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Specialty Payment
Model Opportunities
and Design

Gastroenterology Technical
Expert Panel Summary (Final)

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Prepared for:
Claire Schreiber
Mary Kapp, Centers for Medicare &
Medicaid Services

Prepared By:
Mark McClellan
Kavita Patel
John O'Shea
Chelsey Crim
Jeffrey Nadel
Elise Presser
Andrea Thoumi
Judith Tobin

The Brookings Institution
1775 Massachusetts Avenue, NW
Washington, D.C. 20036

Introduction

The Brookings Institution convened a technical expert panel (TEP) to solicit input on how best to design an alternative payment approach for gastroenterology specialty care. This TEP was part of the Specialty Physician Payment Model Opportunities Assessment and Design project, a Center for Medicare & Medicaid Innovation (CMMI) effort with the intent of identifying opportunities for better alignment of high quality care delivery and supporting payments in gastroenterology and additional specialties. The project aligns with CMMI's goals of developing models that improve quality of care, reduce total costs of care, or both. CMMI's objective is to create and evaluate models based on these two constraints and scale them nationally.

Gastroenterology was selected as the third specialty for analysis in this project because it accounts for a significant portion of total health care spending in the United States. An aging national population is placing an upward demand on gastroenterological services in Medicare and increasing the total disease burdens found in the Medicare population. Stakeholders in gastroenterology are actively engaged in numerous efforts to reward higher value care through the following mechanisms:

- Shifting funds away from fee-for-service (FFS)
- Paying for services that are not fully covered in the current reimbursement system
- Shifting funds among providers

The Gastroenterology TEP was held on April 28, 2014 in Baltimore, MD. In addition to the invited TEP members, staff from Brookings, RAND, MITRE, and CMMI attended the meeting as facilitators or listeners. A list of TEP members and meeting attendees is included in Appendix A.

Methods

The primary purpose of the TEP was to obtain feedback on the trajectory of gastroenterology payment reform by providing an opportunity for a range of stakeholders to offer their perspectives on the types of reforms available and the potential impact these reforms may have. The goal was not to achieve consensus or produce a formal recommendation, but rather to begin to consider how different reform components may fit together in an alternative payment model. In addition, the TEP included discussion of necessary operational elements necessary to support changes in payment and care delivery. Based on the preceding environmental scan that combined ideas from a literature review and 30 stakeholder interviews, TEP members were asked to use three illustrative models as a starting point for discussion: bundled payments, multidisciplinary care teams, and an advanced mixed payment model that incorporates a shared savings component. These illustrative models were not exhaustive, but contained key concepts across a range of gastroenterology payment reform options. Thus, these concepts provided a practical foundation for further assessment of payment reform models. The meeting agenda is available in Appendix B.

TEP Meeting Objectives:

As articulated to the TEP members before the discussion, the objectives of the panel were as follows:

- To provide input on how to best design payment and delivery reform models based on:
 - Care delivery structure
 - Payment structure
 - Requirements for provider groups
 - Potential undesirable consequences
 - Quality measures

- To address general questions when discussing alternative models, including:
 - What should the structure of the payment models be?
 - Which patient populations should be included in the models?
 - How do the models improve care coordination between providers, particularly primary care and gastroenterologists?
 - How do the models improve appropriate use of diagnostics, procedures, and other treatments?
 - How do the models promote efficiency in care delivery?
 - How should site of service payment differentials be addressed?
 - What data and infrastructure improvements are necessary for the models to succeed?
 - What quality measures are needed with the models?
 - What are the key barriers to implementing the models, particularly for small practices and those in underserved areas?
 - How feasible are the models in the short and long term?

- To identify and discuss key elements needing further development within each of the following categories to support redesign framework:
 - Performance measurement
 - Data infrastructure
 - Aligning IT systems
 - Patient engagement
 - Provider engagement

- To discuss specific concerns regarding each of the illustrative alternative payment models identified by Brookings.

- To discuss the feasibility of implementing each of these illustrative alternative payment models.

Prior to the in-person meeting, TEP members received a preparatory briefing booklet that included the following documents:

- An up-to-date draft of the Gastroenterology Environmental Scan for review and comment
- A list of related quality measures
- Pre-meeting reading materials:
 - Arora, S., et al. (2011). "Outcomes of treatment for hepatitis C virus infection by primary care providers." *N Engl J Med* **364**(23): 2199-2207.
<http://www.nejm.org/doi/pdf/10.1056/NEJMoa1009370>
 - Brill, J. V., et al. (2014). "A Bundled Payment Framework for Colonoscopy Performed for Colorectal Cancer Screening or Surveillance." *Gastroenterology*.
<http://www.ncbi.nlm.nih.gov/pubmed/24480681>

Conceptual Framework

The meeting was organized around in-depth discussions of illustrative alternative models that represent the main payment reforms identified in the environmental scan. Figure 1 illustrates how various forms of each model moves away from traditional FFS towards payment aggregation at the individual provider level and across multiple providers.

The following conceptual framework was used to guide the TEP:

1. *How does the payment reform relate to the traditional payment method? Does it add onto the existing FFS structure or does it shift away from FFS?*

Each model includes a portion of payment that is not based on service volume or intensity. However, some models may be in addition to existing FFS payments, while others shift away from traditional FFS. Additionally, the degree of financial risk that gastroenterologists take on in each payment model depends on the degree of movement away from traditional FFS payment methods. The amount of risk a provider bears directly affects the strength of the incentives providers face to modify current practices.

2. *What is the size and scope of the case/person-level payment?*

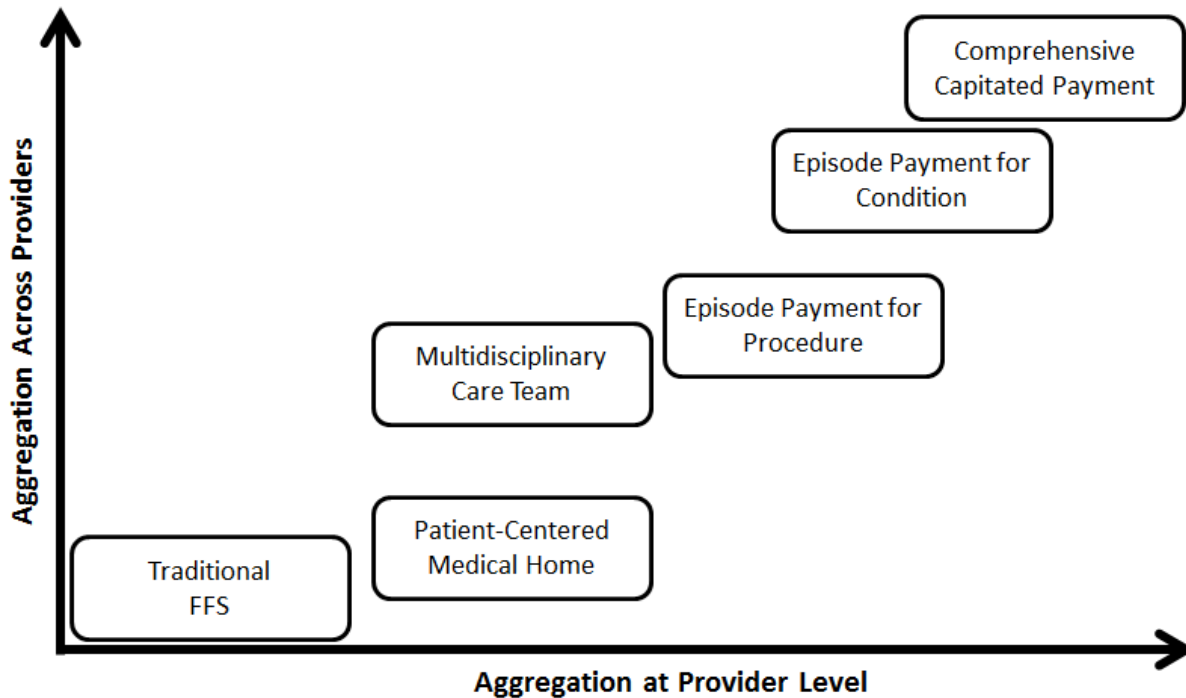
The size and scope of these payments relates to how accountable the gastroenterology practice becomes for delivering quality care for all types of services. Furthermore, the larger the payment, the greater the number of services included within it. Larger payments can expand the care team beyond the immediate gastroenterologist or practice. As payments shift to include additional aspects of care, greater incentives exist to limit costs and shift care delivery.

3. *Are savings accrued to both physicians and Medicare included on care outside the case or episode payment?*

Models may offer providers an opportunity to share in savings accrued through the implementation of these models if costs are below a determined target. These models may include symmetrical risk, which places a limited financial risk on providers if total payments exceed the target price. Alternatively, some models only offer the asymmetrical, positive incentive of sharing in cost savings without the risk of a penalty for exceeding the target. The strength of the incentive for providers to modify current practices is dependent on the level of

risk they take on.

Figure 1: Model Progression by Case-based Physician Payment and Bundling/Aggregation across Providers



Alternative 1: Bundled Payment

In a bundled payment model, select services that are currently reimbursed piecemeal through FFS are instead reimbursed through a single global payment. The bundle can cover services surrounding either a procedure or a condition. The most extensive discussion around bundled payments in the literature involves colonoscopy for colorectal cancer (CRC) screening and surveillance. The TEP discussion on bundled payment focused almost exclusively on a colonoscopy bundle, although one TEP member expressed interest in focusing on condition-based bundles, as they represent a stronger shift away from FFS.

Generally, TEP members expressed enthusiasm about CMS' ability to develop and standardize a bundled payment model that private payers could support and replicate within gastroenterology. Although not widespread, TEP members emphasized the existence of current private payer colonoscopy bundles that are being implemented by both large and small gastroenterology practices. However, many TEP members described challenges that small provider practices may experience with regard to negotiating the pricing and elements included in the bundle. TEP members believed that small practices may also experience challenges in controlling utilization of the services that are included under the bundled payment. In general, TEP members expressed concern over having ancillary services included in the

bundle, such as anesthesia or pathology, that may be outside their control. Despite concern over these services, many TEP members agreed that including these services was critical to improving care coordination and reducing waste.

Care Delivery Considerations

One TEP member noted that there has been a dramatic decrease in CRC in the past decade, primarily due to CRC screening and surveillance. According to this TEP member, Medicare claims data between 2005 and 2013 showed a decrease in procedural claims relating to colonoscopy. The TEP member stated that the number of polypectomies remained roughly the same while the number of biopsies has increased dramatically. A different TEP member explained that this drop was the result of progress using high-resolution technology to look for pre-cancerous lesions. Improved technology has allowed for an increase in significant findings, and therefore diagnostic procedures, but ultimately caused the dramatic decrease in CRC. Multiple TEP members noted that CRC screening and surveillance is still underutilized and emphasized the importance of allowing alternative testing, such as CT Colonography, to encourage more patients to get tested. TEP members briefly discussed the potential of including these alternative methods in a bundled payment, but focused more on the importance of providing them as a general testing option. As one TEP member noted, “the best test is the test that gets done.” The TEP member noted that some patients refuse to have a colonoscopy. TEP members agreed that these patients may be more receptive to an alternative testing method, such as CT Colonography or fecal occult blood testing.

TEP members also discussed the inclusion of pathology in the bundled payment. One TEP member questioned if including pathology would provide a disincentive for finding and removing polyps, thereby reducing the quality of the procedure. Another TEP member suggested setting guideline thresholds, similar to those in CT Colonography, for polyps that should be removed and sent to pathology. A patient advocate expressed that, from a patient perspective, not removing all polyps was unacceptable. In response, a TEP member discussed the potential for a ‘resect and discard’ technique, where all polyps are removed and only those that meet the guideline thresholds would be sent to pathology. The TEP member said that this technique has been shown to be feasible and cost analysis using Medicare data suggested there could be more than \$1 billion savings per year in the United States. However, physician TEP members noted that this technique is risky from a physician perspective, as they do not want to miss important findings.

Additionally, TEP members discussed if the inclusion of complications in the bundle would give physicians a disincentive from removing polyps, as that is how the majority of bowel perforations occur.

Payment Reform Considerations

TEP members believed that although bundled payment for colonoscopy is one of the most feasible payment reform options for gastroenterology, it is not a particularly innovative payment approach because procedural bundled payments are still a type of FFS. The TEP members noted that bundled payments could be an effective way to reduce waste and inefficiency, but that reducing overall

payment, and especially costs of other gastroenterological care, would have to be done through quality improvement such as reducing complications and catching problems early. Further, multiple TEP members discussed the need to reduce unnecessary procedures, particularly repeating colonoscopy more often than the timeframes indicated by guidelines. One TEP member noted that data on providers who are consistently overusing colonoscopy is available now and believed CMS should begin to hold these providers accountable.

TEP members discussed how determining who controls the bundle to dispense individual fees is one of the main considerations in a bundled payment model. In a physician network model such as an ACO, if the network is given the bundled payment and the physician continues to be paid through FFS, there is little incentive to change behavior. However, TEP members recognized that physician control of the bundle increases provider risk. Particular concern arose over physicians taking on the risk without being able to control all the aspects of the bundle. One TEP member described how high costs of an ancillary service could drive total costs over the bundle price. TEP members believed that this was a particular problem for smaller practices with less control over all of the services in the bundle. Additionally, TEP members voiced concern over complex, complicated cases. TEP members agreed that with a set bundled price, high-risk or complicated patients would be a significant burden for the physician. Some TEP members suggested risk-adjusted pricing and one payer explained their use of practice-specific risk-adjustment.

Multiple TEP members voiced their disagreement with the decision by CMS that obligates propofol to be administered by anesthesia professionals. TEP members noted that even though the payment for an anesthesiologist under Medicare is 85% that of a gastroenterologist, including anesthesia professionals in colonoscopies dramatically increased cost of the procedure. TEP members believed that using anesthesia professionals would not only increase costs unnecessarily, but would also be problematic for smaller practices that use ancillary anesthesia services.

Finally, TEP members discussed site of service issues, emphasizing that the same procedure has very different costs across sites, largely due to the different facility fees. One TEP member stated that many of the requirements for an ambulatory surgical center (ASC) that in effect increase the facility fees are unnecessary for colonoscopy and do little to improve the quality of the procedure. TEP members agreed that without addressing site of service differentials, developing a reasonable bundled payment would be challenging.

Operational Considerations

TEP members focused on the importance of ensuring high quality colonoscopies for all patients. Multiple comments emphasized the variation that currently exists across colonoscopy procedures, and the limited ability of patients to determine physician quality. One TEP member noted that the FFS payment model represents a barrier to patient understanding of quality, since each part of the procedure is viewed separately.

Many TEP members agreed that current quality measures are not appropriate. Discussion focused on adenoma detection rate and cecal intubation rate. One TEP member noted that although adenoma detection rate is used, evidence has emerged that there is no clear minimum threshold for adenoma detection. A patient advocate also noted that although many advocates advise patients to ask their physician for his or her adenoma detection rate, they are unaware of what a good rate is. Physician TEP members noted that no patient has come to them to ask for their adenoma detection rate.

Barriers to Implementation

The TEP members stated that the main barrier to implementation is determining the flow of funds as well as determining what risks providers can and should take on. TEP members noted that without physician control of the bundle, little incentive exists for physicians to change their behavior. However, placing physicians in charge of the payment, particularly when they are not owners of all the services included in the bundle, was also viewed as problematic. Therefore, many TEP members believed that small practices will face significant challenges with a bundle payment model because they are less likely to have direct control over all of the services.

Another issue discussed was the need to design a new model to properly assign incoming service claims to a bundle. This issue is particularly challenging in smaller practices where follow-ups or complications might be addressed by physicians outside of the group that performed the procedure. Additionally, one TEP member noted that developing the coordination structure necessary to effectively reduce costs for a bundle payment was challenging and costly.

Finally, one TEP member noted that some states have regulations covering in-office ancillary services that may limit the ability of the physician to bring these services under one roof. Even with a bundled approach from CMS, the state-level regulations would unbundle the services, which diminishes a practice's ability to control the services and cost of elements included in the bundle. The TEP member cautioned that this could undo any progress made by CMS.

Alternative 2: Coordinated Care—Multidisciplinary Care Team

The second model the TEP considered was a multidisciplinary care team model. The focus of this model is to enhance care coordination and patient management by aligning new team-based delivery reforms with supportive alternative payment mechanisms. Though several multidisciplinary care team pilots currently exist in gastroenterology, there is no standardized definition of the services included in a multidisciplinary care team. Two of these pilots—Project ECHO and Project Sonar—are described below.

Project ECHO is an educational initiative in New Mexico that focuses on linking primary care providers in rural and underserved areas with specialists who help provide counsel on patient management. Project ECHO allows specialists to offer telehealth consultations to primary care providers in parts of the country where access to specialty care is limited. The project initially focused on Hepatitis C patients, and has since expanded to approximately ten other conditions. In the consultations, primary care physicians and specialists work together to develop patient care plans, discuss difficult cases, and

participate in continuing education. Eventually, as they work together over time, a participating primary care provider becomes a local expert on the particular condition and can help other local primary care providers when necessary. Early data shows that the care provided by the primary care physician through this model is equivalent with what the patient would have received from a specialist. The project has been primarily funded through state, foundation, and grant support.

Project Sonar is an initiative in Illinois that aims to improve comprehensive care management for patients with Crohn's disease. Many Crohn's disease patients do not participate in regular disease management, and may only seek care once symptoms have gotten out of control and require more intensive treatment or even hospitalization. Project Sonar promotes the idea that better communication between patients, providers, and practices could prevent delays in care and related costly complications. The practice uses a patient portal to support proactive outreach and reminders so that the practice can monitor and track each patient's symptoms and care needs. In addition, providers have access to a host of clinical decision support tools to help change provider behavior and encourage adherence to evidence-based guidelines. This model is funded by Blue Cross Blue Shield of Illinois, where they provide a supplemental per-member-per-month (PMPM) payment to the practice for implementing the care management reforms. There is also a retrospective shared savings arrangement.

Care Delivery Considerations

TEP members largely agreed that the innovative approach to care delivery redesign found in both of these models could help accomplish the goals of better care and reduce costs. Many TEP members noted that the focus on population level management, while still retaining a condition-based structure was an attractive feature.

Specifically for Project ECHO, one TEP member appreciated its primary care focus. This TEP member indicated that many primary care providers are uncomfortable with managing complex chronic diseases, although they are often the more appropriate provider for care management. The payer partner for Project Sonar noted that being able to work jointly with the practice to select the patients included in the model made the partnership attractive. Additionally, the payer stated that the use of a nurse care manager for augmented patient care was beneficial.

Beyond standard gastroenterological care, the incorporation of psychosocial care was discussed in the context of multidisciplinary care teams. Specifically for inflammatory bowel disease (IBD), one TEP member noted that IBD-associated anxiety and depression are frequent and do not always dissipate with treatment of disease flare-ups. It is important to treat psychological symptoms with appropriate psychosocial care. This TEP member is running a pilot at a major academic medical center for IBD psychosocial intervention. Another TEP member reiterated the importance of psychological care, noting that their practice employed a psychologist even when the payer did not agree to fund the cost.

TEP members discussed which types of additional staff resources were most ideal to provide the additional patient support systems found in multidisciplinary care teams. In many cases, nurses or psychologists are hired to coordinate and manage care, and support psychosocial needs. However, one

TEP member asserted that nurses and psychologists are not always formally trained for these exact duties, and are more expensive compared to social workers. In fact, social workers are educated to manage the entire spectrum of ancillary care and cost around 30% less to hire than a nurse or psychologist. This TEP member indicated that hiring social workers would make these changes more affordable and improve the outcomes associated with the delivery reform.

Finally, the TEP discussed the importance of patient engagement in a multidisciplinary care team model. Since any care delivery reforms center on coordinated, well-managed care, the patient must also be active and engaged in their care. TEP members noted that patient buy-in is extremely important. Some members suggested that payers could offer financial incentives to patients, such as lower copays or premiums. Other TEP members advocated for finding ways for providers and practices to empower patients.

Payment Reform Considerations

TEP members began the discussion of payment considerations for a multidisciplinary care team model with the recognition that payment alignment is important to achieving delivery innovation. TEP members advocated for payment reforms that would fund population management infrastructure and enable innovations in team-based care delivery. Specifically, TEP members discussed two major payment mechanisms to fund multidisciplinary care teams: (1) PMPM payments to providers and (2) changes in relative value unit (RVU) payments for certain services.

Some TEP members preferred the use of PMPM payments to fund innovative care delivery practices and the associated practice infrastructure development. One member noted that the PMPM allowed them to cover administrative costs, incentives, and add-on programs like behavioral health services. In addition, one payer noted that as new ideas arise, they can be funded through increased PMPM reimbursement. However, several TEP members suggested that the PMPM payments may not alter their net revenue. Instead, unless these reforms reduce other costs, all of the PMPM payments go to covering the overhead of the multidisciplinary care team. To incentivize the transition to new delivery and payment models, several TEP members argued that it was essential to couple PMPM reimbursement with an augmented payment, such as a tiered outcomes-based PMPM payment or shared savings. TEP members responded that a \$30 to \$50 PMPM could potentially cover the overhead costs of practice transformation and expansion, leaving no additional revenue to the physician in the absence of other changes.

TEP members agreed that for any of these value-based payment arrangements to work, there need to be appropriate risk adjustments and safeguards as providers and health plans begin to bear more risk. Additionally, TEP members noted the importance of ensuring accurate data collection related to risk.

Finally, one TEP member believed that implementing this type of payment model at the individual physician or practice level may be too cumbersome due to the practice expansions required. Instead the TEP member suggested gastroenterology delivery of care may be better suited to larger physician groups or networks, such as ACOs.

Operational Considerations

Many TEP members agreed that both process and outcomes measures were important, especially in the context of multidisciplinary medical teams. One member suggested that for IBD, the four most important outcomes are hospitalization status, surgical status, quality of life, and use of steroids for management. Another TEP member added several other measures that were relevant for medical homes, including interactions between patients and nurse care manager, patient satisfaction, cost analyses, and specific HEDIS measures.

Barriers to Implementation

In their discussion, the TEP members identified a number of potential barriers that should be addressed in a multidisciplinary care team model. First, one member suggested that in order to create a smooth transition to value-based reimbursement, a consistent quality improvement culture is necessary. Because clinicians are rarely trained in quality measurement and improvement, improving education around these efforts would support their knowledge building and training. Another TEP member suggested that if CMS implements strict regulations outlining which delivery efficiencies must be demonstrated to receive payment, innovation will be impeded. Instead, this member requested that CMS allow flexibility and dynamism in the model while still encouraging patient-centered, outcomes-based payment.

A TEP member noted that approximately 40% of gastroenterology practices have six providers or fewer. The fact that many providers are in small or independent practices raises problems for implementing many of the efficiencies needed for a multidisciplinary care team. For example, small practices may not have the funding to hire a nurse care manager or social worker to care for patients. This funding issue suggests that some form of up-front payments not related to volume of services (e.g. PMPM payments described above) would be necessary to overcome the barriers to practice transformation.

TEP members discussed the best outreach techniques to allow for increasingly effective interfacing with patients. Although personal telephone calls for follow-ups are ideal, nurse care managers or social workers do not have the capacity to call all patients in a practice. As such, some multidisciplinary care teams are using high-functioning patient portals to interface with patients. One TEP member suggested that patient portals are becoming outdated, and that smartphone applications are a better way to interact with patients. However, elderly populations overwhelmingly do not use smartphone technology.

Finally, TEP members discussed how patient attribution is essential in determining fee schedules and assessing impact. Specifically, TEP members noted that patients should not be doubly attributed. For example, if a multidisciplinary care team becomes part of an ACO, patients cannot be attributed to both the ACO and the medical care team. Additionally, TEP members discussed the importance of attributing the 'right' patients to the model, specifically those who would benefit most from the enhancements in care delivery.

Alternative 3: Population Health: Advanced Mixed Payment Model

Shared savings coupled with various payment reform models described in this paper can create an advanced mixed payment model. This model adds provider accountability for population health to the elements of care and practice transformation already present in other payment models. This additional shared savings component increases physician incentive to improve coordination and care at the population level. TEP members suggested that additional payments such as a PMPM or case management fee are generally placed entirely into developing the infrastructure required for the new care delivery. Therefore, financial incentives for the physicians could be created through the opportunity to share in the savings accrued through the use of the improved care models.

Care Delivery Considerations

TEP members discussed the possibility of coupling one of the above reimbursement mechanisms of multidisciplinary care teams with shared savings arrangements. In a shared savings arrangement, the payer, provider, and any other entities involved—such as the health system or patient—share in any savings accrued from the care delivery and payment reforms. One TEP member argued against the use of shared savings arrangements. This member noted that the care delivery model is always changing. Thus, when evaluating the effects of a reform in a shared savings arrangement, the care delivery system being evaluated may not reflect the current state of care delivery in the practice. Pilots are sometimes dissolved before there are savings to be shared; however the savings may be downstream and delayed. This member noted that although nice in concept, they prefer having payments with quicker onset and more direct ties to the practice.

Most current models employing shared savings are within ACOs and similar types of arrangements. In existing ACO models, gastroenterologists may directly participate in ACOs, which are organizations that are reimbursed in part based on the quality and costs of overall care, including gastroenterology, of patients in a defined population. One TEP member suggested that models for bundled payment are particularly advantageous in an ACO setting as all services included in the bundle can be more easily controlled under an ACO.

An advanced mixed payment model including shared savings or other population-based payments can also be employed utilizing the care delivery structures found in a multidisciplinary care team model. For example, Project Sonar is a multidisciplinary care team model with the potential for retrospective shared savings. One TEP member suggested that a multi-center approach that divides a large overall population into manageable sections with a medical director and part-time nurse manager at each center allows for improved control over the patient population and therefore greater potential for accruing savings that can be shared.

Payment Reform Considerations

In the advanced mixed payment model, accrued shared savings are added on top of an existing payment reform effort, such as bundled payment or an ACO. One TEP member described a relationship between

a private payer and relatively small GI practice that exists within an ACO. The payer sets a practice-level, risk-adjusted, target price based on the last two years of data. Providers are then paid at a set FFS rate and costs are evaluated annually with any savings shared evenly between the payer and provider. Other models give a bundled payment directly to the ACO, allowing the ACO to allocate the funds for the services provided.

In a mixed model with a multidisciplinary care team, the infrastructure development and practice enhancements are funded through the case management or infrastructure fee in the form of a PMPM. Additionally, the physicians share in a portion of the accrued savings that are gained through improved care.

One TEP member raised the concern that shared savings given at the ACO level was unlikely to noticeably affect financial incentives for a particular specialist. Another TEP member representing a payer organization described the payment arrangements they use for physician groups that he said were similar to an ACO. This model enables the payer to raise the RVU-based fees to help fund clinical delivery innovations and provides a system for tiered reimbursement. Instead of providing an additional PMPM payment, five percent of the total pool of payments to providers is given to the practice/organization group as a whole for infrastructure development. Additionally, they activate care management codes to which providers may bill. Annually, a proportion of physicians receive a five or ten percent raise in the RVU schedule payments based on their population-level quality outcome measures. With the combination of augmented fees, the initiation of additional fee-for-service billing codes, and a pool of dollars set aside for infrastructure development, the TEP member believed that they had created a payment model that allows for flexibility of services to fill the clinical need.

Operational Considerations

The infrastructure required for the model implementation would be similar to that of the basic models themselves. TEP members noted that adding the shared savings component would require data and analysis to determine if savings were accrued.

Barriers to Implementation

Multiple TEP members expressed concern over making sure that the physician was receiving a share of the savings. This was of particular interest in the advanced ACO model where, after paying for overhead and other organizational aspects, some TEP members were concerned the component of the shared savings that reaches the physician is likely to be too small to influence their behavior. Multiple TEP members noted that it was challenging to get payers and organizations interested in developing a model for gastroenterology because of so many diverse interests vying for attention. Additionally, one TEP member noted that because gastroenterology services are primarily provided on an outpatient basis, it is rare for an organization to look at total cost of care for a condition.

Elements to Support Redesign Frameworks

In mobilizing any new payment and delivery reform, there are a number of vital operational considerations to help the model function properly. TEP members discussed the type of supports CMS or others would need to provide to implement a redesigned framework. Much of this discussion revolved around data infrastructure as well as patient and provider engagement.

Timely access to data

For any major payment reform to take hold, TEP members agreed that linked clinical and claims data should be available to both the provider and payer in a timely fashion. TEP members largely agreed that the paucity of payment by CMS for data collection made it difficult to evaluate clinical information, claims information, and the total cost of care. While most TEP members desired real-time data, many agreed that as long as the data was available within 90 days, it would help them to start making innovative changes.

There were discrepancies regarding what type of data would be most beneficial between medical claims data, clinical data, and pharmacy data. However, TEP members once again viewed timely access to these types of data as a major resource to empower physicians to implement real change. Furthermore, TEP members agreed access to these data would allow providers to break down the type of service for every patient who has gone through the episode of care.

One TEP member discussed the difficulty in determining the correct control group with so many different interventions being implemented at once. Practices must adjust for various defects that currently exist, as well as focus on total cost to accurately implement a payment model.

Patient engagement

TEP members emphasized the importance of patients being engaged with their physicians. Referencing a Patient Centered Outcomes Research Institute (PCORI) meeting, a TEP member asserted the physician's office is the most effective place to engage patients as this is where they are most open to hearing and engaging with new information. Additionally, this TEP member praised the team-based approach and believed there should be reimbursement mechanisms for incentivizing practices with this type of care delivery.

A few TEP members suggested building out meaningful use frameworks and integrating them with one another to increase patient engagement. While discussing best practices for engaging patients, TEP members agreed that traditional forms of communication, such as mailings, might be best to directly access the Medicare patient population, and that newer technologies, such as internet campaigns and phone-based applications, may be best to access the Medicare patient population's caregivers.

One TEP member suggested CMS lead efforts to educate patients about certain health issues as a way of keeping patients out of the physician's office until appropriate.

Provider engagement

One TEP member said the group must acknowledge that most endoscopy centers are owned by gastroenterology groups. There is a trend of driving colonoscopy towards ASCs, which are cheaper than hospital out-patient settings. However, procedures furnished in ASCs cost significantly more than physician office-based procedures. Another TEP member identified CMS' unique position to use payment reform as a mechanism to address overutilization.

Quality Measures

Patient satisfaction

TEP members generally agreed that patient satisfaction is important in quality measures. One TEP member stated that many colonoscopy-centered measures can effectively be tied back into a survey about patient satisfaction. However, one TEP member noted that CAHPS surveys on patient satisfaction should be adjusted for gastroenterology. The TEP member pointed out patient wait time specifically, suggesting that long wait times do not necessarily equate with decreased patient satisfaction.

Care coordination

One TEP member said that their practice is collecting compliance to screening intervals. This TEP member explained that working within an ACO ensures coordination with primary care physicians for population measures, which is beneficial to the patient.

One TEP member noted that the American Gastroenterological Association is working to set up communications between primary care physicians and other specialists. This TEP member also identified the importance of sharing anti-coagulation medication data with other providers.

Incorporation of initial holistic evaluation

There was consensus that there should be a baseline behavior or mental status and well-being assessment. One TEP member noted that traditionally, specialists do not address aspects of care outside of their specialty, but believed it is important to care for the patient as a whole, including psychosocial care. Building off this point, another TEP member asserted that everyone should be responsible for patient quality measures, even if it is outside of the specialty. This TEP member said that the feasibility to collect measures and gain access to timely data decreases if registries are unavailable. Another TEP member stated that his program includes a general well-being measure with a sub-question asking how patients feel that they are doing.

Conditions

Colonoscopy: TEP members indicated that looking at colonoscopy performance measures alone is inadequate. The TEP agreed that measures regarding overall screening intervals and population

screening rates should also be incorporated. One TEP member proposed replacing polyp detection rate with adenoma detection rate.

IBD: A TEP member stated that many of the performance measures listed for IBD have not yet been proven. Additionally, this TEP member believed it would be valuable to have some sort of psychosocial measure added. This TEP member's foundation uses the Hospital Anxiety and Depression Scale, but they believe that it does not believe it addresses patient satisfaction. Instead, this foundation modified the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey to look at patient satisfaction directly. Another TEP member pointed to validated Inflammatory Bowel Disease Questionnaire (IBDQ) forms, although stated that these are process measures. This TEP member suggested an important outcome measure for IBD patients would be quality of life.

GERD: One TEP member suggested removing "Inappropriate use of barium swallow" and stated it was only reported in the Product Quality Research Institute (PQRI) very early on, but later removed.

Other issues

A TEP member stated their foundation sees many misdiagnosed IBD patients that act as an enormous burden of cost on society and the patient. This TEP member suggested creating better incentives for avoiding delayed or missed diagnoses, possibly based on objective measures of inflammation.

RAND Analysis Plan

The RAND team provided an overview of their role in the project moving forward. In order to explore the opportunities under new Medicare payment models for gastroenterology, RAND, with the help of CMS and Brookings, will define a series of model characteristics to be simulated. The two data sources to be used in the modeling phase of the project are full Medicare claims and enrollment information—available through 2013. Through these analyses, RAND will determine and assess eligibility for the payment model, the impact of different levels of payment and utilization for different categories of services, and variation both between and within providers.

RAND aims to investigate the following questions:

1. What are the opportunities around these payment models?
2. What are the implications of design decisions?
3. What is the range of possibilities for the effects of the alternative payment models?

Conclusion

The TEP concluded on a positive note with optimism about the future of payment reform in gastroenterology. The comments of the day were briefly summarized, and TEP members were reminded that they would be contacted for ongoing participation in this effort as the Brookings, RAND, and CMS teams continued to refine the design of the model and simulate its effects. Finally, it was noted that

although the discussion was highly constructive, no one single model was selected as a path forward, and the final model would likely include components of each framework discussed during the day.

Appendix A

Name	Affiliation	Attendee Status
Anton Decker	Banner Medical Group	In Person
Charles Accurso	Digestive Health Care Center	In Person
David Kim	University of Wisconsin School of Medicine and Public Health	In Person
Douglas K. Rex	Indiana University Hospital	In Person
James Leavitt	Gastro Health	In Person
Joel Brill	FAIR Health, Inc.	In Person
John Allen	Yale Medical Group	In Person
John Yao	Blue Shield of California	In Person
Kenneth Strople	Palisades Healthcare Solutions, LLC	In Person
Larry Kosinski	Illinois Gastroenterology Group	In Person
Laura Porter	Colon Cancer Alliance	In Person
Lili Brillstein	Horizon Blue Cross Blue Shield of New Jersey	In Person
Marci Reiss	IBD Support Foundation	In Person
Martin Kistin	Gastrointestinal Motility Lab, University of New Mexico	In Person
Mary Igo	Digestive Health Specialists	In Person
Richard B. Colletti	ImproveCareNow	In Person
Ron Fogel	Digestive Health Centers of Michigan	In Person
Tom Deas, Jr.	Gastroenterology Associates of North Texas, Fort Worth	In Person
Tom Simmer	Blue Cross Blue Shield of Michigan	In Person
Walter Hollinger	Blue Cross Blue Shield of Illinois	In Person
Additional Attendees		
Rahul Rajkumar	Centers for Medicare & Medicaid Services	In Person
Mary Kapp	Centers for Medicare & Medicaid Services	In Person
Claire Schreiber	Centers for Medicare & Medicaid Services	In Person
Pamela Pelizzari	Centers for Medicare & Medicaid Services	In Person
Lara Strawbridge	Centers for Medicare & Medicaid Services	In Person
Mark McClellan	The Brookings Institution	In Person
Kavita Patel	The Brookings Institution	In Person
John O'Shea	The Brookings Institution	In Person
Josh Sclar	The Brookings Institution	In Person
Judy Tobin	The Brookings Institution	In Person
Andrea Thoumi	The Brookings Institution	In Person
Chris Botts	The Brookings Institution	In Person
Jeff Nadel	The Brookings Institution	In Person
Elise Presser	The Brookings Institution	In Person
Chelsea Crim	The Brookings Institution	In Person
Joanna Platzman	The Brookings Institution	In Person
Christina Flores	The Brookings Institution	In Person
Lisa Ackerman	The Brookings Institution	In Person
Peter Hussey	RAND Corporation	In Person
Dan Speece	MITRE Corporation	In Person
Heidi Giles	MITRE Corporation	In Person
Ren Resch	MITRE Corporation	In Person

Appendix B

Specialty Payment Model Opportunities Assessment and Design Technical Expert Panel for Gastroenterology Agenda

- 8:30 a.m. Welcome and Introductions**
Rahul Rajkumar, MD, JD, Senior Advisor to the Deputy CMS Administrator
- 8:45 a.m. Overview of the Day and Project**
Mark McClellan, MD, PhD, Director, Initiative on Innovation and Value for Healthcare and Senior Fellow, The Brookings Institution
- 9:00 a.m. Frameworks for Payment Reform and Clinical Redesign Pilots:
Alternative 1: Bundled payment**
Kavita Patel, MD, MS, Fellow and Managing Director at the Engelberg Center for Health Care Reform, The Brookings Institution – *Facilitator*
- 10:30 a.m. Break**
- 10:45 a.m. Frameworks for Payment Reform and Clinical Redesign Pilots:
Alternative 2: Coordinated Care**
Mark McClellan – *Facilitator*
- 12:15 p.m. Lunch delivered**
- 12:45 p.m. Frameworks for Payment Reform and Clinical Redesign Pilots:
Alternative 3: Population Health and Savings Accrued to Providers and Payers**
Mark McClellan – *Facilitator*
- 1:45 p.m. RAND Approach to Data Analysis**
Peter Hussey, PhD, Senior Policy Researcher and RAND Project Director at the RAND Corporation – *Presenter*
- 2:00 p.m. Elements to Support Redesign Framework – Implementation Challenges**
Kavita Patel– *Facilitator*
- 2:45 p.m. Break**
- 3:00 p.m. Elements to Support Redesign Framework – Quality Measures**
Mark McClellan– *Facilitator*
- 3:30 p.m. Concluding Remarks**
Mark McClellan
- 4:00 p.m. Adjourn**
***Note: shuttle will be departing directly to BWI (Concourse C) at 4:15 p.m.**