Society of Hospital Medicine
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March 9, 2017

Amy Bassano, Acting Director
Center for Medicare and Medicaid Innovation
Centers for Medicare and Medicaid Services
7500 Security Blvd.
Baltimore, MD 21244

Dear Ms. Bassano:

The Society of Hospital Medicine (SHM) is pleased to offer the following recommendations for consideration as CMS develops an Advanced Bundled Payment for Care Improvement Initiative (Advanced BPCI).

SHM represents the nation's nearly 52,000 hospitalists whose primary professional focus is the general medical care of hospitalized patients. As the single largest specialty participating in the current BPCI program, SHM and the hospitalists we represent share Medicare's commitment to taking alternative payment models such as BPCI to the next level. We welcome the opportunity to work with you on initiatives that create incentives for better outcomes and reward providers for efficient use of resources.

In formulating the structure of Advanced BPCI, SHM asks that CMS keep the following recommendations in mind:

Transition from BPCI to Advanced BPCI

For those PGPs currently participating in BPCI, the transition to Advanced BPCI should recognize the investment already made in the BCPI program. The transition should be reasonable, straightforward, and achievable. Any new requirements that could necessitate further investment should be kept to an absolute minimum.

Advanced BPCI should, without question, be structured to qualify as an Advanced APM within MACRA. Participating providers should also feel secure with a predictable MIPS exemption that will not be impacted by minor differences in patient attribution from year to year. Furthermore, SHM continues to have serious concerns about providers within episode based models and their ability to meet requisite payment or patient thresholds under MACRA. In particular, Hospitalists, as inpatient providers, are not in a position to choose their patients and generally have no control over whether a given patient, or services provided in caring for a patient, would or would not count towards Advanced APM attribution or payment thresholds. This is compounded by the fact that patients are free to seek care outside of an APM at any time. The methodology of attributed/attribution eligible will make it difficult for BPCI providers to meet the 25% threshold in 2019, let alone its scheduled increase to 75% by 2023.

In the final MACRA rule, CMS indicated that it will utilize waiver authority and consider model specific calculations in meeting these thresholds, which we commend and urge CMS to utilize whenever possible. If a hospitalist group undergoes the significant investment to initiate and participate in a qualifying Advanced APM, the resultant MACRA benefits should be safely assumed under any threshold calculation.

Quality Measurement and MACRA

When considering approaches of incorporating MACRA requirements into Advanced BPCI, we recommend a minimum set of global metrics coupled with the option for participating groups to add or substitute custom metrics on a regional basis. CMS should also recognize the variability of data access and reporting capabilities of PGPs and that metrics under a physician initiated model should not be one size fits all.

Below is a list of measures that are applicable to the BPCI program that are within current MIPS methodology. However, as experience is gained, participating organizations should be given the option to pull from this as a "menu set" or use alternative measures developed by the participating PGP that are demonstrably useful in measuring BPCI performance:

- *PQRS #46 - Medication Reconciliation Post-Discharge*
- *PQRS # 47 - Advance Care Plan*
- *PQRS # 130 - Documentation of Current Medications in the Medical Record*
- *PQRS #154 - Falls: Risk Assessment*
- *PQRS #155 - Falls: Plan of Care*
- *PQRS #182 - Functional Outcome Assessment*
- Total per capita cost
- Medicare Spending per Beneficiary
- *An all-cause hospital readmissions measure applicable to a bundled episode of care* (outcome measure)

It is also important to note that not all measures in the above list are currently available for reporting by hosptialists or post-acute providers. When applying any measures to a program such as BPCI, it is critical to not only ensure a measure's value to the model, but also whether or not the measure is available to the model participants who are expected to report it.

Precedence Rules

For the sake of predictability and fairness, CMS should keep the current precedence rules that favor attribution to physician initiated models over hospital initiators and the current mandatory bundles. Hospitalist groups currently participating in BPCI have invested enormous amounts of time and resources to achieve success under the current program and under the current precedence rules. They should feel confident in their assumption that the current rules will remain in place.

It should also be noted that BPCI (and ABPCI) are the only APM models where specialist and hospital based physicians can take risk on their own patients. Any change in the precedence rules that effects this opportunity runs the risk of negatively impacting the tremendous physician engagement that has been evident in BPCI.

Roles of organizations & relationships necessary for participation

New types of relationships should be allowed in furtherance of assisting participants with care transformation in an Advanced BPCI model. For hospitalists in particular, allowing a PGP to partake in multiple BPCI programs under multiple TINS would greatly assist with participation levels. Currently, individual NPIs cannot participate in BPCI if they work under several different TINs. This not only discourages hospitalist participation, but also hampers the participation of physicians working under several TINs or within a multi-site group practice.

Additionally, under current BPCI rules, payout follows the NPI rather than the TIN. Advanced BPCI rules should seriously consider the fact that it is the TIN making the investment in the infrastructure BPCI necessitates, and therefore all payouts should remain with the TIN.

Setting Bundled Payment Pricing

In considering approaches to setting bundled payments under Advanced BPCI, we strongly support the creation of prospective rates, as well as basing rates on regional experience and pricing. When seeking to rebase bundled payment rates, an annual cost of living adjustment would also be beneficial.

Target pricing must be kept stable for reasonable periods of time rather than the current practice under BPCI of PGPs being asked to hit ever moving pricing targets. Setting the basic target prices for a minimum of 5 years with cost of living increases would increase predictability for model participants and encourage wider participation.

Mitigating risk of high-cost cases

The potential negative financial impact that high-cost episode cases could have on some providers should be taken into consideration. To address this risk, we strongly support the concept of establishing an outlier pool for risk adjustment or accounting methodology for outliers.

Alternatively, or even coupled with risk adjustment, an additional incentive could be made available for bundles made up of higher risk (sicker) patients, which would be similar in concept to the enhanced incentive available under the Value Based Payment Modifier for groups treating high-risk patients.

Further, and in keeping with a flexible approach, CMS should consider analyzing risk thresholds separately based on participating provider, hospital, and patient characteristics (i.e., major teaching vs. community hospitals; high DSH vs. low DSH hospitals, prevalence of dual eligible population, etc.). To the extent that the thresholds are found to be materially different, CMS could institute separate thresholds for the different peer groups that emerge from this methodology.

Data Needs and EHR Use Under MACRA

Data transparency and lack of access to facility data is a major impediment for PGPs who wish to enter the BPCI program. We urge CMS to require hospitals and PAC providers participating in the Medicare program to deliver comprehensive data feeds from their EMRs, including clinical and administrative

details, to any Episode Initiator (and their Convener/Facilitator) participating in the BPCI program. Data feeds should include, but not be limited to, federal quality data, benchmarking information, and compliance with care plan information. Broadly, shared data would better enable the gathering and dissemination of critical clinical, functional, and administrative data for care teams serving patients in BPCI episodes.

With over 90% of hospitals now meeting Meaningful Use requirements; BPCI participants/groups working in a hospital that is using certified EHR technology (i.e. achieved Meaningful Use) should be deemed, for purposes of Advanced APM criteria, to be using certified EHR as well. Thus "use" of CEHRT technology within an Advanced APM should not imply ownership, control, or the ability to meet overarching, explicit, criteria. "Use" should be the actual use of that technology to meet the needs of the Advanced APM and its patients – a deeming framework for providers as the end-users of a hospital's certified EHR would accomplish this goal.

Additionally, it will be important to recognize that in meeting the MACRA EHR requirement, patients in a physician initiated Advanced BPCI episode will be unlikely to remain on the same EMR throughout their episode. SHM recommends that if the physician and patient start the episode on an EMR (whether or not it is owned by the PGP), they and the model will have been deemed to meet the Advanced APM EHR requirement for purposes of MACRA.

Non-PECOS Based Physician Attribution

Episode attribution to PGPs had been a significant challenge under the BPCI program, and is a significant risk for any PGP considering participation in future iterations of voluntary bundle programs. Specifically, the efforts used to attribute an episode of care to a participating PGP entity through the use of hospital claims data, and the current process to use PECOS as the determining source for attribution of providers to participating entities has been challenging**.** To address this problem, SHM recommends the following:

a. Transition to attribution of episodes to PGPs based solely upon Medicare Part B claims data, which has both the NPI and the TIN information. This will directly allow for episode attribution to the TIN, without having to use intermediary logic related to the NPI.

b. If Part B claims logic cannot be used as the sole information source for episode attribution, then CMS should transition from PECOS rosters to NPI/TIN rosters submitted by participating PGP participants with any verification of accuracy required by CMMI.

Gainsharing Issues

In terms of gainsharing, we suggest adding more flexibility in the use of NPRA funds and gainsharing options for providers. For example, under current guidelines providers cannot participate in gainsharing above the limitations placed on the amount they are billing Medicare. This puts heavy restrictions on gainsharing for providers such as group practice leaders, who may be contributing heavily in the care redesign process or other aspects of a successful bundle, but are not doing significant amounts of direct billing and cannot participate in a level of gainsharing that corresponds with their efforts. This same sentiment applies to many front-line hospitalists who are often called upon to do significant amounts of non-billable work within a bundled payment; they are charged with improving care processes, care coordination, quality improvement and in some circumstances, co-manage patients within existing surgical bundles. These are efforts that weigh heavily on cost reduction within a bundle – however, their

level of direct billing and resulting gainsharing allowance does not reflect this effort, and they receive very little return.

It is clear from the current experience in BPCI that the amount of individual gainshare to a provider often does not correlate with the contribution that provider has made to overall organization success. We therefore recommend that the decision for the use of gainshare dollars should be left to the participating organization to use at their discretion to create incentives to optimize success.

Conclusion

SHM is not only very interested in the development and refinement of BPCI, but also in other future alternative payment arrangements that represent important steps in moving away from fee for service and paying for value. There is much work to be done, and SHM appreciates the opportunity to continue partnering with CMS in efforts aimed at reforming and advancing the efficiency and quality of care provided to our patients. If you have any questions or need more information, please contact Josh Boswell, Director of Government Relations at jboswell@hospitalmedicine.org or 267-702-2632.

Sincerely,

Brian Harte, MD, SFHM

President, Society of Hospital Medicine

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cc. Patrick Conway, M.D.