Charles N. Kahn III
President and CEO

April 29, 2020

The Honorable Nancy Pelosi
Speaker
U.S. House of Representatives
Washington, DC 20515

The Honorable Mitch McConnell
Majority Leader
U.S. Senate
Washington, DC 20510

The Honorable Kevin McCarthy
Minority Leader
U.S. House of Representatives
Washington, DC 20515

The Honorable Charles Schumer
Minority Leader
U.S. Senate
Washington, DC 20510

Dear Majority Leader McConnell, Speaker Pelosi, Minority Leader Schumer, and Minority Leader McCarthy:

The Federation of American Hospitals (FAH) is the national representative for over 1,000 leading tax-paying hospitals and health systems throughout the United States. FAH members provide patients and communities with access to high-quality, affordable care in both urban and rural America. Our members include teaching and non-teaching, acute, inpatient rehabilitation, behavioral health, and long-term care hospitals and provide a wide range of inpatient, ambulatory, post-acute, emergency, children's, and cancer services.

The FAH offers our sincere appreciation for the swift actions taken thus far by both the Congress and Administration to support hospitals on the frontlines of the COVID-19 pandemic. While we are encouraged by some indications of progress in the battle against COVID-19, we also recognize that we are nowhere near the end. To ensure both the short-term and long-term stability of the nation's hospitals and health care infrastructure, we need Congress to continue its bipartisan efforts to provide the resources and regulatory relief necessary to keep our doors open for our patients. As Congress considers the next iteration of COVID-19 legislation, we urge you to consider the following recommendations.

Strengthen Programs that Provide Immediate Financial Support to Hospitals

FAH hospitals are immensely grateful for the two primary sources of funding enacted and amended by Congress to provide immediate financial support to hospitals across the country that are struggling with significant financial and operational hardships associated with:

- Near curtailment of scheduled procedures, diagnostics, and treatments
- Preparing for a COVID-19 surge
- Treating COVID-19 cases

The Public Health and Social Services Emergency Fund (PHSSEF or Provider Relief Fund) and the Medicare Accelerated and Advance Payment Programs have infused hospitals with much-needed funds to help them maintain their ability to provide vital services for patients and their communities.

CMS Accelerated and Advance Payment Program

The *Coronavirus Aid, Relief, and Economic Security (CARES) Act* expanded access to the Centers for Medicare & Medicaid Services (CMS) Accelerated and Advance Payment Programs, which provide a vital infusion of operating capital to hospitals in order to address immediate cash-flow concerns. While the payments to hospitals under this program were expeditious and predictable, the programs were recently paused by CMS for an unspecified amount of time. The continued financial impact caused by the pandemic may make it difficult for hospitals to repay the funds received through the program, and the repayment terms as currently written create uncertainty, and risk prolonging cash-flow related problems rather than solving them. Hospitals need both short-term and long-term certainty in order to simultaneously prepare for and respond to COVID-19 and resume normal operations.

Under the current structure, hospitals and other entities eligible for advance or accelerated payments can receive either three or six months of their typical Medicare payments in advance. Repayment begins 120 days following the receipt of funds (i.e., July or August 2020) in the form of zero percent Medicare reimbursement until the advance is recouped. For most hospitals, repayment must be made in full within 12 months (seven months for some). If repayment is not complete by this time, interest begins to accrue on the balance at the current rate of 9.625 percent.

While the immediate impact of this program had a positive effect before its pause, it was not designed with the current crisis in mind. The financial impact of the COVID-19 pandemic will certainly remain significant in July and August, and beyond. As a result, hospitals will face a zero percent Medicare reimbursement rate while still attempting to overcome the significant headwinds created by the crisis. This sudden and precipitous drop in reimbursement will only compound the challenges of the crisis, rather than alleviate them. In addition, the onerous interest rate does not align with other loan provisions contained within the *CARES Act*.

At a minimum, several improvements to the program are urgently needed to remove uncertainty and provide much needed financial stability so that hospitals have the resources

needed for direct patient care and to support our health care workforce in the short- and long-term. While the FAH believes the Department of Health and Human Services (HHS) and CMS may have the necessary regulatory and statutory authority, they have not yet exercised their power to refine the program, and the recent pause suggests that they remain reluctant to do so**. Therefore, we respectfully request that Congress include the following policies in the next COVID-19 related legislation:**

- **Increase the amount that can be advanced to hospitals from three or six months of Medicare payments to 12 months of Medicare payments**
- **Extend the period before repayment begins from four months to at least 12 months**
- **Reduce the amount of the Medicare claim reduction during repayment from 100 percent to 25 percent**
- **Extend the repayment period for acute and post-acute providers from 12 months (or 210 days) to a minimum of 36 months before hospitals must pay the outstanding balance and before interest begins to accrue**
- **Waive the interest rate (or the collection of interest); at a minimum, the interest rate should be no more than two percent**
- **Allocate the funds from general revenues rather than from the Medicare Hospital Insurance Trust Fund.**

The ongoing COVID-19 pandemic has had significant negative financial impacts on hospitals thus far – and these impacts will continue over the coming months. We share the concerns of other hospital associations that it may not be feasible for some hospitals to repay these accelerated and advance payments. **As such, we urge Congress to carefully consider forgiving repayment of these funds to help ensure financial stability for hospitals and sustained operations for patients and their communities into the future.**

Provider Relief Fund

FAH members deeply appreciate the $175 billion in funding Congress has provided via the Provider Relief Fund. These funds constitute a vital lifeline for hospitals across the country collectively losing billions of dollars each day. Unfortunately, struggling hospitals are still awaiting the Administration to fully distribute the first $100 billion allocated, let alone the recently added $75 billion. We are concerned that the formulaic approach used by the Administration has not yet succeeded in getting the necessary funds to entities most impacted by COVID-19. And while the PHSSEF is often referred to as funding for hospitals, the Provider Relief Funds have been distributed widely across the health care sector, with only approximately 44 percent provided to hospitals thus far. The Administration has also signaled plans to reserve approximately $10 billion of the funds for testing and treatment costs for uninsured individuals. The FAH strongly supports funding for the testing and treatment for uninsured individuals. We believe, however, that there are more appropriate policies to better support the newly unemployed in maintaining their health coverage as well as improving access to health coverage for other uninsured individuals rather than using a Fund that Congress intended for other purposes. Those policies are discussed further below.

As Congress exercises its oversight of the Administration's disbursement of the Provider Relief Fund, it is imperative that much more of these funds be targeted toward hospitals, with a focus on lost revenue in 2020, as well as extraordinary expenses related to COVID-19. It is unclear just how long the COVID-19 pandemic will last, leaving the very real possibility that the Provider Relief Fund may need to be replenished again in the future. **To ensure those funds are available when needed, we urge Congress to consider legislating funding replenishments based on a triggering event, such as the funds dipping below a certain amount and/or hospital losses continuing to mount. We also urge Congress to legislate distribution of the funds based on actual extraordinary COVID-19 costs and lost revenues to better target the Fund toward hospitals and other providers most impacted by the crisis.**

Ensure and Maintain Health Insurance Coverage

Individuals who may be infected with COVID-19 should not delay testing and/or accessing care due to concerns about potential costs or cost-sharing. While the current protections provided by Congress from cost-sharing related to COVID-19 testing are an important step, more certainty must be provided to patients regarding their ability to access treatment. While FAH members have longstanding charity care and discount care policies to assist patients in need, the FAH is concerned that uninsured or underinsured individuals may delay or forgo testing and/or care until their condition significantly deteriorates and requires high-intensity hospital-level care.

Concerns regarding access to affordable health insurance coverage extend beyond conditions related directly to COVID-19. With unprecedented levels of unemployment, individuals and families are at risk of losing their employer sponsored coverage, with no viable means of affording COBRA or the premiums associated with coverage provided on the health insurance exchange. This loss of coverage could lead to the deferral of necessary care, increased enrollment in public health programs, and additional stress on hospitals as they shoulder the disproportionate share of uncompensated care.

We urge Congress to take all necessary steps to ensure Americans can maintain or gain access to affordable health insurance coverage, especially as it relates to Employer Sponsored Insurance (ESI), including:

- **Subsidies and/or tax credits to employers to partially offset the cost of continuing to provide ESI to their employees**
- **Federal assistance to recently unemployed individuals to offset the full cost of their coverage through COBRA and an extension of the COBRA election period from 60 to 180 days**
- **Special Enrollment Period for Federally Facilitated Exchanges (FFEs) to enable previously uninsured individuals to access affordable health coverage**
- **Enhanced eligibility for subsidies on the Exchanges.**

For already insured individuals, Congress should require that <u>all</u> insurance plans (including Short-Term Limited Duration (STLD) plans and Association Health Plans (AHPs)):

- **Provide coverage for COVID-19-related testing, treatment, and post-acute treatment**
- **Waive patient cost-sharing for COVID-19-related services and reimburse providers for the cost-sharing portion**
- **Remove prior authorization requirements related to COVID-19 care to ensure patients receive timely services**
- **Remove prior authorization requirements related to post-acute care to preserve inpatient hospital resources.**

For those individuals who remain uninsured after implementation of the aforementioned policies, the FAH recommends that Congress provide a unique funding allocation to cover the costs associated with providing COVID-19-related treatment to uninsured individuals – similar to how such funding is provided for testing and testing-related services via the *Families First Coronavirus Response Act.*

<u>Provide Liability Protection for Health Care Professionals and Facilities Responding to the COVID-19 Pandemic</u>

The FAH urges Congress to provide broad relief to health care professionals and facilities (including hospitals) from the threat of legal challenges as they adopt an all-hands-on-deck approach in addressing, preparing for, and responding to the coronavirus national public health emergency.

Hospitals, health care professionals, and the facilities where they treat COVID-19 and other patients are experiencing unprecedented conditions, including:

- Severe shortages of medical supplies (e.g., personal protective equipment, ventilators)
- Workforce shortages
- Delays of important elective surgeries
- Insufficient information and/or changing guidance from federal, state, and local government officials.

As America's health care community continues to treat patients around the clock throughout this national emergency, they put themselves at significant health and legal risk. Nevertheless, they continue to treat patients, save lives, and do everything possible to bring comfort to patients and their families.

As these conditions and the COVID-19 national emergency continue, health care professionals and facilities also face the untenable and daunting threat of medical liability lawsuits. **We therefore urge Congress to provide liability protection for health care professionals and facilities, such as hospitals, similar to some states, such as New York, and immediately adopt legislation that provides immunity from civil liability for any injury or**

death alleged to have been sustained because of any acts or omissions undertaken in good faith while providing health care services in support of the nation's COVID-19 response. This legislation should not preempt stronger or broader state liability protections and should maintain vital protections for those who are victims of acts of gross negligence or willful misconduct.

These legislative protections would ensure that professionals and facilities that are critical to providing health care during this crisis and beyond do not face unwarranted legal action for their heroic efforts to respond to the COVID-19 crisis. Federal action is necessary to provide a uniform level of protection and avoid varying liability laws among states that would lead to unequal treatment of our frontline health care providers and facilities during this national crisis.

Support Frontline Health Care Workers

Medical Education Loan Forgiveness Program

Our nation's COVID-19 frontline health care workers are risking their lives, and we will forever be in their debt. And now, Congress has the opportunity and duty to alleviate these health care heroes of their medical education debts. **The FAH supports the establishment of a COVID-19 Medical Education Loan Forgiveness Program for physicians, nurses, and other health care providers on the frontlines of the COVID-19 pandemic that would either eliminate or drastically reduce educational debt.** If such loans have already been paid in full, the health care professional should be eligible for comparable tax credits.

The program should be made available to health care workers involved with treating patients in response to the COVID-19 pandemic and should not be limited based on the setting or tax-paying status of the provider's health care facility.

Support Health Care Providers with H-1B and J-1 Visas

The FAH urges Congress to ensure that the U.S. Citizen and Immigration Services allows greater flexibility in the mobility and specialty practice limitations placed upon health care providers with H-1B and J-1 visas. During this pandemic, it is critical that such health care providers can provide medical care beyond the limited circumstances tied to their immigration status (i.e., employer, location, and specialty). Unless such restrictions are waived, physicians and other health care providers on H-1B and J-1 visas (including physicians in the Conrad State 30 program) are unable to move freely to hospitals and other health care facilities on the frontlines and in need of additional providers. The willingness of these providers to work in COVID-19 hotspots or in underserved communities should be commended, and their immigration status should not be jeopardized.

In addition, **Congress should ensure that the immigration status of the families of immigrant health care workers are protected in the event of the health care worker's death or disability due to COVID-19.** These health care workers are vital to our nation's efforts to overcome this pandemic, and Congress should provide them with the certainty that their families will be protected.

Expand Access to Telehealth / Broadband

The FAH appreciates the swift response by Congress and the Administration to expand access to telehealth in response to this pandemic. In previous COVID-19 legislation, Congress took decisive action to expand the availability and utilization of telehealth to screen, diagnose, and treat patients with mild symptoms who do not require hospitalization. Congress should continue in this vein by providing **additional funding to the Federal Communications Commission's (FCC) recently launched COVID-19 Telehealth Program, while also expanding the program's eligibility criteria to ensure full participation from a broad number of health care stakeholders, including tax-paying hospitals.** As currently defined by the FCC, the eligibility criteria for the COVID-19 Telehealth Program makes tax-paying hospitals ineligible for participation. This unjustly penalizes patients living in communities across the United States that are served by a tax-paying hospital and should be fixed by Congress.

Similarly, **the FAH supports *H.R. 6474, The Healthcare Broadband Expansion During COVID-19 Act,* a bipartisan bill that expands telehealth and high-quality internet connectivity, but believes that the FCC's Healthcare Connect Fund Program (HCFP) must be expanded to provide eligibility for tax-paying health care facilities.** Along with not-for-profits, our member hospitals are simultaneously on the frontlines of the COVID-19 pandemic and are enduring the same financial hardships and must overcome the same challenges. Coronavirus does not distinguish between patients or between the tax-paying status of their closest hospital.

Provide Additional Stability to Hospitals and Health Systems

Halt Finalization of the Medicaid Fiscal Accountability Regulation

On November 19, 2019, CMS proposed the Medicaid Fiscal Accountability Regulation (MFAR), which would apply new parameters to how common Medicaid financing arrangements such as provider taxes, intergovernmental transfers, and donations will be evaluated and approved by CMS. If finalized, the proposal will likely force states to raise taxes or cut their budgets, as well as harm Medicaid beneficiaries by potentially limiting access to providers or cutting their Medicaid programs.

If finalized, MFAR is estimated to result in an annual reduction in Medicaid spending of $37-49 billion. Of that reduction, $23-31 billion would result from reduced payments to hospitals.[1] At a time when hospitals are fighting to provide high-quality crisis response to the communities they serve, while simultaneously struggling to remain financially viable, additional uncertainty regarding Medicaid reimbursement could have devastating and irreversible effects. It may take years for hospitals to return to normal operations following the COVID-19 crisis. **The looming threat of CMS finalizing the MFAR rule at any time must be dealt with either by CMS formally withdrawing the proposed rule or by Congress placing an extended statutory moratorium on MFAR.**

[1] Analysis provided by Manatt Health, 2020.

Protect Indirect Medical Education Payments to Teaching Hospitals

Indirect medical education (IME) payments are based partly on an institution's intern- and resident-to-bed ratio. Because of this formula, under current law, teaching hospitals are concerned that their IME payments would be adjusted down as a result of adding temporary inpatient beds in order to surge and respond to the COVID-19 crisis. **The FAH urges Congress to protect teaching hospital payments and ensure that Medicare IME payments are not reduced because teaching hospitals have increased bed availability in response to the COVID-19 crisis or any other public health crisis.**

Support Rural Hospitals

As COVID-19 hotspots spread from major metropolitan areas to rural America, it is vital for rural hospitals to maintain their ability to provide care for their communities. Even before COVID-19, rural hospitals faced dire financial stress, resulting in an alarming number of closures across the nation. An April 2020 analysis conducted by Guidehouse (following a 2019 Navigant study) further exposed the financial instability of many of America's rural hospitals:

- 25 percent of rural hospitals nationwide are at a high risk of closing unless their financial situations improve
- Of these hospitals, 82 percent are considered highly essential to their communities.[2]

While the recommendations outlined in this letter will support rural hospitals, additional actions should be taken by Congress to ensure that the COVID-19 pandemic does not further exacerbate the rural hospital closure crisis. **The FAH recommends that the next COVID-19 legislative package include *S. 3559 / H.R. 6365, Immediate Relief for Rural Facilities and Providers Act.*** This legislation will provide mandatory grants and other funding mechanisms to Critical Access Hospitals (CAHs) and rural Prospective Payment System (PPS) hospitals to mitigate the devastating financial impact of the COVID-19 pandemic, including loss of revenue.

Bolster Behavioral Health Funding and Telehealth Coverage

With nearly one in five Americans living with a behavioral health disorder, there is widespread need for expanded access to services. Approximately 30 percent of adults with a medical condition also have a behavioral health disorder and close to 70 percent of behavioral health patients have a medical co-morbidity.[3] FAH members are on the frontlines in addressing the medical needs of their communities by preparing and surging for COVID-19 patients. At the same time, FAH members are addressing and preparing for the surge of behavioral health patients. The worry of or actual job loss, fear of contracting COVID-19, and the mandated shelter in place orders are difficult for those without mental illness, but most certainly will disproportionately impact those with an existing behavioral health condition. The number of patients requiring behavioral and mental health services will grow steadily as social and

[2] Guidehouse 2020 Rural Hospital Sustainability Index, April 2020, https://guidehouse.com/insights/healthcare/2020/rural-hospital-sustainability-index

[3] AHA Trend watch, May 2019, https://www.aha.org/system/files/media/file/2019/05/aha-trendwatch-behavioral-health-2019.pdf.

economic circumstances change over the coming months, and preparing for this surge must be a national priority.

Therefore, the FAH urges Congress to ensure access to funding for behavioral health providers, including inpatient and outpatient providers, as well as residential treatment centers and reduce barriers that will increase access to those services**. More specifically, Congress should waive the Medicaid Institutions for Mental Disease (IMD) exclusion for at least the duration of the COVID-19 crisis response and allow state Medicaid programs to cover and pay for care provided in inpatient psychiatric facilities.** This will allow inpatient psychiatric facilities (IPFs) to relieve the pressure on general acute care hospitals that are increasingly challenged in their capabilities and provide additional capacity to address the behavioral health needs of this patient population, which are likely to linger well beyond the formal end of the public health emergency declaration. **The IMD waiver along with a temporary waiver of the 190-day lifetime limit on Medicare coverage of services in free-standing psychiatric facilities will allow patients to continue to receive much needed care during and after this public health emergency.**

In addition, Congress must act to improve compliance with the federal mental health and addiction treatment parity law to ensure equitable access to behavioral and mental health services. The FAH urges Congress to address the coverage inequity specific to telehealth by improving coverage for behavioral health via telehealth. **More specifically, Congress should ensure that hospital outpatient departments (HOPDs) can provide and bill for telehealth for critical outpatient therapy and psychiatry programs, and revise existing law that would allow CAHs to directly bill for behavioral health telehealth services regardless of their billing method.** It is critical that coverage of services provided via telehealth is consistent with in-person services – including behavioral and mental health services.

Suspend Payment Impacts of CMS Penalty and Performance-Based Payment Programs and Hold Harmless Participants in Alternative Payment Models

Hospitals and health systems have taken a leadership role in transforming our health care delivery system from largely fee-for-service to a system focused on outcomes and value. Congress has further accelerated adoption of value-based approaches through various quality reporting and pay for performance programs enacted as part of the *Affordable Care Act* and the *Medicare Access and CHIP Reauthorization Act*. Unfortunately, neither the Center for Medicare and Medicaid Innovation (CMMI) alternative payment models (APMs) nor the various payment penalty and performance-based programs (e.g., the Hospital Readmissions Reduction Program (HRRP), the Value-Based Purchasing (VBP) program, and the Hospital-Acquired Condition Reduction Program (HAC)) are able to adequately account for the disruption caused by COVID-19. Hospitals and health systems are facing considerable risk and uncertainty as a result of the COVID-19 pandemic, which translates into risk and uncertainty regarding penalty and performance-based payment programs, as well as APMs. As such, the FAH urges Congress to take the necessary actions recommended below to stabilize these programs and prevent the reversal of progress achieved to date.

Penalty and Performance-Based Payment Programs

Recognizing the considerable uncertainty surrounding performance-based and payment penalty programs, CMS granted exceptions and extended the deadlines for measure reporting across all programs in March. The FAH appreciates CMS' actions regarding these programs but believes that more must be done to ensure the unprecedented impact of COVID-19 on hospital operations does not result in payment penalties that are inequitable and unfairly punitive by punishing providers for circumstances beyond their control. The direction of this public health emergency – and potentially some of the post-emergency recovery period – is non-representative of hospitals' ongoing efforts to improve quality. As reporting during one fiscal year impacts quality performance for multiple future fiscal years, the impact of COVID-19 on these programs will be felt for a few years to come. **To prevent significant payment disruption to hospitals and health systems resulting from COVID-19, the FAH urges Congress to suspend any payment impacts of CMS payment-based performance programs, including the HAC, HRRP, and the Hospital VBP programs for any fiscal year impacted by COVID-19.**

Alternative Payment Models

Similar to the concerns facing the penalty and performance-based payment programs, the various APMs also face significant disruption as the response to the COVID-19 pandemic is not representative of participants' ongoing efforts to improve quality and value. As such, Congressional action is needed to ensure that APM participants do not face unexpected losses during the 2020 performance year.

On April 13, 2020, the National Association of ACOs (NAACOS) reported that 56 percent of accountable care organizations (ACOs) surveyed stated that they are likely to drop out of the program because of fear of losses directly resulting from the COVID-19 pandemic.[4] Such attrition in these programs will severely slow the progress shown by these models thus far.

Participants in ACOs, value-based payment models, and quality reporting programs need to be shielded from financial penalties as their costs and outcomes are largely out of their control as a result of the COVID-19 pandemic. The resources invested in preparing for and the disruption to care delivery resulting from COVID-19 will lead to invalid data and inappropriate performance comparisons. **Therefore, the FAH urges Congress to hold APM participants (e.g., ACO's, Bundled Payments for Care Improvement Advanced (BPCI-A)) harmless from any losses incurred in the 2020 performance year and, where applicable, prohibit CMS from mandating that providers advance to higher levels of risk in 2021.**

Finally, the Comprehensive Care for Joint Replacement Model (CJR) is a CMMI model that was established with the goal of improving efficiency and quality of care for Medicare beneficiaries through a retrospective bundled payment for an episode of care. On February 24, 2020, CMS proposed extending the CJR model for an additional three years through December

[4] NAACOS Press Release, April 2020, https://www.naacos.com/press-release--more-than-half-of-participants-likely-to-leave-cost-saving-medicare-program

31, 2023.[5] In light of COVID-19's impact on the volume of elective surgeries and non-essential medical procedures, such as those performed under the CJR model, along with the disruption caused by the surge of COVID-19 patients, the FAH believes the CJR model should terminate at its original completion date of December 31, 2020. This would allow CMS the opportunity to more fully evaluate the program, determine lessons learned, and reassess how best to move forward. **The FAH thus urges Congress to sunset the CJR effective December 31, 2020.**

Support Resumption of Medically Necessary Services

The impact of COVID-19 has been felt by patients and their families across the country, from those patients infected with COVID-19 to non-COVID-19 patients whose medical services or procedures were put on hold during the country's response to the pandemic. As the federal government, along with state and local governments, look to resume certain activities, there is a pent-up need for non-COVID-19 services and procedures. Often referred to as "elective" procedures, these scheduled procedures and services can range from those where delay would not impact the well-being of the patient (e.g., some preventive screenings) to those procedures where delay risks harm to the patient's health and well-being (e.g., removal of cancerous tumors).

The FAH appreciates the recent, updated guidance from CMS as a framework for hospitals and state and local officials to work together to monitor the prevalence of COVID-19 in their communities and safely address the needs of non-COVID-19 patients. Resuming these elective procedures is vital for patient health and well-being and will also rejuvenate the operating capacity of hospitals and assure a full engagement of the health workforce.

Critical to the return of hospital services will be widespread COVID-19 testing capacity, including serological testing. This is vital to the success of these efforts, as it will enable hospitals to safely and effectively test patients and their families prior to any scheduled services or procedures, as well as test the health care workforce. Additionally, sufficient personal protective equipment (PPE) is critically necessary to protect patients, their families, and health care workers. **The FAH urges Congress to support patients, their families, hospitals, and the health care workforce by increasing access to testing and PPE across the country.**

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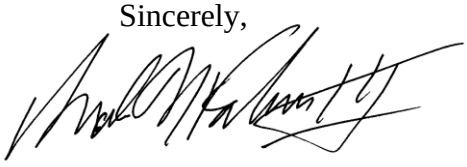
Thank you for the opportunity to provide our recommendations on how Congress can continue to support hospitals and their patients in response to the coronavirus pandemic. We appreciate Congress' engagement and consideration of these recommendations and look forward to partnering with you to address the challenges ahead. If you have any questions or wish to speak further, please do not hesitate to reach out to me or a member of my staff at 202-624-1534.

Sincerely,



[5] CMS CJR Fact Sheet, February 2020: https://www.cms.gov/newsroom/fact-sheets/comprehensive-care-joint-replacement-model-three-year-extension-and-changes-episode-definition-and