March 1, 2018

Ms. Amy Bassano
Acting Deputy Administrator for Innovation
Center for Medicare and Medicaid Innovation
7500 Security Boulevard
Baltimore, MD 21244

Dear Ms. Bassano:

This letter is in response to the announcement of the Bundled Payment for Care Improvement (BPCI) Advanced model. We, the undersigned organizations, awaited this announcement in anticipation of exciting improvements. For our members who currently participate, they sought continued opportunities to improve care for the older adults they serve. Needless to say, we were surprised by the direction of and changes to the new model. Specifically, we are concerned that by minimizing the role of post-acute care (PAC) providers, CMS is missing an opportunity to improve overall care delivery and, potentially, realize efficiencies and cost savings. We offer some possible next steps in this letter.

In addition, we request a meeting with you to discuss our concerns and proposed solutions.

Our concerns with the BPCI Advanced program are:

- **Eliminating and changing the role of post-acute care providers in the BPCI Advanced model misses a big opportunity for Medicare savings and quality improvement.** We understand that the BPCI Advanced model is intended to replace the current BPCI model. However, eliminating the opportunity for Model 3 – PAC only bundles and only permitting bundles led by hospitals and physician group practices does little to incent changes in hospital costs of care, the highest cost setting. Nor does it promote redesigned care practices beyond changing the PAC settings they choose to discharge patients to, along with their expectations of these PAC providers to change their practices by demanding shorter lengths of stay. As a corollary, PAC providers under the new model do not receive any compensation for the financial loss that accrues to them as the PAC "partner." As noted in the October 2017 evaluation report "CMS BPCI Models 2-4: Year 3 Evaluation and Monitoring Annual Report", "…reducing PAC spending is particularly important in achieving positive NPRA [Net Payment Reconciliation Amount] because the hospital payment, which is often the largest component of the episode payment, is a per discharge amount. Reducing resources used during the hospital stay can contribute to internal cost savings for the hospital, but is unlikely to affect Medicare's payment …".

- **BPCI Advanced excludes PAC providers from being episode initiators, despite demonstrated savings.** The October 2017 evaluation report notes that Model 3 skilled nursing facility (SNF) participants were able to reduce major joint replacement of the lower extremity (*MJRLE*) episodes by 7.1% relative to a comparison group, and home health agencies in Model 3 were able to reduce Medicare spending by 3.6% for Congestive Heart Failure (CHF) episodes. The report also notes that the results they evaluated were for those participants who had been in BPCI for an average of three quarters, which may have been insufficient to fully affect results on payments and quality from care redesign. While the results may be inconclusive to date among Model 3 providers, there are demonstrated successes. Why prematurely discontinue programs that are currently: 1) generating savings for taxpayers/CMS; and 2) have engaged multiple providers and episodes in redesigning clinical pathways resulting in reduced hospital readmissions and shorter SNF lengths of stay, and return to the community? This position, eliminating successful Model 3 participants, is a waste of resources — time, staff, expertise gained so far, etc. -- that were dedicated to care redesign and improvement. Instead, CMS is outright abandoning these providers who will financially fail if they continue the care redesign practices they employed under BPCI, as they will lose fee-for-service per diem revenue from shorter lengths of stay and fewer PAC episodes without any reward for savings that will accrue to Medicare.

- **Offering the option for PAC providers to continue to participate but only as conveners of "upstream" providers fails to recognize the practical reality in the marketplace.** For several reasons this is an impractical role for PAC providers. As a Convener Participant, a PAC provider would bear financial risk for the Episode Initiator, which would be an upstream acute care hospital (ACH) or physician group practice (PGP). This would appear to require the PAC Convener to be responsible for all of an ACH or PGP's episodes within a clinical category, including those they discharged to another PAC provider. This scenario would place extraordinary risk on the PAC provider with little say in the discharge location and consequently the services provided at those settings. Also, it is only in rare cases, if any, that a hospital, health system or PGP would willingly allow a PAC provider to "control" the bundle, or participate in such an arrangement where the financial incentive and risk accrue to the PAC provider. ACHs and PGPs would prefer to keep the gains for themselves. Evidence suggests (October 2017 evaluation report) that while 61% of Model 2 BPCI Awardee agreements contained gainsharing arrangements, physicians were the most likely recipients of these payments. This is even while these models reduced their utilization of SNFs and/or the length of stay in these settings. This reduction in PAC spending "was particularly important in achieving positive NPRA." In other words, there would have been fewer gains to share without PAC spending reductions yet PAC providers realized little or none of the gainsharing that they had a role in producing. While physicians play an important role in successful outcomes for these Medicare beneficiaries, the success of bundled payments and specifically, the reductions in Medicare spending under BPCI have a lot to do with the role of the PAC providers. As such, PAC engagement warrants a portion of any gainsharing. BPCI Advanced would perpetuate that practice with potentially harmful effects to access to care for Medicare beneficiaries due to the lost revenue experienced.

- **CMMI provides insufficient time to complete the tasks required to build and meet all aspects of the BPCI Advanced application.** In addition to the unlikelihood of an "upstream" provider - ACH or PGP - entertaining this option, even if they would, there is inadequate time for conversations between PAC provider conveners and "upstream" providers to ensue and memoranda of understanding to be completed in advance of the application deadline. Therefore, one can assume that CMS really is only seeking limited participants in this new model and they should be ACHs or PGPs who already have established relationships. Innovation and partnerships take time to build.

- **Some of the BPCI Advanced requirements are clearly relevant or achievable only for certain providers.** For example, the criteria for BPCI Advanced care partners to use Certified Electronic Health Record Technology (CEHRT) may pose a restrictive barrier of entry for PAC providers, given the traditional challenges that these providers have had with health information technology (HIT) adoption. CEHRT as a certification criterion is designed for providers eligible for CMS HIT Meaningful Use incentives (again, hospitals and physicians). If PAC providers were allowed to participate in BPCI Advanced, these requirements would need to be reviewed and adapted for these providers.

We understand that sometimes in an effort to move ahead quickly, unintended consequences may result. We assume that CMS/CMMI did not mean to abandon successful care delivery models that reduce Medicare costs without a realistic path for current providers to continue. Therefore, we offer the following possible ways CMS could resolve the issues outlined above:

1. We recommend CMMI issue guidance indicating that all current Model 3 PAC-only bundles will be allowed to extend their BPCI contracts for another 3-5 years and/or until an adequate replacement program is made available. Conceivably, CMMI could opt to only continue bundles for those participants/conveners who demonstrated savings and/or significant quality outcomes or delivery system improvements.

2. CMMI should commit to amend the BPCI Advanced model to permit PAC providers to be episode initiators and modify additional elements to the program such as CEHRT requirement that would pose unnecessary barriers to entry.

3. We further recommend that CMMI convene a group of interested PAC and long-term service and support (LTSS) providers and/or their representatives to develop and test additional alternative payment models that allow these providers to lead innovative care models, accept financial risk, and share in financial rewards by leading these efforts. These models should also test full service integration from a Medicare beneficiary's home to hospital. We have every reason to believe these models, thoughtfully designed and implemented, will result in substantial savings. Minimally, CMMI should consider chronic care bundles that were suggested under the original BPCI proposal as future models for testing. LeadingAge also proposed a

couple of models that could be led by PAC and LTSS providers as part of our November 2017 Comments Letter to CMMI. These models included: chronic care management in the community using telehealth and remote monitoring; and reducing hospitalizations and hospital readmissions of nursing home residents using two-way video conferencing telemedicine and telehealth. We look forward to an opportunity to meet, discuss, flesh-out, and/or partner with CMMI on developing these or other models for testing.

Thank you for your consideration of our concerns and we look forward to hearing from you in the near future to set up a meeting. Please contact Nicole Fallon, Vice President of Health Policy & Integrated Services at LeadingAge at 202-508-9435 with any questions or to set up a meeting.

Sincerely,

AMDA – The Society for Post-Acute and Long-Term Care Medicine

ElevatingHOME, subsidiary organization, VNAA

LeadingAge

National Association for the Support of Long Term Care (NASL)

National Association of Home Care & Hospice

Terrence A. O'Malley, M.D.