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February 12, 2018

Seema Verma  
Administrator  
Centers for Medicare & Medicaid Services  
Hubert H. Humphrey Building  
200 Independence Avenue, S.W., Room 445-G  
Washington, DC 20201

***RE: Bundled Payments for Care Improvement Advanced***

Dear Ms. Verma:

On behalf of our nearly 5,000 member hospitals, health systems and other health care organizations, and our clinician partners – including more than 270,000 affiliated physicians, 2 million nurses and other caregivers – and the 43,000 health care leaders who belong to our professional membership groups, the American Hospital Association (AHA) is writing to request additional information and a delay in implementation of the Centers for Medicare & Medicaid Services' (CMS) Bundled Payments for Care Improvement Advanced Model (BPCI Advanced) announced on Jan. 9.

Our members support the health care system moving toward the provision of more accountable, coordinated care and are redesigning delivery systems to increase value and better serve patients. **As such, the AHA agrees with the principles underlying the BPCI Advanced model and believes it could help further these efforts to transform care delivery through better aligned incentives for providers, as well as through performance and financial accountability.** In addition, the AHA appreciates that CMS designed the BPCI Advanced model to qualify as an advanced alternative payment model (APM) under the Quality Payment Program (QPP) established by the Medicare Access and CHIP Reauthorization Act (MACRA) of 2015.

However, CMS's announcement of BPCI Advanced and the corresponding materials raise important questions for our members about the model's implementation. Of particular concern is the lack of sufficient operational detail about the model, making it difficult for hospitals and clinicians to make well-informed decisions as to participation. **Therefore, we recommend that CMS provide a complete package of detailed programmatic information, per the below recommendations, by March 1 and delay the application deadline from March 12 to April 16.**



## CALCULATION OF TARGET PRICES

Under the BPCI Advanced model, CMS will reconcile all non-excluded Medicare fee-for-service (FFS) expenditures for a clinical episode against a target price. CMS will calculate this target price based on the historical Medicare FFS expenditures for most items and services furnished during the clinical episode. To account for the variation in Medicare expenditures, CMS will adjust the target price using risk adjustment models that account for hospitals' past performance, patient characteristics and peer group characteristics. **We appreciate CMS's publication of detailed target price specifications for model years 1 and 2. We urge CMS to provide target price specifications for future model years in a timely manner.**

We also appreciate CMS's inclusion in its target price specifications a risk adjustment methodology that accounts for participants' case mix. This is particularly important considering CMS's use of peer group and regional spending in the target price calculation. Specifically, use of these factors would, to some degree, hold groups of hospitals to the same target price, despite the fact that they treat patient populations with differing levels of severity and, therefore, differing episode costs. **A robust risk-adjustment methodology in the BPCI Advanced program prevents penalizing hospitals treating the sickest, most complicated and most vulnerable patients.**

**In addition, in calculating the target price, we urge CMS to consider additional policies that would help ensure that a hospital does not have to compete against its own best performance.** Hospitals that generate savings should not be penalized in subsequent performance years by having their success make future savings more difficult to achieve. We appreciate CMS's use of peer group characteristics, including a regional component based on census divisions, to adjust the target price and believe this approach could help address this issue. However, we note that the use of a regional pricing component can disadvantage hospitals in low-spending areas that have low expenditures because they are already performing efficiently. To generate appropriate incentives for BPCI Advanced participants in both high- and low-spending areas, **we urge CMS to also consider using the higher of national or regional historical episode payments to adjust the target price.** Of course, no matter the adjustments CMS makes, programs that are designed to achieve savings for the Medicare program year after year will see diminishing returns over time. Providers in low-spending areas will first begin to encounter such limited opportunities for additional gains in efficiency, but eventually, the agency will no longer be able to continue decreasing target prices for any providers without putting quality of care at risk.

Finally, CMS has indicated that it will adjust the target price on a semi-annual basis. **We urge the agency to provide a detailed methodology for how it will re-base target prices and to ensure that any re-basing methodologies do not progressively lower target prices at an unachievable rate.** Additionally, a number of hospitals participating in the BPCI and Pioneer accountable care organization models have indicated that the target prices for these programs have often changed during the performance period, sometimes significantly and inexplicably. To further stabilize the target prices for BPCI Advanced participants, we urge CMS to update its underlying assumptions related to the target price annually, rather than semi-annually.

## **PARTICIPATION REQUIREMENTS**

There are two categories of participants in the BPCI Advanced model: convener participants (conveners) and non-convener participants (non-conveners). Convener participants bring together multiple downstream entities, or “episode initiators,” to participate in BPCI Advanced, facilitate coordination among them and bear and apportion financial risks. Episode initiators must be acute care hospitals or physician group practices (PGP), both of which may also participate as conveners themselves. A non-convener participant is a PGP or acute care hospital that bears financial risk only for itself and not on behalf of downstream episode initiators.

Under this approach, both conveners and non-conveners must take on downside risk at the start of the model. With respect to conveners, we are concerned that this requirement shifts all of Medicare’s risk to the participating conveners, including for events outside their control. **To facilitate additional participation in the BPCI Advanced model, we encourage CMS to distinguish between Medicare enrolled and non-Medicare enrolled conveners, and allow the latter to participate in the model without downside risk, similarly to its distinction between awardee and facilitator conveners in the original BPCI program.** Doing so would create a pathway for organizations that are unable to bear risk but that can provide critical infrastructure and dissemination of information to contribute to the success of BPCI Advanced.

## **REGULATORY RELIEF**

The waiver of certain Medicare program regulations is essential so that hospitals and health systems may coordinate care and ensure that it is provided in the right place at the right time. **BPCI Advanced participants should have maximum flexibility to identify and place beneficiaries in the clinical setting that best serves their short- and long-term recovery goals.** CMS stated that it has requested fraud and abuse waivers for BPCI Advanced, however, it does not appear that they have been granted yet. **We wish to emphasize that waiving the physician self-referral law and the Anti-kickback Statute with respect to financial arrangements formed by participants in the model that comply with its requirements is essential to the program’s success because it will enable participants to form financial arrangements with other providers collaborating in the model, without which they would have no real ability to make sure those providers – for whose outcomes participants will be held accountable – have a stake in achieving the model’s goals.**

In addition, we are pleased that CMS plans to waive the three-day SNF rule, geographic site requirements that limit Medicare coverage of telehealth services, and the direct supervision requirement for post-discharge “incident to” services provided in the home. **However, we urge the agency to also provide waivers of the inpatient rehabilitation facility (IRF) “60% rule,” the IRF “three-hour rule,” the 25% Patient Threshold rule<sup>1</sup>, and the home health homebound rule.** Doing so would allow post-acute care (PAC) providers to participate in this program in a more meaningful way, which is especially important given that CMS did not continue the PAC-only bundle it had included in the original BPCI program. Finally, the waivers

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<sup>1</sup> The current moratorium on the 25% rule expires Oct. 1, 2018, when BPCI Advanced is scheduled to begin.

would provide our members with valuable tools to increase quality and reduce unnecessary costs, commensurate with the level of risk and accountability that CMS is asking them to assume as it shifts the burden of risk further away from the Medicare program onto providers.

## **EXCLUSIONS FROM BUNDLED PAYMENT**

Each clinical episode in the BPCI Advanced model will exclude certain services. **We appreciate CMS's stated intent to provide an episode-specific list of MS-DRGs that will be excluded from the bundled payment, and urge the agency to do so as soon as possible.** We also encourage CMS to continue reviewing the list of exclusions from the original BPCI model and recommend that it continue its research to expand the list of services to be excluded from the bundle.

## **ATTRIBUTION METHODOLOGY**

The BPCI Advanced model will operate under a total-cost-of-care concept, in which all Medicare FFS spending for all items and services furnished to a beneficiary during the clinical episode, aside from certain specified exclusions, will be included in the clinical episode expenditures. As part of this model design, participants in BPCI Advanced will generally be financially liable for all Medicare FFS expenditures, including care furnished to beneficiaries by providers and suppliers that are not participating in the model. This degree of financial risk makes the episode attribution methodology an important part of the BPCI Advanced model.

**To that end, we urge CMS to explore more equitable options for attribution, such as those used in other BPCI models.** As it is currently designed, BPCI Advanced will attribute clinical episodes at the episode initiator level, relying on the following hierarchy of attribution:

- First, episodes will be attributed to the PGP that submits a claim that includes the attending physician;
- Second, episodes will be attributed to the PGP that includes the operating physician; and
- Third, episodes will be attributed to the hospital where the services that triggered the clinical episode were furnished.

By placing hospitals at the bottom of this hierarchy, the approach puts them at a disadvantage and may deter them from entering the model. Moreover, BPCI Advanced does not incorporate any time-based precedence rules used in earlier iterations of the BPCI program into the attribution hierarchy. This further handicaps hospitals, as physician groups who enter the program in later years can significantly reduce the episodes attributed to a hospital that has participated in the model since its inception. **Hospitals are well poised to bring providers together to improve the value and patient experience of care, and a more equitable attribution model would support their participation in BPCI Advanced.**

## USE OF QUALITY MEASURES IN PAYMENT DETERMINATION

Composite Quality Score Adjustment. Payment under the BPCI Advanced model will be tied to participants' performance on certain quality measures, using a pay-for-performance methodology. CMS will calculate a score for each applicable quality measure at the clinical episode level, and then will scale these scores across all clinical episodes attributed to a given episode initiator. CMS will then weight the scores based on clinical episode volume and total them to calculate an episode initiator-specific Composite Quality Score (CQS).

At reconciliation, CMS will adjust the positive total reconciliation amount or negative total reconciliation amount by the episode initiator-specific CQS. For the first two years of the model, CMS will cap the amount by which the CQS can adjust the reconciliation amount at 10 percent. **We urge CMS to provide more detailed information on this CQS adjustment, including how quality measure benchmarks translate to the CQS, so that applicants can determine how the CQS adjustment approach may impact them.**

**The AHA also urges CMS to clarify which of the quality measures would be applied to which clinical episodes.** As we understand it, CMS would require a hospital-wide readmission for all episode initiators and the advanced care plan measure for all PGP initiators. But it is not clear which of the five other measures included in the initial set would be applied to which clinical episodes. Without that information, it is difficult to judge fully the appropriateness of the selected measures.

Limitations of the Proposed Measures. The AHA appreciates that CMS has attempted to minimize provider data collection burden by proposing measures that already are reported in CMS programs. Nevertheless, when applied to the BPCI Advanced model, the measures have certain drawbacks, detailed below, that limit their utility in assessing the quality of care delivered under the model and that make them poorly suited for use as pay-for-performance measures in the BPCI Advanced model.

*Misalignment with BPCI Advanced Model.* **The AHA is concerned that most of the proposed quality measures are poorly aligned with the care episodes and patient populations in the BPCI Advanced model.** For example, the advanced care plan measure is required for all clinical episodes, but can only be applied to physician group initiators, as the measure is not specified or endorsed by the National Quality Forum (NQF) for application to hospitals.

**The AHA also has significant concerns about the application of the hospital-wide readmission measure that would be required for all episodes in the model.** The hospital-wide readmission measure is required for all episodes, but it is not clear which patients will be included in the measure score. Will all hospitalized patients be included in the measure, regardless of whether they are in the model? Or will CMS score the measure using just those patients in a particular episode? Either approach could prove to be highly problematic. The inclusion of all hospitalized patients in the readmission measure would be consistent with how the measure is designed, NQF-endorsed and implemented in other programs, but would mean that BPCI Advanced participants would be scored on patients not included in the model. As a

result, a significant portion of a participant's CQS would have little to do with the patients in the model.

Alternatively, limiting the measure to just those patients in the model would align more appropriately with the care episode. However, this approach is also inconsistent with how the measure is designed, and may degrade significantly its reliability and validity. **If CMS is intent on using the hospital-wide readmission measure in the BPCI Advanced model, we strongly urge the agency to re-test the measure for reliability and validity when applied to just those patients in the care episode.**

Another measure included in the measures for specific clinical episodes, AHRQ Patient Safety Indicators (PSI-90), is not currently specified for ICD-10 methodology and has significant issues with reliability and validity. **We urge CMS to reconsider the inclusion of PSI-90 in BPCI Advanced, or, at a minimum, not include PSI-90 in BPCI Advanced until ICD-10 specifications are available and have been used in the Hospital Inpatient Quality Reporting program for at least one year.**

*Lack of Sociodemographic Adjustment.* **We urge CMS to include a sociodemographic adjustment to the readmission, complication and mortality measures.** While these three topics are important, a significant body of research has demonstrated that community factors beyond providers' control – such as the ability for patients to afford medications, easy access to appropriate food and so forth – can significantly influence the likelihood of a patient's health improving after discharge or after an outpatient procedure. A sociodemographic adjustment using a well-established proxy for community factors – such as income or dual-eligibility for Medicare and Medicaid – would help to level the playing field among providers caring for large numbers of disadvantaged patients and those who do not do so. To implement a sociodemographic adjustment, CMS could use the approach it has applied to the hospital readmissions penalty program in which it places hospitals into peer groupings based on the proportion of dual-eligible patients they treat. Or, the agency could use an approach similar to the “complex patient bonus” in the Merit-based Incentive Payment System (MIPS) in which clinicians are awarded bonus points based on a combination of their proportion of dual-eligible patients, and their HCC score (which is a proxy for clinical complexity).

Furthermore, a failure to adjust measures for sociodemographic factors when necessary and appropriate can harm patients and worsen health care disparities by diverting resources away from hospitals and other providers treating large proportions of disadvantaged patients. It also can mislead patients, payers and policymakers by blinding them to important community factors that contribute to poor outcomes. Hospitals and other providers clearly have an important role in improving patient outcomes and are working hard to identify and implement effective improvement strategies. However, as a growing body of research demonstrates, there are other factors that contribute to poor outcomes. If quality measures are implemented without identifying those other factors and helping all interested stakeholders understand their role in poor outcomes, then the nation's ability to improve care and eliminate disparities will be diminished.

## DATA SHARING

Beneficiary Claims Data. Pursuant to a Data Request and Attestation (DRA) form, CMS will provide applicants with beneficiary-level claims data for the historical period used to calculate target prices as well as other historical Medicare claims data. Applicants accepted into the model then must submit a different DRA to request similar data during their participation in the model. **The AHA appreciates CMS's commitment to making these data available on a monthly basis, as the agency stated during its January 30 BPCI Advanced Open Forum. However, we urge CMS to enter into Data Use Agreements (DUAs) with participants, thus allowing the agency to provide data on a routine basis without the necessity of a lengthy data request process that is burdensome to both hospitals and CMS.** A streamlined process that ensures hospitals certify that they will meet the requirements of the Health Insurance Portability and Accountability Act (HIPAA) privacy rule also could be conducive to this end.

We support CMS's intention to make the data available in two formats (summary beneficiary-level reports as well as line-level claims data), though we believe that all participants should routinely receive both sets of data. Specifically, the summary-level data would be highly beneficial to all participants, in allowing them to quickly ascertain performance and potentially intervene in episodes as they are occurring.

**Finally, we urge CMS to provide the data in the form in which it has provided data to BPCI participants to date, which has facilitated its use.** Specifically, CMS should provide fully adjudicated claims with the episodes already constructed. In this format, only relatively minor manipulations have been necessary to place the data into a usable form.

Aggregate Regional Data. BPCI Advanced requires the establishment of tight alignment between all participants that contribute to total spending per beneficiary. To do so, participants need data regarding Medicare spending in their markets. **Therefore, we urge CMS to also provide BPCI Advanced participants with aggregate, non-beneficiary-identifiable data on the average total expenditures for relevant episodes in their census division, ideally on a monthly basis for a rolling 18-month period.** We believe these data will be critical to hospitals in tracking their performance relative to benchmarks over time.

## ALLOW PARTICIPATION IN HOSPITAL-CONVENED MODELS TO COUNT AS A MIPS APM

**The AHA applauds CMS for allowing participation in BPCI Advanced to count towards the physician QPP's advanced APM track. However, we are disappointed that participation in hospital-convened BPCI Advanced models would not count as a MIPS APM, and urge the agency to reconsider this approach.** CMS indicates that hospital-convened BPCI Advanced models would not fulfill one of the QPP's criteria for a MIPS APM – that is, having at least one MIPS-eligible clinician on a participation list. Yet, we believe CMS can actually enable hospitals to meet this requirement. Indeed, CMS has provided the ability for other facility-led APMs (i.e., the Comprehensive Care for Joint Replacement, or CJR, model) to

create participation lists. We believe this same approach should be extended to BPCI Advanced, and all other APMs (including CJR) to enable those clinicians working closely with hospitals to benefit from it. Indeed, many of these clinicians enter into financial arrangements that allow them to take on some risk for performance under the model.

The changes we recommend above would help facilitate hospitals' participation in and success under the BPCI Advanced model with regard to providing quality care to Medicare beneficiaries and achieving savings for the Medicare program. We appreciate your consideration of these issues and look forward to continuing to work with CMS on matters of great importance to hospitals, beneficiaries and the Medicare program.

If you have any questions, please feel free to contact me or have a member of your team contact Shira Hollander, senior associate director of payment policy, at (202) 626-2329 or [shollander@aha.org](mailto:shollander@aha.org).

Sincerely,

/s/

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