



April 19, 2017

Seema Verma, Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services Attn: CMS – 5519IFC
Room 445-G, Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201

Submitted electronically via <http://www.regulations.gov>

Re: CMS- 5519-IFC, Medicare Program; Advancing Care Coordination through Episode Payment Models (EPMs); Cardiac Rehabilitation Incentive Payment Model; and Changes to the Comprehensive Care for Joint Replacement Model; Delay of Effective Date

Dear Ms. Verma,

Trinity Health appreciates the opportunity to provide comments on the Centers for Medicare & Medicaid Services' (CMS) interim final rule with comment period (IFC) that delays the effective date of the new acute myocardial infarction (AMI), coronary artery bypass graft (CABG), and surgical hip/femur fracture treatment (SHFFT) Episode Payment Models (EPM), as well as the Cardiac Rehabilitation (CR) Payment Program and changes to the Comprehensive Care for Joint Replacement (CJR) program until October 1, 2017. Our comments and recommendations to CMS reflect a strong interest in public policies that support better health, better care and lower costs to ensure affordable, high quality, and people centered care for all.

Trinity Health is one of the largest multi-institutional Catholic health care delivery systems in the nation, serving diverse communities that include more than 30 million people across 22 states. Trinity Health includes 93 hospitals, as well as 120 continuing care locations that include PACE, senior living facilities, and home care and hospice services. Our continuing care programs provide nearly 2.5 million visits annually. Committed to those who are poor and underserved, Trinity Health returns almost \$1 billion to our communities annually in the form of charity care and other community benefit programs. We have 35 teaching hospitals with Graduate Medical Education (GME) programs providing training for 2,080 residents and fellows in 184 specialty and subspecialty programs. We employ approximately 97,000 full-time employees, including more than 5,300 employed physicians, and have more than 15,000 physicians and advanced practice professionals committed to 22 Clinically Integrated Networks that are accountable for 1.3 million lives across the country.

General Remarks

We are firmly committed to transforming our delivery system into a People-Centered Health System focused on delivering better health, better care, and lower costs in our communities, and we view bundled payments as an important part of that journey. Trinity Health has committed to having 75 percent of our revenue in value based arrangements by 2020 as a member of the Health Care Transformation Task Force. We believe bundled payments lead to high-quality, high-value care during Medicare beneficiaries' episodes of care and encourage coordination of care among providers. These outcomes are achieved while ensuring access to care and freedom of choice for all Medicare beneficiaries, regardless of their severity of illness.

This belief is reflected in the fact that Trinity Health has 51 facilities—40 Model 2 hospitals and 11 Model 3 Skilled Nursing Facilities (SNF)—participating in the BPCI program. In addition to our voluntary participation in BPCI, two Trinity Health hospitals are participating in the CJR program, and we have facilities in MSAs chosen for the cardiac EPMS. Our participation and commitment are directly translating to improved patient care. We estimate that we can improve nearly 21,000 episodes of care through these programs.

Given Trinity Health's commitment to the movement to value and our experience with bundled payment programs, we take this opportunity to not only support the delayed start date in this IFC, but we also offer a number of suggestions herein to refine this, and future, bundled payment initiatives.

Timing

Because patients in the cardiac and SHFFT EPMS are often clinically complex, can have multiple entry points into acute settings, and often need care coordinated across multiple providers and settings, a further delay from October 1, 2017 until January 1, 2018 may be beneficial for some providers to adequately prepare. However, we also believe that CMS should also provide an option for EPM participants to voluntarily select the October start date. The voluntary start date of October 1, 2017 will provide an opportunity for EPM participants to gain experience with the model, and provides flexibility for willing participants to move to downside risk sooner than if they are required to wait for a further delayed start date of January 1, 2018.

In addition, the continued delay in the effective date of the CJR is not preferred because it limits the ability of CJR participants to achieve qualified provider status for participating in and Advanced APM for 2017. The delay presents a lost opportunity for providers that intended to participate in the CJR Track 1 (CEHRT) starting in July. We encourage CMS to finalize those changes as soon as possible.

Overlap Between APM Models

Trinity Health supports and appreciates CMS' changes in the final rule to also exclude MSSP Track 3 participants from EPMS, thus leaving the savings in the population-based model. We appreciate the consistent treatment given to the prospectively aligned ACO models and believe this is the best approach. We also know that evidence reflects that prospectively aligned models function more effectively, and ask that you consider converting the Track 1 model to one that is prospective aligned.

In order to encourage bundles to be better integrated as a component of population-health focused value-based payment programs, we believe CMS should consider more flexible, market-based options for providers to elect to manage model overlap based on their individual situation. To assist with this policy development, Trinity Health worked with other members of the Health Care Transformation Task Force (HCTTF) to develop “Principles for Clinical Episode and Population-Based Payment Overlap”, which was released in February 2017. The HCTTF will use these principles to develop market-based strategies that can inform future policymaking and private sector decision making.

Two-sided Risk Model

Trinity Health also supports the phase in of risk under the current EPM programs, and the option to assume risk earlier in year 2 of the program for those facilities able to do so.

Shared Decision Making

Trinity Health supports notification and shared-decision making to ensure that beneficiaries receive appropriate, high-quality care, retain the freedom of choice in selecting providers for services, and understand enough about the episode and alternatives to make an informed decision about desired treatment. **We ask that CMS mandate shared-decision making using tools such as a patient-decision aid, which provides balanced, evidence-based sources of information about treatment options.**

Risk Adjustment and Caring for Vulnerable Populations

Trinity Health strongly supports greater use of risk adjustment. We believe when using measures to reward and penalize a provider, the context within which providers are working, and the patients whom they are serving, must be considered. Risk adjustment allows for fair cross-provider comparisons and does not penalize one provider over another or convey one provider is lower quality simply due to their willingness to treat any patient, or vulnerable populations more broadly, despite an increased risk in poor outcomes due to endogenous factors that are captured in proxy measures such as socio-demographic variables. For example, we recommend CMS to look at the National Quality Forum’s Report on Risk Adjustment for Socioeconomic Status or Other Sociodemographic Factors as a resource to help expend their efforts in this area.

In the context of the current EPMS, articulating a pathway to adjust for sociodemographic factors is critical to prevent facilities from cherry picking patients, or avoiding treating vulnerable populations and more complex patients – a concern that has been voiced recently by other health care experts and providers as well. CMS sought comments on what facilities that care for high proportions vulnerable populations may need to succeed under APMs. We appreciate the agency previously highlighting this issue, and recommend that adjustment for socio-demographic variables is a logical starting point and would treat all providers that care for vulnerable patients and populations equally.

Gainsharing

As CMS has previously acknowledged, the AMI and CABG EPMS are likely to require collaboration with a broader set of providers than the EPMS in the CJR program. As a result, flexibility in establishing partnerships with providers, suppliers – and collaborators or ACOs – is necessary for hospitals to successfully manage care and resources within these EPMS.

Consistent with our comments on the proposed rule, Trinity Health again recommends that CMS eliminate the caps on collaborative gainsharing and alignment payments at the entity level. CMS finalized a 50 percent cap, and in many instances this cap will not be a sufficient incentive for a physician to improve care management and resource use if their Medicare Physician Fee Schedule (MPFS) payment is small relative to the total cost of care for an episode. However, while the MPFS payment may be small in this example, the physician's care may have a large impact or disproportionate impact on the total cost of care.

Reconcile quarterly with Optional Annual Reconciliation

CMMI finalized annual reconciliation of performance and payment for the proposed EPMS. However, **Trinity Health recommends quarterly reconciliations so that organizations producing savings can offset the expenses associated with managing 90-day episodes and to provide relatively faster feedback and rewards to program participants.** We believe that certain categories of hospitals should have the option to elect annual reconciliations, recognizing the actuarial risk associated with small episode volume. For this reason, we believe annual reconciliation should be an option, consistent with the BPCI Initiative.

Quality Metrics

CMS is proposing a similar pay-for-performance approach as is used in the CJR program. Trinity Health appreciates that most measures are already reported in the Hospital Inpatient Quality Reporting (IQR) program, which will reduce reporting burden – reflecting CMS' important consideration of measure alignment. However, as noted in other comments to CMS about quality measures and in the proposed rule, **Trinity Health strongly believes that there are too many measures on which to select from and report, and urges CMS to limit the number of measures to a manageable set (e.g., 5-7 measures) that emphasize patient-reported and patient-generated data.**

Legal Waivers

The movement away from fee-for-service payments toward models that pay for better health and better care at lower costs naturally results in the need and motivation for hospitals and physicians to become financially connected. These alignments facilitate collaboration on quality improvement and efficient care coordination, the adoption of clinical best practices, and the achievement of better patient outcomes. Trinity Health agrees that there are significant obstacles to accomplishing these goals within the current fraud and abuse legal structure, and the Stark law is specifically hindering Trinity Health's progress towards achieving its goal of having 75 percent of revenue in value-based arrangements by 2020. While the Stark Law was enacted to combat certain behaviors in a fee-for-service health care world, it has become increasingly unnecessary for—and is a significant

impediment to—value-based payment models. Trinity Health has made a number of policy recommendations for broader policy change in this area.

Trinity Health continues to recommend that CMS and the Office of the Inspector General offer specific guidance around the program’s fraud and abuse guidelines expeditiously and provide a mechanism for providers to ask questions about the waivers that does not require a full Advisory Opinion.

Other Waivers

Trinity Health appreciates the waivers included in the final rule. However, **we request that CMS provide additional clarity that EPM participants can provide telehealth services that are not covered by Medicare, or for which there is no payment to the provider or supplier, free of charge to the beneficiary if such services are integral to care for the particular episode and improve quality while reducing cost.**

In addition, the three-day hospital stay waiver for SNF payment would require that beneficiaries be discharged to a SNF with a three star or higher rating under the Five-Star Quality Rating System for SNFs, whereas the BPCI program rules only require that the majority of patients be discharged to a SNF that meets this criteria. We continue to be concerned, however, in some areas there may be insufficient availability of SNFs with three stars or better, or insufficient capacity at those facilities. Moreover, the beneficiaries remain in control of which facilities they choose. **CMS should consider accommodation for the use of the SNF waiver in areas with low availability of three star or greater rated facilities.**

In addition, **we urge CMS to extend the SNF 3-day rule waiver to CABG and SHFFT episodes**, as this policy would be consistent with BPCI. We do not believe waivers should be defined by, or be contingent on, disease state, but should promote the best care for patients and use of resources for the system.

Lastly, CMS does not permit the use of the 3-day rule waiver until the hospital bears downside risk. Evidence has demonstrated that excessive use of SNF’s will occur if a waiver is granted. Also, CMS can monitor provider behavior and remove waivers on a case by case basis if there are signs of abuse. **We strongly urge CMS to allow the use of the waiver from the beginning of the EPM program.**

Data Sharing

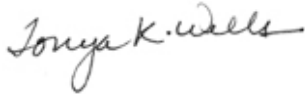
Trinity Health supports CMS’ proposal to make beneficiary-level claims data available for three years prior to the start of the first performance year, and to make monthly claims files available after. However, Trinity Health experienced significant difficulty accessing data following the launch of the CJR program at two of our facilities.

We urge CMS to ensure appropriate processes are in place for the newly proposed EPMs to ensure that providers will be able to access data when needed – especially in a mandatory program

Conclusion

We thank CMS for the opportunity to comment on this IFC and intend for our comments and recommendations to reflect our strong interest in public policies that support better health, better care and lower costs to ensure affordable, high quality, and people-centered care for all. If you have any questions on our comments that follow, please feel free to contact me at wellstk@trinity-health.org or 734-343-0824.

Sincerely,

A handwritten signature in cursive script that reads "Tonya K. Wells".

Tonya K. Wells
Vice President, Public Policy & Federal Advocacy Trinity Health