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September 8, 2015

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

RE: CMS-5516-P - Medicare Program; Comprehensive Care for Joint Replacement Payment Model for Acute Care Hospitals Furnishing Lower Extremity Joint Replacement Services; Federal Register Vol. 80, No. 134, p. 41198 (July 14, 2015).

Submitted electronically via www.regulations.gov

Dear Mr. Slavitt:

UnityPoint Health ("UPH") is pleased to provide the following comments in response to the Centers for Medicare & Medicaid Services' (CMS) Comprehensive Care for Joint Replacement Payment Model for Acute Care Hospitals Furnishing Lower Extremity Joint Replacement Services (CCJR) proposed rule. UPH is one of the nation's most integrated healthcare systems. Through more than 30,000 employees and our relationships with more than 290 physician clinics, 32 hospitals in metropolitan and rural communities and home care services throughout our 9 regions, UPH provides care throughout Iowa, Illinois and Wisconsin. On an annual basis, UPH hospitals, clinics and home health provides a full range of coordinated care to patients and families through more than 4.5 million patient visits. In addition, UPH is committed to payment reform and is actively engaged in numerous initiatives which support population health and value-based care.

Meriter-UnityPoint Health, an affiliate of UnityPoint Health located in South Central Wisconsin, has been part of the Bundled Payments for Care Improvement (BPCI) Initiative Model 2 since January 2014. Specifically, Meriter's BPCI project has targeted lower joint replacements and has served more than 350 beneficiaries. The BPCI project uses standardized tools and enhanced care coordination to improve quality and outcomes. When comparing DRG 470 (major joint replacement or reattachment of the lower extremity without MCC) from 2013 (pre-BPCI) to 2014 (BPCI implementation); Meriter lowered length of stay, decreased 90-day readmission rates, decreased discharges to Skilled Nursing Facilities, and reduced related spending.

As an integrated healthcare system, we believe that patient-centered care is best supported by a value-based payment structure that enables healthcare providers to focus on population health instead of episodic care. The CCJR is one of several CMS initiatives that encourage the transformation of health care to a value-based care delivery system. UnityPoint Health appreciates the time and effort spent by CMS in developing this bundled payment model. We respectfully offer the following comments to the proposed CCJR regulatory framework.

Proposed Definition of the Episode Initiator:

Under the Comprehensive Care for Joint Replacement (CCJR) model, hospitals are proposed as the episode initiator. In addition, hospitals are also proposed to bear the financial risk for the episode of care. The selection of hospitals to be financially responsible is premised on CMS' belief that hospitals are more likely to have resources to appropriately coordinate and manage care throughout the episode, and that key model attributes are currently performed by hospital staff, such as discharge planning and post-acute care recommendations for recovery, key dimensions of high quality and efficient care for the episode.

- *Comment:* UPH agrees that the episode initiator should be the hospital instead of physician group practices. This is consistent with the episode being triggered by admission to an acute care hospital stay. In terms of financial responsibility, we urge CMS reconsider its proposal to make hospitals solely responsible for making any repayment under the model. While hospitals are a common thread in all episodes, selected hospitals are not voluntarily participating nor do selected hospitals possess similar infrastructure or capacity to bear risk. During the care episode, ideal care and successful care coordination involve multiple providers across the care continuum, and quality standards imposed to receive Net Payment Reconciliation Amount (NPRA) payments are highly dependent on post-acute providers. We believe that CMS should affirmatively distribute program risk across all providers within the episode of care and not delegate that function to the hospital. Shared risk would motivate all parties to collaborate regardless of NPRA outcomes. Thus, we request that the CCJR Model be revised so that any provider that impacts patient's care should be able to gain from the Model and also bear proportional responsibility of any financial risk.

Episode Definition:

The CCJR model covers a "90-day post-discharge" episode. These episodes begin with admission to an acute care hospital for an Lower Extremity Joint Replacement procedure that is paid under the IPPS through MS–DRG 469 (Major joint replacement or reattachment of lower extremity with MCC) or MS-DRG 470 (Major joint replacement or reattachment of lower extremity without MCC) and end 90 days after the date of discharge from the hospital. The 90-day post-discharge episode would include the joint replacement procedure, accompanying inpatient stay, and other Medicare Part A or Part B services, include hospitalizations, post-acute care and provider services.

- *Comment*: We agree that a 90-day period is appropriate, although most costs are incurred during the first 30 days. While we generally agree with the list of CCRJ "included services," we would recommend that both inpatient psychiatric facility (IPF) services and hospice services be removed from this list as not be related to or resulting from the joint replacement procedure. The exclusion of both services would be consistent with their treatment under the BPCI model.

Performance Years, Retrospective Episode Payment and Two-Sided Risk Model:

The CCJR model is proposed to begin January 1, 2016, for a five-year period. Under this proposal, all providers and suppliers caring for Medicare beneficiaries in CCJR episodes would continue to bill and be paid as usual under the applicable Medicare payment system. After the completion of a CCJR

performance year, the potential for hospitals to receive reconciliation payments or to be responsible for repayment is calculated retrospectively. CMS also proposes to establish a two-sided risk model for hospitals participating in the CCJR model, with responsibility for repayment of excess episode spending to begin in performance year 2.

- *Comment*: We understand that current BPCI Model 2 participants within selected CCJR markets will be able to continue with the BPCI program for the remainder of that program. Upon the termination of the original BPCI project period, it is unclear whether participants will be given the opportunity to continue in the BPCI program (should it be extended) or if participation in the CCJR will be mandated. We would urge CMS to institute one model in these market areas to avoid confusion among beneficiaries and providers. Should BPCI Model 2 participants transition into the CCJR model, we would request that CMS consider allowing these "new" CCJR participants to begin using CCJR performance year 1 requirements.

  UPH supports the application of retrospective episode payment methodology. While CMS proposes to begin downside risk repayment in year 2, we would respectfully request to delay this repayment obligation for excess episode spending in performance year 3.

Adjustments to Payments Included in Episode:

The CCJR Model contains three adjustments to payment: (1) special payment provisions under existing Medicare payment systems; (2) payment for services that straddle the end of the episode; and (3) high payment episodes. There are further adjustments to account for overlaps with other Innovation Center models and CMS programs. In addition, for Medicare payment systems that have special payment provisions created to improve quality and efficiency in service delivery, such as DSH and IME, the CCJR treats hospital performance and potential reconciliation payment or Medicare repayment as independent of, and not impacting, these other special payment provisions.

- *Comment*: UPH is committed to payment reform and is actively engaged in numerous initiatives which support population health and value-based care. Such initiatives have included the BPCI Model, Pioneer ACO Model, the MSSP ACO Model, the PACE program, and Medicare Care Choices Model. UPH applauds CMS for allowing participants to be involved in multiple initiatives and for developing framework to avoid confounding impacts. We also support CMS in its decision to treat Medicare special payment provision separately, such as DSH and IME.

Proposed Episode Price Setting Methodology:

The CCJR Model proposes to calculate and communicate episode target prices to each participating hospital prior to the performance period. Features of the price setting methodology incorporate differentiated pricing for patient and clinical variations, 3-year historic payment data sets, national trending, transition of hospital-specific to regional pricing, and a discount factor.

- *Comment:* The importance of providing defined targets prior the performance period cannot be understated and UPH supports this approach. Without preset targets, it is difficult to plan and forecast financial outcomes. Likewise, we agree with the Model's use of national trending of historical data to set the target price. This feature promotes and recognizes high quality service delivery and seeks to eliminate regional variation. To further promote and recognize quality, we generally support pricing that uses larger data sets. As presently proposed in the CCJR, pricing transitions from a blend of primarily provider-specific pricing to completely regional pricing. The proposed transitional methodology may motivate poor performers during the startup; however, good performers with efficient process and decreased spending have much less wiggle room for improvement. We recommend that hospitals be permitted to immediately jump to regional pricing instead of hospital-specific pricing to incentivize high-value programming.

Proposed Implementation of Quality Measures for Reconciliation Payment Eligibility:

In this Model, quality performance standards are tied to the ability to earn a reconciliation payment if actual episode spending is less than the target price. The specific quality measures are readmission rates, complication rates and the HCAHPS survey. There is also a payment adjustment for successful voluntary submission of data for patient-reported outcome measure in development.

- *Comment*: Bundled payments require careful construction of processes and care coordination across the episode to achieve efficiencies and cost savings. It is vital that quality benchmarks for the duration of the program are transparent prior to the start of the program and do not change in midstream.

  We also seek clarification on the proposed readmissions measure. As noted, this measure is included within the Hospital Readmission Reduction Program (HRRP). We are unclear on the interplay of the CCJR and HRRP, with the intent of avoiding double counting these readmissions and their subsequent duplication in either savings or penalty calculations. We assume that readmissions for lower extremity joint replacements counted within the CCJR measure will be excluded from the HRRP readmission rate calculation. We also note that proposed readmissions and complications measures are based on a three-year rolling performance period. While we understand that this performance period is utilized in the Hospital Inpatient Quality Reporting program and the HRRP, we believe a one-year period would be more appropriate for CCJR. This request is based on the sheer size, or lack thereof, of the CCJR compared to the referenced all-cause inpatient programs. For example, the number of readmissions is more impactful for a CCJR caseload of 150 than when factored into all inpatient admissions totaling 15,000. When a three-year performance period is used for programs with small caseloads, one project year with high readmissions such as 2012 may adversely impact a total of three project years (2012, 2013 and 2014) because the performance periods would each contain 2012 results. We believe this lag effect subjects hospitals to undue hardship, when other project years do not exceed expected readmissions. We urge CMS to consider reducing the three-year performance period to one year for these measures.

Proposed Adjustments for Program Overlaps:

This CCJR Model provides guidance as to overlap with various Medicare payment reform models. For current BPCI Model 2 hospitals who are episode initiators, these hospitals are excluded from the CCJR Model for the duration of the BPCI program. For scenarios of overlap of CCJR beneficiaries with any BPCI Lower Extremity Joint Replacement episodes, the BPCI episode would take precedence and cancel the CCJR episode. For Medicare ACO Models, CCJR will make a single aggregate reconciliation payment or repayment determination for all episodes in a single year.

- *Comment*: We are supportive of provisions to avoid program overlap during payment reconciliation.

Proposals to Limit or Adjust Hospital Financial Responsibility:

To limit a hospital's overall repayment responsibility for the raw NPRA contribution to the repayment amount, CCJR includes a 10% stop-loss limit in performance year 2 and a 20% limit in performance year 3 and subsequent years.

- *Comment:* We would request that the stop-loss limit be set at 10% of all performance years and, should risk-bearing be expanded to all episode providers, that the stop-loss limit be applied to all entities bearing risk.

Proposed Appeals Process:

For the CCJR Model, a two-step appeal process for payment matters is proposed: (1) calculation error form and (2) reconsideration review.

- *Comment:* We agree that there should be an appeal process. UPH would suggest that the process be user friendly – abbreviated and with ease of access. In our view, the BPCI appeals process is unnecessarily time consuming and complicated due to CMS technical and workflow requirements. Moreover, recalculations of NPRI (true-ups) are not supported with detailed data.

Proposed Financial Arrangements, Beneficiary Incentives, and Proposed Program Rule Waivers:

CCJR is a retrospective episode payment model, under which Medicare payments for services included in an episode of care would continue to be made to all providers and suppliers under the existing payment systems, and episode payment would be based on later reconciliation of episode actual spending under those Medicare payment systems to the episode target price. CMS opines that CCJR hospitals may wish to enter into complimentary financial arrangements with providers and suppliers caring for beneficiaries in CCJR episodes in order to align the financial incentives with Model goals. CCJR also allows targeted beneficiary incentives similar to other CMS programs. The need for and authorization of fraud and abuse waivers will be dependent upon CCJR provisions as finally adopted and promulgated.

- *Comment:* In the BPCI Model 2, we are only allowed to include "positive" NPRA in incentive calculations. If the NPRA is negative, incentives are not impacted and physicians are still paid from internal savings. We would recommend that CCJR include a claw back provision in case of negative NPRA. The CCJR also permits hospitals who are episode initiators to establish financial arrangements in support of the Model, such as gainsharing agreement. We would like to echo the following comments made by MedPAC in its comment letter addressing this Model dated August 19, 2015:
  - CCJR collaborators may not reduce or limit medically necessary services to any beneficiary and physicians must continue to select the devices, supplies and treatments that are in the best interest of the patients.
  - Gainsharing payments can only be made for lowering hospital costs or full episode costs below the target price. Gainsharing payments cannot directly account for the volume or value of physician referrals.
  - The hospital must, in advance, create an accounting formula for estimating the internal hospital cost savings gained from redesigning care with their CCJR partners. After the year is completed, the formula would be used to estimate the savings.
  - Each physician's gainsharing payment would be limited to 50 percent of the sum of the total Medicare payment amounts under the Physician Fee Schedule for the physician's patients in the CCJR episodes.

  We believe that the above parameters establish a minimum foundation by which hospitals can negotiate complimentary financial arrangements.

  We support the ability to provide beneficiary incentives tied to quality, but believe these will be underutilized in a bundled environment until bundled payment quality and financial targets are clear and providers become more experienced with this environment and their capacity to meet outcomes. We also encourage CMS to consider the wavier of any coinsurance and/or deductibles related to relevant follow-up care across providers and settings during the bundled episode of care.

  In terms of the need for fraud and abuse waivers, we urge CMS and OIG to specifically address the application of waivers to the CCJR Model. The Stark law was established to provide protections in a Fee-For-Service setting. As healthcare providers continue to assume more risk and transition toward value-based payments, providers who seek to participate in these Alternative Payment Models need to know their efforts will not result in violations of the Stark law. We would advocate that where

providers are participating in innovative payment models that assume financial risk and contain appropriate quality measures a broad Stark exception should be created.

Proposed Waivers of Medicare Program Rules:

The CCJR model contains waivers to support provider and supplier efforts to increase quality and decrease episode spending. Proposed waivers include post-discharge home visits, billing and payment for telehealth services, SNF 3-day rule, and waivers of Medicare program rules to allow reconciliation payment or recoupment actions. These CCJR waivers are similar to other CMS program waivers.

- *Comment:* UPH enthusiastically supports these programmatic waivers. Several of these waivers have been used successfully by our affiliated Pioneer Model ACO to achieve two years of savings.

Possible New Outcomes for Future Measures:

CMS proposed to use the CCJR Model as a conduit to collect voluntary patient-reported data about functional status both pre- and post-operatively. The purpose of the data collection is to further the development of a functional status measure to assess improvement in patient-reported outcomes following THA/TKA procedures.

- *Comment:* We are supportive of the concept to improve functional assessment processes. It would be ideal if one "gold standard" tool could be designated. Within UPH, we do not currently use one standardized tool across our nine regions. When developing this evidence-based tool, UPH would request that the result be a tool that is easily administered, have a small and targeted number of questions, and is open software to avoid costs relative to its purchase and maintenance. We would also express our concern about the ability to collect data throughout the full episode. While we applaud this goal to be comprehensive, the ability to collect patient outcomes over time may have both practical and administrative barriers that will need to be overcome to receive a complete data set for individual patients.

Data Sharing:

Under this Model, baseline claims data will be available to CCJR hospitals. An initial data feed with occur within 60 days of CMS' receipt of the request by a participant hospital, and updates will occur on a quarterly basis. Beneficiaries may choose to opt-out of claims data sharing. If beneficiaries opt-out, participant hospitals do not receive claims data on those beneficiaries.

- *Comment*: UPH recommends providing baseline data automatically to CCJR upon acceptance in the program. Based on our experience participating in BPCI, claims data has been utilized to monitor trends and pinpoint areas where care practice improvement are appropriate, as well as assess the cost drivers during the acute and post-acute periods of the episode. Ideally, UPH would welcome receiving data on a more frequent basis – monthly after the initial baseline period. In regards to the provision of both aggregate and beneficiary identifiable data to participant hospitals, we recommend that the Model be modified to adapt the BPCI process of data sharing. In the BPCI Model, beneficiaries cannot opt out of having their data shared, data is provided prior to go-live, and claims are updated monthly. In addition, BPCI Model distributes reconciliation performance reports quarterly and retrospectively six months following the end of the quarter. We have found the quarterly reconciliation reports drive quality and service delivery. These reports present opportunities for physicians and hospital leadership to come together to assess episode data and program outcomes for continuous quality improvement.

We appreciate the opportunity to provide comments to the proposed rule for Comprehensive Care for Joint Replacement Payment Model for Acute Care Hospitals Furnishing Lower Extremity Joint Replacement Services. To discuss our comments or for additional information on any of the addressed topics, please contact Sabra Rosener, Vice President and Government Relations Officer, Public Policy and Government Payors at sabra.rosener@unitypoint.org or 515-205-1206.

Sincerely,

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