March 28, 2016

VIA ELECTRONIC MAIL

Lew Sandy, MD
Chair
Clinical Episode Payment Work Group
Health Care Payment Learning and Action Network

Re: Comments on Draft White Paper: Elective Joint Replacement

Dear Chair Sandy:

The Health Care Transformation Task Force ("HCTTF" or "Task Force")[1] commends the work of the Health Care Payment Learning and Action Network's ("LAN") Clinical Episode Payment Work Group ("Work Group") on its draft White Paper on Elective Joint Replacement (EJR) Framework ("White Paper" or "Framework"). The Task Force appreciates the opportunity to provide comments to the Work Group, and looks forward to collaborating with the LAN and all of its work groups to help facilitate widespread health care delivery transformation.

As a general consideration, we continue to advocate for full transparency in all matters related to bundled payment programs, including the specific methodology and data for setting target prices and the way issues such as attribution are handled. We also believe that bundled payments can promote greater transparency for patients in the evaluation and selection of health care providers. Transparency, in general, will lead to shorter cycle times to refine program designs while also creating greater confidence in the technical aspects of any bundled payment program.

[1] The HCTTF is an emerging group of private sector stakeholders who are committed to accelerating the pace of delivery system transformation. Representing a diverse set of organizations from various segments of the industry—including patients/consumers, purchasers/employers, providers, and payers—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 arrangements into value-based payment models, focusing on the Triple Aim goals, by 2020. We strive to provide private sector leadership through policy, operational, and technical support, and expertise that, when combined with the work being done by CMS and other public and private stakeholders, will increase the momentum of delivery system transformation.

We also reiterate our view that EJR is not a prototypical episode and aside from the high-volume nature, may not provide a suitable model for bundled payments associated with other conditions. Conversely, we view EJR as an especially appropriate episode for using an episode trigger related to diagnosis, rather than acute intervention.

Finally, we support options for prospective payment to "accountable entities" that can demonstrate reserve adequacy and the ability to administer claims payments consistent with that particular payer's schedule for payments.

Our recommended refinements to the EJR Model design include:

Patient Population and Transparency in Episode Creation

As a general consideration, we continue to advocate for full transparency in all matters related to bundled payment programs, including the specific methodology for setting target prices for each hospital or participant. Data is key to fostering consensus and reaching agreement on appropriate structures to manage bundled payment programs. We believe greater transparency will lead to shorter cycle times to refine program designs while also creating greater trust in the technical aspects of any bundled payment program.

The LAN should consider and focus on the varied experience of patients who need joint replacement, including dual-eligible and disabled patients. The White Paper alludes to variation in costs due to variation in the acuity of patients, acknowledging that those conditions require and justify more intensive treatment and care and therefore higher costs, but only in the construction of the episode and inclusion/exclusion of these patients in an episode.

In order to ensure access to orthopedic surgery, we agree with the LAN's support of the broadest possible patient population, with risk and severity adjustment to account for age, complexity and socioeconomic factors. We believe that should be acknowledged at the start, and should be considered by the LAN as a challenge to be addressed by constructing episodes that work for a broader set of patients.

The Importance of an Accountable Entity

We strongly support the sharing of risk among physicians, hospitals, and other health care providers. We believe that the "accountable entity" will be paramount in serving this function through the EJR model.

We believe that a wide range of provider and organization types should be encouraged to sponsor accountable entities in bundled payment programs. Adoption speed and quality of execution are often the main reasons commercial programs encourage "General Contractors" to form and develop risk-taking management service organizations. We therefore support the LAN's agnostic view of the types of organizations that may sponsor an accountable entity; this is consistent with the structure of capitation arrangements and Accountable Care Organizations that can accept and pool the risk for participating providers.

Engaging Hospital-based Physicians

We believe that any capable organization should be able to sponsor an accountable entity. We further believe that the clinical model for the EJR episode should acknowledge the importance of hospital-based physicians.

The LAN identifies in Figure 6 the role of orthopedists, who are key physicians for engaging patients far upstream of an inpatient admission and are especially well positioned to set expectations and encourage appropriate next site of care decisions. For voluntary programs, we believe that the care model participants listed in Figure 6 should include hospitalists, who are well-positioned to serve as the principal accountable inpatient provider for high-risk inpatients, particularly those with comorbidities.

Given the current economic and financial pressures on community-based physicians, as well as the increased acuity and comorbidities of inpatients, we believe the LAN should support the designation, where appropriate, of a hospitalist as the principal inpatient accountable provider. The evidence demonstrates that hospitalist co-management of elective joint replacement inpatients, where appropriate, reduces time to surgery from admission, waiting time for specialists consultation and length of stay, and also results in fewer complications.[2]

In 2011, 11.3% of surgical Medicare DRGs listed a hospitalist as "the physician who has overall responsibility for the beneficiary's care and treatment."[3] This percentage represented a 31.3% increase from that in 2009 despite the 8.0% decline in overall surgical DRGs.[4] Moreover, orthopedists have increasingly relied on hospitalists for managing the comorbidities of their inpatients.[5]

This inclusion of hospitalists in the care model has been shown to improve the quality of care in studies of elective joint replacement. Successful outcomes were achieved for this cohort when the orthopedist designated the hospitalist as responsible for pre-anesthetic medical examination, daily patient evaluation during hospitalization, perioperative medical care, subspecialty medical consultation, and discharge planning.[6]

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[2] Huddleston JM, et al., *Hospitalist-Orthopedic Team Trial Investigators. Medical and surgical comanagement after elective hip and knee arthroplasty: a randomized, controlled trial*, 141 ANN. INTERN. MED. 28 (2004). *See also* Peterson MC, *A Systematic Review of Outcomes and Quality Measures in Adult Patients Cared for by Hospitalists vs. Nonhospitalists*, MAYO CLIN. PROC. 248, 249 (2009).

[3] Welch WP, et al., *Use of Hospitalists by Medicare Beneficiaries: A National Picture*, 4 MEDICARE & MEDICAID RES. REV. E1, E6 (2014).

[4] *Ibid*.

[5] Kuo YF, et al., *Growth in the Care of Older Patients by Hospitalists in the United States*, 360 N. Engl. J. Med. 1102, 1106 (2009). In 2006, 37% of all orthopedic inpatients received care from a hospitalist, up from 5% in 1997.

[6] Huddleston JM, et al., *Hospitalist-Orthopedic Team Trial Investigators. Medical and surgical comanagement after elective hip and knee arthroplasty: a randomized, controlled trial*, 141 ANN. INTERN. MED. 28, 30 (2004).

Therefore, we believe Figure 6 should include, in the "event" box, a reference to hospitalists, who often join the care team as either the attending provider for the admission (in co-management cases) or are consulted during the admission.

Patient-Focused Quality Metrics

The HCTTF supports the use of patient-reported outcome and functional status measures. However, we recommend that providers only be subject to performance in quality metrics that have been validated by sufficient data and accepted by institutions such as the National Quality Forum. In the CJR model, patient-reported outcome measures are not mandatory and providers are only being held accountable for the collection of the information, not the measures themselves. As these tools become widespread, the LAN should review and recommend which quality metrics show actual improvement in patient lives and have a dedicated group to continuously review quality metrics and ensure that they are aligned with other value-based arrangements.

Seeking Fraud and Abuse Waivers to Enable Gainsharing

The BPCI Initiative has demonstrated the importance of gainsharing in the design of successful bundled payment programs. While gainsharing helps to align care delivery incentives through financial benefits, gainsharing is often viewed under federal policy as inappropriate remuneration that raises fraud and abuse concerns. Waivers of these policies are key to forging the alignment between providers – hospital and physicians – necessary for success coordination under bundled payment programs. If providers continue to be subject to existing regulations, participants in an EJR model may need more than just waivers; new safe harbors from certain laws should be developed that eliminate potential liability due to the public policy benefits of better aligned care and cost reductions.

Please contact HCTTF Executive Director, Jeff Micklos, at jeff.micklos@leavittpartners.com or (202) 774-1415 with any questions about this communication.

Sincerely,

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