October 3, 2016

Andrew M. Slavitt
Acting Administrator
Centers for Medicare & Medicaid Services
Hubert H. Humphrey Building
200 Independence Avenue, S.W. Room 445-G
Washington, DC 20201

RE: CMS-5519-P. 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); Proposed Rule (Vol. 81, No. 148) August 2, 2016

Dear Mr. Slavitt:

The American Health Care Association and National Center for Assisted Living (AHCA/NCAL) is the nation’s largest association of long term and post-acute care providers, with more than 13,000 member facilities who provide care to approximately 1.7 million residents and patients every year. We appreciate the opportunity to comment on the Centers for Medicare & Medicaid Services’ (CMS) proposed rule Advancing Care Coordination through Episode Payment Models (EPMs); Cardiac Rehabilitation Incentive Payment Model, and Changes to the Comprehensive Care for Joint Replacement Model (CJR), referred to throughout our comments as the “EPM rule.”

While AHCA supports CMS’ efforts to transition Medicare payments out of fee-for-service and into value-based care designs, we continue to have strong concerns that broad expansion of mandatory bundled payments may be negatively impacting patient outcomes and access to care. We believe these unintended consequences are unique to large-scale, mandatory bundling models, such as CJR, and that evaluation of the voluntary Bundled Payments for Care Improvement (BPCI) demonstration, as well as evaluations of older pilots, are insufficient to justify further expansion of mandatory programs. AHCA recommends that CMS halt expansion of the proposed bundling initiatives until it has formally evaluated at least twelve months of data from the CJR demonstration, beginning with the start of downside risk-bearing on January 1, 2017, and is able to demonstrate that these programs are not harmful to patients.
Our comments are organized below into two sections: the first “Key Concerns” section highlights AHCA’s research on the current state of bundled payments, AHCA members’ experiences to date in such programs, and further justification for slowing their expansion; the second “Recommended Refinements” section contains AHCA’s more targeted recommendations on policy proposals contained in the EPM proposed rule. AHCA and the skilled nursing professionals we represent look forward to continuing our work with policymakers to advance long-needed post-acute care (PAC) delivery and payment reforms, including bundled payments.

Sincerely,

Michael W. Cheek  
Senior Vice President, Reimbursement Policy & Legal Affairs  
American Health Care Association
Key Concerns:

1. AHCA continues to have serious concerns with the requirement that the 3-day rule waiver is tied to the SNF 5-Star Ratings system.

   Similar to the CJR program, CMS is proposing to require that a SNF have three stars or greater on the Five Star rating system in order to waive the 3-day stay requirement for SNF participants of new EPMs. The proposed policy is similar to the 3-day stay waiver policies currently being utilized in certain models and tracks of the Bundled Payments for Care Improvement (BPCI) initiative and CMS’ accountable care organization (ACO) programs, respectively. While AHCA appreciates and supports the application of certain criteria to waive the 3-day stay requirement, we object to CMS’ proposal to tie the waiver to a SNF’s Five Star rating. Our primary concerns are as follows:

   a. The Five Star measures were never intended to be used as a proxy for quality for participation in a bundled payment program, are not tailored to post-acute care, and do not focus on the patient population affected by the new EPMs;

   b. This policy will have unintended negative consequences on beneficiary freedom of choice and access to care. For example, over half of the SNFs in target Metropolitan Statistical Areas (MSA) had a rating of 1 or 2 stars in any given month over the past year; and

   c. The frequent fluctuation in a SNF’s overall rating above or below 3 stars will make program implementation difficult and could place beneficiaries in financial jeopardy. More than one-third of the SNFs in the target MSAs did not maintain a star rating of 3 or more for more than 6 consecutive months over the past year.

   We urge CMS to adopt an alternative approach with respect to the SNF qualifications required to access the 3-day rule waiver under the EPM program. In particular, CMS should waive the 3-day stay requirement for all SNFs and require hospitals to provide information to consumers at time of discharge regarding quality of the PAC provider (e.g. SNF) that includes not only their Five Star rating, but also quality measures more applicable to PAC, particularly those related to AMI, CABG, and SHFFT. This approach would protect beneficiaries’ freedom of choice, as required by the Medicare Act at 42 U.S.C. § 1395a(a).

   AHCA believes that CMS should tie SNF performance to waiving the 3-day stay requirement by using performance thresholds on SNF quality measures that are more directly applicable to post-acute care, particularly AMI, CABG, or SHFFT care furnished to beneficiaries, such as: hospital readmission rates, discharge to community rates, improved function and patient satisfaction rates. Reliable and valid measures on SNF performance exist for all of these domains.
Should CMS not adopt AHCA’s recommended approach above – waiving the 3-day stay requirement with respect to all SNFs – AHCA recommends that CMS modify the proposed criteria of “at least 3 stars” to “at least 3 stars overall OR at least 3 stars on both the staffing and quality measure components.” This approach would create the incentive to achieve higher staffing levels and improved performance across the 11 quality measures in the Five Star rating system.

2. AHCA has concerns about risk-adjustment methodology and how it could lead to hospitals “gaming” the system through patient steering and “cherry picking.”

AHCA firmly believes that without proper risk adjustment methodology, bundled payment programs, such as CJR, create strong incentives for providers to avoid certain patients, particularly those who are predictably high-cost. Recent research has shown that in the absence of risk-adjustment, bundled payment initiatives may penalize providers that treat medically complex patients:

- One recent study assessed the net difference in reconciliation payments with and without risk adjustment (HCC score)\(^1\). In this study, reconciliation payments reduced by $827 per episode for every one standard deviation increase in a hospital’s patient complexity. Results suggest that without sufficient and appropriate risk adjustment, hospitals will inevitably be financially penalized for treating more medically complex patients.
- In a recently published JAMA article\(^2\), authors found indications that BPCI participants may have begun to seek a less costly mix of patients in preparation for the initiative.

Other studies examining changes in reimbursement policies have shown that poorly designed incentive mechanisms may result in unintended consequences (e.g., “cherry picking”):

- A 2016 Health Affairs study showed that risk adjustment methodologies are central to designing fair bundled payments and exist to ensure that there are no incentives to avoid treating the more complex, costly patients\(^3\). It is imperative to account for patient differences in costs and outcomes, however, research indicates that customized risk adjustment for such purposes is underdeveloped.
- A 2013 study examined risk-adjusted payments and performance assessments in a primary care setting and concluded that existing data may

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\(^3\) Ellimoottil et al., 2016.
support the risk-adjusted bundled payment calculations and performance assessments that is essential to drive the change in primary care. The paper aimed to address the gap in literature on guidance for calculating bundled payments accounting for risk-adjustment. From this article, it may be inferred that, previously, there was a lack of literature available on the implementation of effective risk adjustment methodologies and without guidance in this area, it would presumably be difficult to design fair bundled payments.

- Another study was conducted to observe the reconciliation payments of Comprehensive Care for Joint Replacement bundled payment program, a program implemented by the Centers for Medicare and Medicaid Services, with and without risk adjustment. Lower extremity joint replacement is one of the most common procedures performed on Medicare beneficiaries; therefore, this program may be considered one of the more aggressive moves towards alternative payment programs implemented by CMS. Because the CJR program determines reconciliation payments by benchmarking the hospital’s performance to other hospitals in the same region without accounting for patient-specific characteristics as medical comorbidities, this may result in unfairly penalizing hospitals that attend to more medically complex patients. Results from this study suggest that without sufficient and appropriate risk adjustment, hospitals will inevitably be penalized for treating more medically complex patients. Future research should focus on defining risk-adjustment variables that “are predictive of episode cost, reflect the underlying severity of illness of patient, and can be relatively easily obtained from administrative claims data.”

It may be inferred from literature that because designing bundled payments is still a relatively recent concept, it is more likely that there are still holes in the design that may contribute to adverse selection. As more literature is available on the area, it should be the goal of CMS to work towards fair bundled payment constructs.

Current research seems to suggest that treating higher-complexity patients may result in lower, or negative, reconciliation payments under episodic payment models, and that in response, at-risk providers may be attempting to avoid patients they believe will cost more to treat. AHCA members who are currently engaged in the CJR demonstration have echoed these same concerns. We are concerned that some hospitals and physician practices seem to be actively screening potential THA/TKA patients, to identify those who they believe will need facility-based PAC, and are referring them elsewhere. AHCA believes that this potentially serious issue warrants immediate attention by CMS.

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5 Ellimoottil et al., 2016.

6 Ibid.
3. The lack of evidence on impact of EPMs for key patient-centered outcomes, such as attributable mortality related to the target conditions, suggest that EPMs require further evaluation before expansion.

There is no evidence of decrease in mortality related to the target conditions attributable to bundled payment initiatives. For the evaluation of Model 2 of BPCI, unadjusted and risk-adjusted 30-day mortality trends were assessed for BPCI patients and patients treated by comparison group providers. For BPCI patients, the risk-adjusted mortality rate remained steady during the baseline period (4.1% to 4.0%) and increased to 4.6% during the intervention period while the risk-adjusted mortality rate remained relatively steady throughout the entire period for the comparison patients. Differences in risk-adjusted mortality rates between the BPCI and comparison patients during baseline or intervention periods, however, were not statistically significant. BPCI Model 2 evaluation found that mortality rates were similar between BPCI participants and the comparison group for surgical orthopedic episodes (excluding spine)\(^7\). The Year 2 evaluations of BPCI Model 2 found similar results to Year 1, with one notable exception. The report finds that there were reductions in cost of care during a 90-day episode for orthopedic and cardiovascular surgery, without negative effects on quality of care. Interestingly, the cost of spinal surgery for BPCI participants was found to increase relative to the comparison group, and there was a simultaneous reduction in the mortality rate. This result requires caution and further inquiry, and reflects AHCA’s concern that incentives to reduce costs from the proposed rule may dissuade care providers from utilizing best practices, which may have higher standard costs but also improve outcomes\(^8\). Evaluation of Provencare, the pay-for-performance bundled pilot system implemented at three Geisinger Health Systems in Pennsylvania in 2007 found that although there were significant increases in adherence to best practices, it is notable that these changes did not translate to significant improvements in health outcomes or mortality\(^9\).

Evidence of impact on hospital readmission rates and ED visits rates is mixed. While readmission rates may have decreased for BPCI participants, ED visit rates increased. Evidence of impact on quality and safety are inconclusive. A BPCI Model 2 evaluation found that 30-day unplanned readmissions were initially higher (8.6%) for BPCI participants than for the comparison group during the base period (7.3%). But, through the intervention period, both decreased and the difference was not statistically significant. For the


BPCI group, ED visits 30 days post-discharge rose from 6.7% to 8.7% from baseline to intervention and were significantly greater than the comparison group. In the Year 2 BPCI Model 3 evaluation, claims based measures were similar between BPCI participants and the comparison group, with the only notable exception being a statistically significant increase in unplanned readmissions for non-surgical cardiovascular clinical episodes\(^{10}\). The Lewin Group’s Year 2 report is the most recent quantitative analysis on bundle payment models, but the study is observational and the conclusions that can be drawn are limited. Detecting differences in quality of care between BPCI participants and comparison groups is dependent on matching characteristics between the two groups, and if there are statistical differences. Furthermore, outcomes reported reflect a single year and changes in care quality and process are expected to change over longer periods. It should also be noted that BPCI participants voluntarily joined this bundled program, and are typically large, urban, non-profit teaching hospital systems.

The quality monitoring measures for BPCI are limited while more extensive quality measures are found in analysis of the ACE demonstration. Twenty-two quality measures were analyzed, 10 of which experienced statistically significant changes during the demonstration period. Six measures demonstrated improvement (e.g., death within 30 days following surgery and 30-day readmission), but there were also statistically significant negative outcomes, notably, IMA grafts for patients undergoing CABG surgery.

Horizon Health Care of New Jersey’s bundled payment model yielded similar results to the ACE demonstration. Unplanned-hospital readmissions decreased by 0.5% and transfusion rates dropped significantly by over 19%. Surgical wound infections and complications remained low at 0.9% for the facility, however, the in-patient complication rate increased by 2.27% during the bundling program. Investigation determined that this was due to increased coding rates for clinically insignificant complications\(^{11}\). This exemplifies how variations in hospital practices can result in significant measurement results, and greater data on these outcomes is required. A meta-analysis conducted in 2012 summarized and drew comparisons between several types of past bundled payment programs and found that there is little evidence to support that bundled payments have any significant consistent impact on quality\(^{12}\).

There is almost no evidence on whether patients’ perceptions about quality of care and satisfaction with care during the episode increased for patients in bundled payment initiatives. Any evidence of improvements in satisfaction was limited to the acute setting. ACE Demonstration interviews with hospital

\(^{10}\) Dummit et al., 2016b.


administrative staff and physicians revealed that quality improvement and patient satisfaction was relatively more important to them than gain sharing or cost improvements (IMPAQ, 2013). However, there is little quantitative assessment of whether bundled payment initiatives are having any effect on patients’ perceived quality of care and satisfaction with care. BPCI has no reported data on this that is publically available while ACE focused on providers and medical staff and did not quantify patient experience, but instead relied on qualitative findings.

Across payment reform programs, patient satisfaction with quality of care typically increases. HHC reported in their findings that HCAHPS score for the hospital was in the 80.9 percentile and nearly 90% of their patients were likely to recommend the surgery. The authors hypothesize that this is due to adoption and streamlining of best practices in care in order to cut costs while not reducing quality in response to adoption of bundling programs. This effect can be seen in Bay State Health’s bundled payment initiative, which was small in size, but whose only statistically significant finding was an increase in adherence to a composite of the Surgical Care Improvement and Project process measure by staff.

The body of evidence supporting or rebuking the effects on patient satisfaction with quality of care after adoption of a large-scale bundle payment model is insufficient. There is variability in both the direction and magnitude of effects with some quality measures showing improvement in some areas yet decline in others, or “studies of the same intervention arriv[ing] at different conclusions about the effect of bundled payment on related quality measures”16. Furthermore, in their review of 58 studies on the issue of payment reform options relating to bundled payments, only two of the 58 were classified as “good” in strength of evidence, with more consistent findings in cost analysis utilization metrics, not quality analysis.

4. AHCA is concerned about the potential pitfalls of expanding EPMs to cover complex conditions such as AMI and CABG.

Complex conditions such as AMI and CABG have multiple evidence-based care pathways. Decisions about appropriate care should be made by physicians and their patients and should be based on each patient’s medical necessity and care preferences. Bundling clinically complex episodes with multiple care pathways may lead to factors other than medical necessity and care preferences influencing the decisions that providers make. Such decisions could have a long-term impact

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13 Ibid.
16 Hussey et al., 2012.
on a patient’s health and wellbeing and may increase costs in the long run while achieving the short-term goal of reducing episodic costs.

5. Despite PAC providers’ organizational commitment to bundled payments, hospitals may not adopt an inclusive approach and involve PACs to form effective partnerships to improve care, care experience, and reduce cost.

We agree with the following statement in the proposed rule encouraging collaboration between hospitals and PAC providers: “With respect to post-acute care, we believe that requiring EPM participants to engage patients in shared decision making is the most important safeguard to prevent inappropriate recommendations for lower-cost care, and that such a requirement can be best effected by requiring EPM participants to make shared decision making a condition of any EPM sharing arrangements with practitioners who provide these services.” (proposed rule text: pg. 50915)

Yet, it is possible that bundled payments have the potential to drastically change the PAC relationships and have the effect of creating “winners and losers among PAC providers”17. Hospitals participating in payment reforms face the decision of where they want to invest their resources, for example: choosing between programs to reduce readmissions or building referral networks with efficient post-acute care facilities or deciding to try to decrease use of post-acute care18. The Year 2 BPCI evaluation found that BPCI participants acknowledged redesign efforts as critical, but also cited the emergence of friction in coordination between hospitals and partners. Some sites reported adoption of new care protocols for BPCI beneficiaries alone, resulting in a possible reduction or differences in care pathways for selected patients within the same facility19. The majority of Model 2 BPCI awardees cited care navigators / coordinators as critical to their BPCI program, but found PAC facilities were not always receptive.

6. Health care systems will have difficulty attributing patients due to overlapping Alternative Payment Model Programs (APMs), and exclusion of some (certain Innovation Center ACOs, Next Gen, Comprehensive ESRD) and not others (MSSP) from participation in new EPMs.

Until CMS provides a mechanism for providers to identify bundle patients in real time, then attribution will remain difficult. BPCI’s Year 2 evaluation report found Model 2 participants had difficulty determining if a beneficiary was BPCI-eligible based on categorization of the MS-DRG by claims data. Patients with comorbidities proved particularly difficult to qualify. This information lag

19 Dummit et al., 2016b.
can place a patient in financial jeopardy if they receive treatment under a 3-day waiver and are subsequently coded as outside of the BPCI program. **One solution may be to avoid implementation of the new EPMs in markets where BPCI or ACOs are active.**

Furthermore, negotiating gainsharing agreements between ACOs and bundled payment participants is a challenge due to the inherent contradictions in how target prices are set within the models. Another concern regarding overlapping ACOs and bundled payments are potential losses to ACOs due to the different way gains are calculated for the two systems. In bundled payments, providers are rewarded or penalized for their per episode spending relative to “target prices” which are based on historical spending per episode. Providers in ACOs, on the other hand, are rewarded or penalized based on annual spending for a cohort of designated Medicare beneficiaries relative to historical prices. Due to these inherently different administrative differences, it is difficult to negotiate gain-sharing arrangements between ACOs and independent bundle participants. According to a recent perspective piece in the New England Journal of Medicine, ACOs are worried that when a participant in a bundled payment program treats an ACO patient, costs could potentially be shifted from a high-cost bundle provider to an efficient, cost-effective ACO. For example, if an ACO has per-episode spending below average but some of its patients are part of a bundled payment initiative with a target price that’s higher than actual spending for those ACO patients, the ACO’s spending will increase and savings will decrease regardless of bundle gains or losses. The author claimed one policy solution to this problem was to exclude ACO beneficiaries from bundled payments unless bundled participants are part of an ACO.

Independent evaluations of bundled payment models do not adequately address administrative complexities when there is overlap between bundled payment models and ACOs. More evidence is also needed on whether bundled payments negatively impact cost savings of overlapping ACOs and how this could affect the sustainability of ACOs moving forward. **Future evaluations of bundled payment initiatives should assess whether they hinder implementation of other alternative payment models, and implementation of new EPMs should be delayed until such interactions are better understood.**

**Recommended Refinements to the Proposed Rule**

1. AHCA would like to see an expanded role for PAC providers in the new EPMs rule, including guaranteed shared savings, as well as a commitment to more broadly test PAC-focused models of bundled payments, such as BPCI Model 3.

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20 Ibid.
Nearly 1,200 post-acute care providers are participating in the risk-bearing phase of BPCI Model 3, including 1,071 SNFs, 101 home health agencies (HHAs), 9 inpatient rehabilitation facilities (IRFs), and 1 long-term care hospital. Early results indicate that Model 3 can work. CMS’ evaluation of the initial year of the model found that Model 3 participants said that they associated their involvement with the BPCI initiative with their investment in improvements across the continuum of care. Participants noted that they wanted to be valued partners with hospitals in particular and they engaged with hospitals while deciding whether to participate in the initiative. AHCA believes continued testing of PAC-only bundles is a critical piece of CMS’ shift to value-based payment design, and CMMI should move to test additional Model 3-like approaches to episodic payment.

In lieu of PAC-only bundles, CMS proposes to allow participating hospitals to share reconciliation payments they receive from CMS, internal cost savings from care redesign, or repayments to CMS, if funds are owed, with providers and suppliers caring for beneficiaries in EPMs in order to align financial incentives. CMS proposes two payment types:

- **Gainsharing Payments** (Payments made from participating hospital to EPM collaborator) – Total gainsharing payments in a calendar year paid to a physician or non-physician practitioner may not exceed a cap of 50 percent of the total Physician Fee Schedule (PFS) payments for services furnished to the hospital’s EPM beneficiaries during an episode by that physician or non-physician practitioner.

- **Alignment Payments** (Payments made from EPM collaborator to participating hospital) - Payments may not exceed 50 percent of the participant hospitals’ repayment amount due to CMS in a calendar year. If no repayment amount is due, then no alignment payment may be received. The sharing arrangement must limit the amount a single EPM collaborator may make in alignment payments to a single hospital to 25 percent of the repayment amount on a hospital’s annual reconciliation report.

AHCA supports the use of gainsharing arrangements to allow providers to collaborate and benefit financially across provider sectors. However, AHCA believes that gainsharing alone does not recognize the importance of PAC providers in the episodes of care. In many cases, PAC represents a significant portion of the episode spending. However, EPM hospitals are not required to gainshare with other providers. We believe that the proposed structure for these financial relationships risks excluding PAC providers from having a significant role in EPMs.

CMS proposes that PAC providers would receive gainsharing payments based on the performance of the pool of PAC providers with which the EPM hospital gainshares. AHCA believes that more flexibility should be granted in the

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23 Dummit et al., 2015.
gainsharing arrangements. While the pooling approach may be preferred by some participating providers, it will unfairly reward providers in some arrangements. PAC providers may have a range of involvement in and contribution to care redesign. EPM should allow hospitals to gainshare with PAC providers on a basis that rewards the individual provider’s performance without excluding others. The numerous types of arrangements between providers are difficult to predict prior to the model’s implementation. BPCI grants greater flexibility in gainsharing arrangements, allowing participants to select one of six savings pools options. A similar level of flexibility should be granted to the new EPMs.

AHCA also recommends that CMS encourage certain other arrangements that may be considered financial arrangements for the purposes of the federal fraud and abuse laws such as the federal Anti-Kickback Statute (AKS) but would help providers and suppliers facilitate the goals of the proposed EPM. For example, none of the current fraud and abuse waivers for CJR would expressly permit a hospital participating in the EPM to provide electronic health record (EHR) or other software to a PAC provider collaborating with such hospital. While such provision of EHR may be covered by the EHR safe harbor at 42 C.F.R. § 1001.952(y), given the multitude of requirements under such safe harbor, it may be impossible to structure such arrangement under the EHR, or other, safe harbor.

2. AHCA urges CMS to modify the 3-day SNF rule waiver to either: (1) provide the 3-day waiver for all SNFs; or (2) allow hospitals to refer patients to facilities with “at least 3 stars overall or at least 3 stars on both the staffing and quality measure components”.

The Five Star measures are not tailored to post-acute care, and do not focus on AMI, CABG, or SHFFT episodes. The Five Star rating system is principally based on measures that apply to long-stay nursing home residents rather than short-stay rehabilitation residents. A SNF’s survey score is derived from regulations that were designed for long-stay residents. The staffing levels are based on time and motion studies and risk adjustment from a study of care that principally used long-stay residents. Of the 11 quality measures in the Quality Measures component, only three apply to short-stay residents. Given the limited quality information about short-stay residents in Five Star, we strongly disagree with the proposal that the Five Star system be used as a quality gatekeeper to waving the 3-day stay requirement. In addition, the way in which CMS calculates the survey score used to rate a SNF’s Five Star ranking can be heavily influenced by one incidence of non-compliance that may not have resulted in an adverse event. As such, it is not uncommon for a SNF to receive a low rating on the survey component yet receive high ratings on both the staffing and QM components. This phenomenon is one of the reasons that the Five Star rating system is often poorly correlated with other clinical outcome measures of quality.

24 42 U.S.C. § 1320a-7b(b).
The survey score is necessarily reflective of a SNF’s overall quality performance across all residents, but rather reflects single incidences of non-compliance.

If CMS believes that it is critical to use a quality rating system for the waiver, we would recommend using quality measures directly related to post-acute care (such as hospital readmission rates, discharge to community rates, improved function, and SNF satisfaction) rather than an overall Five Star rating that is less applicable to this population.

The proposed rule will restrict beneficiaries’ freedom of choice of providers and access to care, contravening the Medicare Act’s beneficiary freedom of choice requirement. CMS also recognizes there are a number of valid reasons that a beneficiary would select a lower-star nursing facility over a higher-star rating, including proximity to family, but through tying the 3-day stay waiver to 3-or-more-star SNFs, CMS will likely significantly limit beneficiaries’ ability to select all SNFs for their post-acute care. Importantly, by excluding 1- or 2-star rated SNFs from post-acute care networks, CMS will arbitrarily restrict a resident’s ability to use other, critical factors, such as geographic proximity to their home or family, in making a decision about SNF admission.

Excluding 1- and 2-star rated SNFs will decrease the availability of beds for patients affected by the proposed rule. Our analysis of Nursing Home Compare data shows that SNFs with star ratings of two stars or lower have the highest capacity for patient care in terms of median number of beds in Core Based Statistical Areas (CBSAs) (Table 1). Limiting participating SNFs to those with 3-star ratings and above will directly reduce access to large-capacity SNFs.

<table>
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<tr>
<th>Table 1: Median SNF Volume (number of beds) by Star Rating</th>
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<tr>
<td>Star Rating</td>
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<tr>
<td><strong>National CBSAs</strong></td>
</tr>
<tr>
<td>1</td>
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<td>2</td>
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We anticipate that hospitals will discharge only to SNFs with 3 or more stars since it will be difficult for hospitals to coordinate discharges with fewer than three inpatient days to only 3-star rated facilities and beneficiaries with more than three inpatient days to any SNF. This proposed requirement de facto forces the creation of post-acute care SNF networks that include only facilities rated 3-star or higher. Therefore, this policy will have the unintended effect of significantly

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25 42 U.S.C. § 1395a(a) states:

Basic freedom of choice—Any individual entitled to insurance benefits under this title may obtain health services from any institution, agency, or person qualified to participate under this title if such institution, agency, or person undertakes to provide him such services.
limiting access and choices available to beneficiaries and their families, which would undermine the beneficiary freedom of choice requirements imposed by the statute and would contravene CMS’ assertion in the proposed rule that “these proposed EPMs would not create any new restriction of beneficiary freedom to choose providers, including surgeons, hospitals, post-acute care, or any other providers or suppliers.” They will no longer be able to select the most appropriate post-acute care setting based on all the information available to them, rather they can select only from SNFs based on CMS-imposed criteria, which arguably does not provide a full or clear picture of the quality of care furnished by a SNF. This is contrary to the language used on Nursing Home Compare to describe Five Star ratings as one piece of information consumers should use when selecting a SNF. Therefore, AHCA recommends that CMS allow all SNFs to participate in the 3-day stay waiver but require hospitals in the proposed CBSAs to provide quality information about the PAC providers, which could include but not be limited to Five Star ratings.

The frequent fluctuation in a SNF’s overall rating above or below 3 stars will make program implementation difficult and could place beneficiaries in financial jeopardy

Since the Five Star rating system is updated on a monthly basis, it is possible that a SNF’s rating fluctuates every month. Analyzing data for a two-year period (prior to the February 2015 rebasing of Five Star), we observe a 15% chance that a SNF, rated 3 stars or higher, will drop below 3 stars in the following 12 months. In Table 2, our analysis of recent Nursing Home Compare data further demonstrates this fluctuation as, no more than 60% of the SNFs maintained a star rating of 3 or more for at least seven consecutive months in the last year despite more than two-thirds of the SNFs being rated three stars or more at any point during the last year.

**Table 2:** Analysis of Star Ratings, Nursing Home Compare Data (September 2015-August 2016)

<table>
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<tr>
<th>CBSAs</th>
<th>Total CBSAs</th>
<th>Total SNFs</th>
<th>CBSAs with over 50% of SNFs with 3 or more Stars for Any Given Month</th>
<th>SNFs with 3 or more Stars for Any Given Month</th>
<th>SNFs with 3 or more Stars for at least 7 consecutive months out of 12</th>
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<tr>
<td></td>
<td>N</td>
<td>%</td>
<td>N</td>
<td>%</td>
<td>N</td>
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<tr>
<td>National CBSAs</td>
<td>945</td>
<td>14,132</td>
<td>855</td>
<td>90.5</td>
<td>10,676</td>
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<td>SHFFT episode CBSAs</td>
<td>67</td>
<td>4,173</td>
<td>63</td>
<td>94.0</td>
<td>3,236</td>
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Not only will this level of fluctuation impact beneficiary choice of provider, but it also will make implementation of the program logistically challenging for hospitals as they try to establish a network of exclusive 3-star-or-higher SNFs. Although CMS states that the waiver will be honored based on the SNF’s status at the time of discharge, hospitals may operate on information that is a month or more old, which could result in beneficiaries inadvertently admitted to what the referring hospital believed to be a 3-star or greater SNF to only find that it dropped to a 2-star. If the SNF does not meet the criteria, the stay would not be covered and the beneficiary could be financially liable for their stay. And finally, we suspect that hospitals will drop SNFs from their networks because of a drop in Five Star score despite the fact that nearly half could quickly regain a 3-star or greater rating. Once a hospital drops a SNF from its network, the SNF may never become a network provider again. We anticipate this fluctuation will create unintended, unnecessary restrictions in beneficiary choice of provider, even if that provider becomes eligible for the waiver.

Finally, AHCA believes that CMS’ reliance on the Five Star rating system for the purposes of the 3-day waiver in the proposed EPM, as well as other CMS-implemented APMs, magnifies the concerns associated with an already-flawed system. For example, the Five Star rating system does nothing to address the significant inconsistencies in how surveyors interpret and apply Medicare and Medicaid requirements and cite deficiencies, and as a result, facilities are subject to surveys based upon differing interpretations and frequently subject to the review of survey teams that lack adequate knowledge and skills to conduct objective surveys. It is often the case that surveys are based on the surveyors’ own interpretation of CMS guidelines, rather than the regulations themselves. Inconsistent survey results feed into the Five Star system, which now feeds into another aspect of Medicare—3-day stay waivers in APMs. Which each step, the issues associated with the prior become exacerbated. As another example, the Five Star system treats similarly situated SNFs differently. Two SNFs in two different states with the same quality standards might have different ratings because the system evaluates nursing home performance within states rather than on a national level. Why should two SNFs—with the same quality standards—receive disparate treatment not only under the Five Star rating system, but also for the purposes of the 3-day stay waiver under the EPM?

Further, we note that more broadly, the independent Medicare Payment Advisory Commission (MedPAC), among others, has questioned the accuracy of the CMS’ hospital quality star rating system and whether or not it penalizes hospitals with the sickest patients. MedPAC and others have pointed out that the system oversimplifies a complex matter and could hurt hospitals’ reputations. AHCA believes the same criticism applies to the Five Star rating system for SNF, and
questions how the rating system could be valid for one provider type and not for another. In sum, AHCA views CMS’ assignment of stars, under the current Five Star methodology, as producing arbitrary and capricious results. By extension, and critically important because it impacts the ability of SNFs to participate in innovative payment models—CMS’ use of the Five Star rating system in the context of the EPM is arbitrary and capricious as well.

Because of the challenges with the proposed policy that we have outlined above, AHCA strongly urges CMS to: (1) apply the 3-day stay waiver to all SNFs; or, alternatively (2) apply the 3-day stay waiver to SNFs that EITHER have an overall 3-star rating OR who have maintained at least a 3-star rating on both the Staffing and Quality Measure components of the Five Star rating system. We believe that the second approach would more appropriately take into consideration the fluctuations in Five Star ratings that create operational challenges for providers and unnecessarily limit beneficiary access to care than CMS’ current proposal. Our approach recognizes the importance of the Five Star rating system while creating an incentive to achieve staffing levels and quality care levels associated with at least a 3-star rating or higher. We believe this approach would ensure that those facilities who may be rated at the 1- or 2-star level are providing a reasonable level of staff and achieving desired quality outcomes.

3. AHCA recommends a waiver for all outpatient therapy provider settings of the (Part B) therapy caps and related policies for beneficiaries involved in AMI, CABG, and SHFFT episodes.

Artificial benefit cap limitations on outpatient therapy services for EPM-eligible beneficiaries run contrary to this CMS expectation. While Congress has permitted some exceptions to the therapy caps through the end of CY 2017, there is no guarantee that these exceptions will be extended. In addition, the cap exceptions process includes several burdensome cost-containment administrative provisions, including mandatory medical review, which if continued for EPM-eligible beneficiaries, would create a disincentive for outpatient therapy providers to participate in EPM.

For example, extended outpatient therapy episodes may be medically necessary for those beneficiaries bypassing more expensive PAC services in the new EPMs. Such increased outpatient therapy utilization will increase the likelihood that the beneficiary would surpass the therapy cap limits, as well as the likelihood of triggering complex manual medical review due to higher utilization patterns than similar beneficiaries that first received the higher cost PAC services. Waiving the therapy cap policy for EPM-eligible beneficiaries will better incentivize creative approaches towards cost-effective care across all PAC providers.

AHCA suggests that this waiver could be implemented relatively easily in CMS systems through edits that would exclude EPM-eligible outpatient therapy service claim lines from being counted against the cap limits.
AHCA also suggests that medical review contractor instructions be provided so that EPM related claims are only reviewed within the context of the EPM bundle, and not in the context of any isolated outpatient therapy policy.

4. **AHCA recommends a waiver for regulatory constraints on how therapy services are delivered to EPM-eligible beneficiaries.**

   For example, waivers of limits on the use of concurrent and group therapy in the SNF as described in the Resident Assessment Instrument (RAI) User’s Manual for EPM-eligible beneficiaries would permit SNF therapists to provide quality care more efficiently. The relaxation of these requirements would permit SNF providers to focus on outcomes and design more creative and cost-effective programs for EPM-eligible beneficiaries within the entire range of activities described in the treating therapists’ scope of professional practice. Quality and value-based payments related to outcomes measures including mobility, self-care, hospital readmissions, discharge to the community, and others will be more effective at developing optimal therapy service delivery models rather than arbitrary constraints on how therapy services are delivered.

5. **AHCA recommends that CMS consider making targeted modifications to the proposed quality measures in this EPM model as well as future EPM programs.**

   AHCA opposes language in the rule that exempts hospitals from EPMs if death occurs during the anchor hospitalization, and not at any point after. Proposed rule explains, “Because of the higher mortality rates for all of the proposed EPM episodes than for LEJR episodes in the CJR model, we do not consider mortality following hospital discharge to be atypical and, therefore, we propose to cancel EPM episodes only for death during the anchor hospitalization.” (pg. 50840). This indicates that while hospitals may be able to receive a non-EPM following hospitalization, PAC providers will not.

   **Until the provisions of the IMPACT Act of 2014 are fully implemented, and standardized cross-setting measure data is available, there is currently no uniform quality assessment mechanism across post-acute care settings to identify differences in risk-adjusted patient outcomes.** DeJong (2014), in his commentary, noted that rehabilitation patients often journey through multiple post-acute settings for the same episode of care. He pointed out there is currently no uniform patient assessment tool for use across post-acute care settings to identify differences in risk-adjusted patient outcomes. The Continuity Assessment Record and Evaluation (CARE) item set, demonstrated the potential to be a cross-setting assessment tool. It is currently implemented in the Bundled Payment for Care Improvement Initiatives to measure patient health, function, and outcome. **The author proposes holding acute care providers accountable for the same outcomes as post-acute providers** (e.g. minimize episode medical complications and readmission, optimize functional performance, enable independent and active living).
The CARE item set has been tested by PAC setting under the Post-Acute Care Payment Reform Demonstration (PAC-PRD), and provides the foundation for the new IMPACT Act PAC assessment items and quality measures which may be further tested to be used in a bundled payment model. Research would be required to identify specific items or measures that would be applicable to AMI, CABG, and SHFFT.

PAC-PRD was mandated by Congress to collect uniform data on patients being discharged from acute hospitals to one of four post-acute care (PAC) settings: long-term care hospitals (LTCHs), inpatient rehabilitation facilities (IRFs), skilled nursing facilities (SNFs) and home health agencies (HHAs). In this demonstration, the standardized Continuity Assessment Record and Evaluation (CARE) item set was administered within 2 days of admission and 2 days prior to discharge. The CARE item set was designed to collect data on patients’ medical, functional, and cognitive status at admission and discharge from each PAC setting and at discharge from general hospitals. PAC-PRD found high reliability in the acute and PAC settings.

Medicare currently uses a different prospective payment system for each PAC setting but many conditions are treatable in more than one type of PAC setting. Each setting uses a different reporting structure and assessment windows, which make it difficult to share data across settings. In addition, patients may be discharged by an acute hospital, with the same condition, to different types of PAC settings based on availability of PAC options, patient choice, and other factors. This prompted the need for a cross-setting assessment tool to measure resources and outcomes in each setting and across settings.

The IMPACT Act provisions seeks to address these limitations through 1) the standardization of key clinical element data reporting across PAC providers and 2) the implementation of standardized patient-centered cross-setting quality measures. Specific IMPACT Act measure domains that are clinically relevant to the patient populations described in this proposed rule include 1) Functional status, cognitive function, and changes in functional and cognitive function, 2) Skin integrity and changes in skin integrity, 3) Incidence of major falls, 4) Discharge to community, and 5) Potentially preventable hospital readmission rates. CMS should consider using these PAC measures as part of bundled payment models, and how their use could be adapted so that they could be also applied to acute hospital and ambulatory outpatient physician and rehabilitative therapy services so that a true patient-centered cross-setting picture of the effectiveness of care can be measured in the bundles.

For example, variations of the CARE item set were tested in the recent CMS Developing Outpatient Therapy Payment Alternatives (DOTPA) study for applicability to outpatient therapy patients residing in facilities (CARE-F) and in the community (CARE-C) with promising results. Further CMS development to

refine these measures and apply them to outpatient therapy services would further align the measurement of risk-adjusted patient outcomes across all provider types covered under the proposed bundles.

6. AHCA suggests including ‘balance measures’ to assess potential unintended consequences of the new EPMs, such as changes in hospital case-mix; overuse of home health services; cost-shifting beyond episode time periods; and inpatient transfers to non-participating hospitals.

Post-operative discharge to PAC settings decreased in most research findings, while number of discharges to home with no home health aide (HHA) remained the same. Year 1 analysis from BPCI Model 2 found that across all Model 2 episodes discharge to SNFs significantly decreased from 66% to 47% after implementation, while the proportion of discharge to home with no HHA remained the same. This reduction in settings was statistically different from that of the comparison group. CMS’s ACE Demonstration, however, did not show any impact on PAC discharges or costs (DID regression coefficients were not statistically significant). Geisinger Health System (GHS), implemented its own bundling model, called ProvenCare, this program’s only statistically significant improvement in care quality was an increase from 81% to 90% in discharge to home after implementation. GHS developed multiple payment reform models for a variety of inpatient procedures, however, the CABG model is the only model which has similar parameters to CMS’s proposed rule and its population size is small (117 participants).

Interviews with medical hospital staff conducted as part of the ACE demonstration research found that PAC providers might be pressured to reduce the LOS of patients and improve their quality of care metrics without the sufficient resources to do so. The Year 1 BPCI report emphasizes that monitoring is required over a longer period in order to accrue the necessary amount of data to uncover any unforeseen negative phenomena. Of the statistically significant negative outcomes in ACE, IMA grafts for patients undergoing CABG surgery were highlighted as a concerning result. IMA grafts have been shown to improve outcomes and, if reduction was caused by

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30 Dummit et al., 2015.
introduction of bundled payments, it exemplifies the type of reduction in utilization that Medicare would want\textsuperscript{31}.

**Another possible adverse effect of adopting a bundled payment model is increasing total volume of care provided by increasing patient volume.** Authors of a 2013 study hypothesize that immediate gains in efficiency within a care system will result in new available capacity, not real cost-savings\textsuperscript{32}. As a result, an increase in volume of any percentage greater than that of the discounted average reimbursement that is paid by insurance will cause negative Medicare cost savings. HHC may exemplify this effect; during the bundling program, TKA and THA procedures increased by 77% and 98% respectively. The Year 2 BPCI Program report found that the “mean lower extremity joint replacement discharges per quarter for BPCI-participating hospitals increased from 61.5 in the period from April 1, 2012, to June 30, 2012, to 64.6 in the period from April 1, 2015, to June 30, 2015, compared with a decline for comparison hospitals from 59.6 to 59.2 during the same periods”\textsuperscript{33}. While this difference was not statistically significant, further research is required to determine if cost shifting is occurring for some care categories, creating an increase in bundles to offset reductions in individual beneficiary fees. Increasing the volume of procedures that are not included in the MS-DRG increases reimbursement in the typical fee-for-service model. During the implementation period of ACE, a single hospital system (OHH) had no changes in volume of procedures, except a decrease in ACE pacemakers. However, there as a similar increase in ACE-related cardiovascular procedures not included in the program by a similar amount. This may support concerns over shifting care outside the DRGs.

**Tighter consolidation between hospitals and SNFs under bundled payments could also negatively affect patient access to appropriate care.** According to one report, when a hospital reduces the number of PACs in their network, some patients may be required to travel farther for care, or be cared for by a provider who is less expensive but not a good fit for their particular condition. Therefore, by encouraging consolidation with hospitals and PACs under bundled payment initiatives, patients may be adversely effected depending on their condition.

**Bundled payment SNF participants that witnessed decreases in LOS expressed safety concerns about discharging high acuity patients early.** Decreased SNF LOS also hindered access to long-term care options. Using a multiple case study approach, the researchers interviewed a total of 70 staff from 24 SNFs in 8 markets throughout the United States\textsuperscript{34}. Staff members included SNF administrators, directors of nursing, and admissions coordinators. The

\textsuperscript{31} IMPAQ International, 2013.
\textsuperscript{33} Dummit et al, 2016b.
\textsuperscript{34} Tyler, D.A., McHugh, J., Shield, R.R., Winblad, U., & Gadbois, E.A. (2016, June). The Unintended Consequences of Reduced Skilled Nursing Facility Length of Stay. Poster Presentation at AcademyHealth’s Annual Research Meeting, Boston, MA.
markets were strategically chosen so that four had high Medicare Managed Care penetration rate and four had a low Medicare Managed Care penetration rate. Within each market, SNFs were chosen that received referrals both from hospitals with high and low readmissions rates. In addition to interviewing the SNF staff members, data was analyzed on risk adjusted SNF median LOS from 2012-2014. The data found that 12 of the 24 SNFs had a reduction in their median LOS, with an average reduction of 4 days. The LOS reduction could be attributed to SNFs in MCOs with pre-determined length of stay requirements. The staff members from these SNFs noted multiple challenges associated with reduced length of stay requirements at their facilities. First, many staff reported having to discharge high acuity patients who they felt were unsafe to be released. This also resulted in less time to help connect these patients with long-term care options.

7. AHCA recommends that CMS provide all PAC providers with timely access to data to inform quality improvement initiatives under the EPM rule.

CMS proposes providing beneficiary-level claims data for the historical period as well as ongoing quarterly beneficiary-identifiable claims data for each EPM hospital in two formats to accommodate varying abilities for hospitals to analyze raw claims data. Data would contain information on claims for each EPM beneficiary in a participating hospital. CMS proposed to limit this data distribution to participating hospitals.

AHCA appreciates CMS’ continued and growing data distribution for certain programs. AHCA believes that any provider who treats a EPM beneficiary during the episode should also have access to the claims data. As discussed in the proposed rule, hospitals will have varying capacity to analyze raw claims data. Further, many hospitals have different degrees of preparedness and interest in bundled payments. We do not believe that CMS should rely solely on the hospitals to share data with other providers.

Making data available to PAC providers and physicians will allow them to better collaborate with the hospitals in EPM. Providers would be able to analyze the data and develop approaches to care redesign, especially when the hospital has not expended the resources to do such analytics. This analysis would allow PAC providers to demonstrate their value to a hospital. It would also allow PAC providers to better position themselves when entering into gainsharing arrangements with a participating hospital.

8. AHCA recommends that CMS consider adding measures to more aggressively monitor provider behaviors that would seek to restrict beneficiary access to care.

CMS proposes to monitor the new EPMs for beneficiary choice and notification, quality of care, delay of care, and access to care. AHCA firmly believes that the rule does not go far enough to address serious concerns about beneficiary choice, skimping on care and conflict of interest. CMS
should provide greater detail on how it will protect beneficiaries from reduced access to care and patient steering.

**Under bundled payments, low-referral, independent SNFs often are left to care for high-acuity, poorer, medically complex patients with lower reimbursement.** In the context of bundled payments between hospitals and SNFs for a particular episode, SNFs in preferred hospital-PAC networks are able to cherry pick healthier, less complicated, and ultimately higher reimbursed patients. This process is facilitated by using hospital nurses to screen for these low-acuity patients. According to a recent paper on this topic, the researchers concluded that this drastic difference in patient acuity among high-referral SNFs (those integrated with hospital systems) and low-referral SNFs (independent organizations not a part of preferred hospital-PAC networks) causes a significant care disparity for medically complex, long-term care patients...

Proposed monitoring measures to assess key areas unaddressed by current monitoring measures

We propose the additional monitoring measures to assess concerns about beneficiary choice, access to care, quality of care, cost and utilization, and potential “gaming” issues. Table 4 presents proposed measures that address the following key questions.

a) Is quality, cost of care, and beneficiary access to negatively impacted by the new EPMs model?

b) Are EPM participant hospitals restricting beneficiaries’ freedom of choice?

c) Are EPM participant hospitals inappropriately coding for hip fractures and engaging in other types of code shifting?

d) Are EPM participants inappropriately shifting patients to other providers and suppliers or others outside of the EPM model?

e) Are EPM participants using the EPM program rule waivers appropriately and complying with the model requirements?

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<thead>
<tr>
<th>Measure Domain</th>
<th>Potential Monitoring Measures</th>
<th>Sources of Information</th>
<th>Potential Usability Issue</th>
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| **Beneficiaries’ freedom of choice** | **Beneficiary-complaints**: Volume and type of complaints  
Participant non-compliance with beneficiary choice/notification: Number and proportion of beneficiaries not receiving appropriate documentation of choice/notification from participants.  
Collaborator non-compliance with beneficiary notification: Number and proportion of beneficiaries not receiving appropriate documentation of notification from participants. | Complaints registered to 1-800-Medicare and state QIOs  
Beneficiary surveys by evaluation contractor  
CJR participant beneficiary communication documents | -  
-  
- |
| **Beneficiary access, quality, and cost of care** | **Total Cost of Care**: 90-day total episode spending broken up into hospital, post-acute, physician, outpatient and other spending  
Cost Shifting beyond episode: post-episode total 30-90- and 180-day spending  
Cost Shifting to beneficiaries: beneficiary out of pocket spending 90-day episode; 30-, 90-, 180-days post-episode  
Utilization: 90-day episode and, 30-90- and 180-day post-episode rates for the following measures: unplanned readmissions, all-cause hospitalizations, emergency department visits including observation stays, evaluation & management visits, acute | Claims data  
Complaints registered to 1-800-Medicare and state QIOs  
Patient Reported Outcomes (PRO) data  
Hospital CAHPS  
Home Health CAHPS; Clinician & Group CAHPS | -  
-  
Availability  
Specificity to LEJR Pop  
Specificity to LEJR Pop |
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| SHFFT participants’ coding for hip and femur fractures and ‘upcoding’ | **Inpatient length of stay; post-acute care use and length of stay;**  
**Quality:** HCAHPS global rating and composite scores; access to care scores from evaluation contractor surveys; fall-related injuries during episode; hospital-level risk-standardized complication rate (RSCR) following THA & TKA. (NQF #1550) and its component measures (readmission for acute myocardial infarction, pneumonia, or sepsis/septicemia within 7 days of admission; readmission for surgical site bleeding, pulmonary embolism or death within 30 days of admission; mechanical complications, per prosthetic joint infection, or wound infection within 90 days of admission);  
**Beneficiary-complaints:** Volume and type of complaints | Beneficiary surveys by evaluation contractor | Availability |
| Patient shifting | **Case Mix:** MS-DRG/ fracture patient mix at the EPM hospital and at each post-acute care setting (home health, SNF, IRF, long-term acute care hospital); Charlson Index & CMS HCC Score based on all diagnoses during SHFFT hospitalization up to 6-months prior. | Claims data | - |
| EPM participants’ use of waivers and | **Volume:** Episodes seen at each participating hospital and post-acute care setting  
**Patient Shifting:** AMI, CABG, and SHFFT inpatient transfers to non-participating hospitals including BPCI hospitals, Rates of procedures by physicians in hospitals outside the MSA, EPM participant use of BPCI Model 3 PAC providers.  
**Beneficiary-complaints:** Volume and type of complaints | Claims data linked to CJR participant-collaborator lists, Provider of Service & MD-PPAS files  
Complaints registered to 1-800-Medicare and state QIOs | - |
| | **Overuse of Home Visits:** Proportion of patients with home visits with more than 9 home visits during the episode | Collaborator lists from Participant hospital websites  
Claims Data | - |
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<th>Potential Monitoring Measures</th>
<th>Sources of Information</th>
<th>Potential Usability Issue</th>
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<tbody>
<tr>
<td>compliance with other rules</td>
<td><strong>Substitution of home health with telehealth visits:</strong> Ratio of episodes with home health to telehealth visits</td>
<td>CJR participant beneficiary communication documents</td>
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<td><strong>Discharge to low quality SNFs:</strong> Proportion of patients with &lt;3-day hospital stay discharged to SNFs with a rating</td>
<td>Financial agreements</td>
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<td>of below three stars (for seven of last 12 months)</td>
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<td><strong>Non-compliance with in-kind beneficiary incentives:</strong> Number and proportion of beneficiaries receiving in-kind</td>
<td>Site visits documentation</td>
<td>-</td>
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<td>beneficiary incentives unrelated to the EPM episode. Number and proportion of beneficiaries receiving in-kind beneficiary</td>
<td>Documentation of beneficiary incentives</td>
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<td>incentives valued greater than $1000</td>
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<td><strong>Non-compliance with financial arrangements:</strong> Number and proportion of PAC collaborators, PGPs, suppliers without</td>
<td>Financial records of reconciled payments/recoupments</td>
<td>-</td>
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<td>financial arrangements</td>
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<td><strong>Non-compliance with payments/recoupments:</strong> Number and proportion of PAC collaborators, PGPs, suppliers making/receiving</td>
<td>Claims linked to and PAC provider data sets (e.g. Nursing Home</td>
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<td>downside risk recoupments/gainsharing payments above the limit defined by the rule.</td>
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