American Society of Anesthesiologists®

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September 8, 2015

Acting Administrator Andrew Slavitt
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-5516-P
P.O. Box 8013
Baltimore, MD 21244-1850

Re: CMS-5516-P, Comprehensive Care for Joint Replacement Payment Model for Acute Care Hospitals Furnishing Lower Extremity Joint Replacement Services

Dear Acting Administrator Slavitt:

The American Society of Anesthesiologists® (ASA), on behalf of over 52,000 members, appreciates the opportunity to comment on the above-captioned proposed rule published in the July 14, 2015 *Federal Register*. Anesthesiologists are well positioned to contribute to multi-disciplinary system improvements and comprehensive care for patients undergoing procedures such as joint replacement surgery. Our members often represent the single common pathway for all surgical patients across subspecialties in surgery. As such, we very much appreciate the opportunity to comment on this proposed rule to implement a new retrospective bundled payment model for lower extremity joint replacement procedures performed in acute care hospitals in selected geographic areas. We share CMS's goal of identifying and testing models that have the potential to better coordinate clinical needs and optimize outcomes for this patient population.

This proposal will have significant impact on not only patient care, but also the relationship between all providers, inpatient facilities and rehabilitation services involved in the management of this patient population. Many important aspects of the proposal warrant careful and deliberative review. Since the changes proposed for the care and payment for these clinical services, by design will require improved collaboration and coordination through the continuum of care, the ASA has significant concerns regarding the proposed timeline. Since the comment period for this rule closes on September 8, 2015, a final rule cannot be issued until the 4th quarter of 2015. The proposed implementation date of January 1, 2016 does not seem practical or realistic to address the needs of patients or the affected hospitals and providers.

If CMS finalizes its proposal for mandatory participation of acute care hospitals located within specified geographic areas, facilities with little or no experience in providing care under a bundled payment system will be hard pressed to design, test and implement systems to go into effect on January 1, 2016. Even those who have experience via the Bundled Payment for Care Initiative (BPCI) or other mechanisms may need to adapt policies, processes and procedures to comply with the provisions specific to this new model of payment. Providing care under the proposed Comprehensive Care for Joint Replacement (CCJR) model will require clinical and administrative changes, many of which cannot be initiated until after release of a final rule. We understand that CMS attempts to address this by phasing in risk, initially relying more on local spending then regional spending when setting a hospital's CCJR target amount and other means. However, the challenges are simply too numerous and difficult to be offset by this phased approach.

The proposed rule discusses requirements that must be included in CCJR Sharing Arrangements/ Agreements between a participant hospital and its CCJR Collaborators. Successful implementation of the CCJR model will necessitate new clinical pathways and new responsibilities. Often these roles will be for new

and additional physician care that has not been recognized or compensated by existing payment systems. These arrangements may include, but are not limited to, complex matters such as gainsharing and/or alignment payments that require thoughtful structuring to achieve quality and efficiency improvements desired under the CCJR model and compliance with fraud and abuse, antitrust and other applicable laws. CMS proposes limits on the amounts of any payments between the hospital and the physicians (and other providers) involved in the episode of care along with rules about how the payments may be distributed. These agreements will also address data sharing, both what the hospital should provide to CCJR collaborators and what CCJR collaborators must make available to the hospital. We believe that all providers to the agreement should receive equal access to the relevant data with appropriate administrative, technical, and physical safeguards to protect the confidentiality of the data set file(s) and to prevent unauthorized use or access to it. Negotiating these arrangements/agreements is contingent upon decisions that CMS will not announce until a final rule is in place. Such time constraints may have the unintended consequence of compelling participating hospitals to make independent changes without meaningful collaboration with other providers at various levels of care.

The proposed rule addresses potential beneficiary incentives. Again, associated limitations and specifications must be finalized before a participating hospital and its CCJR collaborators can create appropriate care pathways.

CMS recognizes that waiver of certain existing Medicare Program rules such as the already controversial three-day inpatient stay rule will be necessary for the CCJR model to function successfully. Operationalizing those changes will require thorough review and analysis to ensure that all involved processes are updated to facilitate these waivers. Other waivers include allowing separate reporting of post-discharge home visits within the surgical global period, revision of supervision requirements for any incident-to care, and waiver of the requirement that a patient be home bound in order to receive home health services. These and potentially more waivers and revisions to some existing programs require time to be properly executed and communicated to all stakeholders.

Quality of care is a key element of the CCJR. ASA has expressed support for measures that promote shared accountability across specialties and practitioners. We are confident that anesthesiologists can contribute to reductions in the costs and increases in the quality of care for patients undergoing the procedures within the CCJR. While the reporting of three specific quality measures is a prerequisite to any gainsharing payment, CMS also presents several options on reporting of patient-reported outcome data. Those options cover not only how that information might be collected, but also how the information will impact the hospital's levels of risk/benefit. This is yet another unknown element that must be appropriately explored and decided before new systems can be created or existing ones appropriately modified.

ASA is eager to work with CMS to ensure that patients receive the highest quality care via collaboration between all involved healthcare professionals and facilities. We understand the urgency of the problems we face in today's healthcare environment. Nonetheless, we must urge CMS not to rush into solutions but rather, allow the necessary time to get to the right solutions in the right way.

Thank you for your consideration of our comments. Please contact Sharon Merrick, M.S., CCS-P, ASA's Director of Payment and Practice at s.merrick@asahq.org or (202) 289-2222 with any questions.

Sincerely,

J.P. Abenstein, M.S.E.E., M.D.
President
American Society of Anesthesiologists