AMERICAN ACADEMY OF
OTOLARYNGOLOGY–
HEAD AND NECK SURGERY

April 10, 2014

Patrick Conway, MD
Director
Center for Medicare & Medicaid Innovation
7500 Security Boulevard
Baltimore, MD 21244

Re: Request for Information on Specialty Practitioner Payment Model Opportunities

Dear Dr. Conway:

The American Academy of Otolaryngology-Head and Neck Surgery (AAO-HNS)[1] appreciates the opportunity to provide comments to the CMS Innovation Center in response to the Request for Information (RFI) to obtain input on policy considerations for the development of innovative payment and service delivery models for specialty practitioner services furnished mainly as outpatient care for patients with specific medical conditions and/or specific patient populations.

I. AAO-HNS Initial Efforts: Developing Payment Models Appropriate for ENT Surgeons

As we have shared during previous meeting with you and your staff, the AAO-HNS created an Ad Hoc Payment Model Workgroup in 2013, which includes volunteer physician leaders with expertise in payment, quality improvement, and research to explore the use of alternative payment models. The goal of this group is to review current and future payment trends in otolaryngology-head and neck surgery and other specialties. We are looking to identify otolaryngology disease processes where payment reform is likely and focus on payment model development for future use by otolaryngology-head and neck surgeons. This has included outreach to private health insurance and groups who are involved in building commercial and Medicare bundles to discuss partnership opportunities, including discussions around which otolaryngology services best lend themselves to alternative payment methods. We have also discussed these efforts with CMS and continue to provide comments to the House Ways and Means, Energy and Commerce Committees and Senate Finance Committee for consideration as they developed proposed draft framework for payment reform.

1 The AAO-HNS represents approximately 12,000 physicians in the United States who diagnose and treat disorders of the ears, nose, throat, and related structures of the head and neck. The medical ailments treated by this specialty are the most common that afflict all Americans, old and young, including hearing loss, balance disorders, chronic ear infections, rhinological disorders, snoring and sleep disorders, swallowing disorders, facial and cranial nerve disorders, and head and neck cancer.

A. Exploration of Bundles, Noting Continued Fee-For-Service Needed for Most ENT Surgeons

We strongly believe that a new payment system should be able to recognize ongoing quality improvement activities that are being undertaken by specialties, as well as the positive impact of these programs on both the culture of the specialty and performance in practice. **Allowing physicians the flexibility to participate in an alternative payment model at any time is essential to the success and adoption of new payment models.** This will foster collaboration and best practices, and allow for greater flexibility for increased participation, as well as invite new creative methods for incentivizing quality care and effective resource use.

In addition, the AAO-HNS strongly agrees with the development of pilot and demonstration projects to determine if bundled payments, or other alternative payment models, are an appropriate mechanism to improve the Medicare payment system. Although we are currently evaluating potential alternative models of payment that might work best for otolaryngology, we realize **bundling or episodes of care may not be the correct solution for reimbursement in all cases for otolaryngologist-head and neck surgeons, and regardless of what reforms are ultimately adopted, a fee-for-service payment option will need to remain an integral part of physician payment for the foreseeable future.** Further, we urge the use of pilot and demonstration projects, as we believe they will help reduce the sense of risk and uncertainty for physicians.

B. Shared Risk Among Patients, Physicians, and Payers

We also support the development of new and innovative payment models that involve patients, physicians, and payers; as well as shared savings programs between hospitals and physicians and the removal of any legal barriers restricting these types of arrangements. In addition, the AAO-HNS is supportive of CMMI developing specialty payment model pilots and demonstration projects to determine if bundled payments or other alternative payment models are an appropriate mechanism to improve the Medicare payment system for different specialties.

C. Barrier to Moving Forward with Exploration is Significant Diversity within Specialty

While the AAO-HNS is committed to finding appropriate new, or alternative payment models (APMs) for ENT participation, we face many challenges, as with measure development, due to how highly sub-specialized otolaryngology is as a surgical specialty. **Unfortunately, there is not one bundle/episodic model that could be developed for a disease condition that would be applicable to more than 50 percent of all otolaryngologists. As an example, Ohio Medicaid has been experimenting with episodic bundles, and has recognized:**

1. None of the first-round of bundles created in collaboration with the Ohio Medicaid Healthcare Transformation Initiative are within otolaryngology-head and neck surgery due to the heterogeneity noted above.

2. For providers within the Ohio market that have bundles in the private insurance marketplace, none have been in Otolaryngology.
3. For providers with products active in the private market, a small percentage (<10%) of revenue specific to that service-line is coming through episodic bundling, due to the exclusions for co-morbidities, among other technical requirements of defined bundles, even in areas of robust episodic bundling performance (e.g., orthopedic joint replacement).

Thus, to be effective for our specialty as a whole, we would require multiple bundles available across our twelve sub-specialties (general otolaryngology, head and neck oncology, pediatrics, laryngology, bronchoesophagology, sleep medicine, otology, neurotology, rhinology, allergy, geriatrics, and facial plastics) in order for our physicians to participate. This would be a struggle given the resources required to develop even one bundle and pilot and test it. We strongly believe that resources must be employed to work with all specialties and/or exemptions/extensions should be considered for smaller specialties that do not routinely deal with the high cost or disease burden illnesses. PCORI and other grants are almost exclusively given to prioritized conditions and specialties, leaving little or no support for many specialties who are trying to navigate these processes alone, with insufficient resources. We appreciate CMMI's interest in developing a process to establish resources for specialty societies like ours to have the opportunity to explore alternative payment models.

II. AAO-HNS Recommendations: Process for Developing/Approving Payment Models

In response to the request for input, we strongly believe that any process established by CMMI should be defined and include specific information regarding submission of applications as well as timing of feedback provided to applicants and final approval of the application. **Most importantly, CMMI should consider providing some resources for specialties to obtain data prior to submission of the application because without the data, it will be very difficult for a specialty to research and develop alternative models without access to clinically-enriched claims data**. In addition to the data, resources for a statistician and programmer support is also essential. As mentioned above, there should be flexibility in the process to allow for specialty societies to bring their own model ideas to CMMI for approval. We recommend that CMMI use the Bundled Payments for Care Improvement (BPCI) and/or Innovation Award structures and solicit comments on draft request for proposals prior to finalizing awards.

Coordinating the development of payment models is also an important aspect to consider. We recommend harmonization of payment models across payers so that resources that are utilized to build models will allow such models to be utilized with both public and private payers. Consistency of the definitions of key model components is essential to the development of such payment models. These should include:

- the condition or service that triggers the payment;
- activities and services that are bundled in the payment;
- method used to modify the payment based on patient acuity;
- method for determining which provider(s) is/are accountable for managing overall costs within the payment model and assuring quality;
- how the payment is allocated among all providers who delivered services covered by the payment; and
- how to measure quality of the services delivered with the payment model.

An early notice of application period and adequate time for response would be beneficial to applicants. In addition, it would be helpful for those applications that are not accepted to receive timely notification, specific feedback, and guidance on eligibility for further review by CMMI. Finally, it would be helpful for those specialties such as otolaryngology, who may not quite be ready to apply, to review other applications by other specialty societies, to understand what made them successful or what they needed to change in order for their application to be accepted.

III. Types of Payment Models to Be Considered

CMMI should consider more than just procedural-episode based and complex and chronic disease management episode-based payment opportunities. Other payment models could include medical management, not just "procedural" episodes. Many patients need care from non-procedural specialties. Specialists who do procedures still lose revenues under procedural episodes if they use medical management to help patients. While the "complex patient" may involve more spending per patient now, it may be more difficult to reduce spending for this type of patient. Diseases like Meniere's, chronic dizziness, allergic diseases, chronic sinusitis and even hearing loss could conceivably be adapted into a carve out for medical management. "Simple" chronic patients also provide opportunities for savings today but also opportunity to reduce costs in the future.

Another possible model, a PCP-Specialist Team of Medical Neighborhood model, would allow payment for "medical neighborhood" consultations in return for better management of testing/referral spending. There might also be opportunity for savings from reduction of unnecessary and duplicative testing during the process of establishing diagnoses, not just in treatment after diagnosis is defined. However, we again would like to stress that some of these payment models may not be viable options for otolaryngology-head and neck surgeons. Until we are able to analyze data, we will not be sure which payment model would be the best. The AAO-HNS is committed to move forward, with appropriate data and analytic support, in analyzing data to help us determine which, if any, of these types of models might be appropriate for some otolaryngologists.

IV. Ideal Payment Models for Physicians

To expand upon what is mentioned above, the ideal payment model includes flexibility to change the way care is delivered. Physicians should be allowed to determine the best way to spend and allocate funds. Payment models should ensure quality care, provide for adequate, sustainable payment to cover achievable costs, and contain appropriate risk-adjustment methodology.

A. Quality Measures

We place a high priority on the importance of quality measurement in evaluating physician services and in tracking performance improvement over time. As noted above, the broad diversity within the specialty (12 sub-specialties) requires many having adequate measures for meaningful quality improvement. Similar to other specialty societies with diversity like ours, many existing measures are not applicable to all otolaryngologists due to sub-specialization. The development, testing, risk adjusting, and ongoing support of meaningful outcomes, process and cost measures is a complex and resource-intensive process. AAO-HNS does not currently have the infrastructure for all aspects or elements of measure development and have depended upon shared resources through consortia, or outside sources, to assist with these efforts. However, AAO-HNS will be looking to consulting arrangement for developing future measure sets. We will seek federal financial support for development if legislation is passed appropriating funding for quality measure development.

B. Protections for the Physician from Insurance Risk

Payments must be risk-adjusted and risk-limited to account for patients with different illness burdens. This is important as the **varying patient socioeconomic factors and co-morbidities can have an impact on achieving ideal patient outcome goals.** There should also be some protection related to attribution of the patient to the physician who is not the primary care physician. In addition, physicians should not be at risk for patient choices, hospital choices, or Medicare payment policy changes. Patients should not be attributed to physicians based on statistical rules. Patients should be asked to designate the physician who will care form them. Physicians should also be able to review and identify inaccuracies with lists of attributed patients.

V. Responses to Some of the Specific CMMI Questions

A. Criteria for selecting a Disease Process

We are in the beginning stages of reviewing potential disease processes that may make sense for otolaryngology-head and neck surgeons. As noted above, given the significant sub-specialization of the specialty, we would not be able to select a disease that would impact even close to a majority of our specialty. The Ad Hoc Payment Model work group has determined that starting with a disease process that lends itself well to episode bundling and that is less complex would be the best place to begin. We hope to learn from the experience and

eventually address additional disease process. Ideally, the best selection would include a disease process that is already the topic of an AAO-HNS Clinical Practice Guideline (CPG) and has quality measures developed. In addition, it is important to note, that if a provider adheres to a practice guideline, they should be within a "safe harbor" from medical legal action for restricting the use of diagnostic testing to that which is within the guidelines.

B. Opportunities to Improve Quality and Reduce Spending for Otolaryngology Procedures

There has been some interest among the AAO-HNS physician leaders in developing an episode of care or bundle for 5-6 disease processes. However, the ability to access data has been a significant barrier in developing payment models. Until the data is obtained and reviewed, it is difficult to clearly identify quality and cost opportunities. It is very resource intensive for a small specialty society to devote efforts to one disease process that will only capture a small percentage of the membership. The AAO-HNS is looking into multiple avenues for gaining access to data; including work with various payer data sets or forming a partnership for data purchase but these opportunities take time. The following table identifies otolaryngology-specific disease processes which have been discussed as possible opportunities for alternative payment and the related data that would be required to develop the payment models for these conditions.

AAO-HNS Considerations for Otolaryngology Disease-Specific Payment Model Exploration (2014)

Disease	Data Required for Analysis
Congenital deafness / cochlear implants	Medicare
Benign and malignant laryngeal lesions / hoarseness	Medicare, Medicaid and commercial payers
Surgically treated early laryngeal cancer	Medicare, Medicaid, and commercial payers
Tonsillectomy	Medicaid and commercial payers
Sinusitis	Medicare and commercial payers
Thyroid	Medicare and commercial payers

VI. Conclusion

On behalf of AAO-HNS, thank you for the opportunity to provide these comments. We look forward to continued dialogue with CMMI regarding payment model opportunities for otolaryngology-head and neck surgeons. Should you have any questions regarding these comments or need more information from AAO-HNS

physician payment leaders, please contact our Director of Health Policy, Jenna Kappel at (703) 535-3724 or via email at: jkappel@entnet.org.

Sincerely,

David R. Nielsen MD

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Executive Vice President and CEO