THE HEALTHCARE QUALITY COALITION

September 8, 2015

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-5516-P
P.O. Box 8013
7500 Security Boulevard
Baltimore, MD 21244-1850

Re: CMS-1631-P; Medicare Program: Comprehensive Care for Joint Replacement Payment Model for Acute Care Hospitals Furnishing Lower Extremity Joint Replacement Services

Dear Acting Administrator Slavitt:

We write to provide comments on the Comprehensive Care for Joint Replacement (CCJR) Payment Model proposal for hospitals. Overall, the Healthcare Quality Coalition (HQC) strongly supports the development of the value initiatives at CMS. Our members believe properly structured incentives to provide high value care (i.e., high quality, low cost care) will result in better care for patients at a lower cost for payers.

The HQC is comprised of hospitals, physicians, health systems and associations committed to value-based healthcare. Combined, our provider systems have more than 19,000 licensed hospital beds, employ more than 21,000 physicians, and have more than 225,000 employees across the country. Organized in 2009, the HQC supports efforts to create a sustainable Medicare system through incentivizing high-value care. We believe value-based payment policies can drive better quality, lower cost of care, and reduce overall costs for the Medicare program. The HQC strongly supports continued implementation of payment programs that reward value.

Overview

The CCJR program is proposed to extend voluntary bundled payment initiatives to mandatory reimbursement policy for 75 selected geographic regions. This new policy would bundle payment to acute care hospitals for hip and knee replacement surgery. Under this model, the hospital in which the lower extremity joint replacement (LEJR) takes place would be held financially accountable for quality and costs for the entire episode of care, from the date of surgery through 90 days post-discharge. The new bundled payment program would commence on January 1, 2016 and the HQC offers the following comments and concerns on the proposed CCJR payment initiative.

Risk, Benchmarking, and Implementation

Comment: The HQC believes a national benchmark should be used to assess performance in post-acute care utilization. We are also concerned about the rapid implementation of the new payment program (January 2016). In addition, we are concerned with extended time period of the bundle at 90 days post-discharge of hip and knee replacement surgeries on hospitals without necessary tools and flexibility for coordinating care.

In the proposed rule, CMS outlines plans for target pricing benchmarks for hip and knee replacements in the Medicare program. The proposed rule states that CMS will transition target pricing criteria from a blend of hospital-specific targets and average regional spending to fully region-based benchmarks. The HQC has along supported the goals of value-based payment assessed against a national benchmark. National performance benchmarks will enable assessment of all hospitals in the program based on their performance in post-acute care utilization in the CCJR scheme. Moving to a national benchmark would ensure high spending areas would be incentivized to decrease cost, while recognizing lower cost hospitals.

In addition, we are a concerned about the rapid implementation of the new payment policy. In other pay-for-performance initiatives, there were periods of notice-and-comment that spanned rulemaking cycles that allowed for hospitals and providers to provide meaningful input and prepare for implementation, such as the Hospital Value-Based Purchasing Program. Also, the 90 day post-discharge period is an extension of other performance-based programs, such as the Hospital Readmissions Reduction that have a 30-day post discharge time frame. We ask CMS to consider revisions to the program, such as a shorter time-frame for post-discharge assessment, and a more gradual implementation schedule. In addition, providing full accountability to hospitals needs to be complemented with the ability to effectively manage risk for patient care services within the 90 day post-discharge window.

Quality Measures

Comment: The HQC supports clinical and policy alignment between different quality and value-based programs. However, we are concerned with overlapping of similar measures may unnecessarily reward or penalize hospitals the same in separate programs.

The HQC appreciates the use of quality and cost measures in any value-based program. We believe both cost and quality need to be equally weighted to achieve a balanced, comprehensive value-based system. In prior rulemaking cycles implementing hospital and provider value-based payment programs, the HQC commented with concerns on the use of overlapping measures in improvement programs. Organizations may be rewarded or penalized multiple times for the same types of

measures. We agree with comments submitted by the Medicare Payment Advisory Commission[1] asking for the removal of the readmissions measure. Readmission measures already exist in the Medicare Readmissions Reduction program.

In addition, the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey is currently used in the Hospital Value-Based Purchasing Program. In this program, hospital diagnostic related group (DRG) payment is adjusted to hospitals based on performance in domains of quality and cost measures, including patient experience. Applying HCAHPS in the hospital value-based purchasing program setting takes into account a sample of patient surveys, not just those used in hip and knee surgical procedures. Although HCAHPS are important measures in quality and value-based programs, we believe they should not overlap with the CCJR initiative.

Site Selections

Comment: The HQC is concerned with the selection of the 75 metropolitan statistical areas. Hospitals and health systems often span across multiple MSA's, creating different payment models to Medicare patients within their same organization(s).

The proposed rule selects hospitals in 75 MSA's across the country. Representing hospitals, providers and health systems, some members of the HQC span across several regions of the country. Some organizations cross multiple MSA's, creating the potential for different payment models for Medicare patients with similar surgical procedures. We believe the selection of 75 MSA's may create conflicting incentives and payment models within the same organizations, further adding unnecessary administrative burden and complexity.

Conclusion

The HQC appreciates the opportunity to comment on the CCJR proposed rule. Representing hospitals, providers and associations, including integrated healthcare systems, we urge CMS to work together with hospitals and physician groups and take careful consideration in implementing this new payment policy. We look forward to continuing to provide feedback on this program.

Sincerely,

The Healthcare Quality Coalition

The Healthcare Quality Coalition represents healthcare providers throughout the nation dedicated to the concept of value-based care. In short, we believe healthcare entities should be held accountable for the quality and value provided to the patients and communities we serve. The HQC is committed to developing value-based payment initiatives in a way that encourages fair payment to providers delivering high value care to the patients they serve. www.qualitycoalition.net

[1] Medicare Payment Advisory Commission. Letter to Centers for Medicare and Medicaid Services, File code CMS-5516. August 19, 2015. http://www.medpac.gov/documents/comment-letters/medpac-comment-on-cms's-proposed-rule-on-the-comprehensive-care-for-joint-replacement-payment-model-for-acute-care-hospitals.pdf?sfvrsn=0