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October 3, 2016

Patrick Conway
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-5519-P
P.O. Box 8013
Baltimore, MD 21244-1850

Dear Dr. Conway:

Thank you for the opportunity to provide comments on the Centers for Medicare and Medicaid Services' (CMS) recently proposed rule (CMS-5519-P) regarding the proposals for Advancing Care Coordination Through Episode Payment Models (EPMs). The Pacific Business Group on Health (PBGH) is a non-profit organization that leverages the strength of its 60 members—who collectively spend $40 billion a year purchasing health care services for more than 10 million Americans—to drive improvements in quality and affordability across the U.S. health system.

Moving toward value-based payment methodologies like bundled payments has long been a cornerstone of our members' strategy for lowering health care spending while improving the quality of care their employees receive. As part of that effort, PBGH currently administers an Employer Centers of Excellence Network (ECEN), a nation-wide travel surgery program for joint replacements, spine care, and bariatric surgery that features episodic payments to hospitals, physicians, and post-acute care providers. To date, ECEN participants have paid four centers of excellence more than $39 million in bundled payments to care for over 1,600 patients across three clinical areas.

PBGH also has several years of experience with the collection and use of patient experience and patient-reported outcome information. Until 2015, PBGH administered the California Joint Replacement Registry (CJRR), one of the first and most comprehensive joint replacement data registries in the country. Now incorporated into the nationwide American Joint Replacement Registry, CJRR is a "Level 3" registry that includes patient-reported outcome data as well as payer, provider, clinical, surgical, laboratory, pharmacy, and device information. PBGH also administers the Patient Assessment Survey (PAS), an annual survey of patient experience with medical groups among adult HMO and POS enrollees in California. PAS results are published annually at the medical group level and comprise 20% of the pay-for-performance formula administered by the Integrated Healthcare Association (IHA), the largest non-governmental physician incentive program in the country.

These and other PBGH initiatives have generated significant insights in episode payment design, quality measurement, and patient experience that can be brought to bear on CMS's evolving episode

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payment model program. It is with these lessons in mind that PBGH and its members recommend the following modifications for the final EPM rule:

1. **Shift the calculation of payment benchmarks toward negotiated rates or competitive bids (rather than fee-for-service claims).**

   Using a prospective negotiated rate rather than retrospective reconciliation of fee-for-service claims compared to a target price would have two key advantages. First, a negotiated rate would allow providers to experiment with services that do not generate a fee-for-service claim. As we noted in our comments on the initial Comprehensive Care for Joint Replacement proposal, while the proposed waivers allow hospitals to submit billing for certain non-traditional claims like telehealth consultation, many more services than CMS could exhaustively list would need to be included so that hospitals are not penalized when the benchmark is updated. This problem highlights the importance of moving away from the existing fee-for-service payment structures and more fully toward prospective payment.

   We have found that hospitals and surgeons have more opportunity to innovate in how they deploy professional staff, choose technology, and engage with outpatient and home-based services when they have full flexibility within a budgeted payment amount. Prospective bundles are indeed spreading in the hip and knee replacement market; for instance, ECEN uses a pre-negotiated rate for DRG 469 and 470 that includes pre-op diagnostics, facility and professional fees, implants, post-op clearance, and initial physical therapy.

   It is critically important for CMS to move toward a prospectively negotiated case rate since it fosters collaboration between all clinicians involved in patient care and provides predictable pricing. Several potential mechanisms are worth exploring. One involves giving facilities financial incentive to assume the greater risk and uncertainty inherent in a prospective bundle by reducing or eliminating the quality-adjusted discount percentage from the payment benchmark. Narrowing the definition of "related care" in the 90-day post-discharge period will also mitigate risk. Regardless of the ultimate mechanism CMS develops as it pursues prospective payment, we encourage the agency to keep the 90-day target but narrow the definition of related care so that directly related services like outpatient rehabilitation or infection treatment are included but a routine (and unrelated) visit to a dermatologist is not.

   A second benefit of using prospectively determined negotiated rates or competitive bids is a more rapid transformation in cost and resource use. The proposed rule uses a target price based on a provider's historical costs or the region's average costs; this approach is inconsistent with the goal of implementing innovative payment models. Current practice patterns should not be used to set a total cost for care, as widespread evidence points to

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unnecessary care and variations that result from this payment approach.[1] An episode price that strikes a balance between provider-specific and regional utilization history does not take into account an important concern that the overall baseline for these services is too high. Reliance on historical data tends to reinforce supply-side driven utilization patterns and variation that exists today. Instead, we recommend that providers bid their episode price, which would encourage competition among providers to achieve the best outcomes for the lowest cost.

2. **Expand quality measures to reflect a holistic patient experience of care.**

We strongly support CMS's stated belief that episode payment models should use pay-for-performance methodologies that simultaneously reward improvement in patient outcomes and lower health care spending. In addition, we support CMS's proposal to pay on a quality-first principle, only sharing savings with hospitals that achieve a quality score above the 30th percentile and weighting the discount percentage based on quality performance. The proposed quality measures for the cardiac models appropriately focus on patient experience and clinical outcomes; however, the focus on mortality and excess days in acute care is too narrow. CMS should expand the measures used to assess EPM participants' quality; specifically, we recommend that CMS include clinician-level measures such as the ACCF/AHA/AMA-endorsed measures for CAD and hypertension, which include both symptom management and symptom assessment,[2] or the STS CABG Composite Score that includes medication, operative care process, operative mortality, and morbidity. In addition, CMS should consider hospital-level measures that address the most common and most egregious complications and errors, such as measures of medication errors, hospital-acquired infections, and hospital-related injuries.

In future expansions to the EPM program, we encourage CMS to design models in ways that support patient engagement and shared decision-making as much as possible. For cardiac care, we support the use of patient-centered tools including the ACC Framingham and Reynolds Atherosclerosis CV Disease Risk Calculators. We strongly support inclusion of shared decision-making tools for PCI and CABG such as from the Foundation for Informed

[1] In a study based on a National Cardiovascular Data Registry Review, it was found that 12% of PCIs were classified as inappropriate among cases with non-acute indications, with substantial variation across hospitals. See PS Chan, MR Patel, LW Klein et al., Appropriate Use Criteria for Coronary Revascularization and Trends in Utilization, Patient Selection, and Appropriateness of Percutaneous Coronary Intervention, *JAMA*. 2015;314(19):2045-53. doi:10.1001/jama.2015.13764.

[2] Joseph Drozda, Jr, MD, FACC, Joseph V. Messer, MD, MACC, FAHA, FACP, John Spertus, MD, MPH, FACC, FAHA, et al., "ACCF/AHA/AMA–PCPI 2011 Performance Measures for Adults With Coronary Artery Disease and Hypertension A Report of the American College of Cardiology Foundation/American Heart Association Task Force on Performance Measures and the American Medical Association–Physician Consortium for Performance Improvement," *Circulation*. 2011;124:248 –270.

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Medical Decision Making (FIMDM) and others. These tools should take into account patient expectations and outcome goals, risk tolerance, understanding of recovery process, treatment options and consideration of stage of disease progression. However, an episode that is triggered by a hospitalization does not consider the patient engagement and shared care planning that may take place before—or may preclude—a hospitalization. We urge CMS to build the use of shared decision-making tools into the design of any future EPM models.

3. **Encourage the collection and reporting of patient-reported outcomes for cardiac models.**

Capturing and publishing patient-reported outcomes (PROs) is fundamentally important for identifying and improving health care in areas that are meaningful to patients. We support incentives provided for the collection of data to enable the further development of PRO-based measures (PROMs). We are pleased that CMS has continued to support this important work by applying the CJR PRO incentives to the SHFFT model and encourage CMS to add similar program elements to the cardiac models.

Leaders in cardiovascular care support the use of PROs and patient-reported health status in measuring cardiovascular health. For example, the American Heart Association has published a scientific statement advocating for patient-reported health status as a measure of cardiovascular health, citing the Patient-Centered Outcomes Research Institute's emphasis on the goal of "focusing on outcomes that people notice and care about such as survival, function, symptoms, and health related quality of life."[3] We encourage CMS to consider a few instruments that have been broadly tested and recommended by the International Consortium for Health Outcomes Measurement (ICHOM). ICHOM engaged in a rigorous process for determining measures to collect in the assessment of patients with coronary artery disease, including review of current research and registries, an expert panel, and a consensus process.[4] We recommend a parsimonious group of well-validated surveys that includes: the SAQ-7, Rose Dyspnea Score, and PHQ-2. Additionally, we recommend the VR-12 or PROMIS-Global instrument to measure overall health status, in parallel to the instruments available in the orthopedic models.

In the short term, financial incentives for reporting these data should be available to support the incorporation of PRO surveys into clinical practice. To best encourage the collection of

[3] JS Rumsfeld, KP Alexander, DC Goff, et al. Cardiovascular Health: The Importance of Measuring Patient-Reported Health Status A Scientific Statement From the American Heart Association, *Circulation*, June 4, 2013, Vol. 127, No. 22. http://circ.ahajournals.org/content/127/22/2233

[4] RL McNamara, ES Spatz, TA Kelley, et al. Standardized Outcome Measurement for Patients with Coronary Artery Disease: Consensus from the International Consortium for Health Outcomes Measurement (ICHOM), J Am Heart Assoc. 2015;4:e00176 7 doi:10.1161/JAHA.115.001767 (http://jaha.ahajournals.org/content/4/5/e001767)

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PROs, all participating providers should be guaranteed a financial incentive. This diverges from the approach CMS has taken with the orthopedic models; in CJR and SHFFT, providers will only see a financial benefit from their participation in the voluntary PRO option if they are already approaching the performance threshold for a higher payment level. Instead, we recommend moving the incentive for reporting PRO data outside of the quality composite score calculation to be considered separately via impact on the discount or direct financial incentive tied to sufficient PRO data submission. Though we recommend a pay-for-reporting program design in the first performance years, over time we expect CMS to move from rewarding PRO data submission to rewarding actual performance on PROMs.

4. **Establish and support infrastructure for sharing best practices among facilities and providers.**

   Our members and other purchasers recognize the potential for episode payment models to meaningfully redesign care; in addition to achieving a discount, a successful model includes features that motivate internal and external collaboration to innovate and share best practices. ECEN requires regular, facilitated calls with all participating hospitals (including surgeons, operations staff, and clinical representatives) to encourage the sharing of best practices between centers. The centers have discussed a wide range of issues on these calls, including care coordination strategies with home providers and PRO data collection methodology. We support CMS's intention to establish a learning and diffusion program, and we encourage CMS to formally establish and support a shared learning network among and across the various EPMs.

5. **Consider variation in other components of cardiac care for future models.**

   As CMS notes, the clinical conditions addressed in the proposed EPMs are common among Medicare beneficiaries. However, there is a great degree of variation in cardiac care beyond these two episodes. For example, regional differences in ambulatory and hospital care for heart failure are not explained by disease severity and thus may be good candidates for episode or population-based payment models.[5] We encourage CMS to consider future models that take a broader view of cardiac care.

We applaud CMS for making strides toward a value-driven health care system through the expansion of episode payment models in new clinical areas with nation-wide application. We are encouraged that CMS has created a track for EPM and CJR participants to qualify as Advanced APMs, allowing organizations and clinicians willing to transform their practice to reap the benefits of doing so.

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[5] GA Roth, J Brown, DJ Malenka. Medical Practice Variations in Heart Failure, **Medical Practice Variations**, 2015. doi: 10.1007/978-1-4899-7573-7_81-1. http://link.springer.com/referenceworkentry/10.1007/978-1-4899-7573-7_81-1

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Although episode payment models alone will not achieve the full transformation our system needs, they will help increase transparency, improve the coordination and quality of care, and stabilize costs.

Please contact me should you require any additional information or clarification.

Sincerely,

William E. Kramer

William Kramer
Executive Director for National Health Policy
Pacific Business Group on Health