October 3, 2016

VIA ELECTRONIC MAIL

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Room 445-G, Hubert H. Humphrey Building
200 Independence Avenue SW
Washington, DC 20201

Re: CMS- 5519-P

The Health Care Transformation Task Force (HCTTF or Task Force) [1], which is comprised of 43 organizations including patients, payers, providers, and purchasers, respectfully submits our consensus comments on Medicare's Advancing Care Coordination Through Episode Payment Models (EPMs): Cardiac Rehabilitation Incentive Payment Model and Changes to the Comprehensive Care for Joint Replacement Model (CJR) proposed rule (CMS- 5519-P) ("Proposed Rule").

We believe clinical episode-related payments can promote high-quality, high-value and transparent care for Medicare beneficiaries and encourage coordination among providers. These outcomes can be achieved while ensuring access to care and freedom of choice for Medicare beneficiaries, regardless of the severity of their illnesses. Moreover, we applaud many of the design features in the new proposed models; the Proposed Rule outlines the framework for programs that could become very successful at reducing Medicare spending and improving patient care. Our comments offered herein reflect a desire to refine this important initiative to help promote programmatic success in an efficient and effective manner.

Generally, the HCTTF continues to advocate for full transparency in all matters related to clinical episode payment programs, including details about the specific methodology for setting target prices for each hospital. We believe this openness will lead to shorter cycle times to refine program designs while also promoting greater understanding and trust in the technical aspects of any bundled payment program.

[1] The Health Care Transformation Task Force (the Task Force) came together to accelerate the pace of delivery system transformation. We share a common commitment to transform our respective business and clinical models to deliver the triple aim of better health, better care and reduced costs. Our organizations aspire to put 75 percent of their business into value-based arrangements that focus on the triple aim by 2020.

Data is key to fostering consensus and reaching agreement on the appropriate structures to manage bundled payment programs, as discussed further in this letter. We also believe that bundled payments can offer needed transparency for patients in the evaluation and selection of health care providers.

A. Considerations for EPM and CJR within the Quality Payment Program

The Task Force greatly appreciates that CMS has incorporated in this Proposed Rule our earlier recommendation to create a track for EPM and CJR participants to qualify to be Advanced APMs. As noted in our comments to CMS on the Merit-Based Incentive Payment System and Alternative Payment Model Incentives proposed rule, **we support CMS's proposal to provide opportunities for willing APM entities to voluntarily assume additional obligations which would help them move their transformation progress forward.** We commend CMS for allowing organizations willing to push their transformation efforts forward to reap the benefits of doing so.

B. Make program design and monitoring data available to all participating providers as soon as is practical

The Task Force appreciates that CMS recognizes the importance of providing the ability for EPM participants to request baseline data prior to the start of the first EPM, as well as monthly claims files thereafter as soon as is practical. Providing claims data in advance of the program will improve the ability of providers to conduct necessary analyses and undertake thoughtful and informed care redesign. Further, claims data should be made available for all EPM Collaborators and providers affected by the implementation of EPMs. In particular, post-acute care (PAC) providers find it difficult to access the data needed (*e.g.*, claims data on readmissions) to support care coordination capabilities.

In addition to making claims data available, we strongly urge CMS to provide EPM participants with necessary monitoring data on a more frequent basis. Further, CMS should make interim federal evaluation results, which are currently only made available on an annual basis, available more frequently.

C. Improve claims data quality

Similar to CJR, CMS proposes annual financial reconciliation of performance. The Task Force encourages CMS to take the requisite steps to improve claims data quality and operational capacity for performing quarterly financial reconciliations. The Task Force believes that annual reconciliations can diminish the power of financial incentives associated with care re-design, and also create financial hardship for EPM participants. Even for EPM Participants with large episode volumes, the working capital requirement to

manage a bundled payment program approximates 2% to 4% of total claims payments in those programs. **The Task Force recommends that CMS endeavor to refine the data processes and support an option for eligible EPM Participants to elect quarterly financial reconciliation**, similar to that of BPCI. Should quarterly reconciliations not be administratively feasible, we urge CMS to adopt a policy that provides reconciliations twice a year. The optional increased frequency of reconciliations will allow for program participants to fund requisite working capital needs and better utilize the influence of gainsharing payments to drive performance improvement.

D. Continue BPCI and implement additional voluntary bundled payment models

To minimize disruption in the emerging bundled payment programs, we recommend allowing the BPCI efforts in this space to continue. Specifically, for those BPCI programs that have selected episodes that overlap with EPM payments, we recommend allowing their programs to continue as currently structured for at least the duration of the EPM demonstrations.

The Task Force supports the proposal to implement a new voluntary bundled payment model for CY 2018 where the model(s) would be designed to meet the criteria to be an Advanced APM. We again encourage CMS to include stakeholders in the design process in a more substantive way than through the public comment process. We strongly believe that CMS should include private sector clinical episode experts (including BPCI participants), consumers, patients and purchasers in the development of episode's construction methodologies, quality metrics and the sharing of episode risk based on experience with the BPCI Initiative and private sector programs, and urge CMS to meaningfully engage stakeholders appropriately in future episode development. The Task Force is willing to provide feedback on the current voluntary bundle program, and will do so through separate correspondence in the coming months.

E. Protect minimal volume hospitals from variability

The Task Force appreciates that CMS has considered the relative difficultly for hospitals with minimal case volumes to control for variability under bundled payment programs, and supports the proposal to establish a lower stop loss threshold for these programs. However, **we recommend modifications to the proposed low volume policy in order to protect those typically smaller hospitals from the consequences of random variation of outcomes**.

First, we urge CMS to offer a lower stop-loss threshold for hospitals defined as "low volume" under the Proposed Rule. We also recommend that the definition of "low-volume," be defined by cases per year (*i.e.*, annually), rather than as an aggregate of cases across

three historic years. As proposed, the AMI episodes anchored by MS-DRGs 280-282 would have a low volume threshold of less than 75 cases, and the CABG episodes would have a low volume threshold of 50 cases across three historic years. **We recommend increasing the low volume threshold for the AMI episodes anchored by MS-DRGs 280-282 and the CABG bundles due to the relative risk and severity of those cases from a clinical perspective. Further, the proposed SHFFT episode low volume threshold of 50 cases across three historic years should be increase**d due to the relative risk of the episode's higher acuity procedures when compared to other orthopedic episodes such as the lower extremity joint replacements.

F. Extend EPM collaborator definition to include all APM Entities

We applaud CMS for proposing to expand the list of individuals and entities eligible to be an "EPM collaborator" to include hospitals, Critical Access Hospitals, and ACOs. **The Task Force recommends also allowing EPM Participant Hospitals, subject to the existing requirements for billing Part B services during the episode, to make gainsharing payments to and receive alignment payments from all types of APM Entities as defined under the Quality Payment Program.**

These APM Entities – which are often, like those participating in MSSP, "a legal entity separate from" the participants or EPM episode initiators – have "proven track records of providing Medicare providers and suppliers with care redesign and care management assistance for Medicare beneficiaries." (*See* 81 *Fed. Reg.* 50919.) It is possible for a participant under the Next Generation ACO or a BPCI Awardee Convener to serve the same purposes as an MSSP ACO. Limiting EPM Collaborator arrangements to only APM Entities that are participating in MSSP could limit potential for care redesign, care coordination, and patient engagement services provided by these other types of APM Entities.

G. Reward evidence-based clinical decision making

A core principle in value-based care is that patients receive the most appropriate care when they need it. While creating pricing efficiency is an important aspect of value-based care models, the HCTTF believes that clinical decision-making based solely upon cost considerations will not best serve patients. In the case of post-acute services under Medicare alternate payment models, appropriate care choices may be unduly influenced by their cost and impact on the APM entity's bottom line. The HCTTF believes that post-acute providers should be given payment flexibility so they are not bound to accept the Medicare fee-for-service payment rate when participating in a Medicare APM. Creating payment flexibility will allow for better market competition and help ensure that care delivery

choices are made based on evidence-based clinical protocols, quality, and patient needs, and not for an unrelated reason.

In accounting for high cost outliers, CMS proposes to calculate and apply ceilings for high cost outlier episodes such that payments are capped at the price MS-DRG anchor value that is two standard deviations above the regional mean, in alignment with the EPM price-setting groupings. (*See* 42 C.F.R. proposed §512.300(e)(1).) However, the proposal does not distinctly address the cases in which Medicare accepts a beneficiary's appeal of Medicare Provider Non-Coverage after the discharging physician determined not to certify that patient for Skilled Nursing Facility ("SNF") care.

For example, in the case where Medicare allows an appeal for an extended length SNF stay – in contradiction with the Participant hospital's clinical judgement on appropriate level of care – the policy as proposed does not place a cap spending unless it reaches the "high cost outlier" level. **The Task Force believes that CMS should consider creating additional flexibility for hospitals to follow clinically-directed, evidence-based discharge criteria and not penalize hospitals for cases where Medicare allowed an appeal**, regardless of whether that case meets the high cost outlier definition as currently proposed.

H. Explore market-based solutions to managing multiple payment models

The Task Force anticipates that the instances of APM program overlap at the provider and beneficiary level will increasingly occur with the proliferation of APM participation under the MACRA's Quality Payment Programs. The coexistence of multiple APMs is not cause for concern in and of itself; indeed, we consider episode-based payment models to be a valuable mechanism for holding providers who are caring for patients during an episode accountable within a population-based payment model. However, the potential for APM program synergy in achieving the Triple Aim is limited by current precedence policies which create a disincentive for APM adoption and coordination.

In order to encourage bundles to be better integrated as a component of population-health focused value-based payment programs, we believe CMS should allow more flexible, market-based options where parties can mutually agree to manage model overlap based on their individual situation. **The Task Force intends to submit to CMS a set of specific policy recommendations and operational considerations to support market-based solutions for managing model overlap, which will represent consensus positions among ACOs and bundled payment participants along with patients, purchasers, and payers within our membership**. We look forward to working closely with CMS to encourage the increased adoption of value-based payment models and improved opportunities for

providers to achieve the Triple Aim.

Where parties cannot mutually reach an agreement to manage overlap, the Task Force supports testing an approach to manage the model overlap through excluding beneficiaries aligned to the Next Generation ACOs and Comprehensive ESRD Care model participants from EPMs, and potentially excluding MSSP Track 3 beneficiaries to create consistency for two-sided risk, prospectively aligned ACOs. However, we believe CMS should also work on an approach for testing that would allow both programs to claim a beneficiary but more fairly reconcile the payment between the two to encourage a positive interaction between population-based and clinical episode payment models.

I. Modify risk adjustment policy

As noted above, the EPMs proposed in this rule present a higher level of clinical risk when compared to the CJR orthopedic episodes. The Task Force believes that CMS should modify the risk adjustment policy to reflect the relative riskiness of the procedures as well as the beneficiary-specific demographic characteristics and clinical indicators when setting the episode target price and determining the composite quality score.

J. Encourage patient-reported outcomes measures and streamlined submissions

As we noted in our comment letter to CMS on the CJR proposed rule, we support incentives provided for the collection of data to enable the further development of patient-reported outcomes measures (PROMs). We are pleased that CMS has continued to support this important work by proposing to incentivize SHFFT model participants that successfully submit patient-reported outcomes measures. We are concerned that the additional HCAPHS measures for SHFFT will create compounding penalties for the CJR participants that are also selected for participation in the SHFFT model.

While we commend the use of PROMs in the SHFFT model, we encourage consideration of select instruments which have been broadly tested and recommended by the International Consortium for Health Outcomes Measurement (ICHOM) for the cardiac bundles. ICHOM engaged in a rigorous process for determining measures to collect in the assessment of patients with coronary artery disease, including review of current research and registries, an expert panel, and a consensus process. The Task Force supports the use of instruments that measure both disease-specific and quality of life outcomes.

K. Make EPM participants solely responsible for beneficiary notifications

The Proposed Rule would require all EPM participants and collaborators (including providers, suppliers and ACOs) to provide notice to beneficiaries of the EPM model. We find this to be unnecessarily burdensome for providers and potentially confusing for beneficiaries to receive multiple notifications from the various collaborators. **Instead, we recommend that the EPM participants be solely responsible for notifying beneficiaries of the EPM model and also to identify any sharing arrangements or collaborator relationships.** The EPM participants will be in the best position to identify all collaborator relationships and also to identify the initiation of an EPM episode to provide timely notification to the beneficiary.

L. Transfer EPM responsibility in the case of hospital transfers

CMS proposes to continue AMI model episode responsibility under the participant hospital in instances of a "chained anchor" hospitalization. While we appreciate that the transfer hospital's quality measure performance would not be included in assessing the AMI model participant's performance in the AMI model composite quality score, we urge CMS to further limit the risk for the hospitals that need to transfer higher acuity patients by transferring responsibility for the EPM.

M. Modify gainsharing policy

The BPCI program has demonstrated the importance of gainsharing arrangements in the design of successful bundled payment programs. CMS and the Office of the Inspector General should quickly coordinate on unified guidance related to the program's fraud and abuse waivers, as well as provide a mechanism for providers to ask questions about the waivers short of a full Advisory Opinion. We also urge CMS to eliminate the caps on collaborator gainsharing and alignment payments at the entity level.

Thank you for considering our viewpoints on this important public policy matter. For more information, please contact the Task Force's Executive Director Jeff Micklos at jeff.micklos@leavittpartners.com or Director of Payment Reform Models Clare Wrobel at clare.wrobel@leavittpartners.com.

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