Secretary

Better Care,  
Smarter Spending,  
Healthier People

<http://www.hhs.gov/blog/2015/01/26/progress-towards-better-care-smarter-spending-healthier-people.html>



## Perspective

### Setting Value-Based Payment Goals — HHS Efforts to Improve U.S. Health Care

Sylvia M. Burwell

Now that the Affordable Care Act (ACA) has expanded health care coverage and made it affordable to many more Americans, we have the opportunity to shape the way care is delivered and improve the quality of care options, which helps to reduce the growth of health care costs. One of the most effective ways to do this is to focus on how we pay for care. We are working to set a health care system that is more patient-centered, more efficient, and more focused on the quality of care. We are also working to ensure that the ACA's new models for payment are being implemented in a way that is consistent with the ACA's goals. We are also working to ensure that the ACA's new models for payment are being implemented in a way that is consistent with the ACA's goals. We are also working to ensure that the ACA's new models for payment are being implemented in a way that is consistent with the ACA's goals.

The New England Journal of Medicine  
Downloaded from www.nejm.org by 129.17.129.10 on March 5, 2015. The copyright for this article has not been transferred.  
Copyright © 2015 Massachusetts Medical Society. All rights reserved.

Burwell SM. Setting value-based payment goals—HHS efforts to improve U.S. health care. N Engl J Med. 2015 Mar 5;372(10):897-9. PMID: 25622024

8



## Steps to Medicare Reimbursement (Part A & B)

- Regulatory approval (FDA)
- Benefit category determination
- Coverage (CMS/CAG)
- Coding (CMS/CM)
- Payment (CMS/CM)

9

## Benefit Category Determination Reimbursement under SSA §1861

- Hospital Services
- Physician Services or “incident to”
- Drugs and Biologicals that are not self-administered
  - Orals include some anticancer, antinausea and immunosuppressives following transplants
- Etc.

10

## National and local coverage determinations

### NCD

**Definition:** Determination by the Secretary with respect to whether or not a particular item or service is covered nationally under §1862(a)(1)(A).

**Prevention/Screening:** Reasonable and necessary for the prevention or early detection of illness or disability under §1861(ddd).

### LCD

**Definition:** Determination by a Medicare Administrative Contractor (MAC) with respect to whether or not a particular item or service is covered in the MAC jurisdictions under §1862(a)(1)(A).

**Prevention/Screening:** No authority

Most coverage decisions are made on local basis by the MACs.

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## NCD Definitions in SSA

1862(l)(6) National and local coverage determination defined.—For purposes of this subsection—

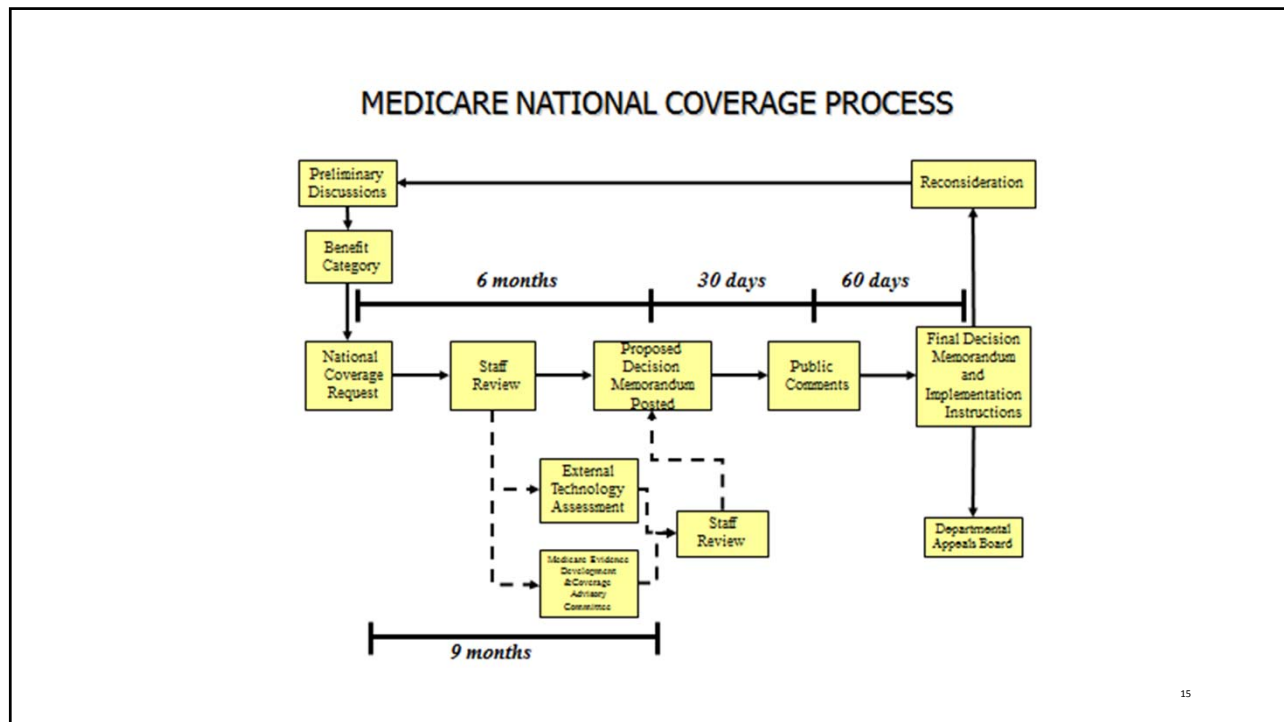
(A) National coverage determination.—The term “national coverage determination” means a determination by the Secretary with respect to whether or not **a particular item or service** is covered nationally under this title

## What prompts NCDs?

- External request (statutory)
  - Current national non-coverage policy
  - Substantial LCD variation
- Internally generated
  - Extensive literature or important new study
  - Technological advance with potential major clinical or economic impact
  - Major concerns about inappropriate use

## NCD Process

- Formal Request (30 day comment period)
- Benefit Category Determination
- Review of evidence by CMS
- Technology Assessment/MEDCAC
- Proposed Determination (30 day comment period)
- Final Determination posted on CMS Web site 60 days later



## MEDCAC

### Medicare Evidence Development Coverage Advisory Committee

- **Meets on controversial issues**
- **Votes only on the quality of the evidence and not on a coverage determination**
- **Not necessarily on NCDs**
  - **Usual Care of Chronic Wounds 2006**

## Medicare Evidence Development

1. Investigational Device Exemptions (IDE)
  - Regulation at 42 CFR 405.201
  - New centralized process
2. Clinical Trial Policy
  - Routine costs in clinical trials
  - National Coverage Determination (NCD) Manual, Pub 100-3, Section 310.1
3. Coverage with Evidence Development
  - Individual NCD policies

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## Coverage with Evidence Development

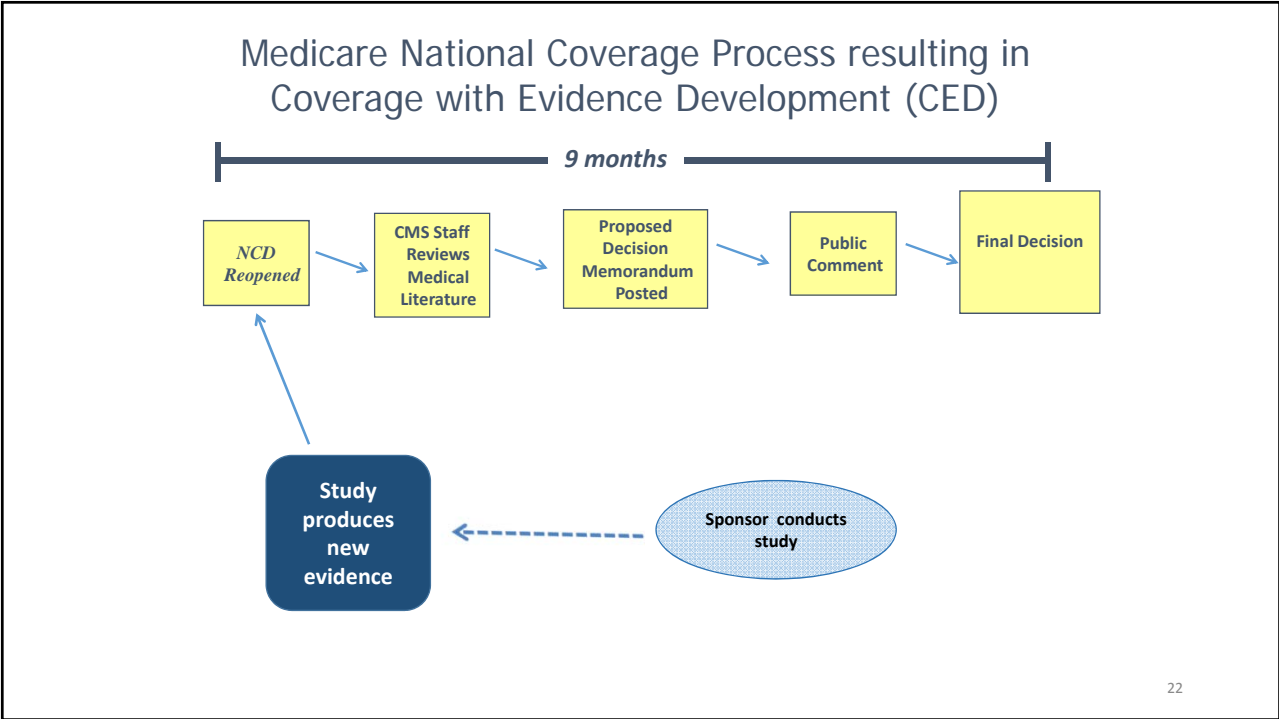
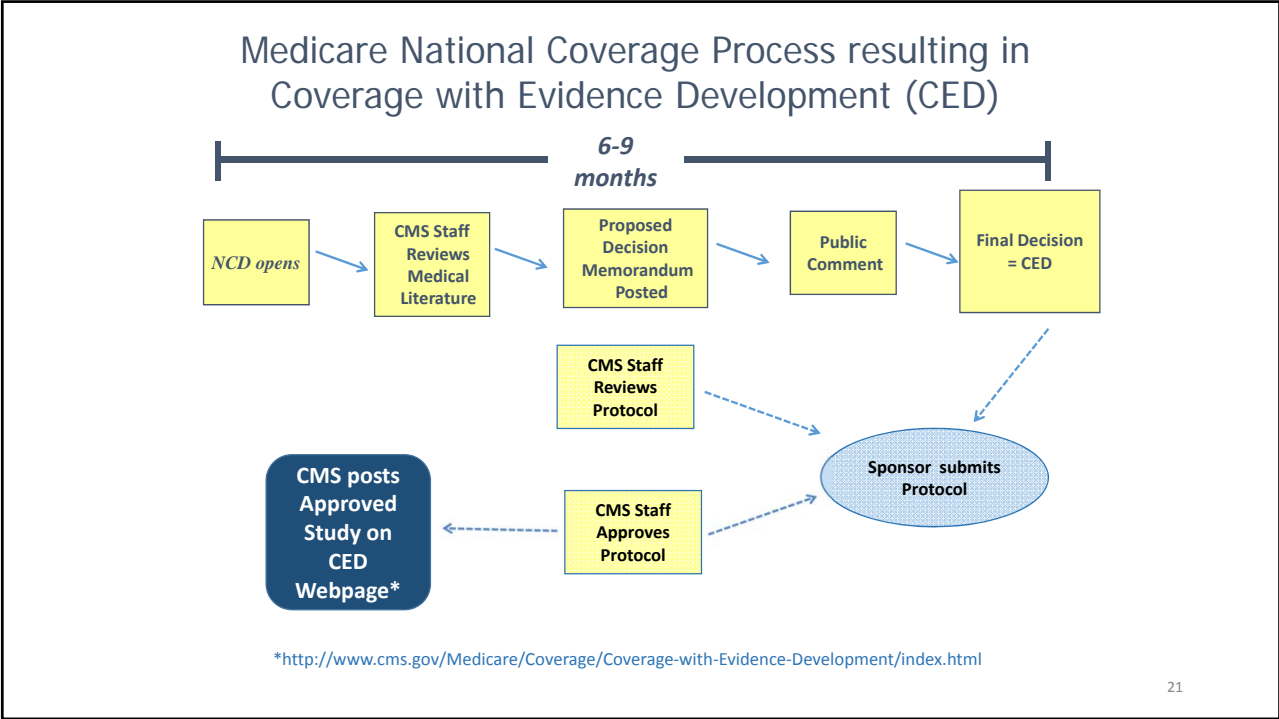
- In CED an item or service is only reasonable and necessary when it is provided within a research setting where there are added safety, patient protections, monitoring, and clinical expertise.
- Without CED, the service would not be covered.
- CED research may include a broader range of studies than randomized clinical trials – may include observational research and registries.
- An NCD requiring CED may be specific about the design, research questions, and outcomes required.

## #1. National Coverage Determinations (NCDs) requiring Coverage with Evidence Development

- CED is a paradigm whereby Medicare covers items and services on the condition that they are furnished in the context of approved clinical studies or with the collection of additional clinical data.
- In making coverage decisions involving CED, CMS decides after a formal review of the medical literature to cover an item or service only in the context of an approved clinical study or when additional clinical data are collected to assess the appropriateness of an item or service for use with a particular beneficiary.

## Coverage with Evidence Development

- Coverage in the context of approved clinical studies or with the collection of additional clinical data
- Allows for positive coverage when evidence is insufficient for a more favorable decision
- May involve randomized controlled trials, observational studies and registries
  - intervention,
  - benefits and harms,
  - health outcomes



## Coverage with Evidence Development (examples of CED studies)

- PET for Solid Tumor (Intended change in management)
- Protein-Rich Plasma for the Treatment of Chronic Wounds
- NaFl PET for Patients Suspected of Bony Metastasis (Improved Health Outcomes)
- Extracorporeal Photopheresis for the Treatment of Bronchiolitis Obliterans Syndrome Following Lung Transplant
- Pharmacogenomics Testing for Warfarin Response
- Allogeneic Stem Cell Transplants for Sickle Cell Disease, Myelofibrosis, Multiple Myeloma

## Health Outcomes of Interest

### *More Impressive*

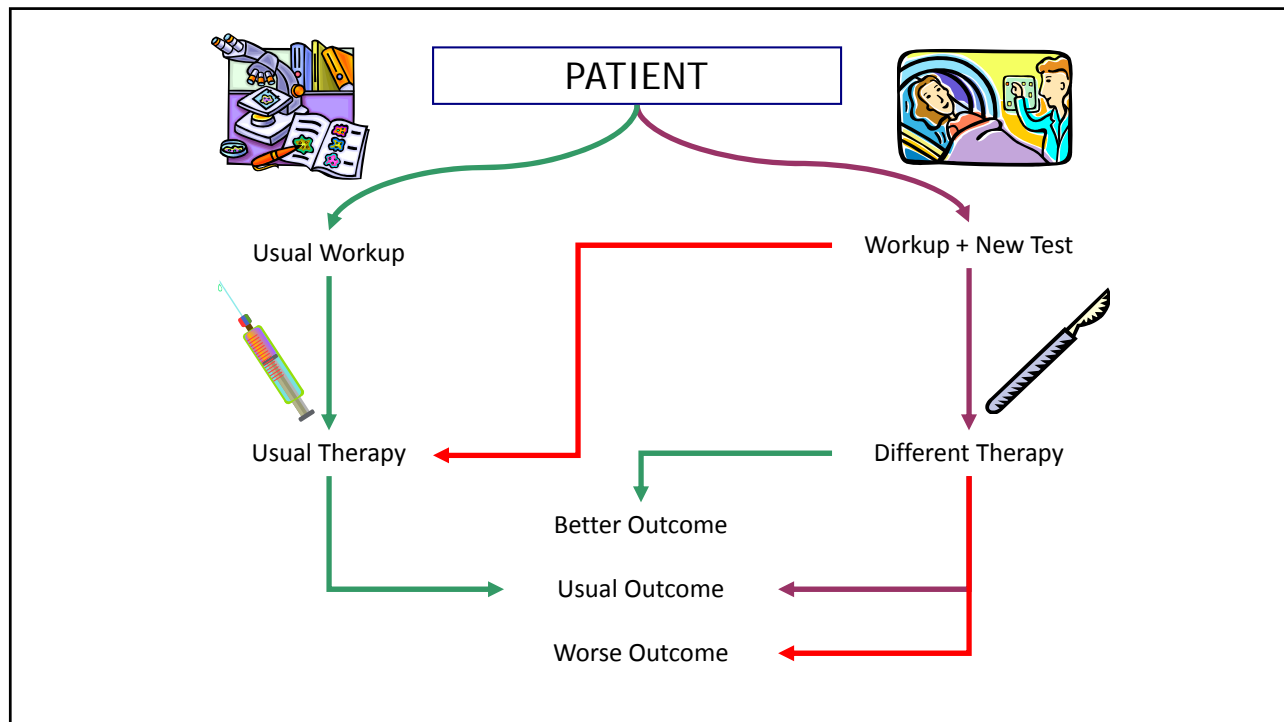
- Longer life and improved function/participation
- Longer life with arrested decline
- Significant symptom improvement allowing better function/participation
- Reduced need for burdensome tests and treatments

### *Less Impressive*

- Longer life with declining function/participation
- Improved disease-specific survival without improved overall survival
- Surrogate test result better
- Image looks better
- Doctor feels confident

*Medicare has stated publicly that as a matter of policy that it does not generally consider cost in making national coverage determinations.*





## Evidence-based Coverage of diagnostic tests

### Analytic Validity

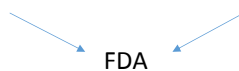
- **Technical performance**
- Ability to accurately and reliably measure the analyte or genotype of interest
- Sensitivity
- Specificity
- Assay robustness
- Quality control

### Clinical Validity

- **Strength of clinical correlation**
- Ability to accurately and reliably identify the disorder of interest
- Sensitivity
- Specificity
- Pos predictive value
- Neg predictive value

### Clinical Utility

- **Impact on health outcomes**
- Likelihood that using the test to guide management will significantly improve health outcomes
- Benefits vs harms
- Efficacy
- Effectiveness
- Value



<http://www.cdc.gov/genomics/gtesting/EGAPP/recommend/method.htm>

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***INNOVATORS'  
GUIDE TO  
NAVIGATING  
MEDICARE***

**Version 3  
2015**

[www.cms.gov/Medicare/Coverage/CouncilonTechInnov/Downloads/Innovators-Guide-Master-7-23-15.pdf](http://www.cms.gov/Medicare/Coverage/CouncilonTechInnov/Downloads/Innovators-Guide-Master-7-23-15.pdf)

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Thank You

Questions

# Meeting Wrap-up



American Society of Hematology  
[www.hematology.org](http://www.hematology.org)



American Society of Clinical Oncology  
*Making a world of difference in cancer care*

American Society of Clinical Oncology  
[www.asco.org](http://www.asco.org)

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## ASH/ASCO CAC Resources from CMS

- [Medicare's Program Integrity Manual, Chapter 13, which outlines the local coverage determinations, the Carrier Advisory Committee \(CAC\), and contractor responsibilities surrounding CACs](#)
- [General Information on CMS' Contracting Reform](#)
- [Medicare Administrative Contractors \(MAC\) Regions and updates](#)
- [Map of Current Jurisdictions](#)
- [Map of Consolidated Regions](#) (*what CMS is moving toward*)
- [Information on MAC Implementation](#) (*last updated January 2016*)
- [Durable Medical Equipment MACs](#)
- [Medicare Coverage](#)
- [Medicare Coverage Center](#)
- [Medicare Access & CHIP Reauthorization Act of 2015 \(MACRA\)](#)



## Ten Things Physicians and Patients Should Question

1

### **Don't transfuse more than the minimum number of red blood cell (RBC) units necessary to relieve symptoms of anemia or to return a patient to a safe hemoglobin range (7 to 8 g/dL in stable, non-cardiac in-patients).**

Transfusion of the smallest effective dose of RBCs is recommended because liberal transfusion strategies do not improve outcomes when compared to restrictive strategies. Unnecessary transfusion generates costs and exposes patients to potential adverse effects without any likelihood of benefit. Clinicians are urged to avoid the routine administration of 2 units of RBCs if 1 unit is sufficient and to use appropriate weight-based dosing of RBCs in children.

2

### **Don't test for thrombophilia in adult patients with venous thromboembolism (VTE) occurring in the setting of major transient risk factors (surgery, trauma or prolonged immobility).**

Thrombophilia testing is costly and can result in harm to patients if the duration of anticoagulation is inappropriately prolonged or if patients are incorrectly labeled as thrombophilic. Thrombophilia testing does not change the management of VTEs occurring in the setting of major transient VTE risk factors. When VTE occurs in the setting of pregnancy or hormonal therapy, or when there is a strong family history plus a major transient risk factor, the role of thrombophilia testing is complex and patients and clinicians are advised to seek guidance from an expert in VTE.

3

### **Don't use inferior vena cava (IVC) filters routinely in patients with acute VTE.**

IVC filters are costly, can cause harm and do not have a strong evidentiary basis. The main indication for IVC filters is patients with acute VTE and a contraindication to anticoagulation such as active bleeding or a high risk of anticoagulant-associated bleeding. Lesser indications that may be reasonable in some cases include patients experiencing pulmonary embolism (PE) despite appropriate, therapeutic anticoagulation, or patients with massive PE and poor cardiopulmonary reserve. Retrievable filters are recommended over permanent filters with removal of the filter when the risk for PE has resolved and/or when anticoagulation can be safely resumed.

4

### **Don't administer plasma or prothrombin complex concentrates for non-emergent reversal of vitamin K antagonists (i.e. outside of the setting of major bleeding, intracranial hemorrhage or anticipated emergent surgery).**

Blood products can cause serious harm to patients, are costly and are rarely indicated in the reversal of vitamin K antagonists. In non-emergent situations, elevations in the international normalized ratio are best addressed by holding the vitamin K antagonist and/or by administering vitamin K.

5

### **Limit surveillance computed tomography (CT) scans in asymptomatic patients following curative-intent treatment for aggressive lymphoma.**

CT surveillance in asymptomatic patients in remission from aggressive non-Hodgkin lymphoma may be harmful through a small but cumulative risk of radiation-induced malignancy. It is also costly and has not been demonstrated to improve survival. Physicians are encouraged to carefully weigh the anticipated benefits of post-treatment CT scans against the potential harm of radiation exposure. Due to a decreasing probability of relapse with the passage of time and a lack of proven benefit, CT scans in asymptomatic patients more than 2 years beyond the completion of treatment are rarely advisable.



## Ten Things Physicians and Patients Should Question

6

### Don't treat with an anticoagulant for more than three months in a patient with a first venous thromboembolism (VTE) occurring in the setting of a major transient risk factor.

Anticoagulation is potentially harmful and costly. Patients with a first VTE triggered by a major, transient risk factor such as surgery, trauma or an intravascular catheter are at low risk for recurrence once the risk factor has resolved and an adequate treatment regimen with anticoagulation has been completed. Evidence-based and consensus guidelines recommend three months of anticoagulation over shorter or longer periods of anticoagulation in patients with VTE in the setting of a reversible provoking factor. By ensuring a patient receives an appropriate regimen of anticoagulation, clinicians may avoid unnecessary harm, reduce health care expenses and improve quality of life. This *Choosing Wisely*® recommendation is not intended to apply to VTE associated with non-major risk factors (e.g., hormonal therapy, pregnancy, travel-associated immobility, etc.), as the risk of recurrent VTE in these groups is either intermediate or poorly defined.

7

### Don't routinely transfuse patients with sickle cell disease (SCD) for chronic anemia or uncomplicated pain crisis without an appropriate clinical indication.

Patients with SCD are especially vulnerable to potential harms from unnecessary red blood cell transfusion. In particular, they experience an increased risk of alloimmunization to minor blood group antigens and a high risk of iron overload from repeated transfusions. Patients with the most severe genotypes of SCD with baseline hemoglobin (Hb) values in the 7-10 g/dl range can usually tolerate further temporary reductions in Hb without developing symptoms of anemia. Many patients with SCD receive intravenous fluids to improve hydration when hospitalized for management of pain crisis, which may contribute to a decrease in Hb by 1-2 g/dL. Routine administration of red cells in this setting should be avoided. Moreover, there is no evidence that transfusion reduces pain due to vaso-occlusive crises. For a discussion of when transfusion is indicated in SCD, readers are referred to recent evidence-based guidelines from the National Heart, Lung, and Blood Institute (NHLBI) (see reference below).

8

### Don't perform baseline or routine surveillance computed tomography (CT) scans in patients with asymptomatic, early-stage chronic lymphocytic leukemia (CLL).

In patients with asymptomatic, early-stage CLL, baseline and routine surveillance CT scans do not improve survival and are not necessary to stage or prognosticate patients. CT scans expose patients to small doses of radiation, can detect incidental findings that are not clinically relevant but lead to further investigations and are costly. For asymptomatic patients with early-stage CLL, clinical staging and blood monitoring is recommended over CT scans.

9

### Don't test or treat for suspected heparin-induced thrombocytopenia (HIT) in patients with a low pre-test probability of HIT.

In patients with suspected HIT, use the "4T's" score to calculate the pre-test probability of HIT. This scoring system uses the timing and degree of thrombocytopenia, the presence or absence of thrombosis, and the existence of other causes of thrombocytopenia to assess the pre-test probability of HIT. HIT can be excluded by a low pre-test probability score (4T's score of 0-3) without the need for laboratory investigation. Do not discontinue heparin or start a non-heparin anticoagulant in these low-risk patients because presumptive treatment often involves an increased risk of bleeding, and because alternative anticoagulants are costly.

10

### Don't treat patients with immune thrombocytopenic purpura (ITP) in the absence of bleeding or a very low platelet count.

Treatment for ITP should be aimed at treating and preventing bleeding episodes and improving quality of life. Unnecessary treatment exposes patients to potentially serious treatment side effects and can be costly, with little expectation of clinical benefit. The decision to treat ITP should be based on an individual patient's symptoms, bleeding risk (as determined by prior bleeding episodes and risk factors for bleeding such as use of anticoagulants, advanced age, high-risk activities, etc.), social factors (distance from the hospital/travel concerns), side effects of possible treatments, upcoming procedures, and patient preferences. In the pediatric setting, treatment is usually not indicated in the absence of mucosal bleeding regardless of platelet count. In the adult setting, treatment may be indicated in the absence of bleeding if the platelet count is very low. However, ITP treatment is rarely indicated in adult patients with platelet counts greater than 30,000/microL unless they are preparing for surgery or an invasive procedure, or have a significant additional risk factor for bleeding. In patients preparing for surgery or other invasive procedures, short-term treatment may be indicated to increase the platelet count prior to the planned intervention and during the immediate post-operative period.

## How This List Was Created (1–5)

The American Society of Hematology (ASH) *Choosing Wisely*® Task Force utilized a modified Delphi technique to collect suggestions from committee members and recipients of its clinically focused newsletter, the *ASH Practice Update*. Respondents were asked to consider the core values of harm, cost, strength of evidence, frequency and control. Fifty-nine of 167 ASH committee members (35%) and 2 recipients of the *ASH Practice Update* submitted 81 unique suggestions. The Task Force used a nominal group technique (NGT) to identify the top 20 items, which were scored by ASH committee and practice community members, with a 46 percent participation rate. ASH's Task Force reviewed all scores to develop a 10-item list. A professional methodologist conducted a systematic literature review on each of the 10 items; the Task Force chair served as the second reviewer. Evidence reviews and source material for the 10 items were shared with ASH's Task Force, which ranked the items according to the core values. The Task Force then identified the top 5 items plus 1 alternate. ASH member content experts provided external validation for the veracity and clarity of the items.

## How this List was Created (6–10)

Suggestions for the second ASH *Choosing Wisely* list were solicited from members of the ASH Committee on Practice, the ASH Committee on Quality, the ASH *Choosing Wisely* Task Force, ASH Consult-a-Colleague volunteers and members of the ASH Practice Partnership. Six principles were used to prioritize items: avoiding harm to patients, producing evidence-based recommendations, considering both the cost and frequency of tests and treatments, making recommendations in the clinical purview of the hematologist, and considering the potential impact of recommendations. Harm avoidance was established as the campaign's preeminent guiding principle. Guided by the 6 principles, the ASH *Choosing Wisely* Task Force scored all suggestions. Modified group technique was used to select 10 semi-finalist items. Systematic reviews of the literature were then completed for each of the 10 semi-finalist items. Guided by the 6 core principles outlined above, and by the systematic reviews of the evidence, the ASH *Choosing Wisely* Task Force selected 5 recommendations for inclusion in ASH's second *Choosing Wisely* Campaign.

ASH's disclosure and conflict of interest policy can be found at [www.hematology.org](http://www.hematology.org).

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### About the ABIM Foundation

The mission of the ABIM Foundation is to advance medical professionalism to improve the health care system. We achieve this by collaborating with physicians and physician leaders, medical trainees, health care delivery systems, payers, policymakers, consumer organizations and patients to foster a shared understanding of professionalism and how they can adopt the tenets of professionalism in practice.

To learn more about the ABIM Foundation, visit [www.abimfoundation.org](http://www.abimfoundation.org).



### About the American Society of Hematology

The American Society of Hematology (ASH) is the world's largest professional society of hematologists, serving more than 14,000 clinicians and scientists from around the world who are dedicated to furthering the understanding, diagnosis, treatment and prevention of disorders affecting the blood.

For more than 50 years, the Society has led the development of hematology as a discipline by promoting research, patient care, education, training and advocacy in hematology. By providing a forum for clinicians and scientists to share the latest discoveries in the field, ASH is helping to improve care and possibly lead to cures for diseases that affect millions of people, including leukemia, lymphoma, myeloma, anemias and various bleeding and clotting disorders.

For more information, visit [www.hematology.org](http://www.hematology.org).



For more information or to see other lists of Five Things Physicians and Patients Should Question, visit [www.choosingwisely.org](http://www.choosingwisely.org).



# Non-ASH Choosing Wisely<sup>®</sup> Recommendations of Relevance to Hematology



An initiative of the ABIM Foundation



American  
Society of  
Hematology

ACR

## Don't image for suspected PE without moderate or high pre-test probability of PE.

While deep vein thrombosis (DVT) and PE are relatively common clinically, they are rare in the absence of elevated blood D-Dimer levels and certain specific risk factors. Imaging, particularly computed tomography (CT) pulmonary angiography, is a rapid, accurate, and widely available test, but has limited value in patients who are very unlikely, based on serum and clinical criteria, to have significant value. Imaging is helpful to confirm or exclude PE only for such patients, not for patients with low pre-test probability of PE. *Source: American College of Radiology (ACR). Wording reflects that of the Radiology recommendation, other societies have similar recommendations, some explicitly recommended D-Dimer testing prior to imaging.*

ASRM

## Don't routinely order thrombophilia testing on patients undergoing a routine infertility evaluation.

There is no indication to order these tests, and there is no benefit to be derived in obtaining them in someone that does not have any history of bleeding or abnormal clotting and in the absence of any family history. This testing is not a part of the infertility workup. Furthermore, the testing is costly, and there are risks associated with the proposed treatments, which would also not be indicated in this routine population. *Source: American Society for Reproductive Medicine (ASRM).*

SHM

## Don't perform repetitive CBC and chemistry testing in the face of clinical and lab stability.

Hospitalized patients frequently have considerable volumes of blood drawn (phlebotomy) for diagnostic testing during short periods of time. Phlebotomy is highly associated with changes in hemoglobin and hematocrit levels for patients and can contribute to anemia. This anemia, in turn, may have significant consequences, especially for patients with cardiorespiratory diseases. Additionally, reducing the frequency of daily unnecessary phlebotomy can result in significant cost savings for hospitals. *Source: Society for Hospital Medicine – Adult Hospital Medicine (SHM). Wording reflects that of the Adult Hospital Medicine recommendation; other societies have similar recommendations.*

AABB

## Don't transfuse red blood cells for iron deficiency without hemodynamic instability.

Blood transfusion has become a routine medical response despite cheaper and safer alternatives in some settings. Pre-operative patients with iron deficiency and patients with chronic iron deficiency without hemodynamic instability (even with low hemoglobin levels) should be given oral and/or intravenous iron. *Source: American Association of Blood Banks (AABB).*

ASCO

## Avoid using positron emission tomography (PET) or PET-CT scanning as part of routine follow-up care to monitor for a cancer recurrence in asymptomatic patients who have finished initial treatment to eliminate the cancer unless there is high-level evidence that such imaging will change the outcome.

PET and PET-CT are used to diagnose, stage and monitor how well treatment is working. Available evidence from clinical studies suggests that using these tests to monitor for recurrence does not improve outcomes and therefore generally is not recommended for this purpose. False positive tests can lead to unnecessary and invasive procedures, overtreatment, unnecessary radiation exposure and incorrect diagnoses. Until high level evidence demonstrates that routine surveillance with PET or PET-CT scans helps prolong life or promote well-being after treatment for a specific type of cancer, this practice should not be done. *Source: American Society of Clinical Oncology (ASCO).*

## The Purpose of This List

Starting in early 2015, the ASH Choosing Wisely Task Force launched a review of all existing Choosing Wisely items to identify recommendations published by other professional societies that are highly relevant and important to the practice of hematology. Using a carefully administered methodology, items were scored for relevance and importance over a series of iterations, resulting in a list of items that were deemed to be especially useful to hematologists. The items in this list represent the top five highest-scoring items. The full list of items is available on the ASH website at [www.hematology.org/choosingwisely](http://www.hematology.org/choosingwisely).

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## How this List Was Created (Non-ASH Recommendations)

A two-phase process was developed to identify and rank non-ASH Choosing Wisely recommendations of relevance to hematologists. First, the ASH Choosing Wisely Task Force independently scored all published ABIM Foundation Choosing Wisely recommendations on the MORE reliability scale, a validated seven-point Likert scale used to assess medical relevance. Modified group technique was used to identify the top 50 unique non-ASH Choosing Wisely recommendations with regard to relevance. Overlapping recommendations from different societies were grouped together as one recommendation. Taking into consideration the core values of harm, cost, strength of evidence, frequency, relevance, and impact, the ASH Choosing Wisely Task Force was asked to score each of the remaining 50 Choosing Wisely recommendations between 1 and 10 for prioritization for inclusion on ASH's top 10 list of non-ASH Choosing Wisely recommendations. Harm avoidance was established as the campaign's preeminent guiding principle. Modified group technique was used to select the top 10 non-ASH Choosing Wisely recommendations of relevance and importance to hematologists and their patients, with the top five highest-ranked items presented in this list.

ASH's disclosure and conflict of interest policy can be found at [www.hematology.org](http://www.hematology.org).

These items are provided solely for informational purposes and are not intended as a substitute for consultation with a medical professional. Patients with any specific questions about the items on this list or their individual situation should consult their physician.

Released December 2, 2015.

For more information or to see other lists of Five Things Physicians and Patients Should Question, visit [www.choosingwisely.org](http://www.choosingwisely.org).

## Five Things Physicians and Patients Should Question

The American Society of Clinical Oncology (ASCO) is a medical professional oncology society committed to conquering cancer through research, education, prevention and delivery of high-quality patient care. ASCO recognizes the importance of evidence-based cancer care and making wise choices in the diagnosis and management of patients with cancer. After careful consideration by experienced oncologists, ASCO highlights ten categories of tests, procedures and/or treatments whose common use and clinical value are not supported by available evidence. These test and treatment options should not be administered unless the physician and patient have carefully considered if their use is appropriate in the individual case. As an example, when a patient is enrolled in a clinical trial, these tests, treatments and procedures may be part of the trial protocol and therefore deemed necessary for the patient's participation in the trial.

These items are provided solely for informational purposes and are not intended to replace a medical professional's independent judgment or as a substitute for consultation with a medical professional. Patients with any specific questions about the items on this list or their individual situation should consult their health care provider. New evidence may emerge following the development of these items. ASCO is not responsible for any injury or damage arising out of or related to any use of these items or to any errors or omissions.

1

### Don't use cancer-directed therapy for solid tumor patients with the following characteristics: low performance status (3 or 4), no benefit from prior evidence-based interventions, not eligible for a clinical trial, and no strong evidence supporting the clinical value of further anti-cancer treatment.

- Studies show that cancer directed treatments are likely to be ineffective for solid tumor patients who meet the above stated criteria.
- Exceptions include patients with functional limitations due to other conditions resulting in a low performance status or those with disease characteristics (e.g., mutations) that suggest a high likelihood of response to therapy.
- Implementation of this approach should be accompanied with appropriate palliative and supportive care.

2

### Don't perform PET, CT, and radionuclide bone scans in the staging of early prostate cancer at low risk for metastasis.

- Imaging with PET, CT, or radionuclide bone scans can be useful in the staging of specific cancer types. However, these tests are often used in the staging evaluation of low-risk cancers, despite a lack of evidence suggesting they improve detection of metastatic disease or survival.
- Evidence does not support the use of these scans for staging of newly diagnosed low grade carcinoma of the prostate (Stage T1c/T2a, prostate-specific antigen (PSA) <10 ng/ml, Gleason score less than or equal to 6) with low risk of distant metastasis.
- Unnecessary imaging can lead to harm through unnecessary invasive procedures, over-treatment, unnecessary radiation exposure, and misdiagnosis.

3

### Don't perform PET, CT, and radionuclide bone scans in the staging of early breast cancer at low risk for metastasis.

- Imaging with PET, CT, or radionuclide bone scans can be useful in the staging of specific cancer types. However, these tests are often used in the staging evaluation of low-risk cancers, despite a lack of evidence suggesting they improve detection of metastatic disease or survival.
- In breast cancer, for example, there is a lack of evidence demonstrating a benefit for the use of PET, CT, or radionuclide bone scans in asymptomatic individuals with newly identified ductal carcinoma in situ (DCIS), or clinical stage I or II disease.
- Unnecessary imaging can lead to harm through unnecessary invasive procedures, over-treatment, unnecessary radiation exposure, and misdiagnosis.

4

### Don't perform surveillance testing (biomarkers) or imaging (PET, CT, and radionuclide bone scans) for asymptomatic individuals who have been treated for breast cancer with curative intent.

- Surveillance testing with serum tumor markers or imaging has been shown to have clinical value for certain cancers (e.g., colorectal). However for breast cancer that has been treated with curative intent, several studies have shown there is no benefit from routine imaging or serial measurement of serum tumor markers in asymptomatic patients.
- False-positive tests can lead to harm through unnecessary invasive procedures, over-treatment, unnecessary radiation exposure, and misdiagnosis.

5

### Don't use white cell stimulating factors for primary prevention of febrile neutropenia for patients with less than 20 percent risk for this complication.

- ASCO guidelines recommend using white cell stimulating factors when the risk of febrile neutropenia, secondary to a recommended chemotherapy regimen, is approximately 20 percent and equally effective treatment programs that do not require white cell stimulating factors are unavailable.
- Exceptions should be made when using regimens that have a lower chance of causing febrile neutropenia if it is determined that the patient is at high risk for this complication (due to age, medical history, or disease characteristics).

## Five More Things Physicians and Patients Should Question

6

### Don't give patients starting on a chemotherapy regimen that has a low or moderate risk of causing nausea and vomiting antiemetic drugs intended for use with a regimen that has a high risk of causing nausea and vomiting.

- Over the past several years, a large number of effective drugs with fewer side effects have been developed to prevent nausea and vomiting from chemotherapy. When successful, these medications can help patients avoid spending time in the hospital, improve their quality of life and lead to fewer changes in the chemotherapy regimen.
- Oncologists customarily use different antiemetic drugs depending on the likelihood (low, moderate or high) for a particular chemotherapy program to cause nausea and vomiting. For chemotherapy programs that are likely to produce severe and persistent nausea and vomiting, there are new agents that can prevent this side effect. However, these drugs are very expensive and not devoid of side effects. For this reason, these drugs should be used only when the chemotherapy drugs that have a high likelihood of causing severe or persistent nausea and vomiting.
- When using chemotherapy that is less likely to cause nausea and vomiting, there are other effective drugs available at a lower cost.

7

### Don't use combination chemotherapy (multiple drugs) instead of chemotherapy with one drug when treating an individual for metastatic breast cancer unless the patient needs a rapid response to relieve tumor-related symptoms.

- Although chemotherapy with multiple drugs, or combination chemotherapy, for metastatic breast cancer may slow tumor growth for a somewhat longer time than occurs when treating with a single agent, use of combination chemotherapy has not been shown to increase overall survival. In fact, the trade-offs of more frequent and severe side effects may have a net effect of worsening a patient's quality of life, necessitating a reduction in the dose of chemotherapy.
- Combination chemotherapy may be useful and worth the risk of more side effects in situations in which the cancer burden must be reduced quickly because it is causing significant symptoms or is life threatening. As a general rule, however, giving effective drugs one at a time lowers the risk of side effects, may improve a patient's quality of life, and does not typically compromise overall survival.

8

### Avoid using PET or PET-CT scanning as part of routine follow-up care to monitor for a cancer recurrence in asymptomatic patients who have finished initial treatment to eliminate the cancer unless there is high-level evidence that such imaging will change the outcome.

- PET and PET-CT are used to diagnose, stage and monitor how well treatment is working. Available evidence from clinical studies suggests that using these tests to monitor for recurrence does not improve outcomes and therefore generally is not recommended for this purpose.
- False positive tests can lead to unnecessary and invasive procedures, overtreatment, unnecessary radiation exposure and incorrect diagnoses.
- Until high level evidence demonstrates that routine surveillance with PET or PET-CT scans helps prolong life or promote well-being after treatment for a specific type of cancer, this practice should not be done.

9

### Don't perform PSA testing for prostate cancer screening in men with no symptoms of the disease when they are expected to live less than 10 years.

- Since PSA levels in the blood have been linked with prostate cancer, many doctors have used repeated PSA tests in the hope of finding "early" prostate cancer in men with no symptoms of the disease. Unfortunately, PSA is not as useful for screening as many have hoped because many men with prostate cancer do not have high PSA levels, and other conditions that are not cancer (such as benign prostate hyperplasia) can also increase PSA levels.
- Research has shown that men who receive PSA testing are less likely to die specifically from prostate cancer. However when accounting for deaths from all causes, no lives are saved, meaning that men who receive PSA screening have not been shown to live longer than men who do not have PSA screening. Men with medical conditions that limit their life expectancy to less than 10 years are unlikely to benefit from PSA screening as their probability of dying from the underlying medical problem is greater than the chance of dying from asymptomatic prostate cancer.

10

### Don't use a targeted therapy intended for use against a specific genetic aberration unless a patient's tumor cells have a specific biomarker that predicts an effective response to the targeted therapy.

- Unlike chemotherapy, targeted therapy can significantly benefit people with cancer because it can target specific gene products, i.e., proteins that cancer cells use to grow and spread, while causing little or no harm to healthy cells. Patients who are most likely to benefit from targeted therapy are those who have a specific biomarker in their tumor cells that indicates the presence or absence of a specific gene alteration that makes the tumor cells susceptible to the targeted agent.
- Compared to chemotherapy, the cost of targeted therapy is generally higher, as these treatments are newer, more expensive to produce and under patent protection. In addition, like all anti-cancer therapies, there are risks to using targeted agents when there is no evidence to support their use because of the potential for serious side effects or reduced efficacy compared with other treatment options.

# Abbreviations

CT, computed tomography; DCIS, ductal carcinoma in situ; PET, positron emission tomography; PSA, prostate-specific antigen.

## How This List Was Created (1–5)

The American Society of Clinical Oncology (ASCO) has had a standing Cost of Cancer Care Task Force since 2007. The role of the Task Force is to assess the magnitude of rising costs of cancer care and develop strategies to address these challenges. In response to the 2010 *New England Journal of Medicine* article by Howard Brody, MD, “Medicine’s Ethical Responsibility for Health Care Reform – the Top Five List,” a subcommittee of the Cost of Cancer Care Task Force began work to identify common practices in oncology that were both common as well as lacking sufficient evidence for widespread use. Upon joining the Choosing Wisely campaign, the members of the subcommittee conducted a literature search to ensure the proposed list of items were supported by available evidence in oncology; ultimately the proposed Top Five list was approved by the full Task Force. The initial draft list was then presented to the ASCO Clinical Practice Committee, a group composed of community-based oncologists as well as the presidents of the 48 state/regional oncology societies in the United States. Advocacy groups were also asked to weigh in to ensure the recommendations would achieve the dual purpose of increasing physician-patient communication and changing practice patterns. A plurality of more than 200 clinical oncologists reviewed, provided input and supported the list. The final Top Five list in oncology was then presented to, discussed and approved by the Executive Committee of the ASCO Board of Directors and published in the *Journal of Clinical Oncology*. ASCO’s disclosure and conflict of interest policies can be found at [www.asco.org](http://www.asco.org).

## How This List Was Created (6–10)

To guide ASCO in developing this list, suggestions were elicited from current ASCO committee members (approximately 700 individuals); 115 suggestions were received. After removing duplicates, researching the literature and discussing practice patterns, the Value in Cancer Care Task Force culled the list to 11 items, which comprised an ASCO Top Five voting slate that was sent back to the membership of all standing committees. Approximately 140 oncologists from its leadership cadre voted, providing ASCO with an adequate sample size and perspective on what oncologists find to be of little value. The list was reviewed and finalized by the Value in Cancer Care Task Force and ultimately reviewed and approved by the ASCO Board of Directors and published in the *Journal of Clinical Oncology*. ASCO’s disclosure and conflict of interest policies can be found at [www.asco.org](http://www.asco.org).

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### About the ABIM Foundation

The mission of the ABIM Foundation is to advance medical professionalism to improve the health care system. We achieve this by collaborating with physicians and physician leaders, medical trainees, health care delivery systems, payers, policymakers, consumer organizations and patients to foster a shared understanding of professionalism and how they can adopt the tenets of professionalism in practice.

To learn more about the ABIM Foundation, visit [www.abimfoundation.org](http://www.abimfoundation.org).



### About the American Society of Clinical Oncology

The American Society of Clinical Oncology (ASCO) is the world's leading professional organization representing physicians who care for people with cancer. With more than 30,000 members, ASCO is committed to improving cancer care through scientific meetings, educational programs and peer-reviewed journals. ASCO is supported by its affiliate organization, the Conquer Cancer Foundation, which funds ground-breaking research and programs that make a tangible difference in the lives of people with cancer. ASCO's membership is comprised of clinical oncologists from all oncology disciplines and sub-specialties including medical oncology, therapeutic radiology, surgical oncology, pediatric oncology, gynecologic oncology, urologic oncology, and hematology; physicians and health care professionals participating in approved oncology training programs; oncology nurses; and other health care practitioners with a predominant interest in oncology.

For more information, please visit [www.asco.org](http://www.asco.org).



American Society of Clinical Oncology



## American Society of Hematology's Practice-Related Resources

ASH offers a wide range of practice-related resources on its website ([www.hematology.org](http://www.hematology.org)). Below, please find a list of resources that may be of interest to you.

### **Resources for Clinicians Section on the ASH Website** (<http://www.hematology.org/Clinicians/>)

This page on the ASH website consolidates information for practitioners and provides the following links:

- **[ASH Practice Partnership](#)** – The ASH Practice Partnership (APP) is a group within the Society that was formed to better represent the interests of practicing hematologists. The APP is comprised of practicing hematologists from across the nation; participants must be board-certified in hematology and active members of ASH. Ideal candidates should be interested in malignant and nonmalignant hematology.
- **[Evidence-based Guidelines, Quick Reference Tools, Including Mobile Downloads](#)** – Access guidelines on the management and treatment of Sickle Cell Disease, Idiopathic Thrombocytopenic Purpura, Antithrombotic Drug Dosing and Management, Heparin-Induced Thrombocytopenia (HIT), Immune Thrombocytopenia (ITP), von Willebrand Disease, Red Blood Cell Transfusion, and Thrombocytopenia in Pregnancy.
- **[The ASH Choosing Wisely List](#)** – Evidence-based recommendations about the necessity and potential harm of certain practices developed as part of Choosing Wisely®, an initiative of the ABIM Foundation.
- **[The ASH Academy](#)** – The ASH Academy provides hematologists with easy-to-use options for knowledge testing (for both MOC and CME purposes), completing practice improvement modules, as well as evaluating ASH meetings you attend and claiming CME credit for participating. The sixth edition of the ASH Self-Assessment Program (ASH-SAP) is also available on the ASH Academy.
- **[ASH On Demand](#)** – ASH On Demand is multimedia platform in which users can browse, purchase, and view a variety of ASH educational content. The portal includes PowerPoint slides, audio, and/or video from a number of ASH-wide programs – including annual meetings, regional meetings, and webinars.
- **[Drug Resources](#)** – Links to patient assistance programs and sample letters of appeal for high-cost drugs, links to REMS resources, an up-to-date list of hematologic drug shortages, resources for physicians dealing with shortages, and links to ASH/FDA webinars featuring an unbiased discussion of newly approved drugs and their uses.
- **[Pediatric to Adult Hematologic Care Transitions](#)** – This new website offers links to assessment and summary forms designed to facilitate discussion about the patient transitions from pediatric to adult care.
- **[ICD-10 Conversion for Hematology Resource Page](#)** – This resource help members prepare for the transition by providing complete conversion charts for all disorders related to hematology.
- **[Consult a Colleague](#)** – A member service designed to help facilitate the exchange of information between hematologists and their peers.

## **ASH Advocacy Resources**

ASH's redesigned [Advocacy Center](#) houses all the Society's policy positions, advocacy efforts, and campaigns. Hematologists and their patients can follow the latest national [policy news](#) and directly campaign their representatives through [ASH Action Alerts](#). The Center also displays ASH's official [policy statements](#) along with [testimony and correspondence](#) related to federal regulation and private insurance developments.

## **ASH Publications**

- [ASH Practice Updates](#) – The *Practice Update* is the society's bi-monthly e-newsletter reporting on breaking news and activities of interest to the practice community.
- [ASH Clinical News](#) – *ASH Clinical News* is a new magazine for ASH members and non-members alike – offering news and views for the broader hematology/oncology community.
- [The Hematologist: ASH News and Reports](#) – An award-winning bimonthly publication that updates readers about important developments in the field of hematology and highlights what ASH is doing for its members.

## **Meeting Information**

- [ASH Meeting on Hematologic Malignancies](#) – September 16 – 17, 2016, Chicago, IL. This event will allow you to hear top experts in hematologic malignancies discuss the latest developments in clinical care and to find answers to your most challenging patient care questions.
- [ASH Annual Meeting and Exposition](#) – December 3-7, 2016, San Diego, CA. Information concerning registration, housing, and meeting content for the Society's Annual Meeting and Exposition designed to provide hematologists from around the world a forum for discussing critical issues in the field. Abstracts presented at the meeting also contain the latest and most exciting developments in hematology research.
- [Consultative Hematology Course](#) – Thursday, September 15, 2016 in conjunction with the ASH Meeting on Hematologic Malignancies or Monday, December 5, 2016 in conjunction with the ASH Annual Meeting. Information concerning registration, housing, and meeting content for this intensive half-day program, which focuses on updates in non-malignant hematology designed for practitioners who are trained as hematologists or hematologist-oncologists, but now see patients with non-malignant hematologic conditions on a less frequent basis.
- [Highlights of ASH](#) – Information concerning registration, housing, and meeting content for this ASH-sponsored meeting designed to provide the highlights of the top presentations from the recent annual meeting.
- [Annual Meeting of the Hematology / Oncology Carrier Advisory Committee \(CAC\) Network](#) – July 21 – 22, 2016, Washington, DC. This annual event brings together the hematologists and oncologists who serve as representatives to regional Medicare Contractors, Medicare Contractor Medical Directors, leaders from hematology and oncology state societies, and members of ASH and ASCO practice committees. The meeting is intended to provide attendees with a better understanding of the CAC process; discuss issues of common concern and develop solutions; and improve the overall CAC process throughout the year.





American Society of Clinical Oncology

*Making a world of difference in cancer care*

## **ASCO Advocacy**

**ASCO in Action (AiA)** –ASCO has dedicated a portion of its website to spotlight timely information on research policy, clinical affairs, government relations, and quality of care issues that affect oncology practice, cancer care, and cancer research. ASCO publishes AiA briefs and alerts and these are all available at <http://ascoaction.asco.org/>

**AiA Beat** - The ASCO in Action Beat is a bi-weekly newsletter which shares timely information on ASCO's policy priorities – be sure to subscribe on ASCO.org.

**ASCO's ACT Network** – This network provides members different opportunities to become engaged in advocacy. The ASCO ACT Network allows individuals to send a message using the pre-drafted editable alerts, find phone numbers and mailing addresses for elected officials, see how members of Congress voted on key issues, and draft a message (e-mail or letter) to a member of Congress. <http://www.asco.org/actnetwork>

**Advocacy Toolkit** – The toolkit provides information about effectively communicating and establishing a relationship with members of Congress. It includes details on how to effectively organize a visit, schedule and participate in a meeting with a member of Congress, and how to write a meaningful letter/e-mail that will get the member's attention. (The toolkit is for members only.) <http://www.asco.org/advocacy-policy/advocacy-center/ascos-advocacy-toolkit>

## **MACRA Education/Activities**

The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), which replaced the Sustainable Growth Rate formula for updates to the Medicare physician fee schedule, lays out far-reaching changes and an ambitious implementation schedule that will profoundly impact reimbursement to oncology practices throughout the United States.

ASCO is your partner in preparing for these changes and ensuring high-quality care for patients with cancer. We will provide a wide range of continually updated resources and tools that are designed to help practicing oncologists satisfy MACRA requirements and move toward a value-based practice environment.

Educational webinars and resources are being offered by ASCO and a list of the past and upcoming events can be found at <http://www.asco.org/sites/new-www.asco.org/files/content-files/advocacy-and-policy/documents/07082016%20MACRA%20calendar%20of%20education%20events.pdf>.

Any questions or comments about MACRA implementation can be sent to [macra@asco.org](mailto:macra@asco.org).

## **Practice Related Items**

**NOTE:** Many of the oncology-practice related products and services offered by ASCO and its Clinical Affairs department are highlighted and summarized in the attached Special Edition of the Oncology Practice Insider.

**Oncology Practice Insider** - The Oncology Practice Insider is a bi-weekly e-communication specifically devoted to oncology practice management issues. The Insider provides updates on Medicare initiatives, drug shortages, regulations affecting physician practices, quality improvement activities, legislative activities, coverage information billing and coding and more. The Insider launched in the spring of 2009 and currently has been relaunched. To subscribe to this free oncology management e-communication e-mail [practice@asco.org](mailto:practice@asco.org).

**Journal of Oncology Practice** - The *Journal of Oncology Practice (JOP)* provides oncologists and other oncology professionals with information, news, research and tools to enhance practice efficiency and promote quality in cancer care. The JOP includes original research, feature articles, and columns on various issues pertinent to daily practice operations, all of which are subject to peer review. For more information about JOP visit <http://jop.ascopubs.org>.

**ASCO PracticeNET** - PracticeNET is a learning collaborative where practices can share and receive insights to enhance their business operations and quality of care in order to assist practices in providing high quality, high value cancer care to patients. Participating practices will submit data for quarterly trend analysis and will be able to request reports to meet their individual practice needs. For more information, please visit [www.asco.org/PracticeNet](http://www.asco.org/PracticeNet) or contact [PracticeNET@asco.org](mailto:PracticeNET@asco.org).

## **CAC Program**

A national meeting for oncology and hematology Medicare Carrier Advisory Committee (CAC) representatives is held every year. Oncology and hematology CAC representatives from across the states are invited as well as Medicare Administrative Contractor Medical Directors (CMDs). The goal of the meeting is to educate attendees on the local coverage process as well as provide opportunities to strengthen communication and collaboration between CAC representatives and Contractor Medical Directors. (The meeting has been co-hosted by ASCO and the American Society of Hematology for the last few years.) Dedicated information for Carrier Advisory Committee (CAC) representatives and related CAC activities can be found on the ASCO website at <http://www.asco.org/practice-guidelines/practice-management-issues/medicare-program/carrier-advisory-committees> under the CAC Program.

## **ASCO State of Cancer Care**

This year, ASCO released the *State of Cancer Care in America: 2016*. This annual publication provides a comprehensive look at demographic, economic, and oncology practice trends that will impact cancer care in the United States over the coming years.

With recommendations for addressing the cancer care delivery system's most pressing concerns, this landmark ASCO report also examines the rapid expansion of health information technology and the growing emphasis on quality measurement and value.

ASCO developed the *State of Cancer Care in America: 2016* report to help cancer care providers, policy makers, and other more effectively shape the future of cancer care during these uncertain times. The Society will issue annual updates that will track trends and identify emerging issues.

For a full report published in the *Journal of Oncology Practice* and additional report content, visit [www.asco.org/stateofcancercare](http://www.asco.org/stateofcancercare).

# Oncology Practice Insider



## e-Digest for Practice Management

Welcome to ASCO's new Clinical Affairs department. This special edition of the Oncology Practice Insider (OPI) shares with you the efforts, initiatives and programs by Clinical Affairs. The department is dedicated to providing services, education and resources to support oncology practices in all settings. The department will support practices across the country in the areas of business analytics, performance improvement, quality certification, and practice management. A brief overview of the projects and initiatives that offer assistance to and that can support your oncology practice are provided below. We are here to serve you. How can we help your practice?

### ASCO's Coding & Reimbursement Service

ASCO offers a service to answer oncology-related coding, billing and reimbursement questions. The coding and reimbursement service is offered electronically and can be accessed at [asco.org/billingcoding](http://asco.org/billingcoding). This is available to ASCO members and their office staff as a member benefit, and a valid ASCO member number must be provided when using the service. To learn more about the service please contact Allison Hirschorn ([allison.hirschorn@asco.org](mailto:allison.hirschorn@asco.org)).

### ASCO PracticeNET

PracticeNET is a new learning collaborative where oncology practices share data and information and receive insights to enhance their business operations and quality of care. The goal of PracticeNET is to assist practices in providing high quality, high value cancer care to patients. Participating practices submit data for quarterly trend analysis and are able to request reports to meet their individual practice needs. PracticeNET is up and running with over 25 practices now participating. For more information, please visit [asco.org/PracticeNET](http://asco.org/PracticeNET) or contact Dave Harter ([david.harter@asco.org](mailto:david.harter@asco.org)).



### Clinical Affairs Data Warehouse

The Clinical Affairs Data Warehouse is a new resource to support ASCO members. The data warehouse includes publicly available data from Medicare such as the Provider Utilization and Payment Data files for 2012 and 2013 and the Part D Prescriber file for 2013, and Medicare's Physician Compare. It also includes practice data from practices participating in PracticeNET; survey data; and data from analytical work performed by ASCO when such use is authorized. We have developed the capability of accepting large PHI payer claims data files for payment reform modeling and have several projects underway. This new data resource is also being used to support PracticeNET reporting and to inform work across ASCO departments. For more information about the Data Warehouse contact Elaine Towle ([elaine.towle@asco.org](mailto:elaine.towle@asco.org)) or Mou Guharoy ([mou.guharoy@asco.org](mailto:mou.guharoy@asco.org)).

### Oncology Payment Reform

ASCO released its first version of an oncology payment reform model in May 2014 and has worked to address challenges and concerns related to the implementation of a new payment model in oncology. A major re-write of the payment reform proposal entitled Patient-Centered Oncology Payment (PCOP) was released in May 2015. Since PCOP's release, Clinical Affairs has hosted educational sessions and initiated discussions with various payers to recognize and pay for services under the ASCO's new oncology payment structure. In addition, Clinical Affairs has been collecting and analyzing clinical and administration data to better define payment amounts, risk corridors and unpaid services. Ongoing work includes piloting programs to test the PCOP model, working with and presenting to other specialty societies, and participating in American Medical Association payment reform initiatives. To learn more about payment reform in oncology and/or ASCO's PCOP model, please contact Walter Birch ([walter.birch@asco.org](mailto:walter.birch@asco.org)).



### Clinical Practice Committee

The Clinical Affairs department provides oversight of ASCO's Clinical Practice Committee. The Committee is comprised of community oncologists in multiple practice settings. Its work focuses on the practice-related issues and the coverage of, access to and quality of oncology care. The Committee provides advice to the Board on policy issues and works closely with the State Affiliate Council (SAC). There are five workgroups currently under the Committee:

- Payment Reform Implementation
- Coding, Billing and Reimbursement
- Practice Administrators
- Physician Compensation
- Data Review

The CPC leadership, consisting of the Chair, Chair-elect, Immediate-past Chair and Board liaison meet bi-weekly to discuss issues. For more information about the CPC and/or its workgroups, please contact Laura Lynch ([laura.lynch@asco.org](mailto:laura.lynch@asco.org)) or Julia Tomkins ([julia.tomkins@asco.org](mailto:julia.tomkins@asco.org)).

Feel free to contact ASCO's Clinical Affairs Department if you have any questions at [practice@asco.org](mailto:practice@asco.org).

## Carrier Advisory Committee (CAC) Program

ASCO and the American Society of Hematology (ASH) annually co-host a national meeting for oncology and hematology Medicare Carrier Advisory Committee (CAC) representatives. Oncology and hematology CAC representatives from across the states are invited as well as Medicare Administrative Contractor Medical Directors (CMDs). The goal of the meeting is to educate attendees on the local coverage process as well as provide opportunities to strengthen communication and collaboration between CAC representatives and Contractor Medical Directors. To learn more about the Annual CAC Network meeting please contact Monica Tan ([monica.tan@asco.org](mailto:monica.tan@asco.org)).

## Provider-Payer Initiative (PPI)

The ASCO Provider-Payer Initiative (PPI) is a forum to increase dialogue with private payers to improve the communication and understanding of ASCO's products and provide expert oncology knowledge. Under this forum, private payer representatives, members of ASCO's Clinical Practice Committee and other selected committee representatives come together once a year to share their perspectives on oncology-related issues and challenges related to the quality of cancer care and care delivery systems. For more information about the PPI, please contact Julia Tomkins ([julia.tomkins@asco.org](mailto:julia.tomkins@asco.org)).

## AMA Activities

ASCO volunteers and Clinical Affairs staff participate in a number of important American Medical Association (AMA) activities such as the AMA CPT Advisory Committee, AMA Relative Value Update Committee (RUC) Advisory Committee and the AMA House of Delegates (HoD). Participation in the CPT Advisory Committee allows ASCO to provide oncology-specific experience and guidance to the AMA CPT Editorial Panel on new and revised CPT codes. Participation in the RUC Advisory Committee allows ASCO to provide oncology-specific insight to the valuation of CPT codes and making value recommendations to CMS. ASCO's representation in the HoD is the vehicle for oncology to be heard on key issues of reimbursement and other broader medical policies being discussed and/or addressed within the AMA. For more information about ASCO's involvement in the AMA CPT and RUC contact Allison Hirschorn ([allison.hirschorn@asco.org](mailto:allison.hirschorn@asco.org)) and involvement in the AMA HoD contact Monica Tan ([monica.tan@asco.org](mailto:monica.tan@asco.org)).

## FDA Alert Program

ASCO, in cooperation with the Food and Drug Administration (FDA) Office of Hematology and Oncology Products (OHOP) and Center for Biologics Evaluation and Research (CBER) office, distributes information about newly approved therapies for cancer patients. These alerts contain a link to the product label and provide relevant clinical information such as the indication, contraindications, dosing and safety. These alerts assist the FDA and the oncology community in learning about recent approvals in a timely manner. In addition to these alerts, ASCO has been working with the FDA to notify the oncology community about FDA safety alerts. For more information about the FDA alerts, please contact Monica Tan ([monica.tan@asco.org](mailto:monica.tan@asco.org)).

## Quality Training Program™

ASCO's Quality Training Program is the leading oncology quality improvement (QI) course that empowers practice teams to improve clinical care and operational performance while maximizing a demanding schedule with competing priorities.



The program prepares your oncology providers to design, implement, and lead successful QI activities in busy practice settings. ASCO's program was developed by oncologists and oncology care specialists for oncology practice teams. The Quality Training Program includes access to renowned faculty and coaches during five focused days of in-person learning in a series of three sessions-including seminars, case examples, and small group exercises - and 6 months of on-demand, remote coaching. Your team will take its QI knowledge and skills to another level, accelerating change and improvement. To learn more about the Quality Training Program please contact Elaine Holton ([elaine.holton@asco.org](mailto:elaine.holton@asco.org)) or Terry Gilmore, RN ([terry.gilmore@asco.org](mailto:terry.gilmore@asco.org)).

## Stavros Niarchos Foundation Grant Brings Quality Improvement Program to Practices Supporting Medically Underserved Communities

The Conquer Cancer Foundation of ASCO has received a generous grant from the Stavros Niarchos Foundation (SNF) in support of a new ASCO initiative, "Improving the Delivery of Cancer Care in Medically Underserved Communities." Over an 18-month period, this initiative will bring ASCO's Quality Oncology Practice Initiative (QOPI®), Quality Training Program, and targeted hands-on assistance to four oncology practices serving high proportions of racial minorities and persons of low socioeconomic status.

Participating practices will receive an on-site assessment, assistance in identifying achievable improvements, targeted toolkits, and hands-on quality improvement training. They will each partner with a mentor practice that will assist with specific areas of quality improvement. Outcomes of the project will be reported at the ASCO Annual Meeting, the Quality Care Symposium, and in the *Journal of Oncology Practice*.

To learn more about the Conquer Cancer Foundation, visit [conquercancerfoundation.org](http://conquercancerfoundation.org). To learn more about ASCO's quality initiatives, visit [institutequality.org](http://institutequality.org) or contact Terry Gilmore, RN ([terry.gilmore@asco.org](mailto:terry.gilmore@asco.org)).

## QOPI Certification

The QOPI Certification is an oncologist lead program designed to promote quality oncology care, provide a possible solution to satisfy external demand for quality activities, streamline quality assessment and improvement programs, and communicate a practice's QOPI certification to patients and the community. To achieve QOPI Certification, a practice undergoes an on-site survey by a select team of oncology professionals once every three years. The purpose of the on-site survey is to evaluate the practice's performance in areas that affect patient care and safety as well as the review of the practice's processes, competencies and policies, and conducting interviews with the clinical staff. QOPI Certification is granted to practices meeting the requirements for a 3-year term. To learn more about ASCO's QOPI Certification Program, visit [institutequality.org/qopi-qcp](http://institutequality.org/qopi-qcp) or contact Tara Conti-Kalchik ([tara.conti-kalchik@asco.org](mailto:tara.conti-kalchik@asco.org)).



Feel free to contact ASCO's Clinical Affairs Department if you have any questions at [practice@asco.org](mailto:practice@asco.org).

# MEETING EVALUATION FORM – ASH/ASCO CAC NETWORK MEETING JULY 21 – 22, 2016 – Washington, DC

*ASH and ASCO are committed to providing the highest quality for the CAC Network meeting. To assist in meeting that goal, we ask that you please complete the following confidential survey and provide and comments or suggestions that you may have.*

## DEMOGRAPHIC INFORMATION

I am (please check all that apply):

- The oncology CAC representative/alternate for my state.
- The hematology CAC representative/alternate for my state.
- The president (or another physician representative) of my state oncology society.
- The executive director/administrator of my state oncology society.
- A member of ASCO’s Clinical Practice Committee.
- A member of ASH’s Committee on Practice or ASH’s Subcommittee on Reimbursement.
- A Medicare contractor medical director.
- An invited meeting speaker.

### Evaluation Key

1	2	3	4	5
<b>Strong Agree</b>	Agree	Neutral	Disagree	<b>Strongly Disagree</b>

Please indicate the degree to which you agree with the statements in each section below by placing a check mark on **1 (strongly AGREE) to 5 (strongly disagree)** for each statement.

## 1. Welcome Reception

WELCOME RECEPTION	1	2	3	4	5
The Welcome reception provided an opportunity to network with other CAC representatives, state society representatives, and committee members.					
The format of the Welcome reception was a valuable addition to the meeting.					

## 2. Group Dinners

GROUP DINNERS	1	2	3	4	5
The group dinners provided the additional opportunity to network with other CAC representatives, state society representatives, committee members, and contractor medical directors.					
The size of the dinner group was appropriate for networking.					
I enjoyed the additional opportunity to network with other CAC meeting attendees.					

**3. General Meeting**

<b>GENERAL MEETING</b>	<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>	<b>5</b>
I learned new information or obtained a better understanding of a particular issue or topic.					
The topics discussed are important to my role as a CAC representative, state society representative or committee member.					
There were adequate opportunities for questions and answers or discussions of topics.					
The contractor medical director participation in the meeting was helpful in obtaining feedback on important issues.					
The open microphone session was helpful in understanding CAC-related issues/topics and fostered communication between CAC representatives and CMDs.					
The written materials and resources provided in the binder were a helpful supplement to the discussions.					
The length of the meeting was appropriate.					
The meeting facility was conducive for the meeting format/structure.					

**4. Presentations/Speakers**

<b>PRESENTATIONS/SPEAKERS</b>	<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>	<b>5</b>
I found the presentation on Part B ASP Demonstration Project - Phase I by Dr. Stephen Grubbs, MD interesting.					
I found the presentation on Part B ASP Demonstration Project - Phase II by Dr. Blase Polite, MD educational.					
The presentation on Merit-Based Incentive Payment System (MIPS) by Koryn Rubin, MHA was helpful.					
The presentation on Alternative Payment Models by Harold Miller was educational.					
The breakout session, Ways to Improve the CAC Process in Your Region was useful.					
The presentation on Palliative Care by Dr. Thomas Smith, MD was informative.					
I found the Coverage with Evidence Development presentation by Dr. James Rollins, MD educational.					

**5. What aspect(s) of the CAC Network Meeting do you find most valuable?**

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6. What aspect(s) of the CAC Network Meeting are most in need of improvement? (Please be specific.)

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7. What topics or themes would you like to see addressed at future meetings?

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8. Overall, how would you rate the CAC Network Meeting? (Please choose one.)

- a) Excellent      b) Good      c) Fair      d) Poor

9. Is the current format of the CAC Network Meeting effective? (Please circle one): YES or NO

- If you circled NO, please provide additional/alternative ways ASH and ASCO can make the meeting more effective.

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10. Are there any additional resources ASH and ASCO can provide to assist you with the local coverage process?

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**\*\* Thank you for your input! Please leave the evaluation form on your table or on the table outside the meeting room. If you are unable to complete the form onsite, please e-mail the form directly after the meeting to ASH staff, Katherine Stark at [kstark@hematology.org](mailto:kstark@hematology.org) \*\***



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## 2016 ASH/ASCO CAC Network Meeting Expense Reimbursement Form

Please fill out the information below and attach all original receipts.  
**All forms must be submitted by August 22, 2016**

Make check payable to: \_\_\_\_\_

Mail check to: \_\_\_\_\_  
\_\_\_\_\_

Meeting Attended: 2016 ASH/ASCO CAC Network Meeting

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Itemized Expenses:**

Date	Description of Expense	Account (internal use only)	Amount
_____	_____	_____	\$ _____
_____	_____	_____	\$ _____
_____	_____	_____	\$ _____
_____	_____	_____	\$ _____
_____	_____	_____	\$ _____
_____	_____	_____	\$ _____

**For ASH Use Only:**

Approval: X \_\_\_\_\_ Date Submitted to Accounting: \_\_\_\_\_

Please return form and original receipts to by August 22, 2016 to:

Katherine Stark  
American Society of Hematology  
2021 L Street NW, Suite 900,  
Washington, DC 20036  
202-292-0252  
[kstark@hematology.org](mailto:kstark@hematology.org)





American Society of Hematology  
[www.hematology.org](http://www.hematology.org)



American Society of Clinical Oncology  
[www.asco.org](http://www.asco.org)

**AMERICAN SOCIETY OF HEMATOLOGY and  
AMERICAN SOCIETY OF CLINICAL ONCOLOGY  
2016 CAC Network Meeting  
Travel Reimbursement Policy**

*The ASH-ASCO CAC Network Meeting Travel Reimbursement Policy is provided to travelers to provide guidance on the reimbursement for costs incurred in order to participate in the CAC Network Meeting. It is expected that the policy will be adhered to explicitly.*

ASCO and ASH will reimburse the following groups for their attendance:

- CAC representatives and alternate representatives for hematology and oncology;
- Members of the ASCO Clinical Practice Committee and ASH Committee on Practice;
- Two representatives from the Hematology/ Oncology State Society\*
- Medicare Contractor Medical Directors (CMDs) for all A/B MAC jurisdictions.

*\*Only two representatives from the state society (excluding CAC representatives) will be reimbursed for attending the ASH/ASCO CAC Network Meeting. State hematology/oncology society presidents and administrators/executive directors should determine who will attend the meeting. If more than two individuals from the state society (excluding CAC representatives) attend the meeting, reimbursement will be the responsibility of the state society or individual.*

Coverage begins at the actual start of a trip, whether it is from the traveler's regular place of employment, home, or other location, and terminates when the traveler reaches his/her original destination. Expenses for spouses and/or dependents are personal expenses and are not reimbursable.

**Original receipts** for all expenditures (including E-ticket passenger receipts, taxis, and parking) of **\$25.01 or more** must be included with the CAC Network Meeting Expense Reimbursement Form. Requests for reimbursement must be submitted within **thirty (30)** days of the meeting for which reimbursable expenses were incurred. The approved reimbursement will be issued by check.

### **Air/Train Travel**

ASH and ASCO will pay for coach class airline tickets (not business or first class), preferably purchased through the ASH travel agency EWA Travel. Airline or train reservations should be made using ASH's travel agent, EWA Travel. Tickets are to be booked at least 30 days in advance of the meeting dates for domestic attendees (no later than June 17). Please contact Marika Delgado at EWA via email at [ASH@ewatravel.com](mailto:ASH@ewatravel.com) or by phone at 1(800) 705-8580.

ASH and ASCO will reimburse the most economical non-refundable coach fares available on a major airline carrier (American, Delta, Southwest, United, U.S. Airways, etc.). When a significantly less



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expensive option is available, reservations made with a particular carrier to benefit the traveler will not be reimbursed in full; rather, the amount reimbursed will equal the amount of the equivalent ticket on the most economical carrier.

If an approved traveler wants to bring a guest, they must provide the ASH travel agent with a personal credit card for the guest's travel.

### **Ground Transportation**

ASH and ASCO encourage the use of the most economical ground transportation to and from the airport or train station and will reimburse such expenses.

Use of a personal or university vehicle will be reimbursed at the mileage rate consistent with IRS rules and regulations (**\$0.54 cents per mile as of 1/1/16, including gasoline**) plus toll and parking charges. (ASH and ASCO will reimburse parking charges and mileage as long as this amount is not greater than the cost of roundtrip taxi or shuttle service.)

If ASH and ASCO approve the use of a rental car, limits will be set and communicated to the traveler by the appropriate ASH or ASCO representative. The maximum rates set by ASH and ASCO take into account the cost of the rental, mileage, gasoline, parking, tolls, and any other expenses related to the use of the rental in order to attend the meeting.

### **Hotel**

One night hotel stay will be provided for by ASH and ASCO. Additional nights can be reserved but the attendee will be responsible for the extra stay. (Individuals that would require two nights based on flight options and/or destinations must contact ASH or ASCO staff prior to making the reservation.)

The traveler is responsible for promptly submitting the [RSVP Survey](#) as requested by the ASH representative handling hotel room block arrangements.

### **Meals**

Meals that are not provided during the meeting will be covered with the following limits including tax and tip:

Dinner	\$75.00
Lunch	\$40.00
Breakfast	\$25.00

ASCO and ASH provide breakfast and lunch for Friday, July 22. Expenses incurred by attendees for either of these meals will not be reimbursed.



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[www.asco.org](http://www.asco.org)

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### **Cancellations and Changes**

When a traveler needs to change or cancel an airline reservation, he/she must contact the issuing agent and notify the appropriate ASH or ASCO representatives **immediately**. Unless the change or cancellation is approved by ASH or ASCO, the traveler is responsible for all penalty fees and any other charges incurred due to such changes or cancellations. If the traveler does not inform the travel agency or airline of the cancellation prior to the scheduled departure time, and the ticket is thereby rendered unusable for future travel, then the traveler will be held responsible for the cost of the original ticket.

If a traveler needs to change or cancel a hotel reservation, he or she must contact the appropriate ASH or ASCO representative at least 72 hours prior to his/her originally scheduled arrival. The traveler is responsible for reimbursing ASH and ASCO for expenses incurred due to last-minute changes, cancellations, no-shows, and early departures.

### **Miscellaneous Expenses**

- Baggage service, up to a maximum of one checked bag per flight and similar expenses are reimbursable.
- Internet service, up to \$14 per day is reimbursable while attending the CAC Network Meeting.
- Tips not included with meals or cab fare should be listed separately on the CAC Network Meeting Expense Reimbursement Form.
- When a trip involves traveling for both the CAC Network Meeting and other purposes, the traveler must reasonably allocate the costs between CAC Network Meeting and the other activity.

If a traveler has any questions concerning any other reimbursable expenses, he/she should contact the appropriate ASH or ASCO representative.