WISCONSIN HOSPITAL ASSOCIATION, INC.

October 16, 2017

Seema Verma, Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Room 445-G, Hubert H. Humphrey Building
200 Independence Avenue SW
Washington, DC 20201
Submitted Electronically

RE: CMS-5524-P; Medicare Program; Cancellation of Advancing Care Coordination Through Episode Payment and Cardiac Rehabilitation Incentive Payment Models; Changes to Comprehensive Care for Joint Replacement Payment Model

Dear Administrator Verma:

The Wisconsin Hospital Association is a statewide nonprofit association with a membership of more than 130 Wisconsin hospital and health systems. Our members include not only critical access hospitals providing crucial services to their rural communities, but also major academic medical centers providing high quality care, research, and training. On behalf of our members, we appreciate the opportunity to comment on the proposed rule, CMS-5524-P, relating to the cancellation of three episode payment models and the Cardiac Rehabilitation incentive payment model, and changes to the Comprehensive Care for Joint Replacement Payment Model.

Wisconsin is home to innovative health systems and was recently ranked first in the nation in health care quality by the Agency for Healthcare Research and Quality. WHA strongly supports payment systems that reward value and believes value-based payment policies can drive better quality, lower the cost of care, and reduce overall costs for health care programs. Such payment systems must be thoughtfully implemented, recognize administrative burdens and complexities and be highly accurate in order to drive improvement.

Proposed changes to CJR Model Participation Requirements: Mandatory and Optional MSAs

The proposed rule signals CMS's intent to implement flexibilities within value-based payment

programs. WHA favors the partial conversion of the CJR program into a voluntary model. Because of that change, hospitals in Wisconsin that are currently participating will be able to make a choice about continuing to participate in CJR, and many will continue to do so because they are performing well in the program.

Although the opportunity to participate in program innovation is always preferable to a mandate, the Center for Medicare and Medicaid Innovation's efforts to push value based payment programs have spurred innovation in our state and have undoubtedly been a factor in our high healthcare quality rankings. Wisconsin's high performing health systems have generally embraced the challenges presented by the mandatory CJR bundle. Participation has moved our providers toward markedly improved coordination of care both within the organizations and with outside entities such as post-acute care providers.

Changing the program to voluntary in over half of the currently participating MSAs might slow innovation because the systems that are already high-performing are the ones that are the most likely to continue participating. We hope that the hospitals in the 34 MSAs that will still be required to participate in CJR will continue to drive toward additional improvements in increasing quality of care for joint replacement patients while holding down costs.

CMS is proposing an "opt-in" process established for hospitals in the voluntary MSAs. First, WHA supports using an "opt-in" rather than an "opt-out" process for continuing participation in the CJR. This affirmative election participation must be received by CMS no later than January 31, 2018 (the first month of performance year 3). WHA members who plan to opt-in to continue participating in the CJR bundle appreciate CMS's acknowledgement that a participation election date of December 31, 2017 is too soon, given that the final rule is not likely to be published much before that date. We strongly encourage CMS to retain the proposed opt-in deadline of January 31, 2018. We also urge CMS to consider adding an additional "opt-in" period in 2019, because some CJR hospital participants in the proposed voluntary MSAs may currently lack the necessary information to make a decision regarding participation, as well as adequate incentives to remain in the program.

As a final important point, in the Calendar Year 2018 OPPS Proposed Rule, CMS proposed to remove total knee arthroplasty (TKA) from the Inpatient Only (IPO) list. If finalized, this policy would create significant negative financial implications for hospitals in CJR. The fate of TKA's position on the IPO list is an important factor in hospitals' decisions regarding participation in CJR. It is highly unlikely that both of these issues will be resolved by January 2018. This uncertainty is another factor in urging CMS to create a second opt-in period in January 2019 to enable hospitals to make an informed decision regarding participation for Performance Years 4 and 5.

Increasing Opportunities for CJR Participating Clinicians Affiliated with Participant Hospitals to be Considered Qualifying APM Participants under the Quality Payment Program

CMS is proposing that each physician, nonphysician practitioner, or therapist who is not a CJR collaborator during the period of the CJR model performance year specified by

CMS, but who has a contractual relationship with the participant hospital based at least in part of supporting the participant hospital's quality or cost goals under the CJR model during the period of the performance year specified by CMS, would be added to a clinician engagement list. The clinician engagement list would also be considered an affiliated practitioner list, which would be used by CMS (in conjunction with the clinician financial arrangement list) to identify eligible clinicians for whom CMS would make a Qualifying APM participant determination based on services furnished through the Advanced APM track of the CJR model.

We have consistently urged CMS, in prior comment letters, to remain flexible and use its waiver authority to create additional pathways for advanced APMs. This provision of the proposed rule appears to do so. Creating this opportunity for practitioners who have contractual relationships with CJR participant hospitals to be considered for determination as Qualifying APMs will allow these practitioners to be eligible for the incentives available under the APM track of the Quality Payment Program.

Proposed Cancellation of Episode Payment Models and the Cardiac Rehabilitation Incentive Payment Model

In the January 3, 2017 EPM final rule, CMS established three bundled payment models for acute myocardial infarction (AMI), coronary artery bypass graft (CABG), and surgical hip/femur fracture treatment (SHFFT) episodes, and a Cardiac Rehabilitation (CR) incentive payment model. Although many of our member hospitals and health systems have already made investments in preparation for the CR incentive payment program and the additional EPMs, we support CMS's plan to cancel these models at this time. Upon publication of this proposed rule in August, many members put their planning efforts for these models on hold. It would be very difficult at this point to resume these planning efforts in time for implementation at the previously scheduled date in 2018.

In the absence of the CR incentive payment model and the three EPMs, 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.

Summary

WHA shares the goals of CMS's continued innovations to move toward a meaningful, value based payment system, and we generally support voluntary programs that spur innovation. We look forward to seeing CMS's plans for creating new, voluntary advanced APMs. In doing so, CMS should put in place meaningful incentives that create momentum with the entire U.S. health care system to pursue higher quality, cost-saving health care that provides the best results for patients.

Thank you for the opportunity to comment on this proposed rule. If you have questions, please Laura Rose, vice president, policy development, at lrose@wha.org.

Sincerely,

/s/

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President and CEO

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