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October 3, 2016

Andrew M. Slavitt
Acting Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
Hubert H. Humphrey Building, Room 445–G
200 Independence Avenue, SW
Washington, DC 20201

Re: CMS-5519-P
Proposed Rule on Advancing Care Coordination Through Episode Payment Models
(81 FR 50794-51040)

Dear Acting Administrator Slavitt:

The Center for Healthcare Quality and Payment Reform (CHQPR) offers the following comments on the proposed rule from the Centers for Medicare & Medicaid Services (CMS) that would implement episode payment models for Coronary Artery Bypass Graft (CABG) procedures, surgical repair of hip/femur fractures (SHFFT), and Acute Myocardial Infarction (AMI), and that requests input on the development of future condition-specific and event-based episode payment models.

Comments on Proposed Episode Payment Models for CABG, SHFFT, and AMI

We urge that CMS withdraw its proposal to implement the proposed episode payment models for heart bypass procedures, hip/femur fracture repairs, and treatment of heart attacks. The proposed approach is essentially identical to the extremely flawed approach that CMS is using for joint replacements in its "Comprehensive Care for Joint Replacement (CJR)" program. CHQPR has detailed the serious problems with this approach in previous comments and reports (see *Bundling Badly: The Problems With Medicare's Proposal for Comprehensive Care for Joint Replacement*, available at http://www.chqpr.org/downloads/BundlingBadly.pdf). As with joint replacements, we believe that the proposed regulation would have serious negative impacts on both Medicare beneficiaries and other healthcare stakeholders by:

- making it more difficult for higher-need patients to obtain the treatment they need;
- discouraging truly innovative approaches to managing the underlying health problems;
- encouraging unnecessary surgeries;
- encouraging further consolidation in the healthcare industry, fewer choices for consumers, and higher prices for private purchasers.

This does not mean that CMS should leave the current payment system unchanged. Many Medicare beneficiaries and other patients with coronary artery disease and hip and knee problems are not currently receiving the highest quality, most affordable care possible because of barriers in the current payment system. Payment reforms are needed to address those barriers, and implementation of appropriate

payment reforms by CMS is essential. Last year, we provided detailed recommendations for how to design and implement a better approach to episode payments for joint replacements (see *Bundling Better: How Medicare Should Pay for Comprehensive Care for Hip and Knee Surgery and Other Healthcare Needs*, available at http://www.chqpr.org/downloads/BundlingBetter.pdf). Our recommendations for designing and implementing an effective payment model for treatment of hip and knee osteoarthritis are equally applicable to treatment of coronary artery disease, hip/femur fractures, and acute myocardial infarctions. **We urge that CMS withdraw the current proposal and work with physicians, hospitals, and post-acute care providers to develop a better approach that is consistent with CHQPR's recommendations.**

Comments on Potential Future Condition-Specific and Event-Based Episode Payment Models

We commend CMS for requesting input in the regulation on how future condition-specific and event-based episode payment models should be designed, and we would like to offer the following recommendations:

- **Do not limit alternative payment models to "episode" payment approaches.** In the proposed rule, CMS says it is seeking comment on model design features for potential future "condition-specific episode payment models" that could focus "…on longer-term care management…given the importance of care management over a long period of time for beneficiaries with many chronic conditions." The concept of an "episode of care" is a very desirable and appropriate paradigm for designing alternative payment models for specific *procedures* and for treatment of *acute conditions and events.* However, it is inappropriate to expand the current "episode payment" approach to treatment of *chronic* conditions or to care designed to prevent the development of health problems. Indeed, **for many types of patients, the biggest opportunity for improving quality and achieving savings is *avoiding* unnecessary episodes and events, not simply paying differently for episodes and events when they occur.** Trying to force alternative payment models for management of chronic conditions into an episode payment framework will be ineffective at best and counterproductive at worst. An example of the serious problems that can be created by trying to apply episode payment models to chronic conditions is contained in CHQPR's report *A Better Way to Pay for Cancer Care*, available at http://www.chqpr.org/downloads/BetterPaymentforCancerCare.pdf.
- **Implement models that pay specialists for management of specific conditions and combinations of conditions using the same payment model concepts being used with primary care physicians in the Comprehensive Primary Care Plus initiative.** Many patients with serious medical conditions need both treatment and care management from a physician practice that specializes in their condition. These specialist physicians want to deliver better care at lower cost for their patients, but they face the same kinds of barriers under the current Medicare payment system as primary care physicians do, e.g., no payment for non-face-to-face contacts with the physician, no payment for services delivered by nurses and other non-clinicians, and inadequate payment for patients with more severe health problems and multiple comorbidities. These barriers could be addressed by implementing the same kinds of payment models for specialists that CMS is implementing with primary care physicians in the Comprehensive Primary Care Plus demonstration, i.e., providing additional monthly care management payments and replacing all or part of office visit payments with a flexible, risk-stratified monthly payment.
- **Focus accountability measures in condition-specific payment models on services directly related to the condition, rather than total spending on all of the patients' healthcare needs.** In our experience, most physicians who are managing a health condition or a group of inter-related conditions are willing to accept accountability for spending on services they deliver or order for those conditions and for any spending needed to treat avoidable complications of the condition, because they are able to control the services that drive those types of spending. In contrast, most physicians

who are managing a particular condition have little or no control or influence over spending on services delivered or ordered by other physicians for other health problems their patients have, and it is unreasonable and counterproductive to put physicians at risk for spending they cannot control. (For more detail on how to separate the types of spending a physician can be accountable for from total spending on a patient's healthcare needs, see *Measuring and Assigning Accountability for Healthcare Spending*, available at http://www.chqpr.org/downloads/AccountabilityforHealthcareSpending.pdf.)

- **Encourage the use of physician-defined patient condition categories to ensure effective risk stratification in condition-based payment models.** Although the fee-for-service payment system is problematic because it can reward overuse of services, it helps assure higher-need patients that they can receive all of the services they need to address their health problems. Alternative payment models that are designed to control overuse need to incorporate effective risk adjustment or risk stratification components in order to protect patients against underuse and to avoid penalizing physicians for delivering and ordering services that patients need. The CMS Hierarchical Condition Category model and other claims-based regression models are not adequate for risk adjustment in condition-based payment models. Condition-based payment models must be risk stratified based on the clinical characteristics and functional status of patients that are most relevant to the types of conditions being managed. MACRA required that Patient Condition Groups be developed to better capture the differences among patients that legitimately impact resource use, and these Patient Condition Groups should be developed in collaboration with physicians so that they can be used in condition-based payment models. (For more detail on the problems with current risk adjustment systems and how to address them, see *Measuring and Assigning Accountability for Healthcare Spending*, available at http://www.chqpr.org/downloads/AccountabilityforHealthcareSpending.pdf.)
- **Allow patients to designate the physician who will be managing care for their condition(s) and require the patients to use the team of providers chosen by that physician for delivery of services related to the condition(s).** In order for condition-based payments or episode payments to be successful, it is essential that physicians know which patients they will be accountable for and that patients use the team of providers who will be working together to manage care for that condition or during that episode. Current claims-based retrospective attribution systems fail to achieve either of these goals and they should not be used as part of future alternative payment models. Instead, the Patient Relationship Categories required under MACRA should be used to indicate the role that an individual physician is playing in a patient's care. (For more detail on the problems with current attribution systems and how to address them, see *Measuring and Assigning Accountability for Healthcare Spending*, available at http://www.chqpr.org/downloads/AccountabilityforHealthcareSpending.pdf.
- **Set target spending amounts for condition-based payments and episode payments prior to the beginning of the performance period.** Physicians, hospitals, and other providers cannot plan for the delivery of healthcare services to patients if they do not know how much money they will have available to support those services. Condition-based and episode payment models need to define a risk-adjusted budget for the condition or episode *in advance*, not after care has already been delivered. Moreover, these payment amounts need to be updated annually to reflect inflation. Periodically, the actual costs of delivering services for the condition or episode should be studied to determine whether revisions in the payment amounts are needed, but this must be based on the *actual costs* of *all of the services* being delivered, not just the amounts that would have been paid under the fee-for-service system for the subset of services that would have been separately billable. (For more detail on how payment amounts should be set and updated over time, see *Bundling Better: How Medicare Should Pay for Comprehensive Care for Hip and Knee Surgery and Other Healthcare Needs*, available at http://www.chqpr.org/downloads/BundlingBetter.pdf.)
- **Allow physicians and other providers to be paid for high-value services that are not currently billable as part of condition-based and episode-based payment models that use retrospective reconciliation.** As long as payment/budget *amounts* are established *prospectively*, it can be administratively easier for multiple providers to continue billing for services under the current fee-

for-service system and then retrospectively reconciling the spending against that payment/budget rather than trying to make a single prospective payment to one of the providers or to a new entity. However, a weakness in this approach is that it can cause cash flow problems for providers who want to implement new, high-value services that are not currently billable. Although the providers may ultimately be able to cover the costs of those services when the reconciliation is done, small providers may not have adequate working capital to wait for that reconciliation to occur. To address this, new payments for high-value services should be made to providers who have agreed to be accountable for overall spending related to a condition or episode.

- **Encourage and assist physicians who manage and treat specific health conditions to develop alternative payment models for those conditions, and implement as many of those models as quickly as possible in the Medicare program.** Although we commend CMS for inviting comment on how to design additional payment models, we urge that CMS and CMMI not attempt to design new payment models itself as it has to date. Rather CMS and CMMI should encourage physicians, hospitals, and other providers to develop innovative payment models and then CMS and CMMI should move as quickly as possible to implement as many of those provider-developed models as possible. Most of the CMS and CMMI alternative payment models implemented to date have had disappointing results, and a major reason for this is that they were designed in a top-down way by CMS and CMMI with little or no input by the physicians, hospitals, and other providers who would need to actually use the payments to support services. It is time to take a different approach – a bottom-up approach – that (1) encourages providers to develop alternative payment models and (2) re-engineers the Innovation Center so that it can rapidly implement and test as many of those APMs as possible.

Thank you for the opportunity to offer these recommendations. We would be happy to answer any questions you may have about the recommendations or to provide any additional information or assistance that would be helpful to you in implementing them.

Sincerely,

Harold D. Miller
President and CEO

cc: Patrick Conway, MD, Acting Principal Deputy Administrator, CMS