AMERICAN ACADEMY OF
OTOLARYNGOLOGY–
HEAD AND NECK SURGERY®

August 17, 2023

**VIA ELECTRONIC MAIL**

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The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare and Medicaid Services
U.S. Department of Health and Human Services
Attention: CMS-5540-NC
7500 Security Boulevard, Mail Stop C4-26-05
Baltimore, MD 21244-1850

**Re: File Code CMS-5540-NC: Request for Information; Episode-Based Payment Model**

Dear Administrator Brooks-LaSure:

On behalf of the American Academy of Otolaryngology-Head and Neck Surgery (AAO-HNS)[1], I am pleased to submit the following comments on the agency's Request for Information (RFI) on Episode-Based Payment Models. We thank the Centers for Medicare and Medicaid Innovation (CMMI) for seeking input from the physician community and support the agency's broad goal of providing enhanced patient care in the context of value-based reimbursement arrangements.

Through these comments, we seek to provide input on a subset of topics presented by CMS in the RFI given the short 30-day public comment window which coincides with the agency's release of both the Calendar Year 2024 Physician Fee Schedule and Hospital Outpatient Prospective Payment System proposed rules.

## I. Essential Elements for Success in Creating Episode-Based Payment Models and Other APMs

Any strategy considered by the agency must include the ability to utilize and continually refine outcome measurement tools to assure patients are getting the most appropriate care. A conversion to this approach must also include adequate funding and staffing from CMS to train and implement both primary care and specialty physicians in models they are unfamiliar with. The Academy recommends that CMS exert their influence to create a single basic model common to all payers. It will be impossible for physician groups to

[1] The AAO-HNS is the world's largest organization representing specialists who treat the ear, nose, throat, and related structures of the head and neck. The Academy represents approximately 12,000 otolaryngologist-head and neck surgeons who diagnose and treat disorders of those areas.

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learn and be efficient in multiple new payment models. It is therefore imperative that the program does not include a multitude of systems that operate differently, if the agency expects an efficient transition to new care models. Additionally, any model which advances must also include some residual Fee for Service alternative for less common conditions. Finally, a successful model must also incorporate some sort of protection from commoditizing specialty services as was done in the late 1990s/early 2000's in capitated models that also had perverse incentives for withholding care.

As part of the RFI, the agency states, "We anticipate this model would require participation by certain entities, such as Medicare providers or suppliers or both located in certain geographic regions, to ensure that a broad and representative group of beneficiaries and participants are included. Further, requiring participation would also help to overcome voluntary model challenges such as clinical episode selection bias and participant attrition." The AAO-HNS feels it is critical that all providers be treated equally and equitably and not mandated to participate in a program based on geographic location and specialty access parameters.

**II. Structuring Episodes of Care to Increase Integration and Improve Patient Experience and Clinical Outcomes**

In defining "episodes of care" that can reliably delineate and attribute costs related to a specific episode, it is critical that the timing of referrals is appropriate and the entity responsible for each component of the episode of care is clearly documented. It is also valuable to construct the components of each episode of care through the lens of clinical pathways that physicians are accustomed to using regularly in their current practices that will allow some semblance of familiarity to patient flow instead of introducing an entirely new system and way of thought.

An "episode of care"-based system also needs to limit the risks of participating physicians to those which they can directly control. Currently, most physicians have no control over pricing of diagnostic testing, pharmaceutical intervention and cost of institutional goods and services. The major construct of systems related to episodic care must still be "best care".

**III. Supporting Providers Required to Participate in an Episode-Based Payment Model**

Transparent, educational descriptions of the model, including how to develop episodes in a standard fashion will be invaluable both pre-implementation and during the early stages of conversion to this payment model. CMS should also provide education on assessing risk and transitioning practice to

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value-based care so that consistency across providers creates a more homogeneous system for patients to navigate.

### IV. Ensuring Patient Choice Through Transitions Between Health Care Settings and Providers

Physicians, not payers or facilities, are in the best position to understand which services need to be delivered in a coordinated way to achieve optimal outcomes for their patients and how physician-led teams should be organized to deliver those services. Practicing otolaryngologist-head and neck surgeons also understand which patients have needs that are too complex for a baseline payment model that is focused on a specific health condition or procedure. In order to achieve equity in access and outcomes for all patients, physicians should be permitted and encouraged to select different patient need categories and different payment methods within models for appropriate subgroups of patients that will enable physicians to address all patients' unique needs. Creating sufficient flexibility within models to accommodate the full range of patient needs will enable as many specialists as possible to participate in APMs, ultimately preserving patient choice and promoting equity.

Additionally, education of the patient population will be critical to the successful transition to this type of payment model. While patient choice may have some medically reasonable limitations, it must be clear that unlike the capitated models of the late 1990s and early 2000's, care will not be withheld, and high-quality treatment will be given to all participants.

### V. Relationship (employment, affiliation, etc.) Between a Population-Based Entity and a Specialist

The relationships described here have the greatest potential to lead to failure if there is not equality and equity between the population-based entity and specialist physicians. Historic relationships in a prior attempt that similar models resulted in "heavy handed" treatment of specialists by population health communities with attempts to commoditize and de-value their services. The same mistake will end up having the same result twenty-five years later.

### VI. Health IT Standards and Functionality, Including Interoperability

In designing any new model, CMS should consider the role of clinical registries, like the AAO-HNS/F's Reg-ent registry, in collecting and analyzing data on specified outcomes submitted by physicians, hospitals, and other types of health care providers related to a wide variety of medical procedures, diagnostic tests, and/or clinical condition. Registries play an essential role in promoting quality of care. Clinical data registries are major sources of real-world evidence, including patient-reported outcomes data. Given the statutory mandates included in MACRA,

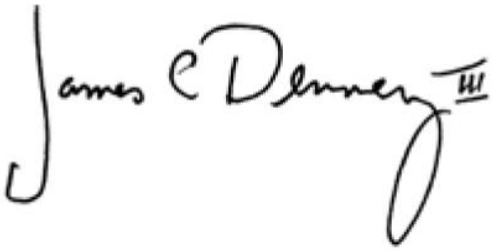
it is important that in any forthcoming model, CMS must adopt policies that provide clinical data registries with meaningful access to Medicare claims data.

For registries to be effective in informing the medical community of "best care" parameters leading to true outcome-based payment coverage, it is essential that CMS along with other governmental agencies demand a standard language that allows interoperability between the large number of practice-based and institutional-based electronic medical records be enforced. Without true outcomes data, appropriate budgeting considerations will continue to be based on the current fallback, cost.

## VII. Conclusions

The American Academy of Otolaryngology-Head and Neck Surgery appreciates the opportunity to provide comments and recommendations regarding these important policies on behalf of our members. We look forward to working with CMS as it continues its efforts to improve patient access to quality care. If you have any questions or require further information, please contact healthpolicy@entnet.org.

Sincerely,



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