

April 19, 2017

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

RE: CMS-5519-IFC, 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; Delay of Effective Date; Interim Final Rule with Comment Period (Vol. 82, No. 53), March 21, 2017.

Dear Ms. Verma:

On behalf of our nearly 5,000 member hospitals, health systems and other health care organizations, and our clinician partners – including more than 270,000 affiliated physicians, 2 million nurses and other caregivers – and the 43,000 health care leaders who belong to our professional membership groups, the American Hospital Association (AHA) appreciates the opportunity to comment on the delayed effective date for the Centers for Medicare & Medicaid Services' (CMS) Cardiac and Comprehensive Care for Joint Replacement (CJR) Bundled Payment Model.

Our members support the health care system moving toward the provision of more accountable, coordinated care and are in the process of redesigning delivery systems to increase value and better serve patients. As such, the AHA agrees with the principles underlying the cardiac and surgical hip and femur fracture treatment (SHFFT) bundled payment models and believe they could help further these efforts to transform care delivery through improved care coordination and financial accountability. However, we had previously raised concerns about CMS's pace of change, given that it had planned to implement these new programs just 15 months after the CJR program began. **Accordingly, we are supportive of the agency's delay, from July 1 until Oct. 1, of the start date for both the cardiac and SHFFT models.**

We also support the agency's proposed further delay of these programs until Jan. 1, 2018, for the reasons outlined below. However, we caution CMS against any further delays beyond Jan. 1, 2018. To do so would effectively turn the start date for these programs into a



moving target – hospitals and health systems would continue to expend resources to prepare for something that we fear would never come to fruition. This would clearly waste valuable resources, as well as create large amounts of frustration.

In supporting an additional delay until Jan. 1, 2018, we agree with CMS that performance periods of at least six months are preferable. A shorter performance period, including of only three months as would exist with an Oct. 1 start date, would have very few episodes. For example, a three-month performance period beginning Oct. 1 would include episodes that began on or after Oct. 1 and ended on or before Dec. 31. Given that episodes are 90 days in length, only those that began on Oct. 1 or 2 would actually qualify. Such a low volume would almost certainly lead to anomalous performance results for many, if not all, hospital and health system participants – an inappropriate and undesirable outcome for all stakeholders.

In addition, we believe that a further three-month delay would provide valuable time for hospitals and health systems to prepare for the program. Doing so is no small task – it requires significant investments of time, effort and finances. Hospitals and health systems need to build upon their current infrastructure for health information technology, patient and family education, care management and discharge planning. They must identify key physician groups and post-acute organizations to partner with in order to coordinate care. They also need to analyze their organizations to find systematic, unwarranted variability in care pathways. In order to assist hospitals and health systems in accomplishing these tasks, CMS has stated it will provide them with beneficiary-level claims data. However, to date, hospitals and health systems have not received such data. **In order to fully maximize the agency's delay in the program, we urge the agency to provide these data to participants as soon as possible.**

We also believe an additional three months could, and should, be effectively utilized by CMS to continue to analyze and improve the CJR, cardiac and SHFFT programs. Additional analysis on the CJR program could help yield important lessons on how to achieve success in bundled payment models for hospitals and health systems of all sizes and types, and at all the points along the way in the transformation process, which could then be applied to the cardiac and SHFFT programs. Those programs themselves also should be re-analyzed independently so as to simplify and improve their design. Below, we outline several recommendations that we believe the agency should consider, many of which we have set forth previously.

First, we continue to urge the Health and Human Services (HHS) Secretary to, as soon as possible, use the full scope of the combined authority granted by Congress to issue waivers of the applicable fraud and abuse laws that inhibit care coordination to enable participating hospitals to form the financial relationships necessary to succeed in the cardiac and SHFFT models. Specifically, the HHS Secretary should waive the Physician Self-Referral Law and the Anti-kickback Statute with respect to financial arrangements formed by hospitals and health systems participating in the models that comply with the requirements in the rule. HHS ultimately recognized the necessity of these waivers to the success of the CJR, issuing them in conjunction with the rule finalizing that program. We urge that the same occur for these models. These waivers are essential to enable hospitals and health systems to form financial arrangements with other providers collaborating in the models, without

which they would have no real ability to make sure those providers – for whose outcomes hospitals will be held accountable – have a stake in achieving the model’s goals.

In addition, we urge CMS to implement smaller discount factors in the cardiac model than currently exist. Specifically, to determine a hospital’s bonus payments, CMS sets a target amount equal to their historical spending minus a percent discount. The discount factors for the cardiac model are the same as those CMS uses in the CJR program. However, the opportunity to achieve savings under the cardiac model is *not* the same as in the CJR program – it is much less. This is especially true over time, as target prices decline further. To avoid turning this cardiac model into a straight payment cut, CMS must provide hospitals and health systems with a fair opportunity to achieve enough savings to garner a reconciliation payment.

We also are concerned that the scope of the models’ payment waivers is too limited. **We urge CMS to give providers maximum flexibility to identify and place beneficiaries in the clinical setting that best serves their short- and long-term recovery goals.** The waiver of certain Medicare program regulations in all years of the program, including discharge planning requirements that prohibit hospitals from specifying or otherwise limiting the information provided on post-hospital services, the inpatient rehabilitation facility (IRF) “60% Rule,” and the home health homebound rule is essential so that hospitals and health systems may coordinate care and ensure that it is provided in the right place at the right time. CMS also must begin to consider innovative approaches for overcoming the challenges that are created by building a bundled payment system on a fee-for-service foundation, including the waiver of payment rules to allow flexibility in how providers such as IRFs are paid. **Doing so would allow for efficiencies that are gained in these settings to be reflected in their payments, which would help not only achieve savings, but also ensure beneficiary access to these critical services.**

Finally, the AHA recognizes that, in crafting the regulation, CMS attempted to achieve a balance between offering incentives for providers who achieve success and fulfilling CMS’s obligation to protect taxpayers and the Medicare Trust Fund. **However, as it exists, the rule places too much risk on providers with little opportunity for reward in the form of shared savings, especially in light of the significant upfront investments required.** A more appropriate balance is needed. For example, CMS should:

- Ensure downside risk continues to not be implemented until at least 18 months after the models begin;
- Provide additional protections in the form of lower stop-loss limits for hospitals and health systems that have a low volume of episodes;
- Remove the excess days in acute care measure from the acute myocardial infarction (AMI) model measure set and adopt a flexible reporting approach to the voluntary AMI mortality measure; and
- Assess all measures for the impact of socioeconomic factors and incorporate adjustments if needed.

The changes we recommend above would help optimize the effectiveness of the bundled payment models in terms of efficiently testing how to best transform care delivery through

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improved care coordination and financial accountability. They would help provide hospitals and health systems with the necessary tools to be successful under the program and appropriately balance the risk versus reward equation.

We appreciate your consideration of these issues. Please contact me if you have questions or feel free to have a member of your team contact Joanna Hiatt Kim, vice president of payment policy, at (202) 626-2340 or jkim@aha.org.

Sincerely,

/s/

Thomas P. Nickels

Executive Vice President

cc: Thomas Price, Secretary, Department of Health and Human Services

Daniel R. Levinson, Inspector General, Department of Health and Human Services