January 24, 2017

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

RE: American Society of Anesthesiologists Comments on The Comprehensive Colonoscopy Advanced Alternative Payment Model for Colorectal Cancer Screening, Diagnosis and Surveillance

Dear Committee Members,

The American Society of Anesthesiologists (ASA) appreciates the opportunity to comment on The Comprehensive Colonoscopy Advanced Alternative Payment Model for Colorectal Cancer Screening, Diagnosis and Surveillance. We are strong supporters of physician-focused payment models and this process, which allows impacted specialties to have input on the model design.

Due to the team-based approach of this APM, it is difficult for stakeholders to truly assess the effects of this proposed APM without having additional information. The ASA appreciates the submitters' thoughtfulness in designing a model that has vital goals in seeking to reduce both inappropriate utilization and costs across the healthcare system. We would like to outline two areas which need further development.

The first area is the lack of an outline of the options envisioned for an attribution model. Without a baseline understanding of the relationship of the clinicians to the APM entity, it is difficult to evaluate the impact on clinicians. As specialist providers within this APM, it would be helpful to receive straightforward data regarding how current pilots have attributed care, as well as guidance from the submitters. Indeed, the proposal does little to describe the structure, governance or other key features of the model APM entity contemplated. As we've stated to the committee in the past, a one-size-fits-all approach to risk-reward distribution models is not ideal and should be left to individual APM entities to collaboratively develop with the Qualifying Participant clinicians.

An additional area needing review is the development of the parameters for measuring downside risk. In several key areas, including setting the re-do rates and identifying the quality metrics, it appears the endoscopist is the sole decision maker. High quality anesthesia care is a crucial component of patient satisfaction with these procedures. If multiple specialists are to assume downside risk, having collaborative input into the benchmarking of these key features is vital not just to the success of the APM but also to ensure the model's goals remain patient-centered. The care described is collaborative and multidisciplinary. The design of the quality program, and consequently the quality measurement and associated risk sharing, needs to be collaborative and multidisciplinary as well.

We realize that some of these issues surrounding the lack of information stem from the PTAC's intended approach to limit the size of the proposals. In general, we agree with this approach, which is more open, encouraging participation from stakeholders with varying levels of expertise. We also agree that the submitters have acted in good faith to present this complex model in an efficient package. However, the issues outlined above are simply too critical to leave unaddressed. Additional collaboration and broad-based input from the specialists involved in the APM is necessary.

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

Sincerely,

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