September 8, 2015

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

Re: CMS-5516-P

The Health Care Transformation Task Force (HCTTF or Task Force), which is made up of 39 organizations including patients, payers, providers, and purchasers, respectfully submits our consensus comments on the proposed Comprehensive Care for Joint Replacement (CCJR) program.[1] Members of the HCCTF have over 3,000 episode initiators live in the Bundled Payments for Care Improvement (BPCI) program today.

We believe bundled payments can promote high-quality, high-value care during Medicare beneficiaries' episodes of care and encourage coordination among providers. These outcomes can be achieved while ensuring access to care and freedom of choice for Medicare beneficiaries, regardless of the severity of their illnesses. Moreover, we applaud many of the design features in the CCJR model; our suggestions herein reflect a desire to refine this important initiative. The proposed rule outlines the framework for a program that could become very successful at reducing Medicare spending and improving patient care.

As a general consideration, we continue our advocacy for full transparency in all matters related to bundled payment programs, including the specific methodology for setting target prices for each hospital. We believe this will lead to shorter cycle times to refine program designs while also creating greater trust in the technical aspects of any bundled payment program.

Lower Extremity Joint Replacement (LEJR) is not a prototypical episode and aside from the high volume nature, should not be a model for bundled payment associated with other conditions. Because LEJR is a scheduled surgery in most cases, it does not lead to the systemic care coordination changes required for the 80% of Medicare admissions

[1] The Health Care Transformation Task Force (the Task Force) came together to accelerate the pace of delivery system transformation. We share a common commitment to transform our respective business and clinical models to deliver the triple aim of better health, better care and reduced costs. Our organizations aspire to put 75 percent of their business into value-based arrangements that focus on the triple aim by 2020.

that come in through the emergency room and are generally medical admissions, not surgical.

Our recommended refinements to the CCJR Model design include:

The CMS Discount to the Target Price Should Vary Based on Non-DRG Costs

We encourage CMS to discount a hospital's target episode price based on the fraction of post-acute care spending relative to total episode spending. Because the diagnosis-related group (DRG) payment is fixed, a 2% fixed discount, by consequence, makes it relatively harder for high-efficiency providers—as well as for providers operating in local markets where excess utilization of post-acute services is not observed – to achieve meaningful savings. It is more difficult for providers with historically low total post-acute episode costs to reduce waste in episode spending. We propose that the average cost provider have a 2% discount, while providers with historically low post-acute episode spending have a discount smaller than 2%.

Re-Open the Discussion of Episode Definition and Methodology

The Task Force encourages the Secretary to appoint a Federal Advisory Committee of relevant stakeholders, including BPCI participants, consumers, patients and purchasers, to develop episode construction methodologies, quality metrics and the sharing of episode risk informed by their experience in the BPCI Initiative. An example of an issue to address includes setting target prices based on MS-DRGs that differentiate between surgeries precipitated by a degenerative condition and those resulting from a fracture. Such differentiation is necessary because fractures more frequently occur in very frail individuals and, therefore, recovery for fractures is longer and more costly than for elective replacements. Another example of an issue to address is the effects of the proposed quality metrics on major teaching and disproportionate share hospitals.

Reconcile Quarterly, with Optional Annual Reconciliation

CMMI proposes annual reconciliation of performance. We recommend quarterly reconciliations so that organizations producing savings can offset the expenses associated with managing 90-day episodes and to provide relatively faster feedback and rewards to program participants. We believe that certain categories of hospitals should have the option to elect annual reconciliations, recognizing the actuarial risk associated with small episode volume. For this reason, we believe annual reconciliation should be an option, consistent with the BPCI Initiative.

Provide Claims Data Prior to the Start of the Model

CMMI proposes that baseline data will not be available "sooner than 60 days after January 1, 2016, the effective date of the model."[2] CMS should consider the benefits of making historical claims data available before the effective date of a bundled payment program. Providing this claims data in advance of the program will improve the ability of providers to conduct necessary analyses and undertake care re-design.

Allow BPCI Participants to Continue for Five Years

To minimize disruption in the emerging bundled payment programs, we recommend allowing the BPCI efforts in this space to continue. Specifically, for those BPCI programs that have selected major lower joint replacement payments, we recommend allowing their programs to continue as currently structured for the duration of the CCJR pilot.

Lower the Stop-Loss Level for Hospitals with Minimal Volume

We recommend offering a lower stop-loss threshold for hospitals with less than 35 annual LEJR cases, to protect those low volume, typically smaller hospitals, from the consequences of random variation in outcomes.

Beneficiary Protections

The Task Force supports the beneficiary protections included in the Proposed Rule. Beneficiary notification and shared decision-making could help CMMI ensure that beneficiaries receive appropriate, high-quality care and retain the freedom of choice in selecting providers for joint replacements and post-discharge services. Furthermore, we support the incentives provided for the collection of data to enable the further development of patient-reported outcomes measures.

Seek Fraud and Abuse Waivers to Enable Gainsharing

The BPCI program has demonstrated the importance of gain-sharing in the design of successful bundled payment programs. CMS should consider the benefits of making these same waivers available to hospitals mandated to participate in the CCJR model. CMS and the Office of the Inspector General should quickly coordinate on unified guidance related to the program's fraud and abuse waivers, as well as provide a mechanism for providers to ask questions about the waivers short of a full Advisory Opinion.

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[2] *Id.* at 41292.

Thank you for considering our viewpoints on this important public policy matter. For more information, please contact Susan Winckler at susan@leavittpartners.com.

Sincerely,

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