



AMERICA'S ESSENTIAL HOSPITALS

October 3, 2016

Mr. 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

Ref: CMS-5519-P: Medicare Program; Advancing Care Coordination Through Episode Payment Models; Cardiac Rehabilitation Incentive Payment Model; and Changes to the Comprehensive Care for Joint Replacement Model

Dear Mr. Slavitt,

Thank you for the opportunity to submit comments on the above-captioned proposed rule. America's Essential Hospitals appreciates and supports the Centers for Medicare & Medicaid Services' (CMS') work to encourage improved care delivery across the entire health care industry. However, we are concerned that mandatory participation in the proposed episode payment models (EPMs), as well as provisions contained in the cardiac rehabilitation (CR) incentive payment model, might have a negative effect on essential hospitals—those dedicated to serving the most vulnerable. To this end, America's Essential Hospitals asks CMS to consider the unique challenges inherent in caring for these patient populations when finalizing this rule.

America's Essential Hospitals is the leading association and champion for hospitals and health systems dedicated to high-quality care for all, including the most vulnerable. Filling a vital role in their communities, our nearly 275 member hospitals provide a disproportionate share of the nation's uncompensated care and devote approximately half of their inpatient and outpatient care to Medicaid or uninsured patients. Essential hospitals treat more patients who are dually eligible for Medicare and Medicaid than the average hospital. These patients often have multiple comorbidities and chronic conditions and are among the most difficult to treat. More than a third of patients at essential hospitals are racial or ethnic minorities who rely on the culturally and linguistically competent care that only essential hospitals can provide. Our members provide this care while operating on margins substantially lower than the rest of the hospital field: zero percent in aggregate compared with 8.3 percent for all hospitals

nationwide.¹ Through their integrated health systems, members of America's Essential Hospitals offer a full range of primary through quaternary care, including trauma care, outpatient care in their ambulatory clinics, public health services, mental health services, substance abuse services, and wraparound services critical to vulnerable patients. Many of the specialized inpatient and emergency services they provide are not available elsewhere in their communities.

The high cost of providing so much complex care to low-income and uninsured patients leaves essential hospitals with limited resources, propelling them to find increasingly efficient strategies for providing high-quality care to their patients. Essential hospitals are constantly engaging in robust quality improvement initiatives, which range from reducing patient harm by preventing falls and bloodstream infections to reducing readmissions. They also focus on improving the patient experience by breaking down language barriers and engaging patients and families. For example, an essential hospital in Illinois began an initiative to help Chicago's chronically homeless reach stability and, in turn, reduce health care costs by providing them with permanent homes. In addition to an apartment, each patient is paired with a case manager, who helps the patient schedule doctor appointments and get on track to better health.

But improving care coordination and quality while maintaining a mission to serve the most vulnerable is a delicate balance. Some members were selected for the mandatory Comprehensive Care for Joint Replacement (CJR) model, while other members have voluntarily opted to participate in alternative payment models, such as the Medicare Shared Savings Program (MSSP), investing in infrastructure development to become part of an accountable care organization (ACO). Whether mandatory or voluntary, our members face challenges finding the resources necessary for participation in such payment models, including technology upgrades, process redesign, personnel changes, care coordination, expanded quality measurement, risk management, compliance, network development, governance, and legal restructuring. These resource constraints likely will affect essential hospitals that have been selected and would be required to participate in the proposed EPMs and CR incentive payment program.

For these reasons, America's Essential Hospitals does not support the testing of additional payment models through required hospital participation and urges CMS to consider the concerns outlined in the following comments before finalizing the proposed rule.

1. CMS should not require mandatory participation in the proposed EPMs for acute myocardial infarction (AMI) and coronary artery bypass graft (CABG) and should delay expansion of the CJR model to include surgical hip/femur fracture treatment (SHFFT).

As with the CJR model, CMS is proposing to require participation in EPMs that bundle Medicare payments to selected acute care hospitals for episodes of care involving an

¹ Landry C, Ramiah K, Rangarao S, Roberson B. *2014 Essential Data, Our Hospitals, Our Patients; Results of America's Essential Hospitals 2014 Annual Member Characteristics Survey*. America's Essential Hospitals. June 2016. <http://essentialdata.info/>. Accessed August 10, 2016.

AMI or CABG with payment provided retrospectively through a reconciliation process. As proposed, an episode of care would begin with an eligible Medicare beneficiary's inpatient admission to a participating hospital for a procedure assigned to specific Medicare-severity diagnosis-related groups (MS-DRGs) 280-282 and 246-251 for AMI, and MS-DRGs 231-236 for CABG.² Additionally, CMS proposes to expand the CJR model to include MS-DRGs related to hip fractures; namely, MS-DRGs 480-482. In all proposed models, the episodes of care would last from the date of admission through 90 days after the date of discharge from the hospital and include the inpatient stays, as well as all related care covered under Medicare parts A and B within the 90 days after discharge.

The proposed EPMs are largely based on bundled payment models being tested by CMS, such as the Bundled Payments for Care Improvement (BPCI) initiative. However, participation in the BPCI initiative and other episode-based bundled payment models is voluntary. CMS wants more participants, which would help the agency better understand the effects of bundled payment models on a broader variety of Medicare providers. As with the CJR model—the first mandatory bundled payment model, which began April 1, 2016 CMS believes mandatory participation will enable the agency to obtain information representing a wide and diverse group of hospitals that might not otherwise opt-in to such a payment model. With the CJR model, CMS reasoned that its results would help to inform the agency of how such a payment model might function if more fully integrated within the Medicare program. Given that CJR model participants have had very little experience with the model, they need to become familiar with one demonstration before potentially being required to participate in two simultaneous models—i.e., the CJR model and the proposed EPMs for AMI and CABG. We urge CMS to delay implementation of these new EPMs and any expansion of CJR.

In a recent letter to CMS, members of Congress also voiced their concerns with the speed at which experimental models are being imposed upon participants.³ The Sept. 29 letter called for CMS to cease all current and future planned mandatory initiatives under the Center for Medicare and Medicaid Innovation (CMMI). **America's Essential Hospitals does not support mandatory participation in another demonstration payment model**, such as the proposed EPMs for cardiac care, or the extension of the CJR model until hospitals have further experience with existing models. **We urge CMS to limit the size and scope of these demonstrations and ensure open, transparent communication with stakeholders in the development of new CMMI models.**

² MS-DRG 280-282 includes admission to an IPPS hospital for AMI that is treated with medical management; MS-DRG 246-251 includes admission to an IPPS hospitals with an International Classification of Diseases (ICD)-Clinical Modification (CM) AMI diagnosis code describing an initial AMI diagnosis in the principal or a secondary diagnosis code position; MS-DRG 231-236 represents an IPPS admission for this coronary revascularization procedure irrespective of AMI diagnosis.

³ Price T, Boustany CW, Paulsen E, et al. Letter to Andrew Slavitt and Patrick Conway on September 29, 2016. [http://tomprice.house.gov/sites/tomprice.house.gov/files/assets/September 29%2C 2016 CMMI Letter.pdf](http://tomprice.house.gov/sites/tomprice.house.gov/files/assets/September%2029%202016%20CMMI%20Letter.pdf). Accessed October 3, 2016.

2. If CMS moves forward with mandatory participation, the agency should consider factors related to a hospital's readiness to implement care redesign activities when selecting hospital participants for the EPMs for AMI and CABG.

CMS proposes to require participation of all hospitals, with limited exceptions, paid under the Inpatient Prospective Payment System (IPPS) that are physically located in a county in a metropolitan statistical area (MSA) selected through a simple random selection methodology. In its selection of 98 MSAs and hospital participants for the proposed EPMs, CMS considered important factors but ultimately did not use those factors in its selection process. Those factors included the degree to which a market might be more capable or ready to implement care redesign activities, such as ACO penetration and experience with other bundling efforts.

Additionally, CMS did not incorporate any MSA-level demographic measures in its selection process, such as distributions of population by age, gender, or race; percent of population dually eligible for Medicare and Medicaid; percent of population with specific health conditions; and other demographic composition measures. These factors vary not only between MSAs, but also by hospitals within an MSA, and they could effect a hospital's chances of success in the proposed EPMs. Specifically, these factors highlight the unique difficulties essential hospitals face in providing care to vulnerable populations and might unfairly hinder the success of such hospitals in the model. **We urge CMS to use demographic factors in its methodology for selecting hospital participants before finalizing the list of MSAs included in the proposed rule.**

The proposed rule also places financial risk solely on participant hospitals—as the episode initiators—based on CMS' assumption that, “[i]n comparison to other health care facilities, hospitals are more likely to have resources that would allow them to appropriately coordinate and manage care throughout the episode.” In making such an assumption, CMS fails to recognize that not all hospitals may have these resources. In particular, the financial preparations essential hospitals would have to make—while operating on margins substantially lower than the rest of the hospital field—would be difficult, if not impossible. If essential hospitals perform more poorly in the EPMs, they would be unfairly penalized. They would not receive any reconciliation payment and would be responsible for repayment to Medicare simply due to a lack of resources other hospitals have to build a care coordination infrastructure. For these reasons, **we urge CMS to consider the financial burden on essential hospitals when selecting participants for inclusion in the EPMs.**

3. CMS should recognize the challenges essential hospitals face in caring for vulnerable patients with complex post-discharge needs, which might disproportionately affect their success in the proposed EPMs.

We applaud CMS for its recognition that certain hospitals serving a high percentage of vulnerable populations face factors outside their control that might impede their ability to achieve savings in the proposed EPMs. Under the proposed rule, rural hospitals are afforded additional protections, as CMS recognizes “the importance of preserving Medicare beneficiaries’ access to care from these hospitals.” **We urge CMS to consider**

extending comparable protections to essential hospitals, given that they face similar challenges in preserving access to care for the most vulnerable among us.

The chronic conditions chosen by CMS for this new mandatory demonstration require not only medical intervention, but also long-term behavioral changes, combined with sustained beneficiary adherence to treatment plans, to achieve desired outcomes. Members of America's Essential Hospitals understand the critical contribution social services make to achieving effective care transitions and improved outcomes, including reduced readmissions. For example, one essential hospital in Missouri developed a care transitions program that led to fewer hospital admissions, fewer emergency department (ED) visits, and cost savings. This hospital identified the need to establish a multidisciplinary team, bringing together licensed clinical social workers, client-community liaisons, and advanced practice registered nurses, among other staff, so that a hospital could focus on not only the clinical, but also the social issues affecting their patient population. Taking into account the patient's care goals and treatment preferences, while also addressing access barriers that might affect a patient's chance of being re-hospitalized, is an ongoing challenge for essential hospitals.

As noted in the recent National Academies of Sciences, Engineering, and Medicine (NASEM) report examining methods of incorporating social risk factors in Medicare payment, "achieving good outcomes (or improving outcomes over time) may be more difficult for providers caring for patients with social risk factors precisely because the influence of some social risk factors on health care outcomes is beyond provider control." To achieve CMS' intended goals for the proposed EPMS, essential hospitals face the compounded task of identifying a patient's or caregiver's capability and availability to provide necessary post-discharge care, as well as the availability of community-based services, including non-health care services such as transportation, meal services, housing for homeless patients, and language assistance. For these reasons, essential hospitals require additional protections under the proposed rule.

For the first two performance years of the EPMS, participants will be compared largely against their own historical episode cost performance data in the setting of target prices for the episodes of care included in the EPMS. However, we are concerned that essential hospitals will be disproportionately impacted in later performance years, when episode benchmarks and quality-adjusted target prices are based heavily on regional cost performance data—i.e., two-thirds regional data and one-third participant-specific data in performance year 3 and only regional data in years 4 and 5. As noted by CMS in the proposed rule, non-health care factors unrelated to practice patterns, such as a beneficiary's socioeconomic status, "could become more germane" in performance year 3. Therefore, it is important that CMS appropriately identify these hospitals upfront that are providing care to a high percentage of vulnerable populations.

We urge CMS to look to Section 1900 of the Social Security Act (SSA) to identify hospitals serving a high number of vulnerable patients. The SSA directs the Medicaid and CHIP Payment and Access Commission (MACPAC) to review and report on payment policies under Medicaid and the Children's Health Insurance Program (CHIP), including "[d]ata identifying hospitals with high levels of uncompensated care

that also provide access to essential community services for low-income, uninsured, and vulnerable populations, such as graduate medical education, and the continuum of primary through quaternary care, including the provision of trauma care and public health services.” CMS should identify hospitals meeting these characteristics and account for them in policies related to the proposed EPMs. In doing so, the agency will ensure that essential hospitals can successfully meet the goals of these EPMs while sustaining their missions to fulfill community needs. Like the agency does for rural hospitals, **we encourage CMS to incorporate policies that address known challenges of essential hospitals and ensure fairness in the implementation of the proposed EPMs.**

4. CMS should only include in the model reliable and valid measures that are risk-adjusted for sociodemographic factors, endorsed by the National Quality Forum (NQF), and specific to the selected EPMs to provide an accurate representation of hospital quality of care and patient experience without unduly penalizing essential hospitals.

Similar to the CJR model, CMS proposes a pay-for-performance methodology for the proposed EPMs. CMS would rely upon a composite quality score to assign EPM participants to quality categories. The agency would issue a reconciliation payment for EPM hospital participants that achieve a level of quality based on their composite quality score in each performance year and show that actual episode spending was less than the target price set by CMS. Hospitals would be eligible to receive reconciliation payments beginning in performance year one and continuing through each of the five years of the model. A hospital that does not achieve a certain quality threshold would not receive any reconciliation payments and, in the event that its actual episode spending exceeded the target price, the hospital would be responsible for repayment to Medicare.

CMS proposes quality measures for each of the proposed EPMs, as follows:

For the AMI Model:

- Hospital-level 30-day risk-standardized complication rate (RSCR) following acute myocardial infarction (NQF #0230)
- Excess Days in Acute Care after Hospitalization for AMI (AMI Excess Days)
- Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey measure
- Voluntary Hybrid Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate Following AMI Hospitalization (NQF #2473)

For the CABG Model:

- Hospital-level 30-day RSCR following coronary artery bypass graft (NQF #2558)
- HCAHPS survey

For the SHFFT Model (same quality measures used in the CJR model):

- Hospital-Level Risk-Standardized Complication Rate Following Elective Primary Total Hip Arthroplasty (THA) and/or Total Knee Arthroplasty (TKA) (NQF #1550)
- HCAHPS Survey
- Voluntary THA/TKA Patient-Reported Outcome and Limited Risk Variable data submission

America's Essential Hospitals has concerns about these measures, in particular the outcomes measures for AMI and CABG, as these measures are not risk-adjusted for sociodemographic factors and therefore do not accurately represent the quality of care provided by essential hospitals. Additionally, the AMI Excess Days measure lacks NQF endorsement and requires further experience by hospitals before implementation. We also disagree with CMS' proposed inclusion and weighting of the HCAHPS survey measure. A measure assessing patients' experience with inpatient care is a poor measure of quality across a 90-day episode, most of which will occur after the patient is discharged from the hospital. **CMS should select a set of measures that are closely related to the procedures targeted in the proposed EPMS, endorsed by NQF, and an accurate representation of quality of care across a 90-day episode. Doing so would assist hospitals as they work to improve outcomes for these conditions and benefit the public by accurately reflecting the care being offered by hospitals.**

- a. CMS should risk-adjust for sociodemographic factors in the proposed quality measures included in the EPMS.

CMS should ensure the methodology for calculating a participant hospital's quality threshold includes adequate risk-adjustment for sociodemographic factors.

Outcomes measures, such as those found in the proposed EPMS, do not accurately reflect hospitals' performance if they do not take into account sociodemographic factors that can complicate care and are outside of hospitals' direct control—such as homelessness, income level, education, and primary language. Patients who do not have a reliable support structure at discharge are more likely to be readmitted to a hospital or other institutional setting. The methodology used in calculating these quality measures in other Medicare programs (e.g., the Hospital Readmissions Reduction Program and Hospital Value-Based Purchasing Program) does not incorporate appropriate risk-adjustment that accounts for socioeconomic status, language, insurance status, post-discharge support structure, and other factors that make providing care to vulnerable populations uniquely difficult.^{4,5}

In 2014, NQF convened an expert panel to examine whether the lack of sociodemographic adjustment might lead to incorrect conclusions about quality (i.e., the conclusion that hospitals with a disproportionate share of disadvantaged patients provide lower quality simply as a function of their case mix). The panel, which

⁴Nagasko EM, et al. Adding Socioeconomic Data to Hospital Readmissions Calculations May Produce More Useful Results. *Health Affairs*. 2014; 33(5): 786-791.

⁵Ellimoottil C, Ryan AM, Hou H, Dupree J, Hallstrom B, Miller DC. Medicare's New Bundled Payment for Joint Replacement May Penalize Hospitals That Treat Medically Complex Patients. *Health Affairs*. 2016; 35(9): 1651-1657.

ultimately recommended risk-adjusting certain quality measures for sociodemographic factors, found that excluding such factors could lead to greater disparities in care. For example, disadvantaged populations could lose access to care if providers who work primarily with them are asked to achieve the same results as those who work with wealthier populations.⁶ Without proper risk-adjustment, those providers (many of them essential hospitals) face impediments, unrelated to the quality of care delivered, that reduce their ability to achieve the quality levels required for reconciliation payments under the proposed EPMs, leaving them with even fewer resources to treat disadvantaged populations with chronic conditions.

Furthermore, the NQF board of directors approved the Sociodemographic Status (SDS) Trial Period in July 2014. The SDS Trial Period is a two-year period in which NQF will allow inclusion of SDS factors in risk-adjustment of performance measure scores when there are conceptual reasons and empirical evidence that inclusion is appropriate. At the end of the trial period, a determination will be made to either make the policy change (or some modification) permanent, extend the trial period, or rescind the temporary policy change. Additionally, as required by the Improving Medicare Post-Acute Care Transformation (IMPACT) Act, HHS' Office of the Assistant Secretary for Planning and Evaluation (ASPE) is conducting studies and making recommendations on the issue of risk-adjustment for socioeconomic status on quality measures and resource use. The results of the NQF SDS Trial Period, along with the ASPE study of risk-adjustment for SDS factors in quality measures, are forthcoming. We urge CMS to closely examine the findings of both the NQF Trial Period and ASPE study, and to align its quality programs across settings to accurately capture hospital quality performance and not unfairly penalize hospitals that serve complex and vulnerable patients. This position is supported by a growing body of literature that points to the need for such adjustment.⁷

Most recently, NASEM investigated the social risk factors that could influence performance in the CMS quality reporting and payment programs. NASEM reports that community-level elements could indicate risk that is unrelated to quality of care and generally cannot be modified by provider action.⁸ By not fully considering the differences in patients' backgrounds—which might affect complication rates and other outcome measures—the quality composite scores under the proposed EPMs will inevitably be skewed against hospitals providing essential care to people who are minorities, those who have sociodemographic challenges, and those who are uninsured. **America's Essential Hospitals urges CMS to only include in the EPMs measures that are risk-adjusted for factors relating to a patient's background, such as socioeconomic status, language, and post-discharge support structure.**

⁶ See, e.g., NQF Technical Report. *Risk Adjustment for Socioeconomic Status or Other Sociodemographic Factors*. August 2014.

http://www.qualityforum.org/Publications/2014/08/Risk_Adjustment_for_Socioeconomic_Status_or_Other_Sociodemographic_Factors.aspx. Accessed June 2015.

⁷ See, e.g., America's Essential Hospitals. *Sociodemographic Factors Affect Health Outcomes*. October 21, 2015. <http://essentialhospitals.org/institute/sociodemographic-factors-and-socioeconomic-status-ses-affect-health-outcomes/>. Accessed June 2016.

⁸ National Academies of Sciences, Engineering, and Medicine. *Accounting for social risk factors in Medicare payment: Criteria, factors, and methods*. Washington, DC. 2016.

- b. CMS should not include the HCAHPS survey as a quality measure in the EPMs or, alternatively, should reduce the weight percentage assigned to this measure.

The HCAHPS survey is one method of formally recognizing that patient experience is central to health care, shifting quality metrics from the provider to the patient perspective. However, the inclusion of this survey in the EPMs could negatively affect essential hospitals if used as part of the quality composite score used to determine hospital eligibility to receive reconciliation payments. Research has shown a greater likelihood of low HCAHPS scores reported from patients admitted via the ED, as patient-provider interactions often are more limited due to the stressful nature of the ED.⁹ Hospitals with higher ED volumes might score lower on the HCAHPS despite the fact that their quality could be the same or better than other hospitals, including those with lower ED volumes. An essential hospital, with higher ED volumes and potentially lower HCAHPS scores, might fail to meet the quality benchmarks under the EPMs and thus be ineligible to receive reconciliation payments for reasons unrelated to the quality of care provided to their surgical patients.

Additionally, the HCAHPS survey assesses the overall inpatient hospital experience, while the proposed EPMs are designed to examine and evaluate the relationship between care coordination, cost of services, and quality of outcomes for a specific subset of conditions and procedures over a much longer period of time. To capture meaningful patient experience data, the measure chosen for the EPMs should also be narrowly defined and focused on the procedures captured in the model's episode of care (i.e., hip/femur fracture and cardiac care). For these reasons, **CMS should not include the HCAHPS survey in the EPMs.**

- c. CMS should not include the proposed AMI Excess Days measure in the EPM for AMI.

The proposed AMI Excess Days measure was finalized for the Hospital Inpatient Quality Reporting (IQR) Program FY 2018 payment determination (under the FY 2016 IPPS final rule). This measure seeks to overcome the gaps believed to exist in existing measures that publicly report readmission and mortality rates following hospitalization for AMI. Specifically, the measure captures acute care utilization in the inpatient and outpatient settings, including ED visits, observation stays, and readmissions. This is a poor measure of quality because high readmission rates, included in the measures, could stem from the legitimate need to care for chronically ill patients in high-intensity settings.¹⁰ Hospitals should not be punished for high readmission rates when they are associated with lower mortality rates and good access to inpatient hospital care. By not fully considering the differences in patients' backgrounds, which might affect

⁹ Kahn SA, Iannuzzi JC, Stassen NA, et al. Measuring satisfaction: factors that drive hospital consumer assessment of healthcare providers and systems survey responses in a trauma and acute care surgery population. *The American Journal of Surgery*. 2015;81(5):537-43.

¹⁰ Brotman DJ, Hoyer EH, Leung C, Lepley C, Deutschendorf A. Associations between hospital-wide readmission rates and mortality measures at the hospital level: Are hospital-wide readmissions a measure of quality? *Journal of Hospital Medicine*, September 2016 DOI: [10.1002/jhm.2604](https://doi.org/10.1002/jhm.2604).

readmission rates in the AMI Excess Days measure, the measure calculations will inevitably be skewed against hospitals providing essential care to people who are minorities, have sociodemographic challenges, and are uninsured. CMS should gain a better understanding of the effect of this measure before including it in the EPMs.

Further, the proposed AMI Excess Days measure has not been endorsed by NQF. NQF endorsement and approval by the Measure Applications Partnership are imperative to ensure measure validity and reliability. Through these processes, measures are fully vetted and approved through a consensus-building approach that involves the public and interested stakeholders. We urge CMS to not include the AMI Excess Days measure in the proposed EPM for AMI, until hospitals and CMS can gain more experience with the measure through the IQR program.

5. CMS should provide guidance, technical support, and adequate time for hospitals to evaluate data obtained through participation in this new payment model.

It is important for hospitals to have the opportunity to analyze beneficiary-level and regional aggregate expenditure data. As such, CMS proposes to provide hospitals with historical and ongoing claims data on episodes of care for the EPMs. **We urge CMS to provide hospitals with all the claims data for any historical hospital and non-hospital episode claims included in the three-year look-back period used to set the target price for each hospital.** This data should be provided no later than December 31, 2016 in order for hospitals to begin the program July 1, In doing so, hospitals will be better able to estimate acute inpatient and post-acute spending within the applicable episode of care, evaluate practice patterns, and adequately structure care pathways. America's Essential Hospitals supports CMS' proposed data sharing for participants within the proposed EPMs. This data sharing will allow hospitals to share best practices and improve procedures, ultimately leading to aggregate improvement across hospitals in the model. The success of these proposed EPMs lies in the ability of a hospital to assess current care coordination practices, determine if alternatives exist that might be more appropriate, and ultimately improve on practices over time. **We urge CMS to afford hospitals ample time to evaluate their outcomes and resource use data to ensure success under the EPMs.**

6. CMS should adopt a definition of measure improvement that allows for more participants to receive improvement points.

Similar to the CJR model, CMS proposes to recognize EPM participants that have "substantial improvement" from the prior year's measured performance on that measure by adding into the EPM-specific composite quality scores up to 10 percent of the maximum value for each EPM quality measure. While the CJR model defined measure improvement relative to national performance, in the EPMs it would be defined as any improvement in a participant's own measure point estimate from the previous year—provided that the participant is in the top 10 percent of participants based on the national distribution of measure improvement. CMS is limiting the ability of participants to receive improvement points by only allowing those in the top 10 percent of all hospitals to receive such points. **CMS should adopt an approach that provides the greatest incentives to hospitals to achieve high or improved quality of**

care under the EPMs and is aligned with the CJR model and existing CMS programs, such as the hospital Value-Based Purchasing Program.

7. CMS should delay implementation of downside risk until at least performance year three to give hospitals adequate time to incorporate care redesign tailored to the needs of their patient population.

CMS proposed that at the completion of a performance year, the total payments for a hospital's episodes would be reconciled against an established target price that is based on a blend of the hospital's historic payments and regional payments. If a hospital's total episode payments are below the target price, the hospital would receive the difference in the form of a reconciliation payment. If spending is in excess of the target price, CMS would require repayment by the hospital, subject to applicable stop-loss limits. CMS proposes to phase in repayment responsibility, beginning in the second quarter of performance year two. **We strongly urge CMS to further delay repayment responsibility, until at least performance year three.**

As noted in the NASEM study, the achievement of good outcomes might be costly for providers caring for patients with social risk factors "owing to additional costs required to tailor care appropriately or because these patients have fewer resources outside the health systems available to contribute to outcomes."¹¹ Essential hospitals require time and resources to engage in care redesign and targeted interventions that will have the best effect on the vulnerable populations they serve. This time is particularly important due to the fact that CMS has not released the final 98 MSAs included in the EPMs and will not do so until the rule is finalized. In not knowing which hospitals will be included in this new mandatory demonstration, it is unreasonable to expect hospitals to invest resources upfront in the event that the hospital could be randomly selected for participation. This is unrealistic for essential hospitals already operating on limited or no margins.

Likewise, after the 98 MSAs are released, hospitals will only have performance year one and the first quarter of performance year two in the "no downside risk" phase. To ensure the greatest success by all hospitals in the proposed EPMs, **we urge CMS to allow EPM participants adequate time, after release of the 98 MSAs, to invest resources in development of infrastructure and care coordination without the risk of repayment responsibility, which would deplete valuable resources for improving outcomes.**

8. CMS should provide clarification and ongoing guidance related to transfers and episode attribution to avoid adverse incentives or unintended consequences.

In the proposed rule, CMS addresses hospital transfers of beneficiaries with AMI by considering common transfer scenarios that could occur based on the beneficiary's clinical needs and the hospital's treatment capacity. The success of these proposed EPMs is tied directly to a hospital's ability to properly attribute beneficiaries to an EPM

¹¹ National Academies of Sciences, Engineering, and Medicine. Accounting for social risk factors in Medicare payment: Criteria, factors, and methods. Washington, DC. 2016.

and to understand which hospital will be financially responsible for the episode of care. We are concerned with the complexity of the scenarios outlined by CMS and the risk of confusion in the field. For example, CMS describes a scenario in which a beneficiary is admitted to an initial treating hospital that is an AMI or CABG model participant and later transferred to a hospital that is not a participant. In this scenario, CMS notes that the episode would initiate at the initial treating hospital and would only be canceled for beneficiaries discharged from the transfer hospital under MS-DRGs that are not anchor MS-DRGs for AMI or CABG model episodes. We support this proposal to cancel episodes that include a final discharge MS-DRG that is ineligible for the cardiac EPM. However, we are concerned that, for those episodes not canceled, any and all care provided after transfer—i.e., care not in the control of the initiating hospital—would be included in the episode of care for which the initiating hospital is solely and financially responsible. It seems counter to the goals of the proposed EPMs that participants who have purportedly engaged in care redesign for the purpose of improving efficiency and outcomes would then have limited control over the care provided to beneficiaries transferred to a nonparticipating hospital that is not engaged in the same level of care redesign efforts. **We urge CMS to provide clarification and ongoing guidance and support related to transfers and episode attribution, and to monitor any unintended consequences.**

9. We urge CMS to consider the amount of resources required to achieve care coordination among patients with social factors affecting adherence to treatment plans and to expand the list of services eligible under the CR incentive payment model.

In addition to the newly proposed EPMs related to AMI, CABG, and SHFFT, CMS proposes a new CR incentive payment model. CMS has set incentives at \$25 per CR and intensive cardiac rehabilitation (ICR) service for each of the first 11 CR/ICR services paid for by Medicare during an AMI or CABG model episode. After the first 11 CR/ICR services are paid for by Medicare for a beneficiary, the level of the per-service CR incentive amount would increase to \$175 per CR/ICR service for each additional CR/ICR service paid for by Medicare. The goals of the CR incentive model are to: prioritize referral of beneficiaries following an AMI or CABG for CR/ICR services; monitor for beneficiary adherence to a treatment plan; and coordinate care.

Essential hospitals provide care to disproportionately high numbers of uninsured patients, many of whom have multiple comorbidities and chronic conditions, such as coronary artery disease. We understand and support CMS' goals of improved care coordination and beneficiary adherence to a treatment plan. However, we urge CMS to account for the complexities of patients at essential hospitals in the CR incentive payment model, as the costs required to achieve levels of treatment adherence will vary greatly depending upon the population being treated and sociodemographic factors beyond the control of the hospital. Cardiac diseases are chronic and common, and CR can serve as an effective prevention program, as well as being crucial in management of these diseases. As noted by CMS, these rehab services often are underutilized. When appropriately designed, incentive-based approaches could support and augment care coordination efforts already underway at essential hospitals. We are pleased that CMS is focused on addressing the gap in underutilization, particularly as it relates to vulnerable

populations and their underuse of CR services. We urge CMS to further examine the reasons for underutilization in these populations, which can vary from personal beliefs and motivation, to access to services and resources needed to comply with a treatment plan. As such, methods of promoting use of CR/ICR services and success under the proposed CR incentive payment model, will vary by hospital based on the population served and variables beyond the control of the hospital.

Care coordination is resource intensive and can be challenging for essential hospitals that serve a population with complex social needs. Our member hospitals are continuously working to develop innovative strategies aimed at overcoming potential barriers to accessing care and learn how to best engage patients in their own care. By working with patients in their homes, teams at an essential hospital in San Francisco gained important insights into their patients' social network, medication knowledge and skills, and ability to do self-management. These home visits also build trust between the family and the team. Costs associated with such activities—including, but not limited to, training for staff on patient self-management and technology to track data continuously and assess utilization to improve day-to-day efficiency and focus on at-risk patients—would not be accounted for under the CR incentive payment model. However, these care redesign costs are necessary to achieve the goals CMS has set forth for the CR incentive payment model. **We urge CMS to consider and address the amount of resources required to treat certain patients, such as those with complex conditions and social risk factors when finalizing the CR incentive payment model.**

Further, beneficiary adherence can be influenced by factors such as language access. Individuals with limited English proficiency (LEP) require appropriate language assistance or auxiliary aids and services to fully involve them in the discharge process. While people with LEP account for about 8 percent of the U.S. population, they represent more than 20 percent of the uninsured population and 12 percent of the Medicaid population.¹² Language barriers jeopardize the health of many LEP individuals and their communities by affecting their ability to access care and communicate with providers. A patient's ability to read, understand, and act on instructions has a direct effect on the likelihood of readmission and adherence to treatment plans.

CMS proposes a limited list of codes for services that would be included in the CR incentive payment model. CMS recognizes that there are other options of rehabilitation that might be used by hospitals, such as diabetes self-management training. **We urge CMS to consider expanding the list of services for which participating hospitals could potentially receive incentive payments**, to account for the full variation in services included in CR and allow more hospitals to benefit from receiving incentive payments.

10. CMS should finalize its proposed pathways for physicians participating in the CJR model and the EPMs for AMI and CABG to qualify for Advanced APM qualification.

¹² Gonzales, G. 2014. "State Estimates of Limited English Proficiency by Health Insurance Status." Issue Brief No. 40. Minneapolis, MN: State Health Access Data Assistance Center, University of Minnesota.

CMS proposes to create two tracks for the cardiac EPMS—one that would qualify as an advanced APM under proposed Medicare Access and CHIP Reauthorization Act (MACRA) regulations, and one that would not. To participate in the EPM Advanced APM track, hospitals would need to attest to use of certified EHR technology—a requirement for qualification as an Advanced APM under MACRA. We support CMS' efforts to assist providers who are participating in the CJR model and those who would be participating in the EPMS to qualify for additional financial rewards through the proposed Quality Payment Program under MACRA by including these models in the list of those that could qualify as Advanced APMs beginning in 2018.

America's Essential Hospitals appreciates the opportunity to submit these comments. If you have any questions, please contact Erin O'Malley, director of policy, eomalley@essentialhospitals.org, or at 202-585-0127.