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April 19, 2017

VIA ELECTRONIC MAIL
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Room 445-G, Hubert H. Humphrey Building
200 Independence Avenue SW
Washington, DC 20201

Re: CMS- 5519-IFC

Dear Administrator Verma:

The Consumer-Purchaser Alliance is a collaboration of leading consumer and employer organizations committed to improving the quality and affordability of health care through value-based payment and care delivery, effective measurement, and transparency to drive quality improvement, inform consumers, and guide payment.[1] We appreciate the opportunity to comment on the interim final rule with comment period regarding the implementation timing and effective dates related to the Comprehensive Care for Joint Replacement (CJR) model and the Episode Payment Models (EPMs).

A high-value health care system requires value-driven payment arrangements. We continue to support CMS's pursuit of opportunities to spread effective value-based payment to more providers through the expansion of EPMs. Our constituents have had success improving health outcomes and the value of care with episode-based or bundled payment programs, demonstrating they can be a lever to improve care coordination, align providers, spur effective innovation, and control costs.

Delay of and Changes to the Episode Payment Models

Although we are eager for a system-wide transition to value-based payment and high-value care, we acknowledge the potential benefits of delaying the effective date of the EPMs. In particular, further delaying the EPM start date to January 1, 2018 aligns performance periods with the anticipated start of the Advanced Bundled

[1] For brevity, we refer in various places in our comments to "patient" and "care," given that many Medicare programs are rooted in the medical model. People with disabilities frequently refer to themselves as "consumers" or merely "persons." Choice of terminology is particularly important for purposes of care planning and care coordination, when the worlds of independent living and health care provider often intersect.

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Payment for Care Improvement (BPCI) model, thereby reducing barriers for any EPM participants who subsequently choose to enter into a more comprehensive episode model via BPCI. More broadly, this would provide adequate preparation time for hospitals, clinicians, and other providers who have not yet implemented an episode-based payment model.

Despite our support for this particular delay, we are concerned about broader delays that could impede momentum for moving from volume- to value-based payment. We recommend that CMS use this delay to strengthen the design of the EPM and CJR programs.

- Additional high-value patient-reported outcomes: We were pleased that CMS adopted a voluntary patient-reported outcome for the EPM CABG model. As recommended in our previous comments on these models, we encourage CMS to add incentives for the voluntary collection and reporting of patient-reported outcomes for all cardiac models. We recommend the short-form seven-item version of the Seattle Angina Questionnaire (SAQ-7), the Rose Dyspnea Scale, and the short-form two-item version of the Patient Health Questionnaire (PHQ-2).[2] In addition, we recommend that CMS incorporate global health surveys in the patient-reported outcome voluntary reporting option for any EPM. Specifically, CMS should include the global health surveys currently available for reporting under the CJR program (i.e., VR-12 and PROMIS Global Physical Health). These measures are critical to CMS's ability to evaluate and track the program's impact from the patient perspective.

- Alignment with Quality Payment Program: We support the alignment of CMS's bundled payment programs with the Advanced Alternative Payment Model (AAPM) track of the Quality Payment Program (QPP). This alignment strengthens incentives for clinicians to participate in payment models that have the greatest potential to transform the health care system. We encourage CMS to maintain a high bar for AAPMs through options like the episode models in which providers can opt to take on risk sooner to qualify.

In addition to immediate changes to the program effective in October or January, we strongly urge CMS to make more substantial changes to the program design to improve the value and impact of the models. One such change would be to expand the definition of episodes to begin before hospitalization. A hospital admission trigger offers no mechanism to ensure that the hospitalization itself is appropriate, and may perversely reward the delivery of unnecessary care. An episode that encompasses care in advance of admission better enables shared care planning and

[2] Please see our comments on the initial proposals for the Episode Payment Model program from October 3, 2016. http://consumerpurchaser.org/files/CPAlliance_EPM_Comments_2016.pdf

decision-making and other patient-centered elements of care design and delivery. We recommend the following high-impact changes which, taken together, would significantly improve the value of the program:

- **Episode models must allow for patient-centered evaluations that are comprehensive, multi-disciplinary, and allow for multiple treatment options.** Through the Employer Centers of Excellence Network (ECEN), large employers are improving joint replacement, spine care, and bariatric surgery for patients by using an episode-based payment model that includes a multidisciplinary comprehensive spine evaluation to determine the best treatment plan for each patient. A critical component of the program is the ability for this evaluation to result in a non-surgical treatment plan. In one year, this feature led to 14% of patients avoiding inappropriate surgery.[3]
- **Measures to reduce underuse and ensure access to beneficial, high-value care must be included in the program and updated as new measures become available.** Optimal care and outcomes are foundational, and robust use of patient-reported health and functional status can help identify patients who are best positioned to benefit from different treatment options.
- **Comprehensive shared care planning must be a core component of initial and ongoing care delivery within an episode.** Shared care planning includes collaborative provider-patient goal-setting, decision-making, and monitoring through the use of documented, completed individualized care plans. In the context of an episode of care, shared care planning should prompt patient decisions about treatment that include discussion of patient-reported health and functional status and use of high-quality, up-to-date decision aids. The use of decision aids for elective procedures has been shown to decrease the proportion of patients who choose more invasive treatment options. Comprehensive shared care planning encompasses more than just the use of a decision-making tool or decision aid, and ideally takes place prior to admission to ensure that any admissions reflect patients' informed choices about treatment options, and continues throughout the trajectory of care.[4]

Our further recommendations for future high-value EPMs follow:

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[3] O Ross, Getting to Bundled Payments: Lessons from the ECEN, presented at Maine Health Management Coalition and Maine Medical Association Annual Symposium, October 27, 2016. http://www.mehmc.org/wp-content/uploads/2016/10/Olivia-Ross.pdf

[4] For more information on shared care planning, recommendations for requirements to ensure shared care planning takes place in a meaningful way, and additional appropriateness criteria, please see public comments from the National Partnership for Women & Families regarding the initial CJR proposal from September 8, 2015. http://www.nationalpartnership.org/research-library/health-care/comments-on-medicare-comprehensive-care-for-joint-replacement-payment-model.pdf

- Use patient-reported outcomes before and after treatment to support quality improvement and accountability programs. We urge CMS to include the collection and reporting of patient-reported outcomes in ways that support the further development of patient-reported outcome measures. Specifically, we recommend a pay-for-reporting approach to voluntary reporting of patient-reported outcomes for the initial implementation of EPMs followed quickly by a shift to pay-for-performance directly or as a component of a comprehensive quality assessment.
- Patient experience of care should continue to be a significant component of program design. In many programs, patient experience of care is one of the few measures used to evaluate elements of care that patients and family caregivers identify as most important to improving their health outcomes and to their care experience.
- Use a prospective negotiated rate rather than retrospective reconciliation of fee-for-service claims compared to a target price. A prospective negotiated rate would allow providers to experiment with services that do not generate a fee-for-service claim. In addition, it would promote a more rapid transformation in cost and resource use by relying on market forces and competitive bids to set appropriate rates, rather than extrapolating the cost of an episode based on historical costs.[5]

Finally, these recommendations could be applied to the existing cardiac models by merging the AMI and CABG admissions-triggered episodes into a broader CAD chronic care episode model that is triggered by an initial CAD diagnosis or by some clinically designated threshold of condition severity.

The above recommendation would increase the focus on patients' needs and preferences. We encourage CMS to integrate these design principles into any future episode models beyond cardiac-specific conditions.

APM Beneficiary Ombudsman

In the January 3, 2017 final rule, CMS writes that the agency intends to "establish an Alternative Payment Models Beneficiary Ombudsman [APMB Ombudsman] within CMS who will complement the Medicare Beneficiary Ombudsman in responding to beneficiary inquiries and concerns arising from care under the models addressed in this final rule, as well as other Innovation Center models."[6] We strongly support the

[5] Please see also public comments from the Pacific Business Group on Health regarding the initial EPM proposal from October 3, 2016.
http://www.pbgh.org/storage/documents/commentary/PBGH_EPM_comments_2016_10_03.pdf
[6] Centers for Medicare & Medicaid Services (CMS), "Advancing Care Coordination Through Episode Payment Models (EPMs); Cardiac Rehabilitation Incentive Payment Model; and Changes to the Comprehensive Care for Joint Replacement Model," 82 FR 180 at 430.

creation of this APMB Ombudsman program and ask CMS to move forward with urgency. Beneficiaries whose care is provided through APMs have unique questions and may face a variety of issues, and a centralized, expert resource with information about all of the APMs will support CMS's existing information networks and allow for robust tracking of complaints and problems. The delay of the EPMs and the Cardiac Rehabilitation Incentive Payment model should not delay the establishment of this needed office, which will serve beneficiaries receiving care through all current and future CMS APMs, not only those described in this interim final rule with comment.

Thank you for considering our perspective on the implementation and further evolution of episode-based payment models, and on the urgent need for an APMB Ombudsman program. We believe a well-designed, patient-centered episode payment model can be an important part of the transformation to improve our nation's health care system. If you have any questions, please contact Stephanie Glier, Senior Manager for the Consumer-Purchaser Alliance, at sglier@pbgh.org.

Sincerely,

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