American Hospital Association

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October 10, 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-5524-P, Cancellation of Advancing Care Coordination through Episode Payment and Cardiac Rehabilitation Incentive Payment Models; Changes to Comprehensive Care for Joint Replacement Payment Model (Vol. 82, No. 158), August 17, 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 Centers for Medicare & Medicaid Services' (CMS) proposed cancellation of the cardiac and surgical hip and femur fracture treatment (SHFFT) bundling programs and changes to the Comprehensive Care for Joint Replacement (CJR) bundling program.

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. The AHA believes that bundled payment models could help further these efforts to transform care delivery through improved care coordination and financial accountability. However, we previously had raised concerns about CMS's pace of change, given that, at the time it was unveiled, the cardiac bundling program represented the third mandatory payment model that the agency had proposed in 13 months. **As such, our members generally support the proposed cancellation of the cardiac and SHFFT bundled payment models and cardiac rehabilitation incentive program, as well as the partial conversion of the CJR program into a voluntary model.**

However, some hospitals have expressed concern about the proposed cancellation of the cardiac and SHFFT models, both because they have already expended valuable resources to put them in place, and also because these programs would have qualified as advanced alternative payment

models (APMs) under the Medicare Access and CHIP Reauthorization Act (MACRA). We previously urged CMS not to compel hospitals to expend resources to prepare for something that never came to fruition. We also requested that the agency provide additional opportunities for clinicians to earn MACRA incentives by partnering with hospitals to participate in advanced APMs – to date, few of the models in which hospitals have engaged have qualified as such.

Therefore, in the absence of the cardiac and SHFFT models, we urge CMS to expeditiously pursue the creation of new, voluntary advanced APMs that would allow hospitals to not only capitalize on the work many of them already have done to prepare for such models, but also partner with clinicians to provide better quality, more efficient care. The "Advanced Bundled Payments for Care Improvement" (BPCI) program, which could include, among other conditions, cardiac and SHFFT tracks, is one such possibility. We also urge the agency to consider synchronizing the "opt-in" period for CJR hospitals in voluntary areas with the availability of details on new APMs (such as the new BPCI program referenced above). Doing so would allow hospitals to make more informed decisions about what is best for their patients and communities.

PROPOSED CHANGES TO THE CJR MODEL

As noted above, CMS proposes to convert the CJR program to a partial voluntary model, beginning Jan. 1, 2018. Specifically, the CJR model would continue, but on a voluntary basis in 33 of the 67 areas originally designated. The agency also would allow voluntary participation for rural and low-volume hospitals in any area – these hospitals would be withdrawn automatically from participation in the CJR model unless they proactively opt-in. The agency proposes to define a rural hospital as one with a CMS Certification Number (CCN) primary address in one of the 34 mandatory participation areas, and a low-volume hospital as one with fewer than 20 lower-extremity joint replacement episodes in total across three years of data.

The AHA supports voluntary participation for rural and low-volume hospitals. We also support the agency's proposed definition of a rural hospital. However, we urge the agency to increase its low-volume threshold above what it proposed. Specifically, in the past, we have found that high average losses coupled with high variation in annual episode spending tended to be found in hospitals with fewer than 100 episodes over an 11-quarter period, which equates to about 109 episodes over three years. Thus, our data indicate that a much higher low-volume threshold is warranted.

In addition, we wish to reiterate our comments on the calendar year 2018 outpatient prospective payment system rule regarding the removal of TKA, or total knee replacement, from the inpatient-only list. We are concerned that its removal could put the success of CJR (as well as BPCI) at risk. We put forth several suggestions for how the agency could modify the CJR and BPCI programs to attempt to account for this change to the inpatient-only list, including by introducing risk adjustment into the program. These changes would be meaningful and complex and require much more policy development, stakeholder feedback, and implementation time for CMS and program participants. **We strongly urge the agency to modify the CJR and BPCI**

programs to account for the removal of TKA from the inpatient-only list if it were to finalize such a policy.

Lastly, we ask that CMS consider implementing a policy offering CJR hospitals facing public health emergencies or natural disasters, such as the recent hurricanes, the option of obtaining a waiver to ensure that they are not unfairly penalized due to these circumstances. For example, CJR beneficiaries in emergency and disaster areas could require unplanned, and possibly extensive, health care services as a direct result of evacuations or emergency-related injuries. In addition, hospitals themselves may have difficulty completing their quality reporting submissions under the program. They should not be held accountable for these types of circumstances that are well beyond their control.

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