national partnership for women & families
Because actions speak louder than words.

September 8, 2015

Andy Slavitt, Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1631-P
P.O. Box 8016
Baltimore, MD 21244-8016

Re: Comprehensive Care for Joint Replacement Payment Model for Acute Care Hospitals Furnishing Lower Extremity Joint Replacement Services (CMS-5516-P)

Dear Administrator Slavitt:

The National Partnership for Women & Families appreciates the opportunity to offer comments on the proposed rule for the Comprehensive Care for Joint Replacement Payment Model for Acute Care Hospitals Furnishing Lower Extremity Joint Replacement Services (CMS-5516-P). The National Partnership represents women across the country who are the health care decision-makers for themselves and their families and who want to ensure that health care services are both affordable and of the highest quality. We are deeply invested in improving the quality and value of health care and committed to ensuring that all models of care delivery and payment provide women and families access to comprehensive, high-quality, and well-coordinated patient- and family-centered care.

We applaud CMS for its continued commitment to shifting to value-based payment and moving away from payment models that reward volume rather than quality and value. However, we have significant concerns about the Comprehensive Care for Joint Replacement (CCJR) model as it is proposed. We believe that the model must be modified to address these concerns. We offer extensive recommendations for additional consumer protections, including utilization of shared care planning and appropriateness screenings, and for enhanced quality performance measurement and reporting. We note that the National Partnership strongly supports the consumer protections currently proposed in the rule, as well as the quality performance threshold for gainsharing. Taken together, these provisions are critical for ensuring that beneficiaries receive appropriate, high-quality care from the providers of their choice and that participating entities are held accountable for the quality of care delivered.

If you have any questions about our comments and recommendations, please contact Lauren Birchfield Kennedy, Director of Health Policy, at lkennedy@nationalpartnership.org or (202) 986-2600.

Sincerely,

Debra L. Ness, President

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1. **CMS should require hospitals to develop and demonstrate implementation of an approved, comprehensive clinical care model. Hospitals should also be required to identify a leadership structure that is accountable for management of the clinical care model and for overseeing care coordination.**

While the National Partnership for Women & Families strongly supports the transition to value-based payment, we have concerns with the mandatory nature of the CCJR payment model. Hospitals are required to participate in this model based solely on random selection and geographic location. Unlike other voluntary value-based payment models, including the Bundled Payment for Care Improvement (BPCI) Initiative, there is no requirement that hospitals, prior to selection for the CCJR program, be able to demonstrate a history of providing comprehensive, coordinated care for joint replacements or familiarity with effectively coordinating care across a continuum of providers and settings. We are concerned that, as currently designed, the model could result in beneficiaries receiving low-quality care in a hospital that is unprepared to coordinate their care. We are also concerned that the model, as currently designed, could encourage a hospital to prioritize cost savings over providing appropriate, comprehensive and patient-centered care for beneficiaries.

Therefore, we urge CMS to include in final regulations a requirement that participating hospitals must develop, have approved by CMS, and implement a comprehensive, effective clinical care model and leadership structure for coordinating care and managing implementation of the CCJR program. For example, in the request for applications (RFA) for the BPCI Initiative, CMS articulates several specific requirements that entities must meet in order to show that they are prepared to coordinate care, improve quality, and manage bundled payments. Given that the CCJR model will be required of all hospitals in certain geographic areas – and, thus, some beneficiaries effectively will not be able to opt-out of the CCJR payment model – CCJR-participating hospitals should be held to the same or greater requirements as the BPCI program with regards to clinical care model design and care coordination.

For the CCJR program, CMS should establish basic requirements for care coordination competencies that must be met, independent of payment and measurement. As a minimum starting point, we offer the following requirements that should be made of CCJR-participating hospitals to ensure that they are prepared to successfully deliver high-quality, coordinated care to beneficiaries. These proposed requirements are adapted from the BPCI RFA. Participating hospitals should be required to:

- Provide a detailed plan for how care improvement and redesign will improve quality and patient experience of care, including the aspects of care that will be redesigned, an articulation of how such redesign will improve care, and an assessment of institutional capacity and readiness to undertake care improvement.
- Describe their plans for beneficiary and family caregiver engagement including, for example, use of shared care planning and shared decision-making processes or tools to assess treatment options, and routine assessments of beneficiary and family caregiver experience of care.
- Describe their plans for coordination of care and care transitions including, for example, use of individualized care plans and sharing of electronic health records across providers and between providers and patients and family caregivers.

- Provide a comprehensive plan for how performance on quality metrics will be used internally to continuously improve project operations and address areas where the quality or experience of care can or should be improved.
- Designate a multi-stakeholder leadership body, inclusive of patients and consumer advocates, to oversee the clinical care model and care redesign and provide ongoing oversight of the delivery of care and of patient outcomes.

To further protect beneficiaries and their care, we recommend that, as part of their care coordination efforts, hospitals identify key staff to serve as care coordinators. Care coordinators should be available to answer questions about the payment model, to help navigate patients through the joint replacement treatment process, to coordinate care across providers and settings, and to serve as patient advocates for beneficiaries.

2. To ensure beneficiaries receive appropriate, high-quality care, CMS must incorporate enhanced consumer protections into the CCJR model.

Enhanced consumer protections are needed to ensure that beneficiaries receive appropriate, high-quality care through the CCJR program and retain freedom of choice in choosing providers for joint replacements and post-discharge services. Shared care planning, use of appropriateness criteria, care coordination, and beneficiary notification must be required features of the CCJR model. We strongly support the beneficiary notification and protections laid out in § 510.405 of the proposed rule. However, we strongly urge CMS to go further and create specific requirements for shared care planning, appropriateness criteria and a pre-admission meeting.

Beneficiary Notification

We strongly support the proposed requirements that participating hospitals and collaborating providers disclose their financial relationships and interests to patients, explain the bundle model to patients, and advise patients of their standard beneficiary protections. We specifically commend CMS for fully retaining Medicare "Freedom of Choice" for beneficiaries at § 510.405(a), where Freedom of Choice protects beneficiary ability to see any provider of their choice for acute and post-acute care.

For post-discharge planning, we strongly support the current proposal to provide patients with a complete list of all available post-acute care options. We strongly support requiring this list to include provider- and facility-specific information on cost-sharing and quality performance. Hospitals and providers must respect beneficiary decision-making with regards to choice of hospital and provider, both for joint replacement surgery and for post-acute care.

Shared Care Planning

We strongly urge CMS to incorporate shared care planning into the CCJR model and to require CCJR-participating hospitals to demonstrate use of shared care planning. Shared care planning includes collaborative provider-patient goal-setting, decision-making, and monitoring through the use of documented, completed individualized care plans.

Comprehensive shared care planning encompasses more than just the use of a shared decision making tool or decision aid.

Ideally, shared care planning would take place with a provider prior to admission, so that beneficiaries are made aware of their treatment and provider options before admission to the hospital. To ensure that beneficiaries are active participants in their treatment decisions and aware of all possible options and outcomes, we recommend that hospitals certify that shared care planning occurred prior to admission. At a minimum, hospitals should be required to demonstrate that shared care planning, inclusive of shared decision making, took place with a referring provider or as part of the hospital's admission process.

To assist providers and hospitals in the process of shared care planning, there are several shared decision making aids available that are specific to hip and knee replacement, including ones developed by the Option Grid Collaborative at the Dartmouth Institute for Health Policy and Clinical Practice, Mayo Clinical Shared Decision Making National Resource Center, and Healthwise. Decision aids can be critical to effective shared decision-making. We reiterate, however, that true shared care planning goes beyond use of a single decision aid.

Appropriateness Criteria

Likewise, we also urge CMS to require CCJR-participating hospitals to demonstrate that they have appropriateness criteria in place to assess beneficiary need for joint replacement. Absent demonstrated use of appropriateness screening, we are concerned that hospitals may have an incentive to steer healthier patients towards unnecessary joint replacements and to avoid admitting sicker, higher-needs patients who may be most in need of surgery. CMS could, for example, require hospitals to have in place a pre-admission review process that helps ensure prospective beneficiaries meet established appropriateness criteria for joint replacement. Required utilization of patient-reported outcomes data could also help ensure hospitals are indeed only admitting and operating on beneficiaries for whom joint-replacement surgery is appropriate. These recommendations are not meant to restrict beneficiaries' access to joint replacements in any way, but to ensure that surgery is appropriately recommended based on a beneficiary's current condition or health status.

Pre-admission Meeting

In order to operationalize these additional beneficiary protections, we recommend that CMS require CCJR-hospitals to meet with prospective beneficiaries prior to admission. We recommend that this meeting take place at least one week prior to admission, or at earliest availability thereafter. The current standard for beneficiary notification (§ 510.405(c)) causes notification to take place unnecessarily late in many circumstances. At admission, a patient is in no reasonable position to understand, much less evaluate and act on, CCJR-related information.

At a pre-admission meeting, we recommend that patients be notified of their standard protections, including Freedom of Choice; be screened for appropriateness criteria; and be asked to verify if they engaged in shared care planning with a referring provider or with a hospital provider. Additionally, at a pre-admission meeting, beneficiaries should be

introduced to their care coordinators and oriented to the joint replacement treatment process.

Pre-admission meetings are already common in some hospitals. Requiring such a meeting in all CCJR-participating hospitals would help ensure that there is a designated time to address these critical topics. Further, pre-admission meetings can serve to coordinate care more effectively by engaging beneficiaries and their caregivers in pre-admission education, prescheduling appointments for follow-up care, and discussing post-discharge planning.

3. The current quality thresholds for reconciliation payments should be maintained and accompanied by greater requirements for the use of patient-reported outcomes measures.

The National Partnership strongly supports the current quality thresholds for eligibility for reconciliation payments at § 510.315. We are resolutely opposed to any lowering of the quality performance threshold for any or all of the quality measure domains.

Maintaining the current quality threshold is essential for protecting patient safety. Lowering the quality threshold for gainsharing would signal to hospitals across the country that low quality care is permissible, and even rewarded. We urge CMS to finalize the requirements for quality thresholds as proposed.

We strongly support CMS' proposal to require mandatory reporting on the quality domains of hospital-level complications rates, hospital-level readmission rates, and patient experience as captured through the Hospital Consumer Assessment of Healthcare Providers and Systems Survey (HCAHPS). As proposed, CMS will determine the form and manner in which the quality measures are publicly reported. We strongly recommend that the CMS make the measures publicly available as soon as possible and in a manner that is easily accessed, understood, and used by beneficiaries. It is critical that beneficiaries have as much information as possible about hospitals and providers when making decisions about treatments and providers.

We applaud CMS for incentivizing the reporting of patient-reported outcome measures (PROMs). Hospitals must be accountable to patients, first and foremost, and quality measurement should reflect this principle. We commend CMS for prioritizing the development of PROMs for hip and knee replacements. PROMs are high-impact, high-value measures that are meaningful to both consumers and providers and will help hospitals drive quality improvement. We recommend, however, that CMS make the collection of patient reported outcome measures mandatory, or significantly increase incentives around their collection. We support strategies for encouraging collection and reporting of patient-reported outcomes in CCJR, including per case incentives and/or additional discounts.

We strongly urge CMS to make currently available PROMs a mandatory measure domain. Measuring and reporting on patient-reported outcomes will help prevent inappropriate utilization of joint replacement surgery. Absent the requirement to apply and report these measures, we are concerned that providers may steer healthier and younger (and, therefore less expensive) patients towards joint replacement surgery in order to stay below their

annual target price. Similarly, hospitals may avoid treating sicker patients, who might increase their overall costs of care and make it harder to stay below the target price.

We recommend that patient-reported outcomes, such as functional status, be measured pre-admission and post- joint replacement. Measuring functional status pre and post-joint replacement should bring to light two important findings for CMS and beneficiaries:

1. Whether hospitals and providers are appropriately utilizing joint replacement surgery; and
2. Whether a hospital is generating savings because it is actually improving the health, functional status, and mobility of beneficiaries or because it is mainly treating relatively healthy patients.

Public reporting of these measures can help empower consumers to compare hospital/provider performance across domains of key importance to patient and families and enable CMS to identify hospitals that may be inappropriately utilizing joint replacements.

Finally, we note that we look forward to the final validation of hip- and knee-specific PROMs and recommend that, once finalized, they also be included as required quality measures that must be publicly reported.

4. Accurate risk-adjustment must be in place to ensure unbiased patient selection for joint replacement surgery.

We are concerned with how the proposed CCJR payment model will influence the selection of candidates for joint replacement surgery. Without extremely accurate risk adjustment, hospitals will have an incentive to avoid higher-risk candidates for surgery *and* to convince lower-risk candidates to undergo invasive inpatient surgeries. We have serious concerns about moving forward with a mandatory bundling model that is not accompanied by a highly accurate risk adjustment methodology.

We are supportive of CMS's proposal to exclude certain populations from the CCJR bundles – such as individuals with end stage renal disease (§ 510.205). However, we believe CMS should consider excluding additional populations. We encourage CMS to consider the comments of the Coalition to Preserve Rehabilitation, which references "patients with brain injuries, spinal cord injuries, multiple-limb trauma, amputations, moderate to severe strokes, severe neuromuscular and musculoskeletal conditions, and similarly serious conditions" as populations to be excluded from the CCJR model. We recommend that in the initial iterations of this demonstration, CMS should err heavily on the side of excluding populations that may have complicated or intensive care needs.

5. The duration of the 90-day episode must be maintained.

The National Partnership supports the 90-day episode duration established in § 510.210(a). We believe that a shorter duration could put beneficiary care at risk by encouraging

providers to reduce utilization inappropriately or to shift utilization outside of the episode. We also urge CMS to develop a plan to review care that is provided close to the end of the episode window, in order to have sufficient data for identifying whether needed care is being inappropriately delayed. Unusually high utilization closely following the end of the episode window could signal clear delays in needed care.

Additionally, with respect to § 510.210(b), which describes the possible reasons an episode may be canceled, we are concerned that there are no explicit financial protections for beneficiaries if an episode is later nullified. We urge CMS to hold beneficiaries and providers financially harmless for care received as part of a CCJR bundle – in all settings and in all circumstances – if the episode is later canceled or nullified. We recommend adding explicit language to this section that specifies that, should an episode later be canceled or nullified, resulting costs cannot be shifted to beneficiaries.

6. CMS must ensure that beneficiaries have prompt access to all needed services.

To protect against hospitals stinting on care or seeking to avoid utilization of more expensive services during the episode window, we encourage CMS to develop clear requirements for hospital and collaborating providers regarding provision of information about treatment options and providers. Hospitals should be required to document conversations with patients and family caregivers about all treatment options available to the beneficiary, and these conversations should be on record. We likewise urge CMS to implement a "second opinion" process whereby a concerned consumer can seek an independent medical opinion concerning a post-acute care plan.

Furthermore, CMS should develop a process for identifying where and when stinting on care occurs. We applaud CMS for articulating this concern in § 510.500(d)(8), but we believe the issue warrants greater attention, given that stinting on care may be the greatest threat to consumers in a bundling model. We urge CMS to develop a clear and specific plan for monitoring and enforcing § 510.500(d)(8) and for ensuring that consumers receive the most appropriate care, in the most appropriate setting, at the most appropriate time. The general enforcement authority at § 510.410, for example, should be strengthened to include a financial penalty for stinting on care. The penalty should be sufficient to act as a disincentive for stinting.

Finally, we refer you to the comments of the Coalition to Preserve Rehabilitation (CPR), which recommends exclusion from the bundle for services such as prosthetic limbs, orthopedic braces, and customized durable medical equipment, which are not widely needed, but are critical for some beneficiaries and may be at risk of non-provision due to cost – a risk with historical precedent, as explained in CPR's letter.

7. Additional Recommendations

Waiver of the 3-day SNF rule

We support the requirement that, under the waiver of the 3-day SNF rule, beneficiaries can only be discharged to a SNF that is rated an overall of 3 stars or better in the Five-Star Quality Rating System for SNFs. However, we urge CMS to make clear that, with waiver of the 3-day SNF rule, beneficiaries must be provided with quality and cost information for all available SNFs, including those not participating as CCJR collaborators with the hospital. CMS should require CCJR-participating hospitals to disclose their financial relationships with collaborating SNFs to beneficiaries, to inform beneficiaries of their rights and the full scope of SNF providers/facilities available to them, and to respect beneficiary choice. We reiterate our recommendation that the beneficiary must be held financially harmless if the 3-day SNF rule is waived, but the CCJR episode is later canceled or nullified.

Opportunities for learning and diffusion

We encourage CMS to establish and support infrastructure for sharing of best practices among facilities and providers. CMS should establish and facilitate collaboration among CCJR participants through conference calls, webinars, and a formal shared learning network. We recommend that this include operations staff and clinical representatives to encourage the sharing of best practices across the continuum of care.

Conclusion

Thank you for this opportunity to submit comments on the proposed rule the Comprehensive Care for Joint Replacement Payment Model for Acute Care Hospitals Furnishing Lower Extremity Joint Replacement Services (CMS-5516-P). If you have any questions about our comments and recommendations, please contact Lauren Birchfield Kennedy, Director of Health Policy, at lkennedy@nationalpartnership.org or (202) 986-2600.