September 2, 2015

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-5516-P, Medicare Program; Comprehensive Care for Joint Replacement Payment Model for Acute Care Hospitals Furnishing Lower Extremity Joint Replacement Services; Proposed Rule (Vol. 80, No. 134), July 14, 2015.

Dear Mr. Slavitt:

On behalf of our over 200 member hospitals and health systems, the Florida Hospital Association (FHA) appreciates the opportunity to comment on the Centers for Medicare & Medicaid Services (CMS) Comprehensive Care for Joint Replacement (CCJR) Payment Model proposed rule, published in the July 14 *Federal Register*. In this rule, CMS is proposing a bundled payment model for major joint replacements of the lower extremity. Hospitals in 75 Metropolitan Statistical Areas (MSAs) would mandatorily participate in the program. Payments for all included services would be compared to a target amount; CMS will recoup payment amounts exceeding the target or make reconciliation payments for amounts under the target. While we support the overall design and scope of the proposed rule, we have specific comments and recommendations for modification of the program.

First of all, we are concerned that CMS has not provided us with all the tools we need to be successful under the CCJR program. Prior to issuance of a final rule, we urge the Secretary to use the full scope of the combined authority granted by Congress under the Affordable Care Act 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 CCJR model. The Secretary should waive the Physician Self-Referral Law and Anti-kickback Statute with respect to financial arrangements formed by hospitals participating in the CCJR that comply with the requirements in the proposed rule. As CMS recognized in the preamble to the Physician Fee Schedule proposed rule that was issued within one day of this rule, the self-referral law was designed for a different world of care delivery and payment. At its core, the self-referral law is about separating hospitals and referring physicians, while the evolving Medicare and Medicaid models "are premised on the close integration of a variety of different health care providers." The Anti-kickback Statute, similarly, is no longer compatible with the new models.

As proposed, any financial arrangement or agreement under the CCJR model that implicates fraud and abuse laws would not be protected unless it falls under an existing exception or safe harbor. Hospitals cannot spend hundreds of hours or thousands of dollars in hopes of stringing together components from the existing exceptions and safe harbors or developing inefficient work-arounds to try to ensure that their efforts do not run afoul of such laws and regulations.

Further, the scope of the proposed payment waivers is too limited, particularly the failure to propose waivers to hospital discharge planning requirements that prohibit hospitals from specifying or otherwise

limiting the providers who may provide post-hospital services. If hospitals are going to be held financially accountable for the quality and costs of an entire episode of care, the Department of Health and Human Services must ensure that impediments created by all of the relevant regulations are removed to allow effective coordination and management of patient care.

In addition, even recognizing that there would be no downside risk in the first year of the program, we are concerned that the proposed January 1, 2016 start date provides a very short amount of time for providers to put in place the care processes and procedures necessary to achieve success in the program. Existing care processes and procedures are structured around Medicare's current payment and delivery systems that will have to change for hospitals to be successful in the CCJR program and doing so will require significant investment of resources – both financial and human.

We urge CMS to restrict the program to elective hip and knee replacement episodes only. The clinical and resource-use differences between this patient population and the hip fracture patient populations included the major joint replacement MS-DRGs are pronounced. Patients receiving a hip replacement due to a fracture are often more elderly and have more comorbidities. In addition, the emergency nature of the service precludes the opportunity to plan for the social impact (family support and other care options) of an admission. Furthermore, including only elective hip and knee replacement episodes would more closely align the various components of the CCJR program. For example, CMS's proposed readmissions and complications quality measures include only elective joint replacement procedures.

Similarly, CMS should incorporate a risk adjustment methodology into the CCJR program. Because the agency proposes to use a regional spending component as part of its reconciliation methodology, it will increasingly hold all hospitals in a region to the same target price. Hospitals' patient populations have different levels of severity and, therefore, differing episode costs. Relying on the MS-DRG as the program's only risk adjustment does not fully account for numerous factors that affect spending and are beyond hospitals' control. It would inappropriately penalize hospitals treating the sickest, most complicated and most vulnerable patients.

In addition, while CMS proposes to eliminate the "three-day rule" beginning in later years of the program, we believe that this should be implemented when the program begins. We also suggest that CMS waive the outpatient therapy caps to allow providers and patients to make better use of outpatient therapy resources, as appropriate to the care needed.

Again, thank you for allowing us to comment on the proposed CCJR methodology. We believe that the changes outlined above would allow our members to achieve success under the program while continuing to work towards the goal of providing more accountable and more coordinated care.

Sincerely,

Kathy Reep

Kathy Reep
Vice President/Financial Services