



Center for Medicare & Medicaid Innovation

Request for Information on Specialty Practitioner Payment Model Opportunities

AGENCY: Centers for Medicare & Medicaid Services (CMS), HHS.

ACTION: Request for Information (RFI)

SUMMARY

The Centers for Medicare & Medicaid Services (CMS) are seeking input on the following areas related to initiatives surrounding innovative models of payment for specialty care.

DATES: *Comment Date:* To be assured consideration, comments must be received by March 13, 2014.

ADDRESSES: Comments should be submitted electronically through the CMS Innovation Center's web page at: <http://innovation.cms.gov/initiatives/Specialty-Practitioner/>.

FOR FURTHER INFORMATION CONTACT: SpecialtyCareModels@cms.hhs.gov with "RFI" in the subject line.

BACKGROUND

Section 1115A of the Social Security Act, as enacted by section 3021 of the Affordable Care Act, authorizes the Center for Medicare & Medicaid Innovation (hereafter, the Innovation Center) to test innovative payment and service delivery models that have the potential to reduce program expenditures while preserving or enhancing the quality of care for Medicare, Medicaid and Children's Health Insurance Program (CHIP) beneficiaries. CMS is interested in testing new models of care that will focus on specific diseases, patient populations, and specialty practitioners in the outpatient setting to incentivize improved care, better health, and lower costs. In this context, the term 'specialty practitioners' is used to differentiate these practitioners from primary care practitioners. These models would complement CMS' existing portfolio¹, which already includes models focusing on both primary care and inpatient hospitalizations as well as care in other settings.

¹ For more information on the Innovation Center's models, please see <http://innovation.cms.gov>.

CMS is issuing this 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. Specialty practitioner-focused models would be designed to improve the effectiveness and efficiency of specialty care, in part by clarifying the specialist practitioner's clinical role. The payment structure for these models could include procedural episode-based payment opportunities, complex and chronic disease management episode-based payment opportunities, or other innovative arrangements. We look forward to receiving comments through this RFI that will inform CMS' consideration of potential models, and we anticipate using these comments to develop payment models that meet all statutory requirements and are consistent with CMS' mission.

This RFI seeks information in relation to the development of models for care managed by specialist practitioners other than medical oncologists, as a potential oncology model is on a separate development track. Through a design contract, CMS is currently working both to develop a payment model surrounding medical oncology and to explore opportunities for episode payment models for care managed by other specialist practitioners. Information about this work is available at the MITRE payment models website (http://www2.mitre.org/public/payment_models/). With regard to medical oncology, the MITRE contractor has convened a Technical Expert Panel (TEP), a summary of which is posted on their website. With regard to other specialties, CMS has received from the contractor a preliminary assessment of model opportunities, which is also posted on their website. CMS welcomes comments on either of these documents through the process established by MITRE and described on their website. The public is invited to provide input through the MITRE process, through this RFI process, or through both processes.

In order to make episode-based payments, we must define the episode of care for which payment would apply. Episodes of care have two major dimensions: 1) a clinical dimension, including the services or clinical conditions that compose the episode; and 2) a time dimension that reflects the beginning and end of an episode. Given CMS' interest in focusing on ambulatory care in a new episode-based payment model, an episode could be defined around a surgical or interventional procedure such as colonoscopy or cardiac catheterization and include any or all related services furnished throughout the duration of the episode, such as any practitioners' services (including anesthesia, pathology, and/or radiology), diagnostic tests, prescription drugs covered under Medicare Part B or Part D, and if applicable, facility payments to ambulatory surgical centers or hospital outpatient departments. For chronic conditions an episode could be defined as a period of time for management of the condition by a specialist practitioner, and it could contain the same comprehensive set of services as described in an interventional model. Episode definition generally requires comprehensive data about diagnoses, comorbidities, type of service, date of

service, payment, and patient and provider identifiers. These elements are generally available in administrative claims and encounter data, which could be the basis for both new payment models described in this document. However, the amount of detail on both diagnoses and services is limited, and the implementation of some models may require the collection of additional data.

In considering a procedure or clinical condition for episode payment, there are several important considerations, including the following:

1. Historical variation in utilization and payment
2. Extent to which this variation is under the practitioner's control
3. Ease with which the practitioner responsible for the episode can be identified

Ideally episode-based payment could be linked to episodes where historical variation is a result of specialist practitioner behavior and under the practitioner's control in the context of actual care relationships among providers. Additionally, an important consideration is determining the primary responsibility for the episode for payment and accountability purposes so that a payment model is feasible for both the specialist practitioner and CMS.

SECTION I: PROCEDURAL EPISODE-BASED PAYMENT OPPORTUNITIES

CMS is interested in building on our experience with the existing Bundled Payments for Care Improvement models that focus on episodes of care related to an inpatient hospital stay to develop an episode-based payment model for procedures furnished in the outpatient setting by specialist practitioners who are primarily responsible for directing the care throughout the episode. In general, we expect that Medicare beneficiaries would have been referred to the specialist practitioner for assessment and performance of a procedure, and the specialist practitioner would not have an ongoing role in the beneficiaries' health care over an extended period of time.

In order to develop a procedural episode-based payment model, it will be necessary to define several parameters of the episode. Considerations on which CMS is seeking input include how to define the episode start (or initiation), what services should be included in that episode (or the methodology of defining including services), and the episode's duration. We would expect that the episodes targeted under this model would be generally of relatively short duration, ranging from several days to several months, depending on the patient's clinical condition(s) and the medical and surgical services being furnished.

CMS would expect that the episodes under the procedural episode-based payment model under consideration would incorporate the wide range of health care resources for which specialist practitioners bear significant responsibility during the episode through their care practice choices. These responsibilities could include choice of procedure, site-of-service selections, drugs, imaging, and laboratory tests. This model could target specific procedures where significant opportunities exist for specialty practitioner engagement in care redesign. Examples of episodes could include surgical procedures furnished in the outpatient setting (such as colonoscopy or cataract surgery), as well as nonsurgical treatments (such as radiation therapy) that would be conducive to an episode-based payment model.

CMS is seeking responses to the following questions related to a procedural episode-based payment model:

- For which outpatient procedure(s) (surgical or non-surgical) or medical condition(s) should CMS consider testing a procedural episode-based payment model? What are the opportunities to improve the quality of care and reduce expenditures associated with such a model in each specific case?
 - What are the important considerations in defining the episode?
 - How could accountability for drugs prescribed be factored into the payment model?
 - Could such a model be developed for a single medical condition where several alternative approaches exist as treatment possibilities?
 - What examples of this model have been tested in the private sector that further the evidence base?
 - What quality measures should be assessed for this type of episode to ensure safe and effective care?
 - How would the method for assigning responsibility for the episode to specific practitioners or practitioner groups be designed?
- What factors would influence a practitioner's decision about whether or not to apply to participate?
- How could CMS encourage the adoption of such a model among other payers?
- What challenges might be encountered in implementing such a model?
- What other factors should CMS consider in the development of a procedural episode-based payment model?

In addition to general information, CMS welcomes presentation of any examples of specific outpatient procedures for which actual episodes have been developed, with an explanation of how the questions above were answered in those episodes.

SECTION II: COMPLEX AND CHRONIC DISEASE MANAGEMENT EPISODE-BASED PAYMENT OPPORTUNITIES

Given the complexities and costs of treatment for Medicare beneficiaries with chronic medical conditions, specialist practitioners may share responsibility with primary care practitioners for a certain aspect of a chronically ill beneficiary's care (such as an ongoing cardiac condition) during an episode. While the beneficiary's primary care practitioner would continue to serve as the principal manager of other existing and emerging medical conditions, the specialist practitioner would play an important and ongoing role. CMS is considering development of a model that would incentivize specialists to more efficiently manage the care provided to beneficiaries with complex or chronic medical conditions over the period of time that corresponds to the specialty practitioner's long-term involvement with managing the beneficiary's care. CMS would also consider scenarios where the specialist practitioner is primarily responsible for both the care a beneficiary receives for a chronic condition and the preponderance of care received by that beneficiary.

CMS recognizes that the model described above may resemble plans for the Medicare Physician Fee Schedule (PFS) to establish a separate payment for chronic care management furnished to patients with multiple chronic conditions, slated to begin in CY 2015 pending notice and comment rulemaking for that year. The separate PFS payment described in the 2014 PFS final rule is expected to be contingent on several aspects of care, such as 24 hours per day, 7 days per week access to address a patient's acute chronic care needs and maintenance of a person-centered plan of care document, and covers chronic care management for 30-day periods of time.

While CMS would intend for any new Innovation Center model developed to coordinate closely with the chronic care management services described in the 2014 PFS final rule (available at <http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Federal-Regulation-Notices-Items/CMS-1600-FC.html>), there would be substantive differences in this new model. Specifically, under the new payment model discussed above, CMS intends to incentivize more rapid changes in both services rendered and expenditures through a more comprehensive payment model that encompasses payment for an episode of care including all applicable payment systems. There is also the potential under this payment model for bundled payment for a prolonged episode. Distinctions

between this payment model and existing primary care initiatives include a more comprehensive payment mechanism as well as the substantial accountability that specialist practitioners can take on over the period of the episode.

Toward the consideration of this model, CMS is seeking responses to the following questions related to complex and chronic disease management episode-based payment opportunities:

- How should CMS define a complex medical management model, both in terms of the applicable medical conditions or diseases, the services furnished, and the payment mechanism?
 - What specific health conditions and/or specific specialties should the model target? Why?
 - Would new services be required under this model in order to improve beneficiary care? If so, what are these new services and how should they be paid for under this model?
 - How could accountability for drugs prescribed be factored into the payment model?
 - What are the important considerations in assigning the responsibility for care (to either the comanaging specialist practitioner or the primary care practitioner) in such a model?
 - What examples of this model have been tested in the private sector that further the evidence base?
 - What quality measures should be assessed for this model to ensure safe and effective care?
 - What opportunities and challenges would exist in defining an episode of care?
- What should be the distinctive characteristics between this complex medical management model and the chronic care management model discussed in the 2014 PFS final rule or other primary care initiatives currently operated by CMS?
- Which factors would influence a practitioner's decision about whether or not to apply to participate?
- How can CMS encourage the adoption of such a model among other payers?
- What challenges might be encountered in implementing such a model?
- What other factors should CMS consider in the development of a complex medical management model?