MEDPAC Medicare Payment Advisory Commission

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September 30, 2016

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

Re: File code CMS-5519-P

Dear Mr. Slavitt:

The Medicare Payment Advisory Commission (MedPAC) welcomes the opportunity to comment on the Medicare proposed rule entitled 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 (CJR)* published in the *Federal Register* on August 2, 2016. In view of their competing demands and limited resources, we especially appreciate your staff's efforts to improve fee-for-service payment.

This draft rule proposes to test three episode-based payment models (EPM) for Medicare fee-for-service beneficiaries—acute myocardial infarction (AMI), coronary artery bypass graft (CABG), and surgical hip/femur fracture treatment (SHFFT) episodes, revise the existing Comprehensive Care for Joint Replacement (CJR) model, qualify EPMs as advanced alternative payment models, and implement an incentive program to encourage hospitals to expand the use of cardiac rehabilitation services.

The Commission's comments are organized into three sections: the proposed episode payment models, the qualification of EPMs as advanced Alternative Payment Models (APM), and the cardiac rehabilitation incentive program. In summary, the Commission generally supports the expansion of episode-based payments and applauds CMMI for seeking to expand this approach to fee-for-service payment. That said, some conditions, including AMI and CABG, may not good candidates for testing bundled payment given the myriad of clinical pathways patients take (in the case of AMI) and the potential for patient selection (in the case of CABG). Further, the proposed EPMs do not meet the Commission's principles for defining Advanced APMs and therefore we do not support defining them as such. Finally, the Commission believes there are simpler approaches to encourage cardiac rehabilitation without increasing program spending.

I. Episode payment models

Under the EPMs, hospitals will be at financial risk for the care provided during the initial hospital stay plus 90 days after discharge from the hospital. By putting hospitals at risk, beneficiary care could improve because hospitals will have an incentive to increase care coordination, invest in infrastructure and care processes that increase quality and efficiency, and use high-value care throughout the 90-day episode. The models will be tested over five years. The SHFFT model will be tested in the same Metropolitan Statistical Areas (MSAs) that were selected for the joint replacement model. The AMI and CABG models will be tested in 98 newly selected MSAs and, consistent with the CJR, hospitals in those MSAs will be required to participate, with limited exceptions. The "new" and the "old" MSAs may overlap so that depending on the MSA, some hospitals will participate in the joint replacement and SHFFT models, others will participate in the AMI and CABG models, and still others will participate in all four models.

Like the CJR, a bundle will include the initial hospital stay and all Part A and Part B services within 90 days of discharge from the initial hospital stay, except for specific services that are unlikely to be clinically related to the episode. All providers will continue to be paid under fee-for-service for services provided during the episode, but at the end of each performance year, the hospital's average actual episode spending for each EPM will be compared to its "target price." If the hospital's average actual spending exceeds the target price, the hospital will be required to repay Medicare the difference between the target and actual price, referred to as a "reconciliation amount." If the hospital's average actual episode spending is below the target price, Medicare will pay the reconciliation amount to the hospital if the hospital meets acceptable quality thresholds.

CMS proposes to define the episodes using the inpatient DRG (in the case of SHFFT) or on subgroups within the AMI and CABG DRGs, defined by whether the episode involves a transfer, whether the beneficiary with a CABG episode had an AMI diagnosis, and whether there is a readmission for a CABG. CMS does not propose any additional risk adjustment beyond the exclusion of certain clinically unrelated services and hospital readmissions.

Each hospital's benchmark price will be based on a 3-year average of spending during the 90 days for each episode type, adjusted for differences in wages, special payments, and exceptionally high-cost outliers. CMS proposes to transition benchmark prices from hospital-specific to regionally-based targets. In years 1 and 2, rates would be based on 2/3 hospital-specific spending and 1/3 on the regional average spending; in year 3, the target price would be 1/3 hospital-specific and 2/3 regional; and in years 4 and 5, the target price would be 100 percent regionally based. Once the benchmark is calculated, CMS proposes to lower it by an effective discount that ranges from 1.5 percent to 3 percent, depending on each hospital's quality performance, to establish each hospital's target price. Hospitals with better quality would be subject to smaller discounts, thus making it easier to meet or "beat" the quality-adjusted target price. Hospitals would not be required to repay any amounts they owe (i.e., if spending was above the quality-adjusted target price) in year 1 and the early part of year 2.

Similar to the CJR model, CMS proposes to use a small set of quality measures for each episode type to monitor whether EPM participants are maintaining or improving the quality of care beneficiaries

receive. The quality measures include the 30-day mortality rates for AMI and CABG episodes, excess days in the hospital for AMI episodes, the complication rate for SHFFT episodes, and a measure of the patient's hospital experience captured by the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) for all three episodes. Points for quality performance will be awarded for each episode measure and then summed to develop a composite quality score. Participants can also achieve "bonus" points for improving quality performance over time. For two of the episode types (AMI and SHFFT), the composite quality scores include points for reporting additional electronic or patient-reported outcomes quality data.

For each episode type, CMS proposes to assign each EPM participant to a quality category (i.e., excellent, good, acceptable, below acceptable) based on its composite quality score. To be eligible to receive a reconciliation payment for any given episode type, each participant must fall in the "acceptable" or higher quality category. These quality categories will also determine an EPM participant's effective discount percentage from the benchmark for each episode type.

CMS proposes that the hospital bear all the financial risk for spending that is above or below the bundle's target price, with stop-loss and stop-gain provisions to limit the aggregate gains and losses for each hospital. Although hospitals bear all risk with respect to the Medicare program, they can opt to make contractual agreements with other providers to share the risk. Providers could include ACOs, physicians, skilled nursing facilities (SNF), home health agencies (HHA), LTCHs, IRFs, physician groups, and other non-physician practitioners including outpatient therapists. The proposal includes important patient protection provisions that limit the gains that can be shared with any given physician. To counter the financial incentive to guide patients to low-cost PAC providers without regard for quality, CMS proposes to require that participating hospitals give beneficiaries a complete list of all PAC options in the market. However, CMS also notes that the Conditions of Participation and the proposed bundling rules do not preclude hospitals from recommending preferred PAC providers.

Comment
The Commission supports episode-based payments for FFS but believes that some conditions are more appropriate for episode payment than others. Because Medicare's per capita spending on post-acute care (PAC) varies more than spending on acute inpatient or ambulatory services, conditions with high PAC use are good places to test bundled payments and will offer ample opportunities to improve care and lower spending. Another consideration is whether the condition has a relatively uniform clinical pathway that simplifies the rules defining and pricing the bundle. Finally, conditions that lend themselves to patient selection should be avoided, at least in the near term, to limit the undesirable provider responses to financial incentives that may occur.

Our bundling work found that most (93 percent) of SHFFT episodes include at least some PAC use and the PAC spending comprises a sizable share of total episode spending (about one third), making SHFFT a good candidate for bundled payment. The SHFFT episodes will also give hospitals already participating in the CJR model the experience of managing care for hip/femur fracture cases that typically present emergently, rather than as planned, elective surgery common for joint replacement.

In contrast, the AMI episodes do not appear to be a promising place to further test bundled payment. AMI episodes have relatively low PAC use and the associated spending makes up a small share of total episode spending. Therefore, savings opportunities for participating providers will be smaller compared with other conditions. Furthermore, complex medical conditions, such as AMI, do not involve a single clinical pathway. Rather, they can involve patient transfers to hospitals with more intensive cardiac capabilities and subsequent readmissions for CABG. As evidence of this complexity, CMS has proposed an array of benchmarks and elaborate rules to define when an episode begins, attribute the episode, and establish accurate prices. If the benchmarks are not accurate, they could inadvertently shape clinical practice or encourage selective admissions. Instead of bundling, CMS could consider allowing hospitals to share savings with physicians (gainsharing) as a way to focus physicians on reducing the cost of the inpatient stay. In 2008, the Commission recommended that the Congress grant the Secretary the authority to allow gainsharing arrangements between hospitals and physicians with appropriate safeguards. The evaluation of the Medicare Acute Care Episode Demonstration found limited savings from cardiac episodes, with most of those savings due to savings on device costs. Gainsharing may be able to achieve the vast majority of the potential savings associated with bundling with lower administrative costs.

CABG is also not an ideal condition to expand the testing of bundled payment. Although the majority of beneficiaries undergoing CABG go on to use PAC, the spending on PAC is relatively low compared with the SHFFT cases (our analysis found about $4,500 in average PAC spending for CABG stays compared with almost $21,000 for SHFFT stays). With the inpatient stay comprising the vast majority of the total episode spending, the opportunities to change practice to realize savings are small: the hospital already receives a DRG payment, the surgeon receives a 90-day global payment, and there is typically little PAC use.

An additional concern with bundled payments for CABG is the potential for undesirable provider responses to financial incentives, including patient selection. Studies of cardiac care, including MedPAC's site visits to physician-owned cardiac hospitals, indicate that providers engage in patient selection. We are concerned that, with larger savings at stake, these behaviors could increase. Until the benefits of episode efficiency outweigh the concerns about patient selection, CMS should delay testing the CABG EPM.

For conditions that are not promising for bundled payments, CMS has an array of strategies to focus providers on lowering costs while improving patient outcomes. For example, the Medicare spending per beneficiary (MSPB) measure in the hospital value-based purchasing (VBP) program encourages the same goals: lower spending and improved care coordination. Within the VBP program, the "weight" of the MSPB could be increased to further incentivize hospitals to reduce spending. The hospital readmission policy already encourages hospitals to avoid readmissions for AMIs and CABGs. To increase the pressure to reduce readmissions, CMS needs to move forward with readmission policies in all sectors and increase the penalties for providers with high risk-adjusted potentially avoidable readmission rates. And, as mentioned above, CMS should have the authority to allow gainsharing arrangements between physicians and hospitals.

There are a couple of advantages to proceeding with only the SHFFT EPM. For providers, it would simplify the set of models they are adapting to, including the bundled payments for care improvement (BPCI), accountable care organizations (ACO), and CJR. Second, it would greatly simplify the administrative requirements for CMS. For example, if CMS proceeds with only the SHFFT EPMs, it would not need to select new markets for testing the cardiac EPMs and instead could expand the current CJR model to include the SHFFT EPM.

Episode exclusions: The EPM proposal would exclude stays if the beneficiary dies during the initial hospital stay but does not exclude stays if the beneficiary dies during the 90 days after discharge from the hospital. The Commission believes CMS should exclude stays that end with death —both during the initial hospital stay and during the 90 days after discharge—from the calculations of the target price and reconciliation amounts. On the one hand, stays during which the beneficiary dies could be exceptionally high-cost if the patient lives for most of the 90 days and receives end-of-life care. On the other hand, if the beneficiary dies shortly after discharge from the hospital, the patient may receive little PAC or end-of-life care resulting in unusually low-cost episodes. In either case, the episode spending will not be typical and therefore these stays should be excluded from calculating the target price and reconciliation amount. Excluding these episodes will make the spending data less "noisy" and better reflect the typical spending for the provider. CMS has other tools to encourage low mortality rates (the AMI and CABG mortality rates included in the hospital VBP program) and care coordination (the readmission policy and the MSPB measure included in the VBP program).

The benchmarks: The Commission has consistently found that chronic conditions and advanced age play a major role in explaining variation in spending across beneficiaries. CMS proposes no further risk-adjustments beyond the DRG/subgroups but provides no data to assess whether the proposed stratification is sufficient to adjust for differences in spending across beneficiaries within each episode type. The Commission urges CMS to evaluate whether additional risk adjustment strategies, such as comorbidities and age, would improve the accuracy of the benchmarks. Simple stratification of episode costs by age cohort and presence of comorbidities would indicate whether further risk-adjustment is likely to yield more accurate benchmarks. Otherwise, hospitals and physicians would have an incentive to admit patients who are likely to be low-cost and to avoid higher-cost patients. Although mandatory participation for hospitals in select markets would dampen the ability of hospitals and physicians to selectively admit patients, it will still be possible by guiding patients to one hospital and away from another.

CMS proposes to transition benchmark prices from a blend of hospital-specific prices and average regional spending to benchmarks that are 100 percent regionally-based. National prices are used in other Medicare FFS payment systems and the Commission believes the EPMs should transition to national prices. In 2013, we reported that risk-adjusted spending on post-acute care and readmissions varied about 30 percent between high- and low-spending MSAs for SHFFT episodes. Transitioning to regionally-based benchmarks, as opposed to nationally-based benchmarks, will continue to allow large differences in spending across the country. In markets with long-term care hospitals (LTCH) and inpatient rehabilitation facilities (IRF), these high-cost settings will raise the hospitals' benchmarks. In markets without these providers, on the other hand, PAC is delivered in lower-cost settings and the benchmarks will be lower. CMS should ultimately transition to national

benchmarks to exert pressure on high-cost regions to bring their spending in line with spending in other markets.

Shared risk: The Commission supports arrangements that create opportunities for hospitals to cooperate with other providers to increase the value of care furnished to beneficiaries. The Commission believes that when hospitals are at full risk for the entire episode, they should have the tools and flexibility to recommend high-value providers. The Commission has consistently heard from providers that the rules are not sufficiently clear about what is and is not allowed under Medicare rules regarding recommending preferred PAC providers. CMS could require hospitals to give beneficiaries a list of the PAC providers in their market and indicate which providers are "preferred" (with "preferred" defined as providers with above-average quality). We concur with CMS that hospitals should not be able to charge providers a fee to be on the preferred provider list.

Extending risk to PAC providers and clinicians: While a hospital and its physicians shape the spending during the hospital stay and the selection of the initial PAC provider, physicians are not required to be at risk for the 90-day episode spending. Similarly, PAC providers influence how much PAC is used and the rate of hospital readmissions but are not directly at risk for the 90-day episode spending. Therefore, in future EPM models, CMS could consider directly extending the risk to the other providers, including clinicians. This would ensure that the financial incentives of the key actors shaping care are aligned.

One way this alternative risk-sharing could work is to have the major actors in the episode (the hospital, the clinicians with a material level of part B spending, and the PAC providers) share in any reconciliation amount up to their share of the 90-day actual episode spending during the performance period. For example, if a SNF's spending across all episodes during the performance period made up one third of the episodes' actual total spending, the SNF would be at risk for one-third of the reconciliation amount. Assuming preferred providers have higher volume, they would receive a higher share of any reconciliation amount compared with other providers.

Gainsharing safeguards: We support gainsharing arrangements between EPM participants (hospitals) and collaborators (e.g., physicians) as long as there are quality safeguards and protections for beneficiaries and the Medicare program (e.g., gainsharing arrangements should not be used by hospitals to reward physicians for making referrals). In a 2005 report to the Congress, the Commission recommended that gainsharing arrangements between physicians and hospitals be permitted, with appropriate safeguards.[1] CMS has proposed five key requirements for these arrangements, which we support:

- Gainsharing arrangements must not induce collaborators to reduce or limit medically necessary services to beneficiaries, nor may they restrict collaborators from selecting the devices, supplies, and treatments that are in the best interest of beneficiaries.
- Gainsharing payments can only be made for lowering hospitals' internal costs (e.g., due to care redesign) or lowering full episode costs below the target price.

[1] Medicare Payment Advisory Commission. 2005. *Report to the Congress: Physician-Owned Specialty Hospitals.* Washington, DC: MedPAC.

- Collaborators may only receive gainsharing payments if they meet quality metrics and directly provide services to beneficiaries during the episode.
- Each gainsharing payment to a physician or nonphysician practitioner (NPP) may not exceed 50 percent of the sum of the total physician fee schedule payments received by the practitioner for services provided to patients during the episodes.
- The method for determining the amount of gainsharing payments must be substantially based on the quality of care and the provision of EPM activities.

In addition to these protections, the Commission believes that gainsharing payments to individual physicians or NPPs who are part of the same sharing arrangement should not be allowed to vary based on whether these practitioners were involved in high- or low-cost episodes. This requirement would reduce practitioners' incentive to treat primarily low-cost patients and steer high-cost patients to other physicians at the hospital. To operationalize this principle, we suggest the following approach: If a gainsharing arrangement results in internal hospital cost savings or episode cost savings, the total gainsharing payment should be divided evenly among all the episodes that are part of the arrangement. In other words, the per episode payment amount should be equal for all practitioners in the arrangement. Practitioners who were responsible for more episodes could receive higher total payments, but their per-episode amount should be the same as other practitioners.

The Commission also believes that safeguards similar to those governing gainsharing between hospitals and physicians should apply to the arrangements between hospitals and PAC providers. Hospitals should not be required to offer risk-sharing arrangements to all PAC providers in their markets. Further, the risk or reward should be calculated for all PAC providers in the risk-sharing arrangement, not on a patient-specific or PAC provider-specific basis. This approach to "pooling" the performance of the PAC providers would create incentives for them to cooperate to jointly lower episode costs. Similar to the gainsharing requirements for physicians, the risk-sharing arrangement between a hospital and its PAC providers should be based on the change in per episode spending in the performance period. A hospital should be able to discontinue its risk-sharing arrangement with PAC providers that do not contribute to lowering episode spending.

Quality measures: Under bundled payment, providers have a financial incentive to furnish fewer services than medically necessary or to use low-cost settings even if another higher-cost setting would be more appropriate. To discourage these inappropriate provider responses, CMS proposes to adjust payment based on quality performance. The Commission appreciates that CMS has kept the quality measures to a small set of outcome measures that are aligned with current programs and models.

The Commission notes that hospitals should know the percentile values for each quality measure before the beginning of the year so they can gauge their performance throughout the year. For example, if the threshold level is set at the 30th percentile of the national average, hospitals should know the corresponding 30^{th} percentile score.

As discussed above, the Commission believes that bundled payment should hold all providers at risk (including key clinicians and post-acute care providers) not just hospitals. If all providers are

held at risk, then the bundled payment should be tied to quality measures for other providers, not just hospital quality. For example, CMS should add a relevant PAC measure to the bundles, like the rate of discharge to the community.

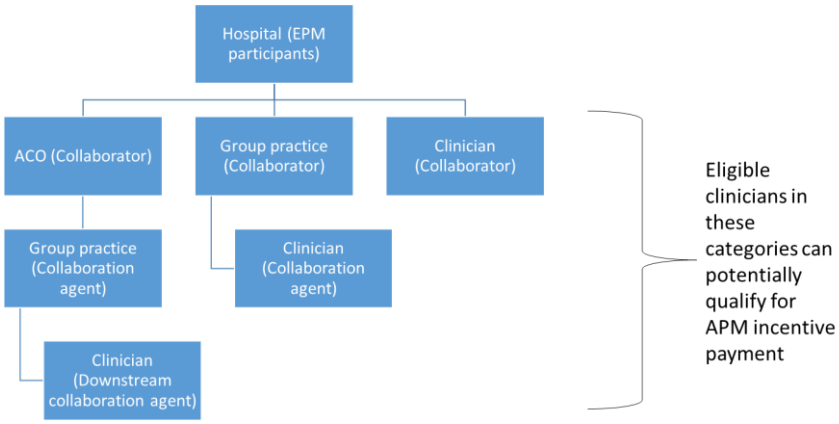
II. EPM and CJR as advanced alternative payment models

The proposed rule creates a process for the EPM and CJR models to qualify as Advanced Alternative Payment Models (Advanced APMs). The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) established payment incentives for clinicians who have a certain level of participation in Advanced APMs. Advanced APMs are a select set of payment models that meet criteria set out in MACRA. Advanced APMs must: require model entities to bear more than nominal risk for gains and losses; make payments based on certain quality measures; and require use of certified electronic health records (EHRs).

CMS proposes that the CJR model would qualify as an Advanced APM as of January 1, 2017, and that Track 1 of the EPM model would qualify as an Advanced APM as of April 1, 2018 (as soon as EPM model participants bear risk for losses).[2]

The participants in EPM and CJR models are hospitals—clinicians do not, by CMS design, take direct financial risk. Instead, CMS proposes hospitals and clinicians could establish financial contractual relationships between each other. CMS proposes that all clinicians who have such a contractual relationship (even a remote one such as a 'downstream collaboration agent'), would be considered to be Advanced APM participants, and so could potentially qualify for an APM incentive payment (Figure 1). Eligible clinicians must also have billed for a service for the attributed beneficiary during the EPM or CJR bundle to qualify as an Advanced APM participant.

Figure 1. Eligible clinicians with either a direct or downstream contractual relationship with the hospital could be qualifying APM participants



[2] The EPM model design does not contain downside risk for first its 15 months (it is proposed to start January 1, 2017), hence it would not meet the statutory criteria for an Advanced APM until April 1, 2018.

Comment
The EPM and CJR models should not be considered Advanced APMs for the purposes of MACRA. In our June 2016 Report to the Congress and June 2016 comment letter, the Commission established six principles for Advanced APMs.[3] EPM and CJR do not meet these principles. In particular, the models do not require model entities to bear risk for all Medicare Part A and Part B spending. Instead, CJR and EPM are time-limited and limited to episode-related spending and quality. Under bundling models, there is an incentive to reduce the cost per episode while increasing the number of episodes. In our view, Advanced APM models should require model entities to be at financial risk not just for the cost per bundle or per episode, but also the total number of episodes. Clinicians within those entities should have strong incentives to change their practice and referral patterns. In contrast, the proposed rule contemplates large, loosely connected groups of clinicians who may have very little involvement with the beneficiaries in EPMs and hence have little reason to change their practice patterns.

In our view, EPM and CJR are not substantive alternatives to FFS payment and do not represent the type of comprehensive delivery system payment reform that should be rewarded with an APM incentive payment. Because these models are part of FFS Medicare and are mandatory for hospitals in selected markets, they are not an 'alternative to the FFS' payment model. Because EPM and CJR are part of FFS, any changes in payment resulting from them essentially is a change in the price of a service. As such, consistent with the basic FFS incentive, there is no incentive to reduce inappropriate episodes and, if the models prove profitable, perhaps an incentive to increase the number of inappropriate episodes.

Viewing EPM and CJR as a FFS policy instead of Advanced APMs also greatly simplifies the problem of overlapping models. The problem of overlapping models arises because the same beneficiaries and providers could be attributed to multiple models and it would be necessary to apportion payments and savings among the different models. For example, the same physician group could be participating in the Comprehensive Primary Care Plus model and an ACO while also being a collaboration agent in an EPM. Elaborate sets of rules are proposed to determine which model takes precedence for beneficiary attribution and how payments are shared among the different models. If EPM and CJR payment adjustments are considered part of FFS payments rather than as Advanced APMs the problem is simplified. For example, expenditures for an ACO that is at risk for total spending for an attributed beneficiary would be computed net of any reconciliation payments made to (or coming back to CMS from) EPM participants. No special rules would be necessary to determine which model to attribute the beneficiary to or how to account for any savings.

Whatever the potential benefits of EPM and CJR, we do not believe that the proposal creates the opportunity for meaningful clinician participation in alternative payment. This is a result of both the model design (such as excluding spending outside of a narrow set of conditions and excluding

[3] Medicare Payment Advisory Commission. 2016. Report to the Congress: Medicare and the health care delivery system. Medicare Payment Advisory Commission. 2016. Comment on the Centers for Medicare & Medicaid Services' proposed rule entitled "Medicare program; Merit-based Incentive Payment System (MIPS) and Alternative Payment Model Incentive under the Physician Fee Schedule, and Criteria for Physician-focused Payment Models."

providers other than hospitals from directly bearing risk) and the fact that it is mandatory. Clinicians will have, at best, a limited ability to control whether they participate in the model—it is dependent on hospital decisions interacting with geographic location. If CMS intends for clinicians to bear risk, they could do so directly without having the hospital as the intermediary.

III. Cardiac rehabilitation incentive program

The AMI and CABG EPMs proposed by CMS would include episode-related part B services within 90 days of discharge from the initial hospital stay, including cardiac rehabilitation (CR) and intensive cardiac rehabilitation (ICR) services. Under these bundled payments, providers would have a financial incentive to furnish fewer services than medically necessary. Concerns about inappropriate provider responses are heightened when the health benefits of the service are not apparent until after the episode (and the period of provider responsibility) has ended, which may be the case with CR.[4] CR services may therefore be particularly vulnerable to stinting.

CMS proposes a CR incentive payment model to test the effects of providing explicit financial incentives to hospitals to encourage greater utilization of medically necessary CR/ICR. The CR incentive payment model would be tested in 45 of the 98 selected EPM MSAs, in hospitals with financial responsibility for AMI or CABG EPMs. (Selected hospitals are referred to as "EPM-CR participants.") The CR incentive payment is intended to reward increased referral of AMI and CABG model beneficiaries to CR/ICR programs and to support beneficiary adherence to participation. CMS proposes to pay EPM-CR participants an incentive amount for each CR/ICR service that occurs during the 90-day AMI or CABG EPM. The incentive payment of $25 per CR/ICR service would initially encourage the use of any CR/ICR services and would increase to $175 per CR/ICR service once a beneficiary exceeds 11 CR/ICR services, until the beneficiary reaches Medicare's CR coverage limit or the 90-day episode ends. CMS would pay the sum total of an EPM-CR participant's incentive payments from the part B trust fund after the end of each performance year.

The CR incentive payment is designed to increase the referral to and use of CR/ICR services under an EPM bundled payment that otherwise might discourage the use of these services. CMS thus proposes that the CR incentive payment be determined and paid separately from the EPM reconciliation payments. Further, the quality-adjusted target prices would not be subject to the limitation on gains specified in the EPM proposal. In addition, EPM-CR participants would not be permitted to include CR incentive payments in the sharing arrangements proposed for the EPM model. Instead, EPM-CR participants could share CR incentive payments with other individuals and entities only under circumstances that comply with all existing laws and regulations, including fraud and abuse laws. Since the vast majority of CR/ICR services are currently furnished by hospital outpatient departments, CMS expects that EPM-CR participants would typically carry out the CR model implementation activities—including coordinating CR/ICR services to

[4] A recent Cochrane review of 63 trials of exercise-based CR, involving 15,000 patients, found that CR/ICR reduces the risk of cardiovascular mortality and hospitalization. Notably, some studies have found that the benefits of CR/ICR appear with longer follow-up—1 to 5 years after the initial hospitalization. See Anderson L., D.R. Thompson, N. Oldridge et al. 2016. Exercise-based cardiac rehabilitation for coronary heart disease. *Cochrane Database of Systematic Reviews*, Issue 1.

beneficiaries—through their own CR programs. CMS expects that all financial arrangements with other entities and individuals under the CR incentive payment model would be narrowly focused on certain activities related to the EPM-CR participant's specific plan to advance the goals of the model.

CMS proposes to allow EPM-CR participants to provide beneficiary-engagement incentives (such as the provision of certain items and services) under certain conditions, as proposed for the EPM. Such items and services must be reasonably connected to medical care provided during a CR/ICR session and must be a preventive care item or service or one that advances a clinical goal; these items and services also must be provided directly by the EPM-CR participant (or by an agent under the EPM-CR participant's direction and control). CMS believes that only one potential beneficiary-engagement incentive likely meets these criteria for CR: provision of transportation to CR/ICR services.

CMS also proposes to provide the CR incentive payment to selected hospitals that are not AMI or CABG EPM participants. This would enable CMS to test the effects of the CR incentive payment within the Medicare FFS program. CMS proposes to allow these FFS-CR participants to provide transportation to CR/ICR services as a beneficiary engagement incentive.

In addition, CMS seeks to increase the availability of CR/ICR services for AMI and CABG model beneficiaries by proposing a waiver of the statutory requirement that CR/ICR services be supervised by a physician. The waiver would allow a nonphysician practitioner (defined as a physician assistant, nurse practitioner, or clinical nurse specialist) to perform the functions of supervisory physician, prescribing exercise, and establishing, reviewing, and signing an individualized treatment plan and would apply to a provider or supplier of CR/ICR services furnished during an AMI or CABG episode. The waiver would also apply to any provider or supplier that furnishes CR/ICR services to beneficiaries who received care for their initial cardiac event from a FFS-CR participating hospital.

Comment
As noted above, the Commission does not support the testing of bundled payments for AMI and CABG at this time. In the absence of the AMI and CABG EPMs, concerns about stinting on CR/ICR services would be unfounded. However, CMS's proposal clearly seeks not just to avoid inappropriate provider responses to bundled payments but also to increase the use of CR/ICR services. CMS cites a number of studies that have found that CR/ICR reduces the risk of mortality and rehospitalization, though overall use of these services remains low, particularly for women and minorities. As CMS notes in its proposed rule, there are a number of reasons why CR/ICR services are underutilized. These include low beneficiary referral rates; lack of strong physician endorsement of CR to patients; financial burden due to coinsurance requirements; lack of accessibility of CR/ICR program sites; and the Medicare requirement for physician supervision during CR/ICR. It is not clear, however, which barriers create the biggest hurdles to effective care. This lack of clarity makes it difficult to determine the best corrective action. Of course, tackling these barriers may require a multifaceted approach.

If one of the most significant barriers is low referral rates, CMS could encourage greater referral to CR/ICR by creating claims-based physician or hospital measures for all providers who care for beneficiaries with AMI and CABG. The measures could gauge the share of beneficiaries who receive CR/ICR services and the share who receive some minimum number of CR/ICR services.

Alternatively, if a bigger problem is the availability of CR programs, CMS's proposed waiver that would allow a nonphysician practitioner (defined as a physician assistant, nurse practitioner, or clinical nurse specialist) to perform the functions of the statutorily required supervisory physician during CR/ICR might reduce barriers to care. This measure, which could be tested in selected sites even in the absence of AMI and CABG EPMs, would reduce the cost of furnishing CR/ICR services, which might increase access by inducing more providers to supply CR/ICR and by allowing more flexibility in the provision of care.

If CMS elects to implement the AMI and CABG EPMs, the Commission would not support going forward with the proposed CR incentive payments. We are concerned that CMS's proposed approach may be unnecessarily costly for the Medicare program. The proposed provider incentive payment of $175 per CR/ICR service once a beneficiary exceeds 11 CR/ICR services considerably exceeds the amount Medicare pays for each service itself, and could add up to a substantial amount per beneficiary. It is not clear how CMS determined the level of the proposed payment incentive, but we question whether such a large amount would be necessary to induce changes in provider behavior. Second, the proposed approach seems overly complex. Curbing inappropriate provider response to the AMI and CABG EPMs could be accomplished by simply carving out CR/ICR services from the bundled payments and continuing to pay for these services separately, without incentive payments for EPM participants.

Conclusion

MedPAC appreciates the opportunity to comment on the important policy proposals crafted by the Secretary and CMS. The Commission also values the ongoing cooperation and collaboration between CMS and MedPAC staff on technical policy issues. We look forward to continuing this productive relationship.

If you have any questions, or require clarification of our comments, please feel free to contact Mark E. Miller, MedPAC's Executive Director at (202) 220-3700.

Sincerely,

Francis J. Crosson, M.D.
Chairman