August 17, 2023

Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
Hubert H. Humphrey Building
200 Independence Ave., SW
Washington, D.C. 20201

SUBJECT: CMS-5540-NC, Request for Information; Episode-Based Payment Model, Federal Register (Vol. 88, No. 136), July 18, 2023

Dear Administrator Brooks-LaSure:

On behalf of our more than 400 member hospitals and health systems, the California Hospital Association (CHA) appreciates the opportunity to respond to the Centers for Medicare & Medicaid Services' (CMS) request for information (RFI) related to episode-based payment models. Many of our members have experience with episodic payment through their participation in Center for Medicare and Medicaid Innovation (CMMI) models such as the Bundled Payment for Care Improvement (BPCI), Comprehensive Care for Joint Replacement (CJR), and Bundled Payment for Care Improvement Advanced (BPCI-A) models. CHA offers feedback based on member experience.

General Comments

CHA believes that episodic payment models, if properly constructed, have the potential to improve patient outcomes while appropriately reimbursing hospitals and other participants for the costs associated with innovating and improving care processes. However, CHA is deeply concerned that CMMI's focus has been on generating cost savings for the program without commensurate emphasis on improving patient outcomes. As an example, we cite the significant changes to the BPCI-A payment model that made participating in the program untenable. CMMI's significant, mid-contract changes forced many providers out of the program and curtailed the quality gains they had achieved with their physician partners. Further, CHA is concerned that the RFI did not include a dedicated section on how any new CMMI model could include features that would meaningfully engage beneficiaries so that they are true partners in their own care. This is a disappointing oversight, and CHA encourages CMS to provide additional details on how these models could better leverage the patient experience.

The RFI states that CMMI is interested in pursuing a mandatory model because it would "help overcome voluntary model challenges such as clinical episode selection bias and participant attrition." However,

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CHA notes there is a considerable body of evidence from internal CMMI reports, its contractors' evaluations of models, and health policy think tank analysis of CMMI models that selection bias is not the issue that has prevented CMMI models from achieving greater improvements in patient outcomes while reducing the total cost of care.[1] Instead, the frequently cited reasons for participant attrition and underwhelming results include CMMI's continued inability to share data with participants in a timely manner, multiple overlapping demonstrations with separate complex requirements, and inappropriately calculated benchmarks that are rebased frequently, making it difficult to achieve future savings. All of these issues are consistent — as discussed in detail below — with feedback from CHA's members who have participated in CMMI's various alternative payment models.

Further, as CMMI contemplates a mandatory model, CHA is concerned that it has little appreciation for the considerable costs associated with participating in an episodic payment program. Participation requires considerable time from internal staff (finance, clinical, patient registration, case management, discharge planning, social workers, and information technology), retaining external consultants/analytics vendors, and external stakeholders (community physicians, post-acute care staff) to review data, re-engineer care pathways, and monitor ongoing results to make improvements to the redesigned care workflows. Additional time is required from these individuals in response to requests from CMMI's evaluation contractors. These requests — which are frequently duplicative — add no value to patient care and require effort for hospitals to respond to.

In voluntary models, hospitals — which know their patient populations and communities — can make an informed decision as to whether or not there is a sufficient volume of patients and an opportunity to improve outcomes to merit the allocation of scarce resources to participate in a specific model, while weighing competing opportunities to improve patient outcomes. In mandatory models, as contemplated in the RFI, CMMI — without knowledge of the needs of a hospital's patient population — foists additional considerable costs upon hospitals. These additional costs also bring with them the potential for revenue reductions that hospitals may not have the ability to control if the bundle is ill-designed. Further, there is an opportunity cost to participating. If there are other conditions that present a better opportunity for patient outcome improvement, the hospital may be forced to deploy its limited resources on the CMMI-mandated episodes (or risk payment reductions) instead.

Given the margin pressures facing hospitals, CHA is deeply concerned that any mandatory model may have the unintended consequences of facilitating the reduction in access for historically underserved populations. California's hospitals continue to face unprecedented financial pressures resulting from the COVID-19 pandemic's impact on the labor market and the health care supply chain. From 2019 to 2022, costs per adjusted discharge rose 25%[2] (driven by increases in salary costs +22%, supply expenses +18%, and pharmaceuticals +19%). However, base payment rates for Medicare have failed to keep pace with input price inflation. Chronic underfunding by Medicare contributed to the recent closure of one hospital in California (Madera Community Hospital[3,4]), drove another into bankruptcy (Beverly Hospital[5]), and has forced others to eliminate financially unsustainable services to ensure the facilities can remain open. And,

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[1] https://www.healthaffairs.org/content/forefront/mandatory-participation-medicare-demonstrations-necessary
[2] https://www.kaufmanhall.com/insights/research-report/california-hospital-financial-impact-report-april-2023-update
[3] https://calmatters.org/health/2023/01/hospital-closure/
[4] https://abc30.com/madera-commuity-hospital-remains-closed-emergency-services-residents/12922392/#:~:text=Ashraf.-,Madera%20Community%20Hospital%20closed%20its%20doors%20in%20December%20of%20last,Madera%20for%20over%20forty%20years.
[5] https://www.latimes.com/california/story/2023-04-20/beverly-hospital-in-montebello-files-for-bankruptcy-in-effort-to-avoid-closure

unfortunately, more hospital closures are anticipated. Kaufman Hall, a nationally renowned consulting firm, estimates 20% of California's hospitals are currently on the financial brink.

The financial challenges facing hospitals — which were recognized in the Medicare Payment Advisory Commission's recent hospital payment update recommendations to Congress[6] — threaten access to care for not just Medicare beneficiaries, but all members of the affected community. Following hospital or service line closures, patients are forced to travel farther distances for care in already overcrowded hospitals, resulting in negative outcomes. Research shows that rural hospital closures increase inpatient mortality by 8.7%, with Medicaid patients (including those who are dually eligible) and racial minorities bearing the brunt of negative outcomes — 11.3% and 12.6% increases in mortality, respectively. These are not abstract data points. Sadly, three individuals' deaths have already been attributed[7] to Madera Community Hospital's closing.

The negative operating margins that result from inadequately low payment rates and high costs limit hospitals' ability to invest in facilities and staff necessary to attract more commercially insured patients. As a result, many hospitals that care for large populations of underserved individuals are forced to close service lines that — while needed by the community — are not financially sustainable[8,9] to ensure the hospital can remain in operation. In the most extreme cases of distress, these hospitals are forced to close,[10] severely limiting access to care for those in the communities served by the hospital. This is what happened to Madera Community Hospital in California.[11] A recent survey to determine the impact of Madera's closure on the Punjabi population and indigenous farm workers in the affected area found that over 60% of respondents would have to find medical centers outside of the community to receive care. Unfortunately, over half of the indigenous farm workers who responded to the survey reported they do not have a reliable mode of transportation to the nearest hospital.[12] This reduced access to care further exacerbates inequitable outcomes for patients who live in socioeconomically disadvantaged areas.[13]

CHA is deeply concerned that any mandatory payment model will exacerbate the already perilous financial situation facing many California hospitals. Further margin degradation will likely necessitate curtailing services that are desperately needed by underserved individuals but have negative margins due to a high governmental payer mix (e.g., labor and delivery services,[14] inpatient psychiatric services[15]). CHA strongly encourages CMMI to not require mandatory participation in future, untested models.

If the agency does compel participation, CHA respectfully asks that CMMI provide appropriate participation waivers for hospitals without adequate episode volume and/or hospitals that are facing significant financial distress.

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[6] https://www.medpac.gov/wp-content/uploads/2023/03/Mar23_MedPAC_Report_To_Congress_SEC.pdf
[7] https://www.fresnobee.com/news/local/article272712840.html
[8] https://www.beckershospitalreview.com/care-coordination/18-hospitals-scaling-back-care.html
[9] https://www.beckershospitalreview.com/finance/10-hospitals-closing-departments-or-ending-services.html
[10] https://www.beckershospitalreview.com/finance/19-hospital-closures-bankruptcies-in-2022.html
[11] https://www.beckershospitalreview.com/care-coordination/in-a-matter-of-days-healthcare-access-deteriorates-in-central-california.html?
[12] https://a27.asmdc.org/press-releases/20230511-community-organizations-release-survey-effects-madera-hospital-closure
[13] https://www.fresnobee.com/news/local/article272712840.html
[14] https://subscriber.politicopro.com/article/2023/08/its-a-crisis-maternal-health-care-disappears-for-millions-00109106?source=email
[15] https://www.beckershospitalreview.com/finance/10-hospitals-closing-departments-or-ending-services.html

Defining Low-Volume Hospitals: While CMS has experimented with winsorization, the greater the protection from outcomes beyond the hospital's control, the lower the opportunity to generate the net payment reconciliation amount (NPRA) necessary to engage physicians and pay for the infrastructure required to participate. Therefore, CHA believes that in any mandatory model, CMMI should set a minimum threshold of cases that a hospital must meet to be required to participate. In CJR and BPCI-A, CMMI incorporated such a threshold — 40 cases over four years — but it was far too low. **Based on conversations with CHA's members and other experts, we believe that 100 cases per year is an appropriate threshold.** Also, CHA notes that in the outpatient prospective payment system (OPPS), CMS has a specific policy for pricing ambulatory payment classifications with 100 or fewer single procedure claims. CHA notes that if CMS struggles to price a discrete outpatient service, that challenge is exponentially greater when trying to set a target price for an extended episode of care for an individual hospital.

Not only does setting a threshold of at least 100 episodes provide financial stability in target prices and help to minimize the insurance risk that participants are forced to assume when they are compelled to participate, but it also supports care process re-engineering in several ways. First, there needs to be a sufficient volume of claims to identify systematic unwarranted variance. CHA continues to hear from its members that minimum scale is necessary to successfully re-engineer care to both identify opportunities for improvement and implement redesigned care pathways. Second, the opportunity to improve patient outcomes needs to be significant enough to engage physicians — both those managing the acute phase of the admission, primary care physicians managing the ongoing chronic condition(s), and post-acute partners. CHA notes that due to state law, California's hospitals are not allowed to employ physicians. While engaging community physicians is critical in any care redesign effort, the success or failure of a California hospital in an episodic payment model is solely dependent on community physicians. CHA notes there is a significant opportunity cost for physicians when they participate in care redesign efforts, as the time they spend reviewing data and attending meetings is currently not billable to the Medicare program. Therefore, for any hospital to engage physicians, there must be a sufficient volume of cases that the potential NPRA available covers the opportunity cost of community physicians' time.

Demonstrated Financial Distress: In addition to insufficient volume, as discussed above, CHA believes that hospitals that can demonstrate they are experiencing financial distress should not be required to participate in a mandatory episodic payment model. CMS should explore using metrics such as the presence of a negative operating margin and days cash on hand below the average ratings agency median for below investment grade debt.

The determination of distress is specific to an individual hospital. Therefore, the determination of whether a hospital is distressed for purposes of excluding it from a mandatory episodic payment model must be made at the individual hospital level. Many hospitals experiencing financial distress are affiliated with larger health care systems that may not be financially distressed overall. Historically, these systems have acquired distressed or safety-net facilities to further their missions of ensuring access to health care for all — especially for individuals who are at greater risk of inequitable health care outcomes. However, if legislators and regulators evaluate financial distress at the corporate level for hospitals that are affiliated with health systems, it will have a chilling effect on these systems' continued willingness to acquire distressed facilities to preserve access in underserved communities.

The determination of whether or not a hospital meets the criteria for financial distress should be based on hospital-submitted data, not publicly available data. First, this will allow for more current data to be used in the determination, which avoids the time lag between most recently available financial results and publicly available data. Second, the days cash on hand and current ratio metrics cannot be accurately calculated for system hospitals using publicly available data. To accurately calculate facility-level days cash on hand and current ratios for individual system hospitals, these facilities will need to submit additional documentation that documents the intercompany transfers of funds, allowing for the accurate calculation of both measures.

Despite the concerns discussed above, if CMMI elects to move forward with a mandatory model with limited exclusions for low-volume hospitals and no exclusion for financially distressed hospitals, CHA strongly encourages the agency to make the model upside only. This will allow for the robust participation necessary for the analysis to be statistically significant, but not expose hospitals — particularly small and/or financially distressed hospitals — to the risk and related payment reductions that could negatively impact access for historically underserved populations.

Finally, if CMMI moves forward with a mandatory model, it needs to offer infrastructure funding to smaller hospitals, similar to the accountable care organization (ACO) advanced incentive payment available to smaller ACOs. These funds could be used — among other things — to make investments in analytical infrastructure, support staff, pay physicians for participating in care redesign efforts, or create linkages with community support organizations that can address social issues that negatively impact outcomes for the targeted population and foster better transitions of care.

Beneficiary Engagement

While all of CMMI's models have made efforts to "engage" beneficiaries, they are both time-consuming and, from the beneficiary's perspective, ineffective at best or confusing at worst. As noted above, CHA is deeply disappointed and concerned the RFI did not seek feedback on how to improve beneficiary engagement and would, as it relates to beneficiaries who should be the focal point of these models, follow the care redesign maxim of "nothing about me without me."

Historically, CMMI has put the onus of educating beneficiaries about episodic payment models on the model participants. However, CHA believes that this education should be a collaborative partnership between CMMI, CMS, and participants. **Therefore, CHA strongly encourages CMS to include education about any new mandatory model as part of the Welcome to Medicare packet, Medicare beneficiaries manual, and specific letters sent to beneficiaries who live in any area where hospitals are compelled to participate.**

Further, CHA notes the mandatory beneficiary engagement letter is cumbersome and labor-intensive to administer as required. It is also challenging for hospitals to administer in many circumstances. The letter is typically provided to beneficiaries based on the "working" Medicare severity diagnosis-related group (MS-DRG) given the mandated time frame in which participants must provide the letter to a beneficiary. As a result, hospitals end up missing some patients (typically patients admitted for medical reasons due to the emergent nature of stays, their short duration, and/or a change in the final discharge MS-DRG). CHA's members note that while they try to provide the letter to all episode-eligible beneficiaries, some

inevitably some slip through the cracks despite their best efforts. When these instances are flagged on audit reports it is demotivating for the care teams involved. **CHA strongly encourages CMMI to work with providers and beneficiaries to design a notification process that is more useful for beneficiaries and less burdensome for providers to administer.**

Clinical Episodes

In the RFI, CMMI suggests that in the anticipated new model, it will move toward episodes designed around an MS-DRG, similar to CJR, and away from episodes designed around service lines (similar to the current BPCI-A model). CHA strongly supports moving the episode definition away from service lines and would prefer to go back to discrete MS-DRGs, particularly if it's a mandatory model. Even still, MS-DRGs over longer episodes are challenging.

MS-DRGs do not predict post-acute spending particularly well. CHA notes there is considerable variability in spend across procedure types that map back to an MS-DRG. CHA encourages CMMI to explore — in a *future voluntary model* — organizing episodes based on procedure code as it may be more predictive of downstream spending. For example, analysis has shown the average episode cost for percutaneous coronary intervention can vary significantly depending on if the patient has acute myocardial infarction/cardiac dysrhythmias, stable coronary artery disease, or another principal diagnosis. In this instance, any variance in the distribution of primary diagnoses during the performance period relative to the distribution during the historical period used to set the target will impact a participant's performance. As a result, a participant's financial results reflect both changes in care delivery and random variation. Given that this hasn't been done before, CHA does not believe it is appropriate to trot this approach out for a mandatory model, but would again strongly encourage CMMI to experiment with ways to address this in the pricing model.

CMS requests feedback on the appropriate length of the contemplated new episodic payment model. CHA notes that there are benefits and challenges to both longer and shorter duration episodes. CHA notes that longer episodes provide a greater opportunity to focus care re-engineering efforts on ensuring that patients receive care in the most appropriate post-acute care setting based on the beneficiary's medical condition, support network, and other social determinants of health. CHA notes that much of the savings generated by prior bundled payment efforts have been the result of reducing the unnecessary use of post-acute care facilities when discharging the patient home with support from home health care and was clinically more appropriate. And, when a patient requires care in a skilled-nursing facility (SNF), ensuring that the length of the stay was clinically appropriate. However, if there aren't appropriate exclusions for unrelated clinical events, longer episodes also inappropriately transfer insurance risk to hospitals and their participating providers. This is why providers tend to favor episodes of shorter duration.

To date, CMMI's models have included narrow carve-outs for unrelated clinical conditions that have transferred insurance risk to hospitals and other participants. CHA strongly encourages CMMI, particularly if it makes the new model mandatory, to appropriately expand the clinical conditions that are excluded from the calculation of an episode's target and actual price. These exclusions should include, but are not limited to, categories such as unrelated trauma, cancer, treatment for substance use disorder, unrelated chronic conditions, and planned inpatient or outpatient services.

In prior models, CMMI has asserted it believes that any spending (except for explicitly excluded items) that occurs during the 90-day episode window is directly related to the episode and is symptomatic of uncoordinated care. However, CHA members believe a 30-day window for exacerbations of existing, unrelated chronic conditions is more appropriate. CHA notes that, for example, some states' lower joint replacement episode definitions include all-cause readmissions only if they occur from the date of surgery to 30 days post-discharge.

CHA believes CMS must exclude all Parts A and B spending resulting from an unrelated chronic condition that occurs after the 30th day post-discharge in any mandatory payment model. Beyond the question of whether the utilization is actually related to the episode, long-term if CMMI attributes all spending for chronic conditions to the episode(s), it will either need to revise the bundle definition when future episodes are introduced or exclude potentially related utilization from new episodes. CHA also urges CMS to exclude hospital readmissions or outpatient procedures that were planned for the patient prior to the start of the episode in any new model. Doing so would be consistent with other CMS policies (e.g., CMS currently excludes planned readmissions from the Hospital Readmissions Reduction Program. Further, CHA asks CMMI to ensure that for any excluded readmission from an episode definition and calculation of target price and actual price, it also excludes post-acute care following an excluded readmission. Holding a participant accountable for all patient pathways is unreasonable given how little is known about the causal relationship between the hospital readmission and subsequent post-acute care services.

Finally, CHA notes that in the BPCI-A program, CMMI created a site-neutral episode target price for lower joint replacement episodes. CHA remains concerned that CMMI has created a blended pricing structure for these episodes that does not recognize the resources required to care for sicker patients who, due to their clinical condition, must receive care in the hospital. **Therefore, CHA respectfully asks that in any upcoming payment model — particularly if it's mandatory — the agency recognize these costs and create separate pricing for inpatient and outpatient episodes of care.**

Health Equity

CHA shares CMS' goals of addressing health care disparities and improving health equity, and we appreciate that CMMI has expressed a commitment to prioritizing the unique needs of providers who care for a large proportion of underserved populations. CHA has long called for risk adjustment under alternative payment models that account for the impact of sociodemographic and health-related social needs (HRSNs) on health care outcomes. CHA has been supportive of recent efforts to include health equity adjustments in the Medicare Shared Savings Program (MSSP) and hospital and SNF value-based purchasing (VBP) programs and appreciates that CMMI is considering similar approaches for future episode-based payment models. However, CHA is not supportive of any health equity adjustment that is implemented in a budget-neutral manner, similar to the benchmark adjustment included in CMMI's ACO Reach model.

For example, CHA strongly supports the recently finalized approach under the hospital and SNF VBP programs to adopt a health equity adjustment based on performance on program quality measures multiplied by an "underserved multiplier" that uses the proportion of the facility's dual eligible population. Under the hospital VBP program, the underserved multiplier is established using a logistic

exchange function such that hospitals that care for the highest proportions of patients with dual-eligible status would have the opportunity to achieve the most health equity bonus points. The SNF VBP program uses a similar approach, but with a floor that requires that 20% of the SNF's resident population be dually eligible for the SNF to be eligible to receive health equity bonus points. This is similar to the MSSP health equity adjustment to the ACO quality score, which is limited to ACOs with an underserved multiplier of 20% or more. While CHA supports the general concept of a sliding scale health equity adjustment that incentivizes hospitals to provide care to a higher proportion of underserved patients, we urge CMMI to refrain from establishing a floor for any health equity adjustment in future episode payment models. This appropriately recognizes that all hospitals care for underserved populations and ensures all participants have the opportunity to be rewarded for exceptional care provided to underserved populations.

Medicare and Medicaid dual eligibility are understood to be the best available — though imperfect — predictor of an individual's vulnerability and predictor of poor health outcomes. While hospitals have experience with dual eligibility as a well-known proxy to identify underserved patients, CHA encourages CMS to continue to examine other factors that may indicate a hospital provides care to underserved patients, such as caring for a high proportion of Medicaid patients, Medicare beneficiaries eligible for the Part D low-income subsidy or utilizing data from new quality measures on screening for HRSNs and related ICD-10 Z-codes.

As CMS considers these additional factors, CHA cautions the agency against relying on area-level indexes such as the area deprivation index (ADI). As noted in our comments on CMS' MSSP health equity adjustment policies, CHA has significant concerns with using the ADI or other similar indexes that rely on national benchmarks. The ADI contains a number of variables that are based on the national average. These include median family income, percentage of families below the federal poverty level, median home value, median monthly mortgage payment, and median gross rent. CHA is deeply concerned that given California's higher cost of living, facilities in California would be disadvantaged by any index that does not take into account the significant regional variation in wages and the cost of living. The table below illustrates the substantial difference in wages, rents, and home values (and, therefore, monthly mortgage payments) between the medians for each of these measures in the United States and California. A recent analysis of the relationship between ADI score and median home value has only exacerbated this concern.[16]

[16] https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2022.01406?

Median Household Income,[17,18] Home Value,[19,20] and Monthly Rent[21]
California Compared to the United States

	California	United States	Diff	% Diff
Median Household Income (2020)	$ 78,672	$ 67,521	$ 11,151	17%
Median Home Value (2022)	$ 788,679	$ 440,300	$ 348,379	79%
Median Monthly Rent (2020)	$ 747	$ 602	$ 145	24%

Further, research has shown that national and regional approaches to understanding area deprivation do not properly model the impact on health outcomes.[22] A study of over 61,000 Medicare beneficiaries found that the ADI was weakly correlated with self-reported social needs (r = 0.16%) and only explained .02% of the observed variation in spending.[23] Given these considerable flaws, CHA's members and others[24] believe that using a model like the ADI in episode payment models could paradoxically worsen[25] payment disparities.

Quality Measures, Interoperability, and Multi-Payer Alignment

CHA appreciates that CMMI is looking to reduce provider burden in episode payment models by focusing on multi-payer alignment approaches to quality measurement. In addition to reducing the time spent on administrative processes, more alignment in quality measures can simplify comparisons of quality performance across models. This would allow CMS and providers to more effectively track outcomes and patient experience to determine to what extent these models improve the quality of care. However, as CMMI identifies model-specific measures, it is imperative to ensure that hospitals are evaluated on specific, actionable measures that assess the inpatient and outpatient care provided by the hospital, rather than measures that assess factors outside of the control of the hospital.

CMMI also notes its interest in developing or including existing patient-reported outcome performance measures (PRO-PMs) in future episode-based payment models. While CHA agrees there is promise in PRO-PMs, we have concerns with the significant burdens associated with data collection for these measures, which utilize data from multiple sources, including pre- and post-procedure survey instruments administered by hospitals to patients combined with claims and enrollment data. Notably, CHA members who participated in the CJR model report that the data collection burden for the voluntary measure was significant, and that measure results were not useful for evaluation data due to high levels of missing patient-reported outcome data. In particular, CHA hospitals report that it will be incredibly challenging to get completed post-operative survey data from patients, as many patients travel

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[17] https://www.census.gov/library/publications/2021/demo/p60-273.html#:~:text=Median%20household%20income%20was%20%2467%2C521,median%20household%20income%20since%202011

[18] https://www.census.gov/quickfacts/fact/table/CA/BZA210220
[19] https://fred.stlouisfed.org/series/MSPUS
[20] https://fred.stlouisfed.org/series/MSPUS
[21] https://www2.census.gov/programs-surveys/decennial/tables/time-series/coh-grossrents/grossrents-unadj.txt
[22] https://www.cdc.gov/pcd/issues/2016/16_0221.htm#:~:text=An%20area%20deprivation%20index%20(ADI)%20is%20a%20multidimensional%20evaluation%20of,outcomes%20at%20various%20geographic%20levels
[23] https://jamanetwork.com/journals/jama-health-forum/fullarticle/2803073
[24] https://www.healthaffairs.org/content/forefront/aco-benchmarks-based-area-deprivation-index-mask-inequities

[25] https://jamanetwork.com/journals/jama-health-forum/fullarticle/2803073?source=email

to a specific hospital for their elective surgeries — often from significant distances — and complete follow-up care back in their home communities under the care of other providers.

While the total knee and total hip arthroplasty PRO-PM is currently voluntary under the CJR model, CMS recently finalized this measure for inclusion in the inpatient quality reporting (IQR) program and proposed it as a measure under the hospital outpatient quality reporting (OQR) program. In the IQR program, the measure is currently voluntary, with mandatory reporting beginning for the reporting period that runs from July 1, 2025, through June 30, 2026, impacting the federal fiscal year 2028 payment determination and subsequent years. Similarly, in the calendar year (CY) 2024 OPPS proposed rule, CMS proposes this PRO-PM as a voluntary measure beginning with the CY 2025 and 2026 reporting periods, and mandatory beginning with the CY 2027 reporting period and impacting the CY 2030 payment determination. As the hospital field gains additional experience with reporting this PRO-PM in the IQR and OQR programs, CHA urges CMS to engage with stakeholders to better understand the challenges of these measures to ensure that they provide useful information that supports improving the quality of care and the patient experience. At a minimum, CHA urges CMS to refrain from including new PRO-PMs in these models until hospitals have gained sufficient experience with mandatory reporting of these measures under the IQR and OQR programs.

Payment Methodology and Structure

In general, CHA's members believe the payment methodology for any mandatory payment model must be as simple and transparent as possible. This will help reduce the costs associated with participating and support participation by physicians and other key stakeholders in the care re-engineering process. One of the common complaints about BPCI-A was the complexity of the payment model and the fact that CMS made significant revisions to the model during an ongoing contract period. The complexity of the model assured that few health systems had the capabilities in-house to project financial results. As a result, hospitals and health systems that participated relied heavily on consultants and analytics vendors. Given this is a niche skill set, CHA is concerned that if CMMI creates a mandatory model, there will not be sufficient, affordable consulting and analytic vendor capacity to support all of the participants.

Balancing against this need for simplicity and transparency, CMMI needs to incorporate a mechanism to eliminate the impact of random variation on the financial outcome of episodes. Without this modification to the program, participants are managing not only performance risk but insurance risk as well. Below please find CHA's specific recommendations related to episode payment methodology and structure.

- *Use Prospectively Set Target Prices*: **CHA strongly supports the use of a prospectively set target price. The price should be communicated well in advance of the performance period to which the price applies.** A stable, prospectively set target price is an accepted practice in commercial bundling arrangements. CHA asks that CMS communicate the final applicable target price to episodic payment model participants 90 days prior to the beginning of the performance period. CHA believes that it is important to have a stable target price that takes into account beneficiary-specific pricing factors. CHA has heard from members that a shifting target price makes it difficult to focus on changes that will reduce episode spending when the baseline fluctuates without sufficient explanation as to why it changed. These random fluctuations can have a de-motivating impact on individuals involved in care process redesign and create distrust between

the entity that is responsible for the episode and the physician partners who are crucial to re-engineering care delivery.

- *Stable Pricing Methodology Across the Life of a Mandatory Model*: **Once payment methodology is established, CMS must not change it.** First, when CMMI has revised the specifications for calculating target and actual prices, it typically does so because it believes participants are too successful in a model. What it fails to consider when it does this is that in most instances, the engagement of community physician participation was secured — in part — on the potential to share in projected NPRA that resulted from community physicians' investment of time and expertise in care redesign processes. When CMMI revised the pricing methodology in BPCI-A, many community physician partners had invested significant time, which has not been adequately compensated for with NPRA shared to date. Specifically, the addition of the Retrospective Peer Group Trend Factor made continuing in the model unsustainable for many participants and has resulted in significant attrition. It created a significant degree of distrust between community physicians and participating hospitals when the revised projections of NPRA payments were revealed to be inadequate relative to physician efforts. In many instances, these community physicians blamed the hospital for these changes, not CMS, which not only complicated the relationship as it relates to BPCI-A, but made future quality improvement efforts more challenging. If the hospital continued participating, this distrust hampered further efforts to re-engineer care pathways associated with the episode of care.

  Second, if CMMI does revise the payment methodology in a future mandatory episodic payment model, it must provide more time before these changes take effect. CHA's large health system members note that given the complexity of episodic payment models, it takes a considerable amount of time to analyze the data based on these changes, communicate them through the various levels of a hospital and health system's leadership structure, and gain consensus on next steps based on the changes. Additional time will allow participating hospitals and health systems to better educate all stakeholders, involve them in planning an appropriate response, and fully execute the necessary next steps.

- *Do Not Rebase Target Prices During a Mandatory Model*: **CHA's members believe that rebasing target prices during an episodic payment model continually stacks the deck against hospitals.** It makes it harder for them to achieve the NPRA necessary to sustain the expenses associated with the data infrastructure, consulting support, dedicated staffing, and gainsharing necessary to maintain robust physician engagement. CHA notes that this is one of the reasons why CMS extended the contract period for MSSP participants from three to five years and began adding back prior savings to an ACO's benchmark as stakeholders had recommended from the outset of the program.

  Similarly, CMMI must avoid the "ratchet effect," or what members describe as a "race to the bottom," in episodic payment models. While CHA appreciates CMS' need to generate savings for the program, if participants believe that the deck is stacked against them, they (or their physician partners) will stop participating due to opportunity cost. This short-sightedness means that improvements in quality and patient outcomes (which is what should be CMMI's focus) will fall

by the wayside. **If CMS does elect to rebase, CHA strongly encourages CMS to do so infrequently and add back prior savings similar to MSSP and other models to avoid the ratchet effect.**

- *Prospective Regional Trend Factor*: **CHA strongly encourages CMS to use a prospective regional trend factor based on hospitals that aren't participating in the model to update target prices included in the model.** Like the use of a regional trend factor in the MSSP, this will reward participants for continued efficiencies while generating savings for the program relative to what the baseline would have been in the absence of the program. It will also help mitigate the issue of rural hospitals and providers in small markets whose target prices are pushed even lower due to their prior successes.

  In any future mandatory model, CHA strongly encourages the use of a prospective trend factor. This allows participants in the model to know their base target price in advance of a model year. And given that the market trend factor is perceived by many to be a "black box" calculation, it is difficult, if not impossible, to know what changed in the target price calculation between the start of a performance year and the actual results. Therefore, the application of a retrospective trend factor makes it impossible to accurately project a hospital's financial results related to participating in a compulsory model. This uncertainty strains a hospital's relationship with the physicians with whom it has entered into gainsharing agreements to improve outcomes for Medicare beneficiaries. Many hospitals attempt to project the available gainsharing payments to physicians to maintain their engagement. However, when the projected gainsharing payments evaporate due to the application of a Retrospective Peer Group Trend Factor that hospital staff cannot explain, it sows distrust among partners, making it harder to collaborate to improve outcomes for Medicare beneficiaries.

- *Eliminate Discount Factors:* **If CMS makes a future two-sided risk model mandatory, it should also not incorporate a discount factor into the pricing methodology.** This is double-dipping on CMS' part and makes it harder for hospitals to generate sufficient savings to support care redesign efforts. CHA notes that hospitals will make substantial upfront investments and incur significant ongoing costs to coordinate care across the continuum to "participate" in a mandatory program. Further, in the current environment, most, if not all, of the revenue generated through the delivery of inefficient care is not realized by the hospital responsible for the anchor admission/outpatient procedure that bears risk in a mandatory model. CHA strongly believes that hospitals must receive a reasonable return on their investments in care coordination and process re-engineering if they successfully improve outcomes and reduce spending. Therefore, it is highly inappropriate for CMMI to both apply a discount factor and continually rebase the benchmark based on more recent data periods that eventually will include performance periods covered under the model. Therefore, CHA urges that CMMI either take a discount or rebase the benchmark, but not both.

- *Improve Timeliness of Data Sharing*: **CHA's members strongly encourage CMMI to expedite data sharing with participants to support timely interventions in beneficiary care processes that will both improve outcomes and reduce the total cost of care.** Based on conversations with

Members who participated in BPCI-A, CHA understands that Medicare's contractor pulls claims data from the Medicare system once a month. It then takes them three weeks to process data and provide it to hospitals (or their analytics partners). At a minimum, it then takes the hospital or its analytic partner three days to create usable reports from the data it received from the Medicare contractor. CHA notes this turnaround time could be as much as 70 days from the initiation of an episode before the participating hospital understands the utilization that occurred during the first month of the episode. CHA strongly encourages CMMI to develop a mechanism to provide real-time updates to episodic payment model participants. This information becomes more important to participants as target prices become depressed.

- *Ensure Fair Reconciliation Process*: **If CMS requires participation in multiple bundles at the same time, reconciliation should occur separately for each episode, not at the enterprise level.** It is unfair to base NPRA sharing for one set of physicians on the results of another, unrelated group of physicians. If CMMI nets the results of gainsharing across multiple episodes for participants, CMMI is violating one of the basic tenets of incentive design by inappropriately holding providers at risk for performance results they cannot influence. In any future mandatory model, CMMI must allow participants to develop and execute separate gainsharing arrangements with physicians (or physician practices) that are tied to the individual episodes for which the hospital is assuming performance-based risk. The ability to share gains with physicians and other participants should be predicated only on the episode-specific outcomes, not the results of all of the episodes aggregated across the enterprise. Moving to episode-specific gainsharing will hold the physician group(s) that are directly involved with re-engineering and managing beneficiary care for an episode responsible only for outcomes that they can control.

- *Improve Data Transparency:* **CMS must provide greater transparency into how data used in the model are pulled (e.g., sources, time frames), how these data elements are calculated, and how these calculations are factored into the reconciliation process.** Any factor that impacts reconciliation should be based on data that are readily available to participants, the calculations should be easily replicable by hospitals based on that data and not require the assistance of consultants for a hospital with average analytic capabilities.

- *Value-Based Purchasing Model Not Recommended:* The RFI briefly describes a potential episode-based payment model that is conceptually similar to the current inpatient hospital VBP program. **While the description of the model was limited, based on it, CHA does not support its deployment in a future mandatory episodic payment model.** CHA has heard this approach is problematic from colleagues in a state where the Medicaid agency is using a value-based purchasing-like methodology for its episodic payment program. The feedback CHA received is that a VBP model is cumbersome and increases the administrative costs incurred by participants related to tracking amounts due to/from the program. If CMMI uses this approach in a mandatory model, CHA is concerned it will only increase the costs associated with the program, reduce the transparency of results, and make it harder for smaller hospitals and independent hospitals to successfully participate.

Participation Burden – Evaluation Activities

CHA's members report that CMMI evaluation activities — data requests, reporting requirements, and site visits — related to the various episodic payment programs have been time consuming. Many of

these requirements and requests are duplicative and take valuable resources away from direct patient care.

Examples cited include:

- Overlapping reporting requirements related to updating program implementation plans and data requested by Medicare's contractor in an attempt to identify best practices/shareable care protocols
- Meeting monthly with program monitors

CHA is deeply concerned about the costs associated with duplicative overlapping evaluation efforts. In any mandatory program, CMMI must make a concerted effort to limit site visits, data requests, and other reporting requirements to the minimum necessary to understand the impact of the program. Further, CMMI in a mandatory model must compensate hospitals on an hourly basis for the time their staff spends on administrative activities resulting from CMS evaluation efforts. CHA believes it would be highly inappropriate for CMMI to mandate that participating physician practices be required to permit site visits. With the considerable time required of physicians to participate in an episodic payment model, CHA is concerned the additional burden will limit the pool of physician practices willing to partner with California's hospitals.

CHA appreciates the opportunity to comment on the episodic payment RFI. If you have any questions, please contact me at cmulvany@calhospital.org or (202) 270-2143, or Megan Howard, vice president of federal policy, at mhoward@calhospital.org or (202) 488-3742.

Sincerely,

/s/
Chad Mulvany
Vice President, Federal Policy