American Hospital Association™
Advancing Health in America

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October 20, 2020

The Honorable Brad Smith
Director
Center for Medicare & Medicaid Innovation
Centers for Medicare & Medicaid Services
7500 Security Blvd
Baltimore, MD 21244

RE: Changes to the Bundled Payments for Care Improvement Advanced Program

Dear Mr. Smith:

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 you reconsider modifications to the Bundled Payments for Care Improvement Advanced (BPCI Advanced) that the Center for Medicare & Medicaid Innovation (CMMI) announced it will implement for model year 4, which begins Jan. 1.

The AHA is deeply supportive of the Centers for Medicare & Medicaid Services' (CMS) efforts to shift the health care system toward the provision of more accountable, coordinated care. As detailed in our Feb. 12, 2018 letter, we have always agreed with the principles underlying the BPCI Advanced model and believe the model is helping further our members' efforts to transform care delivery.

However, we are concerned about the changes to BPCI Advanced that CMMI announced on Sept. 10, 2020. Some of these changes will have deeply negative effects on the program, including on participating providers and the communities they serve. In communications with program participants, the agency detailed the most significant changes to BPCI Advanced, including:

- introducing a "realized trend adjustment" to the peer group trend factor;
- removing the physician group practice (PGP) offset;
- making changes to improve the accuracy of payment for major joint replacement of the lower extremity clinical episodes;
- modifying the clinical episode overlap methodology; and

- requiring participants to select clinical episode service line groups (CESLGs), which group together a wide array of conditions and procedures, instead of one or more defined clinical episode categories.

Of the planned changes, we are most concerned about the move to CESLGs. **Requiring model participants to take on risk for large, diverse bundles of episodes – instead of allowing them to choose individual episodes as is current policy – will require more financial risk than many participants can currently bear.** For example, a BPCI Advanced participant in the sepsis episode would now also have to take on all conditions in the "Medical & Clinical Care" CESLG; these include a huge clinical range of conditions – cellulitis, chronic obstructive pulmonary disease, bronchitis, asthma, renal failure, simple pneumonia and respiratory infections, and urinary tract infection. Many of these have no obvious connection to sepsis. Similarly, a participant in the congestive heart failure episode would now have to also participate in the cardiac arrhythmia and acute myocardial infarction episodes, which would dramatically increase their episode volume and financial risk. Hospitals and health systems continue to face myriad challenges responding to the ongoing COVID-19 pandemic, including expected losses of over $300 billion before the end of the year. With flu season beginning and an anticipated increase in COVID-19 cases, many hospitals simply are not in a position to take on such a new, resource-intensive, financially risky endeavor.

Some of our members have indicated that a change of this magnitude will cause them to drop some or all of the episodes for which they are participating. This would be particularly disappointing given the significant investments many have made to participate in the program and the success they have experienced in engaging, aligning and improving patient care. Specifically, our members have made major investments in centralized care management infrastructure, information technology tools and applications, data analysis and capabilities, and many other tools to redesign care at every point along a patient's journey. Doing so has resulted in increased engagement of both providers and patients, fewer gaps in care transitions, and fewer readmissions – progress that would be quickly lost if participants are forced to withdraw from the program. The structure and funding mechanism of this APM has been critical to our members' ability to fund the care transition teams and other tools and processes that are essential to this work, even during the COVID-19 pandemic. However, when faced with a choice between ensuring they have the resources to carry out their core mission during a pandemic, and participating in this program, many will choose to carry out their core mission. And yet, it would be a grave disappointment to undo the advances in patient care and outcomes that this model has instigated.

We understand that the agency feels it needs to make modifications to the model to see it progress and achieve cost savings. **However, given the competing challenges hospitals are facing right now as detailed above, we urge the agency to, at the least, delay the implementation of these changes until model year 5.** Alternatively,

we recommend that CMMI introduce an episode drop date, with no penalty, of June 30, 2021, as it did in March 2019 when the model began. As described above, participating in BPCI Advanced is a major financial undertaking. Our members need ample time to obtain, process and analyze the data that would drive their decision to withdraw from or remain in the model. They are eager to protect the gains they have made in patient care and stay in the model, but need to be set up for success to do so.

CMMI also could enable participants to gather data on the use of CESLGs by offering a no reconciliation option for the first half of model year 4. This option would protect Medicare finances by canceling any payouts from CMMI to participants that select the option. Simultaneously, this would give participants an opportunity to perform the extensive data analysis and clinical practice changes that will be required to operationalize the additional clinical episodes they must take on as part of the CESLGs. As described above, a sepsis participant will have to participate in an additional eight clinical episodes in order to continue participating in sepsis. Affording these and other participants six months to manage the new information flows and patient volumes of their new episodes could provide the cushion they need to remain in the model in the long run.

While we are most concerned about the shift to CESLGs, we also urge CMMI to delay the other program changes it has announced. Doing so would give participants sufficient time to model their impact and make corresponding participation decisions. While the changes take effect on Jan. 1, 2021, CMMI is requiring participation decisions even sooner – by Dec. 10, 2020, a mere two months away. Given the data lag inherent in any claims-based model, participants must wait for updated data sources on which to base their participation decisions. Moreover, their 2020 data sets will of course not reflect the CESLGs and other changes, underscoring the importance of a no-reconciliation option and no-penalty drop date in 2021.

Again, we thank you for your focus on improving value for patients and providers and for your consideration of our comments. 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.

Sincerely,

/s/

Ashley B. Thompson
Senior Vice President
Public Policy Analysis & Development