October 16, 2017

Seema Verma, Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, D.C. 20201

Re: 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 (CMS-5524-P)

Submitted electronically to https://www.regulations.gov

Dear Administrator Verma:

I write to share the comments of the National Coalition on Health Care (NCHC) on the Notice of Proposed Rulemaking on the Cancellation of the Advancing Care Coordination Through Episode Payment and Cardiac Rehabilitation Incentive Payment Models and Changes to the Comprehensive Care for Joint Replacement Payment Model.

NCHC is a nonpartisan, nonprofit organization representing more than 80 participating organizations, including medical societies, businesses, unions, health care providers, faith-based associations, pension and health funds, insurers, and groups representing consumers, patients, women, minorities, and persons with disabilities. The Coalition is committed to advancing—through research and analysis, education, outreach, and informed advocacy—an affordable, high-value health care system for patients and consumers, payers, employers, and taxpayers.

Episodic bundled payment models are an essential step in the evolution away from volume-based medicine and toward more affordable, person-centered health care.
NCHC enthusiastically agrees with CMS that “cardiac and orthopedic episode models offer opportunities to redesign processes and improve quality and care coordination across the inpatient and post-acute care spectrum while lowering spending.” For this very reason, NCHC has strongly supported the expansion of episodic bundling models and previously argued against changes to those models that could constrict opportunities for clinician participation in Advanced Alternative Payment Models (AAPM). Additionally, we have been concerned about the market signal that CMS’ decisions could have on private providers and payers who are adopting bundled payment approaches.

However, it is clear that CMS now seeks to reconcile a strong preference for voluntary model design with its continued interest in episodic bundled payment models. Therefore, our comments focus on helping CMS strike the best balance possible, while prioritizing the need to provide broad opportunities for AAPM participation beginning in CY 2018.

**Comprehensive Care for Joint Replacement (CJR) Model**

In the event that CMS finalizes a reduction in scope of the CJR Demonstration’s mandatory component, NCHC would support maintaining mandatory participation for some portion of the previously selected geographic areas. We would further agree that the selection of the highest cost geographic areas is the most appropriate approach, and we would urge CMS not to reduce the number of mandatory MSAs below 34. We also support allowing optional CJR participation in any selected geographic area where participation is no longer mandatory. Additionally, NCHC supports providing flexibility for low-volume and rural hospitals to participate on an optional basis.

Given the success of Lower-Extremity Joint Replacement bundles in the Bundled Payment for Care Improvement Model (BPCI) and CJR Year 1, we encourage CMS to consider expanding the reach of the proposed voluntary component of the CJR model on a nationwide basis. This would effectively provide more clinicians, particularly specialty clinicians, a viable pathway to qualify as an AAPM under MACRA. Such an expansion, on a voluntary basis, could mitigate the market signal that scaling back CJR would have on private providers and payers which are adopting bundled payment approaches.

**Cardiac Rehabilitation Incentive Model**

NCHC strongly urges CMS to reconsider its proposed cancellation of the Cardiac Rehabilitation (CR) Incentive Payment Model in light of the proactive participant investments made in preparation for this model.
Overwhelming clinical evidence supports this care model and the underlying hypothesis that broader access to rehabilitation services will improve patient outcomes for beneficiaries following an AMI or CABG episode of care.

Physician practices, other health professionals, and health systems have been preparing to implement this model and stand to lose those investments. Since the model was finalized, providers in the selected geographic areas have made infrastructure and human resource investments in anticipation of the new incentive payment model. These expenditures have included hiring new staff, purchasing and deploying new IT platforms, and modifying operations, with the reasonable expectation of a return on investment when the performance period commenced.

We recognize that some previous commenters, as noted in the NPRM, identified issues with direct supervision and the potential for model overlap. We believe these issues can be addressed without cancelling the model. Rather, in light of the investments already made in preparation for its implementation, the CR model should move forward as soon as possible in calendar year (CY) 2018. NCHC encourages CMS to work with the relevant stakeholders—including the American College of Cardiology, the American Heart Association, and the American Association of Cardiovascular Pulmonary Rehabilitation—to ensure that it does.

**Episodic Payment Model**

In the event that CMS finalizes its proposal to cancel the episodic cardiac models, CMS should ensure that episodic bundled payments for AMI and CABG are available on a voluntary basis to clinicians and providers as soon as possible in CY 2018. Given that Medicare’s experience with cardiac bundles dates to the 1990s, those opportunities should be available nationwide.

Again, providers and health professionals have made plans and investments in preparation for this model. And while the NPRM indicates that “providers interested in participating may still have an opportunity to do so during CY 2018,” the mere possibility of a not-yet-released model is not sufficient to enable providers to prepare. NCHC urges CMS, in consultation with key stakeholders, to rapidly introduce that model, allow participation in the EPM’s AMI or CABG bundles on a voluntary basis, and/or otherwise ensure that episodic bundled payment options are available to clinicians across the country early in 2018.

Providers and clinicians that believe a bundled payment approach is the best option to deliver care should not have that option denied to them—to the detriment of their patients and the Medicare program. Furthermore, we believe that expanding opportunities for participation in cardiac bundling on a voluntary basis, could, to some degree, mitigate the market signal that scaling back EPM would have on private providers and payers.
Should you have questions regarding these comments or other issues with respect to the affected models, please contact NCHC’s Policy Director, Larry McNeely at lmcneely@nchc.org or 202-638-7151.

Yours truly,

John Rother
President and CEO