September 8, 2015

Andy Slavitt  
Acting Administrator  
Centers for Medicare & Medicaid Services  
Department of Health and Human Services  
7500 Security Boulevard  
Baltimore, Maryland 21244-1850

RE: Medicare Program; Comprehensive Care for Joint Replacement Payment Model for Acute Care Hospitals Furnishing Lower Extremity Joint Replacement Services

Dear Acting Administrator Slavitt:

On behalf of the High Value Healthcare Collaborative (HVHC), thank you for the opportunity to provide our comments below on the proposed mandatory pilot program from the CMS Center for Medicare and Medicaid Innovation (CMMI), the Comprehensive Care for Joint Replacement model.

In the interest of full disclosure, the HVHC was funded in part through CMMI grant number 1C1CMS331029-01-00. We would also like to acknowledge the following member participants who contributed to the comments on this important proposed rule: Lyle Sorensen, Lucy Savitz, Robert McConville, Robert Mecklenburg, Christa Shively, Jon Lurie, Nicolas O. Noiseux, Ivan Tomek, Nilay Shah, Matthew DeHart, Matt Schuld, Joe Mott and Greg Poulsen.

We hope that you find our input informative. For more information about the recommendations in our comment, please contact Mabel Balduf, Sr. Program Director, HVHC Program Office at mabel.l.balduf@dartmouth.edu or (207) 805-0886.

Sincerely,

Brent James, MD, MStat  
Chair, HVHC Board

J. James Rohack, MD  
Vice Chair, HVHC Board

On behalf of the HVHC Board
Comment on proposed rule for Comprehensive Care for Joint Replacement Payment Model for Acute Care Hospitals Furnishing Lower Extremity Joint Replacement Services:

The HVHC is a consortium of healthcare systems across the US convened by The Dartmouth Institute for Health Policy and Clinical Practice. The HVHC has been studying hip & knee practice variation across its members and implementing pilots of best practice interventions since 2010. The HVHC hip & knee project focused on three goals: to improve care through patient engagement; understand and improve health status measures before surgery; and reduce costs and outcomes by improving efficiency, reducing complications, and reducing the variability of rates of hip and knee surgeries. Data from the HVHC has shown us significant variability in utilization of the procedures across HVHC members, and significant variability in coordination of postoperative care and associated costs. Observing and reporting data from these member institutions from 2010 to the present has shifted practice and improved quality metrics and lowered costs. These goals are aligned with the interests of CMS in improving quality and affordability of total joint replacement.

The HVHC supports payment and delivery models that incent value over volume and is committed to quality improvement driven by data. We appreciate the opportunity of offering suggestions for improvement of the model.

Driving improvement through timely data
As a collaborative that focuses on using data to evaluate quality and lower costs, we appreciate that CMS will provide raw claims-level data to participating hospitals. We are concerned that CCJR performance data, through the financial reconciliation reports, will only be provided on an annual basis. This means that after a year of experience in the model, a hospital either is rewarded to a specified cap, or would have to reimburse CMS for overutilization of resources. We urge CMS to provide financial reconciliation at quarterly intervals rather than annual to support mid-course corrections and continuous improvement.

We applaud CMS for recognizing the benefits of patient engagement and patient reported outcome measures. We agree with the proposed quality metrics and HCAHPS survey scores as a method to listen to the voice of the patient.
Potential unintended consequences of model design
We are concerned that there is no risk adjustment in the CCJR proposal. The lack of risk adjustment could encourage providers to support earlier surgeries because healthier patients have less risk for readmissions and complications. Risk adjustment is also an important patient protection to ensure that individuals with co-morbidities or contractures at the surgical site have access to needed services. CMS should guard against negative impacts to individual with disabilities or shift costs to the Social Security program or other programs that serve this population. We see this as a potential unintended consequence of the model design and encourage CMS to address these risks in the final rule.

We also noted that the CCJR proposal does not directly address “upstream” care or services prior to the inpatient admission, specifically on the provision of conservative care. Many of our members have adopted care protocols that begin well in advance of the joint replacement procedure and felt the model would be stronger if it provided an incentive for conservative care measures. In light of the mixed evidence regarding pursuing non-operative care as long as possible, we appreciate that the model, as proposed, will allow providers to define these care protocols themselves, maintaining physician discretion. However, we do think the model could be strengthened by giving providers more incentives to adhere to evidence-based care protocols and patient engagement tools.

Strategies for incenting quality
Under the CCJR model design, the beginning of the episode starts with the DRG or anchor hospitalization. Pre-operative care protocols, patient engagement strategies, and shared decision making about the procedure itself are effectively outside of the CCJR model, which can potentially lead to missed opportunities to improve care and clinical pathways.

The HVHC encourages CMS to address this issue by making clear in the final rule that pre-operative care improvement activities can and should be pursued by providers participating in the CCJR. We support providers defining these clinical pathways and request CMS to offer guidance and/or waivers for anti-kickback, self-referral, or gain-sharing that promote these activities. We also request CMS to provide guidance that adherence to such care protocols could be incorporated into physician compensation arrangements to further support clinical integration.

1 Several orthopaedic publications document the detrimental consequences of muscle atrophy, loss or range-of-motion and debility that come from unreasonable delays in TJA.
of those protocols. CMS’s guidance or waivers would bolster existing HVHC’s work on shared decision making programs and our members’ engagement with the Bree Collaborative in the state of Washington (http://www.breecollaborative.org/topic-areas/apm/), advancing innovation beyond what we are able to do today.

**Maximizing impact of alternative payment models**

As the market transitions from fee-for-service to fee-for-value, many of our delivery systems are trying to balance multiple strategic, financial, and operational considerations. These include: allocating significant resources to operationalize alternative payment models, affiliate and employed provider alignment efforts, data capture/sharing capabilities, payer/provider contract changes, member coordination, clinical alignment efforts, and governance. Due to market dynamics and system capabilities, some providers are better suited to pursue episodic/bundled approaches, while others are pursuing more population-based arrangements.

We urge CMS to carefully consider program overlaps and whether organizations participating in ACO models that include full risk, such as the Next Generation ACO model, should be exempt from CCJR. While we support alternative payment models and other future population-based payment models, we are also aware of their complexity and concerned that overlapping efforts may lead to diminishing returns for CMS and for health care organizations. In many respects, the Next Generation ACO model “trumps” the design of CCJR by creating explicit pathways for establishing SNF affiliates and providing gainsharing waivers; it also provides the same program waivers for telehealth, post-acute home visits, and three-day SNF as proposed for CCJR. There are clearly aligned incentives between these two programs and simplicity may yield benefits by focusing provider efforts, reducing the risk of confounding effects, and lessening administrative burden. We encourage CMS to consider allowing Next Generation ACO participants to be exempt from CCJR, just as CMS proposes to exempt Bundled Payment for Care Improvement participants.