

August 19, 2015

Andrew Slavitt, Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Hubert H. Humphrey Building, Room 445-G
200 Independence Avenue, SW
Washington, DC 20201

Re: File code CMS-5516-P

Dear Mr. Slavitt:

The Medicare Payment Advisory Commission (MedPAC) welcomes the opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS) proposed rule entitled Medicare Program; Comprehensive Care for Joint Replacement Payment Model for Acute Care Hospitals Furnishing Lower Extremity Joint Replacement Services; *Federal Register*, Vol. 80, No. 134, p. 41198 (July 14, 2015). We appreciate your staff's ongoing efforts to administer and improve the payment system for hospitals and post-acute care (PAC), particularly given the many competing demands on the agency staff's resources.

CMS proposes to implement and test a new payment model, the Comprehensive Care for Joint Replacement (CCJR) model, for episodes of care initiated by hospital stays for lower extremity joint replacement under the authority of CMS's Center for Medicare and Medicaid Innovation (CMMI). CMMI is authorized to test innovative payment and service delivery models that lower program expenditures while maintaining or improving the quality of care furnished to beneficiaries. Under the CCJR, hospitals will be at financial risk for the care provided during the initial hospital stay plus 90 days after discharge from the hospital. By putting hospitals at risk, beneficiary care could improve because hospitals will have an incentive to increase care coordination, invest in infrastructure and care processes that increase quality and efficiency, and use high-value care throughout the 90-day episode. The model will be tested over 5 years in 75 Metropolitan Statistical Areas (MSA). Within the selected MSAs, hospital participation will be mandatory with limited exceptions.

In the proposed model, a bundle will include the initial hospital stay for joint replacement for lower extremity (diagnosis-related groups (DRG) 469 and 470) and all Part A and Part B services within 90 days of discharge from the initial hospital stay, except for specific services that are unlikely to be clinically related to episode. All providers will continue to be paid fee-for-service but at the end each performance year, the hospital's average actual spending will be compared to a

“target price.” If a hospital’s average actual spending exceeds the target price, the hospital will be required to repay Medicare for the difference between the target and actual price, referred to as a “reconciliation amount.” If the hospital’s actual spending is below the target price, Medicare will pay the reconciliation amount to the hospital if the hospital meets thresholds for three quality measures. The three quality measures include: 30-day readmission rate for hip and knee arthroplasty cases, complication rate for hip and knee arthroplasty cases, and a composite measure of the patient’s hospital experience captured by the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS). The HCAHPS asks patients about their hospital experience regarding communication with nurses and physicians, responsiveness of hospital staff, pain management, communication about medications, discharge information, care transition, cleanliness and quietness of the hospital environment, the overall hospital rating, and whether the patient would recommend the hospital.

Target prices will be based on a 3-year average of spending during the 90 days for each DRG, adjusted for differences in wages, special payments, and exceptionally high-cost outliers. CMS proposes to transition target prices from hospital-specific to regionally-based targets. In years 1 and 2, rates would be based on 2/3 hospital-specific spending and 1/3 on the regional average spending; in year 3, the target price would be 1/3 hospital-specific and 2/3 regional; and in years 4 and 5, the target price would be 100 percent regionally based. Once the target price is calculated, CMS proposes to discount the target price by 2 percent. Hospitals have the option to earn back a portion of the discount (that is, the discount would be reduced to 1.7 percent) by submitting information on patient-reported outcome measures.

The Commission recommended the testing of bundled payments in 2008 and since then has researched alternative bundle designs. In its June 2013 Report to the Congress, the Commission discussed the pros and cons of alternative designs, including a bundle spanning the initial hospital stay plus 90 days. Like bundled payments, our work on site-neutral payments supports narrowing the prices paid by Medicare to reflect a beneficiary’s care needs, not the setting where services are furnished.

The Commission supports the planned program. CMMI was created to test exactly this kind of alternative payment model. Beyond its broad support, the Commission’s comments are organized into five sections: the proposed definition of the bundle, target prices, quality measures, shared risk, and monitoring the program.

Proposed definition of the bundle

The CCJR proposal would exclude stays if the beneficiary dies during the initial hospital stay but does not exclude stays if the beneficiary dies during the 90 days after discharge from the hospital. The Commission believes CMS should exclude stays that include death—either during the initial hospital stay or during the 90 days after discharge—from the calculations of the target price and reconciliation amounts. Stays during which the beneficiary dies could be exceptionally high-cost if the patient lives for most of the 90 days and receives end-of-life care that could result in very high-cost episodes. If the beneficiary dies shortly after discharge from the hospital, the patient may receive little PAC or end-of-life care that would result in unusually low-cost episodes. In either case, the episode spending will not be typical and therefore these stays should be excluded from

calculating the target price or reconciliation amount. In future bundling efforts, CMS should decide on a condition-by-condition basis whether to include or exclude deaths that occur during the 90 days after discharge.

Target prices

To establish the target price for the bundle, CMS proposes to calculate a 3-year average of spending during the 90 days for each DRG (minus the 2 percent discount), adjusted for differences in wages, special payments, and exceptionally high-cost outliers. It does not propose any additional risk adjustment beyond the exclusion of certain clinically unrelated services and hospital readmissions, and the classification of cases into the DRG with or without major complications or comorbidities (DRGs 469 and 470).

The Commission's work on bundled payments and site-neutral payments found considerable variation in spending within joint replacement—between hip and knee replacements and between partial and total hip replacements. In the near term, the Commission urges CMS to compare hospital's actual spending to its target price after adjusting for the procedure mix within the DRG. Without this adjustment, hospitals and physicians would have an incentive to admit patients for lower-cost procedures (knee replacements and total hip replacements) and avoid higher-cost procedures (partial hip replacements). Otherwise, in evaluating hospital performance, hospitals could appear to have changed their spending during the performance year when actually they shifted their mix of cases. Although mandatory participation for hospitals in select markets would dampen the ability of hospitals and physicians to selectively admit patients, it will still be possible by guiding patients to one hospital and away from another. Information to delineate total hip, partial hip, and knee replacements is readily available from hospital claims. In the longer term, CMS should consider other risk adjustment strategies that adjust for differences in patient risk using hierarchical condition categories and functional status.

CMS proposes to transition target prices from a blend of hospital-specific targets and average regional spending to fully region-based targets. The Commission is concerned that the proposed target prices are not nearly aggressive enough to address the wide variation in PAC utilization (and captured in the 90-day spending) across the country that is unlikely to be related to differences in patients' care needs. In 2013, we reported that risk-adjusted spending on PAC care and readmissions within 90 days of discharge from the hospital varied over 50 percent between high- and low-spending MSAs. Transitioning to regionally based target prices, as opposed to nationally based targets, will continue to allow large differences in spending across the country. In markets with long-term care hospitals and inpatient rehabilitation facilities, these high-cost settings will raise the hospitals' target prices whereas in markets without these providers, PAC is delivered in lower-cost settings and the target prices will be lower. CMS should transition to national target prices to exert pressure on high-cost regions to bring their spending in line with the spending in other markets. In implementing other national prices, such as the implementation of the skilled nursing facility (SNF), IRF, and LTCH prospective payment systems, CMS did not include regional pricing in the transition to fully national rates but instead chose blends of provider-specific and national rates before ending at fully national rates.

Quality measures

Under any prospective payment (including bundled payment), providers have an incentive to furnish fewer services than medically necessary or to use low-cost settings even if another higher-cost setting would be more appropriate. To discourage these inappropriate provider responses, CMS proposes to gauge quality performance using three measures: 30-day readmission rate for hip and knee arthroplasty cases, complication rate for hip and knee arthroplasty cases, and HCAHPS score. Before CMS will make reconciliation payments to a hospital, the hospital must meet a threshold level of quality for each measure, in addition to keeping episode spending below the target price. The Commission notes that hospitals should know the thresholds before the beginning of the year so they can gauge their performance throughout year with respect to meeting or beating them. For example, if the threshold level is set at the 30th percentile, the hospitals should know the HCAPS score that corresponds to that percentile before the beginning of the year.

The Commission appreciates that CMS has kept the quality measures to a minimum and the metrics are outcome measures. However, the Commission believes that CMS should consider dropping measures related to readmissions because the hospital readmission penalty already exerts pressure on hospitals to lower their readmission rates.

In addition, over time CMS should require information about the patients' changes in function so it can use this as an outcome measure. The proposed set of required measures do not gauge improvement in function, the primary reason beneficiaries undergo the procedures and subsequent rehabilitation. Although the optional data submission includes this information, hospitals may elect to not submit the information. The Commission believes hospitals should collect the same information on function that is required of PAC providers to comply with the requirements of the Improving Medicare Post-Acute Care Transformation (IMPACT) Act of 2014. The IMPACT Act requires the implementation of quality measures that are standardized and interoperable across PAC settings using standardized patient assessment data. Gathering consistent information across hospitals and all PAC settings would enable comparisons of costs, quality of care, and patient outcomes. Those comparisons, in turn, would allow us to assess the value of the services furnished in each setting.

The Commission also believes that the measure of patient experience should transition to one that captures the beneficiary experience during the full episode. The proposed measure is focused on hospital care and transitions to the next setting but does not gather information about the patients' experience later during the 90-day period. It also includes all conditions and all patients (not just program beneficiaries), and excludes patients referred to SNFs. As a result, the measure may not accurately gauge the experience of beneficiaries recovering from joint replacement. The Commission believes that CMS should transition to a measure that is more narrowly tailored to beneficiaries' experience for these conditions during the entire episode of care.

Shared risk

CMS proposes that the hospital bear all financial risk for bundle spending that is above or below the target price, with stop-loss and stop-gain provisions to limit the aggregate gains and losses for

each hospital. Although hospitals bear all risk with respect to the Medicare program, they can opt to share this risk with physicians, SNFs, home health agencies (HHA), LTCHs, IRFs, physician groups, and other non-physician practitioners including outpatient therapists. The proposal includes important patient protection provisions that limit the gains that can be shared with any given physician. To counter the financial incentive to guide patients to low-cost providers, CMS proposes to require that participating hospitals furnish a complete list of all PAC options in the market and notes that the Conditions of Participation and the transparency requirements with beneficiaries about the payment model do not preclude hospitals from recommending preferred PAC providers. The proposed rule also requires hospitals to engage patients in shared decision-making as a condition of any gainsharing arrangement. CMS states that shared decision-making would help ensure appropriate volume (of particular concern for elective procedures) and the selection of the PAC best matched to the patient's care needs, not simply the lowest cost option.

The Commission supports arrangements that create opportunities for hospitals to cooperate with other providers to increase the value of care furnished to beneficiaries. That said, the Commission believes that when hospitals are at full risk for the entire episode, they should have the tools and flexibility to recommend high-value providers. The Commission has consistently heard from providers that the rules are not sufficiently clear about what is and is not allowed under Medicare rules regarding recommending preferred PAC providers. The Commission believes that CMS should require hospitals to furnish to beneficiaries a list of all PAC providers in the market, indicate providers that are "preferred", and define "preferred" as providers with above-average quality. The proposed rule also does not spell out what would meet the requirement of having adequate shared decision-making. CMS should issue more specific guidance regarding what are, and are not, acceptable approaches to shared decision-making.

Gainsharing between hospitals and physicians

We agree with CMS that gainsharing between hospitals and physicians is appropriate provided that there are protections against gainsharing becoming a way for hospitals to pay physicians for referrals, and there are quality safeguards. CMS has appropriately proposed four key protections for patients and the Medicare program:

- CCJR collaborators may not reduce or limit medically necessary services to any beneficiary, and physicians must continue to select the devices, supplies, and treatments that are in the best interest of the patient.
- Gainsharing payments can only be made for lowering hospital costs (e.g., due to care redesign) or full episode costs below the target price. Gainsharing payments can not directly account for the volume or value of physician referrals.
- The hospital must—in advance—create an accounting formula for estimating the internal hospital cost savings gained from redesigning care with their CCJR partners. After the year is completed, the formula would be used to estimate the savings.
- Each physician's gainsharing payment would be limited to 50 percent of the sum of the total Medicare payment amounts under the physician fee schedule for the physician's patients in the CCJR episodes.

The Commission believes CMS should add other provisions for gainsharing. First, a hospital should not be required to offer risk-sharing arrangements to all physicians in its market. Hospitals should be allowed to exclude physicians who are not contributing to efficiencies or who furnish poor quality of care. Second, a hospital should be required to have the same arrangement for all physicians in the gainsharing pool—the per episode payment should be equal among all physicians in the pool. Third, physicians in the gainsharing pool should be judged across all the cases treated by all of the physicians in the pool, meaning that no bonuses should be paid on a patient-specific basis. These requirements would limit the incentives for physicians to select low-cost patients and encourage physicians to cooperate to lower hospital costs, improve quality, and reduce Medicare episode costs.

Risk-sharing between hospitals and PAC providers

Under the proposed rule, hospitals can elect to pursue arrangements with PAC providers to share the risk for the 90-day bundle spending. The Commission believes that provisions similar to those governing gainsharing between hospitals and physicians should apply to the arrangements between hospitals and PAC providers. Hospitals should not be required to offer risk-sharing arrangements to all PAC providers in their markets and the arrangements they have should be identical across PAC providers. Further, the risk or reward would be calculated for all PAC providers used by a hospital, not on a patient-specific or PAC provider-specific basis. This approach to “pooling” the performance of the PAC providers would create incentives for them to cooperate to jointly lower episode costs. Similar to the gain-sharing requirements for physicians, the risk-sharing arrangement between a hospital and its PAC providers should be based on the change in per episode spending in the performance period. A hospital can discontinue its risk-sharing arrangement with PAC providers that do not contribute to lowering episode spending.

Reporting of risk-sharing arrangements

CMS also asked for comments on whether the hospitals should have to report gainsharing payments made to physicians and other providers. Because the Commission supports transparency around providers’ financial relationships with other entities, it believes this information should be made available. Each hospital should have to report gainsharing payments made to each physician. They should also be required to report the reconciliation payments made to physicians, non-physician practitioners, and each PAC provider. This information can be used to evaluate the size of the incentives needed to change behavior.

An alternative to consider: Extend risk bearing to all providers

CMS proposes to put only hospitals at risk for episode spending. A hospital can, in turn, share its risk with other providers if the hospital and the other providers agree to a risk-sharing arrangement. Yet while a hospital and its physicians shape the spending during the hospital stay and the selection of the initial PAC used, physicians are not required to be at risk for the 90-day episode spending. Similarly, PAC providers influence how much PAC is used and the rate of hospital readmissions but are not directly at risk for the 90-day episode spending. Therefore, in future CCJR models, CMS could consider directly extending the risk to the other providers. Otherwise, the financial interests of the hospital and other providers would align only if both

parties opt for the risk-sharing arrangement. Requiring risk-sharing with other providers would align the financial interests of all providers involved in the care during the episode.

One way this alternative risk-sharing could work is to have the major actors in the episode (the hospital, the hospital-based medical staff, and the PAC providers) share in any reconciliation amount up to their share of the 90-day actual episode spending during the performance period. For example, if a SNF's spending across all stays during the performance period made up one third of the actual episodes' spending, the SNF would be at risk for one-third of the reconciliation amount. Savings would accrue to PAC providers if patients were referred less frequently to PAC, less frequently to subsequent PAC, or more frequently to lower-cost PAC settings. Assuming preferred providers have higher volume, they would receive a higher share of any reconciliation amount compared with other providers.

Monitoring provider behavior

As with any prospective payment system, bundled payments may create an incentive to furnish fewer services than medically necessary, to use low-cost settings even if another setting is more appropriate, to delay care until after the bundle is over, and to increase the number of bundles. These risks increase when providers' incentives are aligned, though continuing to pay providers fee-for-service will dampen this incentive since a provider is paid only when it furnishes care. CMS will need to monitor several aspects of provider behavior that may suggest inappropriate responses to bundled payments.

- To monitor the potential for stinting on care within the bundle, CMS should track readmission rates, complication rates, use of emergency room visits and observation stays, lengths of stay, changes in patient function, and patient experience.
- To detect delays in care, CMS proposes to monitor spending during the 30 days after the 90-day bundles. Indicators of timely care coordination include days lapsed between discharge from the hospital to first PAC use, and days lapsed between hospital discharge and first physician visit.
- To evaluate whether the model resulted in more, potentially unnecessary cases, CMS should compare rates of joint replacement in markets included and excluded from the model.
- To evaluate whether hospitals have shifted their mix of cases, CMS should track the mix of cases (total hip, partial hip, and knee replacements) and the severity of illness of the cases treated.

The proposed design facilitates this evaluation because CMS can compare MSAs included and excluded from the payment model.

MedPAC appreciates the opportunity to comment on the important policy proposals crafted by the Secretary and CMS. The Commission also values the ongoing cooperation and collaboration between CMS and MedPAC staff on technical policy issues. We look forward to continuing this productive relationship.

Andrew Slavitt
Acting Administrator
Page 8

If you have any questions, or require clarification of our comments, please feel free to contact Mark E. Miller, MedPAC's Executive Director at (202) 220-3700.

Sincerely,

A handwritten signature in black ink that reads "Francis J. Crosson M.D." in a cursive script.

Francis J. Crosson, M.D.
Chairman