

November 17, 2016
Physician-Focused Payment Model Technical Advisory Committee
c/o U.S. DHHS Asst. Secretary of Planning and Evaluation Office of Health Policy
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Letter of Intent – Joel V. Brill MD and Scott R. Ketover, MD: Physician-Focused Prospective Payment Model for Screening, Surveillance, and Diagnostic Colonoscopy

Dear Committee Members

On behalf of the Digestive Health Network, a consortium of 40 gastroenterology practices across the United States representing over 1000 physicians, we are pleased to submit this letter of intent to submit a Physician-Focused Payment Model (PFP) for PTAC review during December 2016.

Payment Model Overview

We propose a comprehensive prospective bundled payment model to more effectively manage patients who require colonoscopy for colorectal cancer (CRC) screening and surveillance, for evaluation of a positive finding on other CRC screening modalities as recommended by the US Preventive Services Task Force¹², and for other diagnostic purposes. This prospective dual-risk model, built upon the learnings gained from retrospective models with upside only risk and prospective ‘day-of-procedure’ fixed price models, will establish incentives to pay for higher-value care, will be flexible, and improve quality at a lower overall cost (42 CFR Sec. 414.1465).

Our model will demonstrate improved quality of care and increased cost savings relative to the current fee-for-service model for performance of colonoscopy, whether through a stoma or the rectum³. Colonoscopy is one of the most frequently performed procedures; in 2015, Medicare paid for almost 2,895,000 procedures for non-therapeutic indications. Increases in colorectal cancer screening has been associated with a decrease in colorectal cancer incidence⁴, and there is a correlation between adenoma detection rate (ADR) and decreased CRC incidence⁵. Under the Affordable Care Act, the facility, pathology, and anesthesia for screening colonoscopy are preventive for Medicare beneficiaries; non-Medicare patients also have preventive coverage of the pre-procedure evaluation and management visit and the prep for the procedure⁶. Concerns whether physicians are following guidelines for appropriate surveillance intervals⁷, along with an estimated 10-15% rate of incomplete procedures due to poor prep and/or technical limitations⁸, represent an opportunity for improvement.

¹ Screening for Colorectal Cancer. US Preventive Services Task Force Recommendation Statement. *JAMA* 2016; 315 (23): 2564-2575

² HEDIS 2017 Volume 2 Technical Update. Released October 3, 2016.

³ Brill JV, Jain R, Margolis P et al. A bundled payment framework for colonoscopy performed for colorectal cancer screening or surveillance. *Gastroenterology*. 2014 Mar;146(3):849-853.e9.

⁴ American Cancer Society Colorectal Cancer Facts and Figures 2014-2016

⁵ Corley DA, Jensen CD, Marks AR, et al. Adenoma Detection Rate and Risk of Colorectal Cancer and Death. *N Engl J Med* 2014; 370:1298-1306

⁶ United States Department of Labor. Coverage of Preventive Services. Accessed November 17, 2016

⁷ Goodwin JS, Singh A, Reddy N, et al. Overuse of Screening Colonoscopy in the Medicare Population. *Arch Intern Med*. 2011;171(15):1335-1343

⁸ Lebwohl B, Kastrinos F, Glick M, et al. The Impact of Suboptimal Preparation on Adenoma Miss Rates and the Factors Associated with Early Repeat Colonoscopy. *Gastrointestinal Endoscopy*. 2011;73(6):1207-1214.

Costs reductions can be achieved by ensuring appropriate bowel prep to reduce repeat procedures, ensuring appropriate use of pathology, shifting site-of-service for patients with ASA class I-III from hospital outpatient to ambulatory surgical settings, and ensuring appropriate interval for follow-up studies based on multi-society consensus guidelines^{9,10}. Other key components of this model include:

- Attribution of patients based on ICD-10 codes for screening, surveillance, and diagnostic colonoscopy procedures
- Initial clinical Biopsychosocial Risk assessment
- Interactive linguistically sensitive, culturally specific bowel preparation tools for patients
- Deployment of Clinical Decision Support tools in CEHRT EMRs to capture MIPS-derived measures, ASC and OPPTS measures, and other specialty quality outcomes measures to support algorithm-driven follow-up
- Identification and capture of Patient-Reported Outcomes Measures
- Data reporting into a publicly accessible database
- Incorporating stop-loss reinsurance for surgical care resulting from procedure complications
- Downside-risk based upon clinical and financial performance

Expected Participants and Implementation Strategy: Over 1000 gastroenterologists representing 40 practices are prepared to implement a team-based approach involving physicians, physician assistants, nurse practitioners, pharmacists and other clinical personnel to support this model.

Adjudication of professional and facility claims is a significant barrier to implementation of an outpatient prospective payment model. We have submitted an application to the AMA's CPT Editorial Panel to create a category III CPT code that would allow Medicare, Medicaid, Tricare, commercial payers and third-party administrators to 1) track patient and professional participation in this model, 2) adjudicate claims to prevent duplicate payment for anesthesia, pathology, and facility services during the episode, 3) adjudicate claims to prevent payment for subsequent colonoscopy as a result of poor preparation, 4) track complications as a result of colonoscopy, and 5) establish payment for the episode.

Goals of the Model: Improved management of patients undergoing colonoscopy for colorectal cancer screening, surveillance, and diagnostic purposes would be measured by clinical quality measures and patient outcomes, reduction in potentially avoidable repeat procedures and post-procedure complications, adherence to follow-up surveillance intervals, and reduced healthcare spending.

Timeline: We intend to submit our proposal by December 19, 2016. The timeline for deployment of this PFPM would be the second half of 2017.

Thank you for your consideration.



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⁹ Lieberman DA, Rex DK, Winawer SJ, et al. United States Multi-Society Task Force on Colorectal Cancer. Guidelines for colonoscopy surveillance after screening and polypectomy: a consensus update by the US Multi-Society Task Force on Colorectal Cancer. *Gastroenterology*. 2012;143(3):844–857.

¹⁰ Kahi CJ, Boland CR, Dominitz JA, et al. Colonoscopy Surveillance After Colorectal Cancer Resection: Recommendations of the US Multi-Society Task Force on Colorectal Cancer. *Gastroenterology* 2016; 150:758.