NATIONAL COALITION ON HEALTH CARE

Working Together for an Affordable Future

June 16, 2015

Andrew Slavitt
Acting Administrator
Center for Medicare and 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: Fiscal Year 2016 Proposed Inpatient and Long-Term Care Hospital Policy and Payment Changes (CMS-1632-P)

Dear Administrator Slavitt:

I write to share the comments of the National Coalition on Health Care (NCHC) on the proposed FY 2016 Inpatient Prospective Payment System (IPPS) Rule, and in particular, the Request for Information regarding a potential expansion of the Bundled Payment for Care Improvement Initiative (BPCI).

NCHC is a coalition of health care stakeholder organizations committed to promoting an affordable, high-quality health system in the United States. As the nation's oldest and most diverse group working to achieve comprehensive health reform, we represent more than 100 member organizations, including health care providers, purchasers, payers, and consumers. Collectively, our organizations represent, as employees, members, or congregants, more than 100 million Americans.

The current fee-for-service (FFS) payment model in health care encourages volume and drives up health care costs in the United States. Worse, it provides little incentive for care coordination and quality care that patients, especially the most vulnerable, need. The transition to new models of care and payment is therefore vital to building a high-quality health system we all can afford.

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Bundled payments are an indispensable element of that transition. With the announced goal of directing 50% of Medicare payments through Alternative Payment Models (APMs) by 2018, the time is now to move beyond limited experiments and make episodic payment a definite part of Medicare's future.

A decision to expand episodic bundling's reach and impact would build on a long track record of success in Medicare. Medicare's own bundling pilots and demonstrations, including Geisinger Health's ProvenCare program, the Acute Care Episode demonstration, and BPCI, have already produced real savings and better care for patients.

In the comments below, we offer specific recommendations regarding how such an expansion might be accomplished, and address some of the questions and issues raised in the proposed rule.

Breadth and scope of program expansion:

1. NCHC supports a voluntary, permanent, nationwide expansion by the Center for Medicare & Medicaid Innovation (CMMI), as soon as it is certified by the CMS Office of the CMS Office of the Chief Actuary (OACT).
2. CMS should chart a path for mandatory expansion for select, high-volume procedures shown (in the BPCI demonstration phase) to have achieved the greatest impact in quality improvement and cost reduction, and that meet the CMMI and OACT certification standards for scaling successful Alternative Payment Models. This may be feasible in service lines such as orthopedics, with appropriate volume thresholds below which participation would remain voluntary.
3. We recommend that any mandatory process provide organizations operating under comprehensive value-based payment arrangements with CMS for Part A and Part B services the opportunity to opt-out of the bundled payment program. This opportunity would only be available if organizations can demonstrate use of alternative value-based payment models implemented within two-sided risk programs.

Episode definitions:

1. We advocate developing and testing methodologies for triggering certain bundles 'at diagnosis,' rather than solely at acute intervention. We believe select surgical bundles and other episodes that are patient choice therapies lend themselves to at-diagnosis bundled payments. At-diagnosis triggers will capture the important clinical and patient decisions regarding pathway and site of care for a condition or disease. CMS should carefully monitor testing of these methodologies to prevent stinting on care.
2. We encourage CMMI to explore methods to accommodate changes in mix within an episode (e.g., an increase in hip fractures in the joint episode within the same MS-DRG over time) and allow for select additional exclusions for unrelated events. Current definitions create greater variation and risk in episode costs than truly exists. Appropriate risk adjustment would be a similar compensation for the insurance risk in the current models.
3. We support exploration of bundled payments beyond acute inpatient events, particularly for high-volume procedures that have multiple claims, such as colonoscopies. We believe such

episodes may be much shorter and encourage health care providers to think broadly about the total cost of care. We also encourage consideration of bundled payments for common outpatient surgeries, such as hernia repair and knee arthroscopy.

4. CMS should explore the incorporation in the current episode exclusions definition ICD-9/10 procedure codes and HCPCS codes to accommodate services generally agreed to be unrelated to the episodes (e.g., hemophilia/other high-cost drugs that are unrelated to the specific episode, colonoscopy in a joint bundle).
5. We also believe, however, that certain expensive prosthetics, orthotics, and other customizable durable medical equipment (DME) intended solely for the use of one person should be excluded from the bundle. Inclusion of these items in the initial implementation of the Skilled Nursing Facility (SNF) PPS in 1997 resulted in clinically unnecessary delay of care until the equipment could be billed separately to Medicare Part B.[1] In response to these concerns, Congress subsequently exempted certain prosthetics from the PPS' consolidated billing. They should not be included under this program.

***Models for expansion**:*

1. NCHC believes BPCI's Model 2 should be expanded. By including both post-acute and acute care in a bundled payment, this approach has the greatest potential to incentivize care coordination across settings. But we could also support expansion of the other BPCI Models, provided that those models are shown to produce savings and quality improvements, and CMS determines that their expansion would largely complement rather than undercut the promotion of bundles incorporating acute and post-acute care.
2. Within Models 2 and 3, we support testing options for prospective payment to organizations, provided they can meet standards for reserve adequacy and demonstrate ability to administer claims payments consistent with Medicare payment rules. Organizations receiving prospective payment should meet state insurance department requirements for assuming risk, as well as meet a minimum federal standard for capital sufficiency.
3. For organizations choosing to participate in the retrospective payment option (existing Model 1, 2, or 3), we recommend a $300 fee and a $500 fee for surgical and medical episodes, respectively, as payment for care coordination and administrative services at the time CMS identifies a patient as accreting into a BPCI episode of care.

Roles of organizations and relationships necessary or beneficial to care transformation:

1. NCHC urges CMS to carefully monitor both BPCI and any expansion of the program for unintended consequences, such as stinting on care or diversion of patients to sub-optimal settings of care.
2. Certain expensive prosthetics, orthotics, and other customizable DME intended solely for the use

[1]Peter Thomas, Testimony before the House Energy and Commerce Committee, May 21, 2014. Retrieved from http://democrats.energycommerce.house.gov/sites/default/files/documents/Testimony-Thomas-HE-Medicare-Payment-Reforms-2014-5-21.pdf

of one person should be excluded from the bundle. Inclusion of these items in the initial implementation of the Skilled Nursing Facility (SNF) PPS in 1997 resulted in clinically unnecessary delay of care until the equipment could be billed separately to Medicare Part B.[2] In response to these concerns, Congress subsequently exempted certain prosthetics from the PPS' consolidated billing. They should not be included under any BPCI expansion.

3. Bundled payment for certain highly complex conditions, such as traumatic brain injuries, severe strokes, spinal cord injuries, and multiple limb trauma or amputation, should proceed only with extreme caution, and only on a voluntary basis.
4. In the event that bundled payment for any condition yields evidence of a decrease in quality, CMS should immediately modify the bundle or remove the condition from BPCI or any expanded bundled payment program.
5. To assure effective implementation of BPCI and any expansion, we urge CMS to appoint a multi-stakeholder Advisory Board, including consumer representation, to work with CMS and its contractors on all aspects of program design, pricing, and quality.

***Administering bundled payments*:**

1. We recommend additional qualification requirements for any organization accepting a prospective payment. We believe Awardees, Awardee Facilitators, or Awardee Conveners should be eligible to perform this function. However, the standards required for CMS approval should include a demonstrated ability to pay claims using Medicare payment policies, including proven computerized claims systems used by Medicare Fiscal Intermediaries or Medicare Advantage (MA) Plans. A schedule of administrative requirements should be developed that Awardees/Facilitators/Conveners must demonstrate they have in place before CMS enters into a prospective contract.
2. We further recommend that any Awardee/Facilitator/Convener entering into a Prospective BPCI contract with CMS meet the capitalization requirements outlined in our comments related to "Models for Expansion."

Quality measurement and payment for value:

1. NCHC supports strong quality standards for BPCI participation.
2. For gain-sharing payment eligibility, we suggest modest "pay for reporting" that would reward BPCI participants relying on advanced registry or EHR-based quality outcome measures. Patient-specific quality measures should be limited to a parsimonious set of outcome measures, with a focus on patient-reported experience and functional outcomes.
3. Payments to gain sharers should continue to be impacted by these measures, although we believe there should be no impact on the discount received by CMS for these measures.
4. To effectively measure quality under BPCI and any expanded program, development and adoption of measures pertaining to patient experience, the level of functional restoration or

[2] Ibid

improvement, and quality of life are essential.
5. Ultimately, we believe CMS should move toward a payment methodology that adjusts the savings potential available to participants, based on quality performance.

Modification of Medicare payment policies for BPCI patients:

1. We urge CMS to create additional payment policy waivers, at the option of Awardees/Conveners/Facilitators, to improve the performance of the BPCI program. When a provider or group of providers has taken financial accountability for the cost and quality of a patient's care, as they have under BPCI, regulations designed to limit utilization in a volume-centric, FFS payment environment become entirely obsolete and should be waived. At a minimum, we advocate that CMS:
    a. Permit waivers of hospital discharge planning requirements that prohibit hospitals from specifying or otherwise limiting the information provided on post-hospital services;
    b. Permit waivers of the SNF three-day stay rule, which requires Medicare beneficiaries to have a prior inpatient stay of no fewer than three consecutive days in order to be eligible for Medicare coverage of inpatient SNF care;
    c. Allow waivers of requirements for payment of tele-health services, such as limitations on the geographic area and provider setting in which these services may be received;
    d. Permit waivers of the homebound requirement for home health, which requires that a Medicare beneficiary be confined to the home to receive coverage for home health services;
    e. Allow BPCI participants to use Home Health Agency (HHA) services without triggering a Home Health Resource Group bundled payment. Accessing a modified form of the Low Utilization Payment Adjustment (LUPA)payment would allow participants to use only those HHA services ordered by the patient's physician, on a per visit basis rather than a case rate;
    f. Offer a waiver permitting ACOs to pay for DME supplies for in-home infusion therapy, to enable care in the home for patients who would otherwise be admitted to a post-acute care facility; and
    g. Allow payment for dialysis in an outpatient setting (for non-ESRD patients) in BPCI.

Setting bundled payment amounts:

1. We believe baseline prices must remain fixed for three to five years, subject only to trending, to allow the marketplace to be rewarded for efficient, and high-quality health care delivery. Such trending should take into account baseline pricing, with a lower trend applicable for high-cost regions. Regular re-basing will create disincentives to participate in the BPCI program, as there is no longer a FFS benchmark unaffected by BPCI and ACO initiatives.
2. Any changes to the pricing methodology should seek guidance from the proposed Advisory Board of BPCI participants.

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***Data needs**:*

1. Strong data transparency is critical to improving program performance and driving innovation.
2. We believe that providing multiple years of historic data--for all episodes and all patients for each Episode Initiator—will enable programs to assess systemic challenges faced across service lines, and lead to transformation affecting care processes across a broader cohort of Medicare patients.

Use of health information technology:

1. We recognize that strong health information technology (HIT) systems will improve the chances of program success. For this reason, we support advocate open-source solutions that lower the cost of implementing a BPCI program. This includes distribution by CMS of the software code used by CMS' contractors to bundle claims into episodes, to create target prices and manage reconciliations.
2. We encourage CMS to promote standard data definitions and file sets available via HL7 connection to improve interoperability and access to data.
3. We recommend that CMS deliver to Awardees/Conveners the 12 months of historical claims prior to anchor admission for all patients accreting into a bundled payment arrangement. These claims should be delivered as quickly as is feasible to assist program participants in risk stratification, readmission prediction, and also speed the design of interventions to avert avoidable events.

Should you have questions regarding these comments or other issues, please do not hesitate to contact myself at jrother@nchc.org or NCHC's Policy Director Larry McNeely at lmcneely@nchc.org.

On behalf of our member organizations, we thank you for your ongoing efforts to transform the care available to Medicare beneficiaries and patients across our health system. We stand ready to work with you as you bring successful models of care and payment like BPCI to scale.

Yours truly,

John Rother
President and CEO,
National Coalition on Health Care