MISSOURI HOSPITAL ASSOCIATION

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Andy Slavitt
Acting Administrator
Centers for Medicare & Medicaid Services
U. S. Department of Health & Human Services
Attention: CMS-5519-P
P.O. Box 8013
Baltimore, MD 21244-1850

Re: 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) (CMS-5519-P)

Dear Acting Administrator Slavitt:

On behalf of its 148 hospital members, the Missouri Hospital Association offers the following comments regarding the Centers for Medicare & Medicaid Services' proposed regulations to implement new episode payment models for Medicare coverage of selected cardiac services and surgical treatment of hip and femur fractures. (CMS-5519-P)

CONSISTENCY OF STANDARDS FOR MEDICARE PAYMENT MODELS

Many of the standards established for this proposed episode payment model are consistent with the standards established previously by CMS for the Medicare comprehensive care for joint replacement demonstration model. MHA appreciates this consistency. There are some notable differences in standards between the two payment models. MHA urges CMS to revise its final rule to create as much consistency of regulatory standards as possible. Those differences concern hospitals' ability to collaborate with critical access hospitals or accountable care organizations, the accounting of costs in the event the beneficiary dies, variation in the episode-specific stop-loss calculation and the process of including or excluding reconciliation payments from the baseline. MHA recommends that CMS maximize consistency of regulatory standards for these and future bundled or episode payment models in the Medicare program.

CMS' MANDATORY NATIONAL PAYMENT EXPERIMENTS

MHA supports efforts to develop and deploy payment systems to bring more competition and efficiency to Medicare spending. However, CMS recently has begun designing new Medicare financing and delivery models, such as is proposed here, as national "experiments" with multilayered "control" and "experimental" groups to enable a scientifically valid evaluation. Laudable as the concept may be, it treats the nation's hospitals as "lab rats" in the experimentation, with hospitals randomly assigned to implement components of a growing number of complex CMS initiatives. CMS' assignments and their unforeseen outcomes can affect a hospital's ability to survive or thrive.

MHA asserts that hospitals and other providers should compete based on their efficiency and effectiveness, not by advantages and disadvantages bestowed by regulatory fiat as to which of them are included in, or excluded from, the components of new CMS payment experiments. CMS' approach dictates "winners" and "losers" among hospitals based on their assigned roles in Medicare's experiments. This affects not only the providers, but also their patients. The models are intended to extract savings from the experimental groups, and leave the control group unscathed. On the flip side, the control group hospitals will be denied a role as early adopters.

As troubling is that CMS' recent regulatory pronouncements and responses reflect uncertainty about the effect of these financing and delivery model experiments on access and quality of care.

SELECTION OF THE MANDATORY PARTICIPANTS

If a mandatory payment model is to be imposed, MHA asserts that CMS should be clear not only as to how it will be applied, but to whom it will be applied. CMS does not identify which of the 98 metropolitan statistical areas will be required to participate in the mandatory episode payment model created by the proposed regulations. Those MSAs will be chosen by a randomized selection method after the final regulations are released. MHA urges that in future rulemaking of this type CMS specify which providers and beneficiaries will be compelled to participate. This was done for the substantially similar Medicare payment experiment for joint replacement services.

HOSPITAL RISK/REWARD SHARING

MHA supports CMS' efforts to allow hospitals to share in the potential risk or reward in these episode payment models and welcomes CMS' authorization of collaboration with critical access hospitals in the payment model proposed in these regulations. However, MHA urges CMS to more thoroughly describe how this risk and reward-sharing can be accomplished in light of existing statutory and regulatory constraints on interactions between providers and with beneficiaries.

TREATMENT OF CRITICAL ACCESS HOSPITALS

As proposed, the post-discharge cost of treating a patient at a CAH is included in the episode of care cost. This proposal has the potential to curtail beneficiary options for treatment in rural areas. Since CAHs are paid based on their aggregate cost for treating Medicare patients, participating organizations in the episode payment model could have a disincentive to use critical access hospitals for post-discharge care, including swing-bed services. This impedes the accessibility of local treatment options for rural beneficiaries and their families or support systems. MHA encourages CMS to revise its final regulation to address this concern.

Sincerely,

Daniel Landon
Senior Vice President of Governmental Relations

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