



September 8, 2015

Andrew Slavitt
Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-5516-P
P.O. Box 8013
Baltimore, MD 21244-1850

File Code: CMS-5516-P

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

Dear Mr. Slavitt:

The Healthcare Financial Management Association (HFMA) would like to thank the Centers for Medicare & Medicaid Services (CMS) for the opportunity to comment on the CMS's Comprehensive Care for Joint Replacement (CCJR) Payment Model for Acute Care Hospitals Furnishing Lower Extremity Joint Replacement (LEJR) Services proposed rule (hereafter referred to as the Proposed Rule) published in the July 14, 2015 *Federal Register*.

HFMA is a professional organization of more than 40,000 individuals involved in various aspects of healthcare financial management. HFMA is committed to helping its members improve the management of and compliance with the numerous rules and regulations that govern the industry.

Introduction

HFMA fully supports CMS's goal of transitioning 50 percent of Medicare fee-for-service (FFS) payments to value-based arrangements (such as the payment model proposed in the CCJR rule) by the end of 2018. Over last five years, HFMA has invested significant resources in our Value Project in an effort to help our members and the industry at large prepare for the transition to value-based payments as envisioned by CMS. In addition to these efforts, we have collaborated with our members to submit comment letters proactively suggesting improvements to the Bundled Payment for Care Improvement (BPCI) model and most recently in response to CMS's request for information in the 2016 Inpatient Prospective Payment System (IPPS) proposed rule (links included below).

HFMA would like to commend CMS for its detailed discussion of its choices in designing the CCJR model. As an organization, HFMA supports the concept of bundled or episodic payments. However, the CCJR proposed rule causes us concern on two levels.

At the conceptual level, we are concerned the CCJR proposal may signal CMS's intent to limit its episodic payment efforts to hospitals moving forward. We ask CMS to clarify its intent. If CMS's intent is to limit

responsibility for an episode of care to one provider type, we strongly request that CMS reconsider its approach. HFMA believes, as we commented in response to CMS's request for feedback on the BPCI program in the FY 2016 IPPS Proposed Rule, there is insufficient data from the BPCI program to foreclose experimentation with episodic payment models. HFMA believes that CMS should, in parallel to CCJR, allow for additional cohorts¹ of the BPCI program and/or similar episodic payment models that incorporate other care settings as risk bearing entities (e.g. Ambulatory Surgery Centers once hip and knee replacements are removed from the "inpatient only" list).

At the level of the proposed rule, CCJR contains the same design flaws as BPCI (that we have discussed in prior comment letters) that shift insurance risk (not just execution risk) to providers, fails to provide adequate waivers for gain/risk sharing arrangements, fails to share savings generated for the program with beneficiaries, and provides inadequate data to hospitals so they can re-engineer care so that it is delivered more efficiently. **If CMS elects to move forward with the CCJR as a mandatory model for any group of providers CMS needs to fully address each of the issues described below in their entirety before exposing hospitals to downside risk.**

1. Premature Start Date
2. Inadequate Data Sharing
3. Target Price Setting
4. Use of Regional Data to Set Target Prices
5. Discount Factor
6. Post Acute Monitoring Period
7. Transitioning to Risk
8. Lack of Minimum Volume Threshold
9. Lack of Sufficient Condition Exclusions
10. Lack of Sufficient Risk Adjustment
11. Quality
12. Insufficient Waivers
13. Insufficient Timeframe for Appeals Process
14. Alignment with Ongoing State Efforts
15. Administrative Burden
16. Proposed Financial Arrangements

Premature Start Date:

CMS proposes to start the CCJR model on January 1, 2016. HFMA notes that this will be just three months after CMS transitions to ICD-10. On page 41292 of the proposed rule in the discussion of the Timing and Period of Baseline Data, CMS proposes to make baseline data available to hospitals participating in the CCJR *no sooner than 60 days after January 1, 2016* (emphasis added). It is clear from this statement that neither CMS nor its contractors are ready to execute this model.

Given delays that providers have experienced in receiving complete, accurate data from CMS in other alternative/accountable payment models, HFMA is concerned that it will likely be at least four to six months before all hospitals receive the data necessary to succeed under a risk-bearing model. Once

¹ Assuming CMS incorporates a minimum volume threshold as discussed later in the comment letter that accounts for BPCI cases.

hospitals have the data, the majority will need to use consulting resources to link the files together and analyze them as most hospitals do not have the sophisticated analytic capabilities to perform this work. This adds two to four months to complete the necessary analysis to understand where there is systematic, unwarranted variability in care pathways and identify key physician groups and post-acute organizations to partner with in order to coordinate care. As one of our members succinctly put it, “Until you have the data and can analyze it, you don’t know where your opportunities are, and you don’t know who to partner with.” Additionally, if a hospital wants to develop gain/risk sharing arrangements with these organizations, given the complexity of the regulatory framework CMS has outlined, it will take an additional two to three months to finalize these agreements.

The first year of the program is upside only. However, given the time required to identify opportunities to improve care delivery and organize its network of “CCJR collaborators,” it is very likely that most hospitals will begin the second performance period (which begins phasing in downside risk) with only limited work towards restructuring care completed. As CMS is well aware, from both BPCI and the Medicare Shared Savings Program (MSSP) program, even after care pathways are redefined and targeted interventions installed, it can still take many months for them to yield significant improvements in quality and reductions in the overall cost of care delivery. If CMS insists on beginning the program without allowing hospitals sufficient time to analyze the data and organize their delivery network, any reconciliation payments made in year one will likely be the result of random outcomes, not efforts to improve the delivery of care.

HFMA strongly believes that any entity bearing risk should have all of the data necessary to succeed in a risk bearing model at least 12 months prior to the start of a performance period (even if that performance period is upside only). This is especially true if it is a mandated model that includes downside risk. If CMS elects to move forward with CCRJ (as either a mandatory or voluntary program) **HFMA believes that the first performance period should start no sooner than 12 months after the end of the quarter in which the hospital receives the final data files (complete, accurate, ect). We would encourage CMS to replicate the model used for BPCI Cohort 2 where participants could choose from two, six, or eight months post data to begin bearing risk.** HFMA strongly supports the use of a phased approach similar to BPCI Cohort 2, however we would extend the non-risk bearing window to, four, eight, or twelve months given that most of the CCJR hospitals are not as prepared to take risk as the BPCI participants. We would encourage CMS to pair such a model with positive financial incentives that reward hospitals for moving into the risk-bearing phase sooner rather than later. Further, allowing a “phase I” as described above will allow CMS and hospitals sufficient time to address any issues that develop as a result of the completed implementation of ICD-10.

Data sharing:

Beyond the issue of timing (as discussed above), HFMA has significant concerns regarding CMS’s proposals related to data sharing.

First, CMS states in the proposed rule that:

“...we also expect that CCJR hospitals are able to, or will work toward, independently identifying and producing their own data, through electronic health records, health information exchanges, or other means that they believe are necessary to best evaluate the health needs of their

patients, improve health outcomes, and produce efficiencies in the provision and use of services.”

CMS is correct that hospitals are developing the ability to produce their own data through various means. However, hospitals are unable to produce an accurate longitudinal data file to manage Medicare beneficiaries across the care continuum today, due to both the specific design of the CCJR model and broader healthcare policy decisions. Until the issues discussed below are resolved, it is unlikely that hospitals will be able to “self-source” the data necessary to take responsibility for either episode or population level outcomes for more than a small subset of their patients.

- One of the other challenges facing hospitals (and this extends beyond health IT) is that the CCJR (along with all other accountable payment models in the Medicare FFS program) is based on an “open network” design. Beneficiaries can receive any component of their care from any provider, regardless of whether they are partnering with the hospital. Under the current open network model, bundle participants will need access to an operational regional health information exchange (HIE) to have a clear, real-time picture of the services provided to a patient whose episode of care is attributed to the hospital. However CMS’s assumption that HIEs can provide a solution to data is overly optimistic. First, it ignores the reality that many regional HIEs are a long way from being able to share complete information on all of the patients in a regional in real-time. Second, it assumes that data from post-acute providers will be available in HIEs. However, that assumption is unrealistic.
- Post-acute care providers are not eligible for Health Information Technology for Economic and Clinical Health (HITECH) funding (or subject to the related penalties for non-adoption), if they implemented and used of Electronic Health Records. This omission has left a significant gap in the care continuum in terms of readily accessible patient information once patients move to a post-acute setting. Given that most of the variability in the cost of an episode beyond discharge is driven by post-acute care spending, this is a significant blind spot.

For the reasons above, we fully support CMS’s decision to provide claims level data for qualifying LEJR episodes. Further, even after the issues above are resolved, we ask that hospitals continue to have the option of receiving the data necessary to participate in accountable/alternative payment models directly from CMS or its contractors. We would also ask that CMS and its contractors work to improve the quality of the data it provides CCJR (and BPCI participants). We continue to hear from our members the multiple Public Use Files (PUFs) they receive are unwieldy to work with, frequently riddled with errors, and are not delivered in a timely manner.

Second, CMS proposes to provide hospitals claims data on a quarterly basis upon request. This is unlike the BPCI program (which is voluntary) where participating providers receive a monthly data feed from CMS. **HFMA strongly believes that CMS should automatically provide all of the data necessary to manage outcomes risk in a timely fashion to participants in any accountable/alternative payment model.** Requiring participants to continually request the data is administratively burdensome and will increase costs without improving quality or patient outcomes.

Third, CMS proposes to exclude individually identifiable data related to substance abuse from claims files as it currently does in other programs. This information is key for hospitals to understand the full

risk associated with patients and identify appropriate care management. While we understand the sensitivity of such services and CMS's exclusion of them in the files, we think there are options that would provide risk bearing entities with more information, while not risking beneficiary privacy by suppressing identifiable elements. **Given that hospitals are now forced to bear risk for these patients, HFMA believes that CMS at a minimum must provide the de-identified cost and claim data for these services. If CMS is unwilling to do this, we believe hospitals should not be forced to bear risk for these cases. Additionally, we strongly encourage Center for Medicare and Medicaid Innovation (CMMI) to use its waiver authority to make beneficiary specific claims level substance abuse information available to hospitals. If CMS does not believe it has sufficient authority, it must work with Congress to create an exception to 42 CFR part 2 to provide claims level, identifiable data.**

Fourth, CMS proposes allowing beneficiaries to opt out of having their data shared with hospitals by calling 1-800-Medicare. HFMA appreciates CMS's efforts to simplify the opt out process. However, allowing beneficiaries to opt out will leave hospitals "flying blind" in their attempt to manage a LEJR episode. While hospitals will have data for the acute portion of the anchor admission they will not have the post acute or readmissions data, which is where most unjustified variation (that hospitals must control to be successful) in utilization occurs. Further, in other programs like the Hospital Readmissions Reduction Program (HRRP) where beneficiaries can't opt out of the program also does not provide beneficiaries the option of removing their data from the Quality Net files shared with the responsible hospital. **HFMA fails to see where the CCJR is conceptually different from the HRRP and therefore believes that hospitals should receive data for all included beneficiaries.**

Fifth, HFMA continues to hear from its members participating in BPCI that CMMI's contractors regularly struggle to provide them with the data files necessary to manage the program. These files are frequently received later than promised and include significant errors further delaying analysis and results calculation.

CMS needs to institute and enforce service level agreements (SLA) with its contractors that dictate acceptable timeframes in which to provide CCJR participants with accurate, complete data files. If the contractor fails to meet the terms specified in the SLA, it should be materially penalized. Further, CMS needs to create a CCJR ombudsman who will serve as the conduit for complaints from providers regarding data. The ombudsman will be responsible for determining whether the contractor is in violation of the SLA and subject to penalty.

Target Price:

CMS proposes to communicate target prices to providers in advance of the performance period for which the price applies. Target prices will be set initially using a blend of hospital specific and regional data. The blend transitions over a five year period to a benchmark based on regional data only. Unlike the BPCI program, where the data used to calculate the target price is taken from a fixed baseline period and trended forward, CMS proposes to "rebase" the target price using more recent data prior to the start of performance years three (2018) and five (2020). Any savings achieved in prior performance years will not be added back to the target pricing during rebasing. In the years between rebasing, CMS states that it will trend the baseline data forward to the current year using a national trend factor in a process similar to BPCI. CMS also proposes to apply a "discount factor" to the target price in order to lock in savings for the program.

HFMA believes that CMS needs to make the following changes related to setting the target price before it makes the CCJR program mandatory.

Prospectively Communicated Target Prices: HFMA strongly supports the use of a prospectively set target price. We fully agree with CMS the price should be communicated well in advance of the performance period to which the price applies. A stable, prospectively set target price is accepted practice in commercial bundling arrangements. CMMI is also implementing a similar conceptual model in the “Next Generation” ACO program in response to criticisms about the benchmark in the Pioneer program. **As such, we ask that CMS communicate the final applicable target price to CCJR participants 90 days prior to the beginning of the performance period. Further, HFMA believes that any changes in the composition of BPCI participants in a market that would impact assignment of cases based on precedence rules should not be incorporated once the target price is communicated.**

Under BPCI, CMMI recalculates the target price in the initial and subsequent reconciliation periods. This was not communicated to participants prior to the start of the program as they were under the impression that the target price CMMI communicated to them at the beginning of the performance period would be the final target price used for all reconciliations. Further, CMMI initially stated that the target price would be trended forward based on state experience.

Currently, under BPCI, the target price changes based on precedence rules and adjustment of national trend factors. Given that this can occur through several reconciliation periods, the actual target price is unknown for up to a year after the conclusion of an episode. While the quarter-over-quarter change is capped at plus or minus 3.5 percent, CMMI’s approach to the target price is detrimental to participants for the following reasons:

- A shifting benchmark makes it difficult to focus on changes that will reduce episode spending when the baseline fluctuates without sufficient explanation as to why it changed. These random fluctuations can have a de-motivating impact on individuals involved in care process redesign.
- The reasons for the changes in the benchmark appear to be random within episodes, making it exceedingly difficult to communicate the reasons for the change to participating physicians. This strains the relationship between collaborating organizations. The risk of this occurring is exacerbated for participants who have gain-sharing agreements with physicians and other providers.

The CCJR rule does not discuss changing the benchmark or updating it at the two different reconciliation periods. However, BPCI participants were not made aware of these ongoing changes to the benchmark until after the program began. **HFMA fully supports the use of a prospectively set target price and asks that CMS confirm in the final rule that the target price for a performance period will not be updated once the performance period starts.**

Use of Regional Data to Set Target Prices: For a specific discussion of HFMA’s concerns and recommendations, please see the section below.

Rebasing the Target Price in Prior to Performance Years 3 (2018) and 5 (2020): The proposed rule states CMS will rebase the target price in subsequent performance years. The table below provides CMS’s proposed schedule for rebasing and the time-period that will be used to set the target price.

Proposed Performance Year and Related Dates of Service for Baseline Claims Data

Performance Year	Time Period for Target Price Data
PY 1 (2016) & PY 2 (2017)	CCJR Claims from Jan. 1, 2012 and Dec. 31, 2014
PY 3 (2018) & PY 4 (2019)	CCJR Claims from Jan. 1, 2014 and Dec. 31, 2016
PY 5 (2020)	CCJR Claims from Jan. 1, 2016 and Dec. 31, 2018

As discussed below further in the section related to the discount factor, HFMA believes it is highly inappropriate for CMS to lock in savings using a discount factor and then continually rebase claims so as to prevent hospitals from receiving a return on their investments in process re-engineering and care coordination. This is particularly true in performance year five when the data used to set the target price will be from a prior CCJR performance period. HFMA believes that, if CMS insists on rebasing the benchmark, it should:

- 1) Not apply a discount factor to the target price.
- 2) Only rebase the target price once after year three similar to what is done in the MSSP.

Adjusting the Benchmark for Prior Period Reconciliation Payments from CMS: If CMS insists on rebasing the benchmark based on data from a performance period as proposed for year five, HFMA urges CMS to add prior reconciliation payments to hospitals for the effected periods to the target price. Failing to do so places hospitals that are able to significantly improve the efficiency of care delivery in prior performance periods at a disadvantage. CMS acknowledged this in the MSSP when, in the recent final rule, it altered the target price calculation by adding back shared savings payments.

Use of Regional Data to Set Target Prices:

CMS proposes to use regional data to set target prices. In years 2016 and 2017, the target price would be a blend of one-third regional episode data, two-thirds hospital-specific data. In 2018, the target price would be a blend of two-thirds regional data, one-third hospital specific. And target prices in years 2019 and 2020 would be based entirely on regional data. At each of these intervals CMS proposes to rebase the target price using more recent data.

HFMA long-term supports the use of regional data as it rewards relatively efficient providers. While we generally support CMS’s phased-in approach to allow relatively high cost providers an opportunity to improve before comparing them to a regional benchmark, we believe the phase-in period needs to be longer. As discussed above, it takes time for care coordination and process redesign efforts to bear fruit. HFMA believes the blending period needs to be longer. **Further (as discussed above) HFMA does not support rebasing the target price using more recent data. As such, we recommend that CMS use a blend of both hospital-specific and regional data from CCJR Claims from Jan. 1, 2012 and Dec. 31, 2014 and trend the data forward. The blend of source data in the target price should progress as follows:**

- PY 1: 100 percent hospital specific
- PYs 2 & 3: 66.66 percent hospital-specific, 33.34 percent regional
- PYs 4 & 5: 33.34 hospital-specific, 66.66 percent regional

Discount factor:

CMS proposes to apply a two percent discount factor to the target price in all five years for purposes of calculating “reconciliation payments” to providers. In year two, it proposes to apply a one percent discount factor to the target price for purposes of calculating a hospital’s responsibility for excess episode spending. The discount increases to two percent in years three through five for calculating a hospital’s excess spending relative to the target price.

CMS, if it elects to rebase the benchmark after years two and four using more recent data as proposed, will achieve significant savings as a result of efficiencies generated through hospitals working with other providers to re-engineer care. In the BPCI and Acute Care Episode (ACE) programs CMS/CMMI has justified the applicable discount by asserting that highly coordinated care should create efficiencies. However, in CCJR, CMS will reap its share of the savings related to more efficient care delivery as it rebases the benchmark. This avenue for savings is not available in BPCI as CMS trends the target price forward on a quarterly basis.

Applying a two percent discount on top of realizing savings from more efficient care is tantamount to “double dipping.” Hospitals will make substantial upfront investments and incur significant ongoing costs to coordinate care across the continuum to “participate” in a mandatory program. Further, in the current environment, most, if not all, of the revenue generated through the delivery of inefficient care is not realized by the hospital responsible for the anchor admission that bears risk in CCJR.

HFMA strongly believes that hospitals must receive a reasonable return on their investments in care coordination and process re-engineering if they successfully improve outcomes and reduce spending. It is highly inappropriate for CMS to both apply a discount factor and continually rebase the benchmark based on more recent data periods that eventually will include performance periods covered under the model. Therefore, HFMA urges CMS either take a discount or rebase the benchmark, but not both.

Post Acute Period:

In order to prevent inappropriate shifting of care outside of the 90 day episode, CMS proposes to monitor Parts A and B spending for a 30 period after the end of the episode. Beginning in performance year 2, if the hospital's average post-episode spending is greater than three standard deviations, the participant hospital would repay Medicare for the amount that exceeds the threshold, subject to the stop-loss limits proposed elsewhere in the proposed rule. CMS proposes to monitor spending on both services included and those excluded from the episode definition.

HFMA understands the need to monitor post-episode spending as a beneficiary protection. However, we are deeply concerned that CMS will carry over a practice from BPCI and monitor spending for Parts A and B services that are excluded from the original episode definition. The rule is silent on this aspect. We believe that excluded services should remain so in the post-episode period. While the three standard deviation threshold provides some measure of protection, it is inappropriate to hold a hospital responsible for unrelated services, particularly those related to high-cost conditions like the onset of therapy for cancer or the sudden inclusion of clotting factors for hemophilia.

Transition to Risk:

The proposed CCJR model transitions hospitals to risk by allowing them an initial performance year where participants are only eligible for reconciliation payments from CMS (capped at 20 percent of the per episode amount), if they meet certain quality measures and reduce overall episode spending below the target price. In the second performance year, the opportunity for shared savings continues, however, if episode spending is above the target price, hospitals are required to repay CMS the difference subject to a 10 percent per episode cap. In years three through five, the downside cap on losses increases to 20 percent. As a measure of additional protection for sole community hospitals (SCHs), Medicare Dependent Hospitals (MDHs), and Rural Referral Centers (RRCs) CMS lowers the cap on losses to three percent in year two and five percent in each performance year thereafter. However, CMS states that, if MDH status expires as it is currently slated to do on Oct. 1, 2017, MDHs would lose the protection of lower stop loss caps.

HFMA fully supports transitioning hospitals to downside risk assuming they have sufficient volume (discussed below), are provided sufficient data, and provided time to redesign care as discussed above. We especially appreciate the additional projections CMS has afforded SCHs, MDHs, and RRCs. However, HFMA believes that CMS needs to improve the transition to risk in the CCJR model by:

- Increasing the upside-only period to two years for hospitals other than SCHs, MDHs, and RRCs.
- Limiting SCHs, MDHs, and RRCs to an upside-only model for the duration of the model.
- Retaining the protections afforded to hospitals currently classified as MDHs in the final rule, if MDH status expires. While the special payment mechanism afforded to MDHs due to their unique circumstances may expire, their ability to bear risk (access to capital, smaller sample size which leaves them more exposed to random outcomes) will not expire.
- The stop loss caps for all other participating hospitals should start at five percent and be increased in five percent increments annually through the duration of the model.

Volume Threshold:

The CCJR proposed rule does not have a minimum volume threshold for inclusion in the program. As HFMA understands the proposed rule, if a hospital subject to the IPPS is located in one of the selected regions, it is compelled to participate even if it does only one LEJR procedure a year. The proposed rule attempts to address the statistical stability of price targets for extremely low volume hospitals (less than 20 LEJR procedures over three years) by using 100 percent regional data to calculate the target price for all five performance years.

HFMA is extremely concerned by the proposed rule's lack of a minimum volume criteria for hospitals within selected markets to be included in the CCJR model. CMS's proposal to address the statistical stability issue for extremely low volume hospitals is inadequate. First, the threshold is too low. Second, comparing these hospitals to the regional average may actually disadvantage them. Several members who are in lower volume facilities tell us that much of their volume is for non-elective joint replacements (trauma, hip fractures, etc.), which are much more expensive than an average mix of cases.

Additionally, HFMA continues to hear from its members that minimum scale is necessary to successfully re-engineer care. First, there needs to be a sufficient volume of claims to identify systematic unwarranted variance. Second, the opportunity to improve patient outcomes needs to be significant enough to engage referring physicians and post-acute partners for redesign. From the standpoint of

making best use of scarce resources, Medicare beneficiaries are best served when hospitals, physicians, and post-acute providers focus their efforts on improving outcomes on the highest volume conditions that exhibit the greatest variation. While LEJR episodes as a rule fit this criteria nationally, that will not be the case for every hospital.

In the proposed rule, CMS seems to acknowledge this issue of sufficient volume as it relates to physicians:

*“If we were to assign financial responsibility to the operating physician, it is likely that there would be significant variation in the number of relevant episodes that could be assigned to an individual person. Where the physician was included in a physician group practice, episodes could be aggregated to this group level but this would not be possible for all cases and would likely still have low volume concerns. **We believe that the small sample sizes accruing to individual physician and physician group practices would make systematic care redesign inefficient and more burdensome²....”***

HFMA is unsure as to why this would also not hold true for hospitals with low volumes as well.

Therefore, HFMA recommends that CMS take the following steps:

- **Institute a minimum historic volume requirement for mandatory hospital inclusion in the CCJR.** To be included in the CCJR, a hospital should have at least 100 LEJR eligible cases per year that would have been attributed to the hospital. Any cases that would have been attributed to a BPCI-participating hospital, physician group, or post-acute care provider should be removed from the calculation of the threshold. Should CMS add additional cohorts to the BPCI program once the CCJR program starts, if the number of LEJR episodes attributed to the hospitals falls below the threshold due to precedence rules attributing the case to a physician group or post-acute provider participating in BPCI, the CCJR hospital should have the option of quitting the program.
- **Work with state Medicaid programs and commercial health plans to implement the CCJR model³ to help hospitals generate sufficient volume for inclusion in the program.** HFMA believes it would be appropriate for (assuming the changes discussed in this proposed rule are implemented) CMS to count Medicaid and commercial cases towards the minimum volume threshold if these plans were using a model that mimic CCJR in its construction of episode and assignment of responsibility to the hospital. In particular there should be a significant opportunity for CMS to align this model with Medicare Advantage plans and work with the Office of Personnel Management (OPM) to implement this model in the Federal Employee Health Benefit Plans (FEHBP). If CMS is able to do this, it would be a significant step towards its goal of aligning incentives across payers, which will accelerate care redesign.

HFMA believes that if CMS implements a minimum volume threshold as recommended above, there is no need to calculate a specific benchmark for low-volume hospitals. Three hundred cases over three years should provide sufficient claims experience to calculate a reasonably stable hospital-specific target price, assuming it is appropriately risk adjusted as discussed below.

1. Emphasis added

2. As modified by all recommendations contained in this comment letter

Excluded Conditions:

The CCJR proposed rule excludes certain Part A and B services from inclusion in the both the calculation of the target price and the calculation of the actual episode cost. The list of exclusions in the proposed rule is the same as the list used in BPCI. Based on feedback from our members, HFMA recommends that CMS make the following changes to the exclusions list.

Hip Fractures: Feedback from HFMA's members suggest that joint replacement episodes as a result of hip fractures are operationally different from elective joint replacements. The patients are typically frail and experience higher utilization of post-acute care (both in terms of length of stay and intensity of setting). ***Unless CMS, as recommended below, uses the principle procedure code to more accurately risk adjust the target price, HFMA believes that hip fractures need to be excluded from the CCRJ.***

Unrelated Chronic Conditions: Similar to BPCI, CCJR will include inpatient admissions, post-acute admissions, and Part B services for unrelated chronic conditions, such as cirrhosis, in both setting the target price and calculating actual performance. In the proposed rule, CMS states that it believes that any spending (except for the explicitly excluded items) that occurs during the 90-day episode window is directly related to the LEJR procedure and symptomatic of uncoordinated care. However, our members report that the orthopedists they work with believe a 30-day window for exacerbations of existing, unrelated chronic conditions is more appropriate. HFMA believes it is important to note that in both Tennessee and Arkansas's lower joint replacement episode definitions all cause readmissions are only included in if they occur from the date of surgery to 30 days post discharge.

HFMA believes CMS must exclude all Parts A and B spending resulting from an unrelated chronic condition that occurs after the 30th day post-discharge. Beyond the question of whether the utilization is actually related to LEJR procedure, long-term if CMS attributes all spending for chronic conditions to the LEJR bundle, it will either need to revise the bundle definition when future episodes are introduced or exclude potentially related utilization from new episodes.

Planned Readmissions and Outpatient Procedures: HFMA urges CMS to consider excluding hospital readmissions or outpatient procedures that were planned for the patient prior to the start of the episode in the CCJR model. Doing so would be consistent with other CMS policies (e.g., CMS currently excludes planned readmissions from the Hospital Readmissions Reduction Program (HRRP)).

Post-Acute Spending for an Excluded Admission: In the circumstance when an acute hospital readmission occurs during the episode with an excluded MS-DRG, the cost of the readmission is not counted toward the episode cost. However, costs for any post-acute care that follows the excluded readmission are included in the cost of the episode, because there is no exclusion for post-acute care providers. **HFMA urges CMS to exclude post-acute care following an excluded readmission.** Holding a CCJR participant accountable for all patient pathways is unreasonable given how little is known about the causal relationship between the hospital readmission and subsequent post-acute care services.

Risk Adjustment:

CMS proposes to "risk adjust" LEJR episode payments in CCJR by developing separate target prices for MS-DRGs 469 and 470 by using a complex calculation to blend and then un-blend them. While the proposed rule discusses various risk adjustment methodologies that CMS considered, in justifying the use of only the MS-DRG, CMS states:

“However, we do not believe there is a sufficiently reliable approach that exists suitable for CCJR episodes beyond MS–DRG-specific pricing, and there is no current standard on the best approach. At the time of developing this proposed rule Tennessee, Ohio, and Arkansas⁴ are launching multi-payer (including Medicaid and commercial payers, excluding Medicare) bundles and include hip and knee replacement as an episode. These states’ hip and knee episode definitions and payment models are consistent with, though not the same as, the proposed CCJR episode described in this proposed rule. However, each of these three states uses different risk adjustment factors. This variation across states supports our belief that there is currently no standard risk adjustment approach widely accepted throughout the nation that could be used under CCJR, a model that would apply to hospitals across multiple states. Therefore, we are not proposing to make adjustments based on patient-specific clinical indicators.”

HFMA attributes the lack of a “current standard” to CMS’s failure to work with the broader health plan community to identify one. Without CMS’s leadership, neither DRGs nor APCs would be a widely used by the payer community as they are today. We believe CMS has a number of options from which to choose from. Below are several examples:

- 1) CMS continues to develop an episode grouper, as mandated by the ACA. That grouper includes a method for adjustment for patient severity at the episode level.
- 2) Several private sector payers, including large national health plans such as CIGNA and the State of NY in its DSRIP program are using the methodology developed by the Health Care Incentives Improvement Institute (HCI3) for adjusting episodes of care, including TKA/THA, for the severity of patients.
- 3) Other commercial groupers including Optum’s Procedure Episode Grouper and Truven’s Medical Episode Grouper use various methods to adjust for patient severity at the episode level.

Further, we believe that one of the purposes of CMMI is to experiment with different mechanisms to identify a model that most accurately minimizes the transfer of insurance risk to hospitals while holding them accountable for operations risk.

Given this range of options, HFMA believes using an MS-DRG to risk adjust payment for a 90-day episode of care is highly inappropriate. We would like to remind CMS that an MS-DRG is only designed to predict hospital spending and therefore not valid for predicting expenditure in the post-discharge period. Analysis by MedPAC supports this. A recent report to Congress found that only 8 percent of the variation in charges for 30-day post-acute care-only episodes could be explained by the MS-DRG from the prior acute care hospital stay.⁵

3. HFMA would also like to note that both the Arkansas and Tennessee models exclude all-cause readmissions that occur more than 30 days post discharge (see discussion of exclusions in the section above). This is a significant design difference from the CCJR. While all episodes of care should be appropriately risk adjusted, episodes that include only directly related services transfer less insurance risk to healthcare providers.

4. “Report to the Congress: Medicare and the Health Care Delivery System,” MedPAC, June 2013.

Analysis of a 30-day episode of care for MS-DRGs 469 and 470 by Health Care Incentives Improvement Institute (HCI3)⁶ further proves the point as shown in the table below.

Major Joint Replacement: Average Episode Cost by MS-DRG and Principle Procedure Costs

	469		470	
	# of Episodes	Average Cost	# of Episodes	Average Cost
Average Episode Price	4,713	\$ 32,345	63,033	\$ 19,638
<i>Principle Procedure</i>				
Total Knee Replacement	1,402	\$ 26,812	38,291	\$ 17,813
Total Hip Replacement	961	\$ 30,313	16,561	\$ 19,160
Partial Hip Replacement	2,317	\$ 36,458	7,978	\$ 29,382
Other Grouped Principal Procedure Code	33	\$ 37,904	203	\$ 19,940

While the average episode price for MS-DRG 469 and 470 is \$32,345 and \$19,638 respectively, there is significant cost variation within an MS-DRG, depending on the specific LEJR procedure. Using the data in the table above, within MS-DRG 470, a partial hip replacement there is approximately an \$11,600 (65%) difference in cost for a 30-day episode of care for a partial hip replacement vs. a total knee replacement. For a hospital with only 100 cases annually, assuming only changes in the distribution of procedures within MS-DRG 470, if four cases shifted from total knee replacement to partial hip replacement the facility would lose approximately \$61,000 on the bundle. This loss is not the result of clinical performance but a product of random chance. **HFMA believes that CMS should develop a risk adjustment mechanism for the CCJR model based on principle procedure code.**

Additionally, HFMA continues to hear from BPCI participants (both those in Phase II and those who opted not to continue into Phase II) whose patient population includes a larger share of dual-eligible patients that their organizations are disadvantaged due to a lack of socioeconomic status adjustment. As research has shown, dual-eligible patients typically incur higher cost, particularly across longer episodes.

HFMA believes CMMI should incorporate some level of adjustment for socioeconomic (SES) factors into the CCJR target price. As a long-term solution, HFMA encourages CMS to explore incorporating the National Quality Forum (NQF) SES risk adjustment measure once it is adopted. However, since the CCJR model is hospital specific, we believe an appropriate interim solution would be to base SES risk adjustment on a hospital’s Supplemental Security Income (SSI) ratio as a proxy for SES factors.

In summary, HFMA agrees with CMS’s assertion that there currently isn’t a widely accepted methodology for risk adjusting episodic payments. If CMS moves forward with CCJR as a mandatory model absent a more sophisticated risk adjustment mechanism that better accounts for cost variation related to patient-specific factors, it will knowingly shift insurance risk to hospitals as opposed to performance risk. This is especially true for lower volume hospitals (see discussion above). **We believe that, until CMS develops consensus around a “widely accepted” approach for episode risk adjustment**

5. <http://www.hci3.org/sites/default/files/files/HCI-IssueBrief-5-2012.pdf>

that accounts for socioeconomic factors, it should delay implementation of mandatory episodic payment program.

Quality:

The CCJR proposed rule includes a number of quality provisions that are tied to financial outcomes. A hospital's ability to receive reconciliation payments from CMS is predicated on its performance on three measures:

- Hospital-level 30-day, all-cause Risk-Standardized Readmission Rate (RSRR) following elective primary Total Hip Arthroplasty (THA) and/or Total Knee Arthroplasty (TKA) (NQF #1551).
- Hospital-level RSCR following elective primary THA and/or TKA (NQF #1550).
- Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey (NQF #0166).

For the first three performance years (2016 – 2018), a hospital must be at or above the 30th percentile of the national hospital results calculated for all Hospital Inpatient Quality Reporting (HIQR) program participant hospitals for each of three quality measures to qualify for a reconciliation payment. For the final two performance years, this increases to the 40th percentile. Similar to the Hospital Readmissions Reduction Program (HRRP), for the CCJR proposed rule, the readmissions measure is not adjusted to account for patient- or hospital-level socio-economic factors that have a significant impact on outcomes.

Finally, CMS proposes to reduce a hospital's discount factor by .3 percent, if it collects and submits a patient-reported outcome measure.

HFMA strongly supports tying payment to patient outcomes. While we generally support the quality measures proposed for the CCJR program, we have concerns about the specific items as discussed below:

Inclusion of the Readmission THA/TKA Measure in both CCJR and the HRRP: HFMA supports the use of a THA/TKA measure that is appropriately risk adjusted (discussed below) in the measure set to evaluate the quality of care provided by CCJR participants. Assuming appropriate risk adjustment, we believe it is appropriate for this measure to be used in determining a hospital's ability to receive a reconciliation payment. However, we believe that it is inappropriate for hospitals to be held financially accountable for the same measure in two different CMS programs. Section 3025 of the Affordable Care Act specified readmissions measures for three conditions in the HRRP – pneumonia, heart failure, and acute myocardial infarction. Additional measures have been added at the discretion of the Secretary based on the authority granted under Section 3025.

The THA/TKA readmission measure is not mandated by the Affordable Care Act. **Since THA/TKA is not mandated by the Affordable Care Act (ACA) for inclusion in HRRP, HFMA urges CMS to remove THA/TKA from the HRRP penalty calculation for CCJR participating hospitals. We believe the incentives in CCJR are sufficient to focus participating hospitals on reducing readmissions for Medicare LEJR patients.** Additionally, we are concerned the THA/TKA readmissions measure impacts payment differently under the CCRJ and HRRP, creating the potential for conflicting signals about performance. Given 2,666 hospitals were penalized under the HRRP for FY 2016, it is highly likely that a hospital could simultaneously be penalized under the HRRP (since it is a hospital-specific calculation), while clearing

the threshold to receive a reconciliation payment under CCRJ (since performance is relative to all hospitals).

Insufficient Risk Adjustment for the THA/TKA Readmissions Measure: HFMA continues to be concerned by the dearth of patient socioeconomic variables included in the risk-adjustment mechanism of CMS's readmissions measures, given the role that these factors play in a patient's likelihood of readmission. We appreciate CMS's attempt to analyze the impact of economic status (presented on pages 366-367 of the 2013 proposed IPPS rule) on the penalties meted out by the HRRP. However, we continue to believe that CMS's analysis under-appreciates the effect economic status has on readmissions. MedPAC analysis has shown there is a positive relationship between the percentage of SSI beneficiaries in a hospital's patient population and the likelihood of incurring an HRRP penalty.⁷

HFMA recommends CMS include SSI and other similar economic indicators (e.g., presence of Medicaid as a secondary payer) to improve risk adjustment for the THA/TKA readmissions measure until the National Quality Foundation (NQF) develops a mechanism that fully accounts for economic drivers. In the interim, HFMA supports MedPAC's proposal to evaluate a hospital's readmission rates against rates for a peer group of hospitals with a similar share of economically challenged Medicare beneficiaries as identified by the percentage of Medicare patients receiving Supplemental Social Security Income.

HFMA believes refining the risk-adjustment mechanism is necessary to ensure a level playing field for all hospitals participating in the CCJR, while protecting safety net hospitals and their communities from the unintended and counterproductive consequences of an incomplete risk-adjustment mechanism. For these facilities, inpatient Medicare payments are a larger than average component of their revenue. Any reduction in Medicare payment related to an incomplete risk adjustment will have both direct and indirect consequences. As a direct consequence, it will limit hospitals' ability to invest in programs to reduce unnecessary readmissions and the socioeconomic factors that cause them, further harming Medicare beneficiaries.

Use of Point Estimates as a Threshold for Reconciliation Payments: **HFMA is concerned with the proposed methodology, primarily because using a point estimate to calculate percentiles is not appropriate for the THA/TKA readmissions and THA/TKA complications measures.** The measures are a ratio comparing observed to expected, where expected is based on the national performance. **An individual hospital's performance should be assessed within confidence intervals**, as the measure was originally specified, tested, and endorsed by the NQF. When using a point estimate to determine percentiles, there may not be any statistically significant difference in the performance of hospitals at the 50th percentile and the 30th percentile. For HIQR performance in FY15, the vast majority (approximately 97 percent) of hospitals were no different than the national rate for THA/TKA complications and THA/TKA readmissions, with less than 2 percent of hospitals as worse than the national rate. The CCJR proposed methodology would arbitrarily assign hospitals with similar performance to the eligible for reconciliation payment and ineligible for reconciliation payment. While the ACA statutory requirements necessitate that point estimates be used to calculate hospital performance under the HRRP, no such requirement exists for the CCJR Program. Performance should be placed into one of three buckets: "no different than the national rate," "better than the national rate,"

6. http://www.medpac.gov/chapters/Jun13_Ch04.pdf

or “worse than the national rate.” Hospitals who are “no different than the national rate” or “better than the national rate” should automatically be deemed eligible for any potential savings.

Finally, a three year rolling average performance period means that it is hard for hospitals to demonstrate improvement. As noted earlier, performance has very little overlap with the payment year, so hospitals are not truly assessed on performance within the CCJR model. Recognizing the difficulty in demonstrating improvement and the fact that hospitals are being judged on performance preceding the CCJR model, **we believe hospitals must be given more time to implement quality improvement strategies before they are held accountable.** Accordingly, we suggest that all hospitals who achieve savings beyond the discounted target price should receive a reconciliation payment, so that they can reinvest in quality improvement. Rather than exclude hospitals who perform “worse than the national rate” from savings pools, CMS should ensure they are improving by allowing them to achieve savings and simultaneously requiring a corrective action plan. Hospitals who undertake a corrective action plan should be provided with technical assistance and should be monitored for improvement. Savings could be linked to investment in the necessary tools to achieve greater improvements in subsequent performance years. This would not create undue burden for CMS as less than 2 percent of hospitals were worse than the national average for THA/TKA complications and THA/TKA readmissions in FY15 HIQR performance. It is feasible that only a few hospitals will achieve a savings and have performance that is worse than average.

Submission of a Patient Reported Outcomes Measure: HFMA firmly supports the development of patient reported outcomes measures. We have long encouraged all healthcare purchasers to replace process measures with patient-centered outcome metrics as soon as possible.⁸ In the proposed rule, CMS estimates it will cost hospitals \$75 per survey to collect and submit patient-reported data to CMS. To compensate hospitals for this expense, CMS proposes to reduce a hospital’s target price by .3 percent, if it submits data related to this measure for 80 percent of applicable patients.

HFMA appreciates CMS’s efforts to compensate hospitals for the costs they incur helping to develop this important measure. However, we are concerned that reducing the benchmark is an inadequate mechanism for reimbursing hospitals for their assistance in this effort. For example, a hospital that submits the appropriate data for 80 percent of the applicable patients would receive no compensation for their efforts, if despite meeting the financial target to receive a reconciliation payment, it failed to surpass the quality threshold.

To avoid this situation, HFMA suggests that CMS pay hospitals \$75 per survey for each reported patient instead of lowering the benchmark. Also, we believe that CMS needs to lower the threshold. Our members’ experience with surveying patients suggests that an 80 percent response rate is unrealistically high.

Waivers:

In the CCJR rule, CMS proposes a number of waivers of existing program requirements. Below, please find HFMA’s specific comments.

7. <http://www.hfma.org/ValueProject/Phase2/>

Canceled Episodes/Ineligible Beneficiary: In BPCI, a waiver may be used to deliver care as part of an episode that is subsequently rescinded. For example, if a patient has one hip replaced and a few weeks later has the other hip replaced, the first hip bundle is nullified and the second hip bundle is activated. This means that a provider who uses the three-day stay waiver as part of the first hip loses that waiver protection and the beneficiary is responsible for the associated Skilled Nursing Facility (SNF) stay. In this case, CMS has not been willing to allow the bundlers to cover the expense for the beneficiary, or allow this clinically appropriate SNF stay to be waived, thus our members are rarely using the waivers.

The proposed rule clearly addresses canceled episodes by allowing waivers to apply to “the care of beneficiaries who are in CCJR episodes at the time when the waiver is used to bill for a service that is furnished to the beneficiary, even if the episode is later cancelled as described in section III.B.3.b⁹ of this proposed rule. **HFMA is greatly appreciates CMS’s effort to address this issue.**

However, it is unclear if the proposed rule allows waivers to apply to beneficiaries who are retrospectively identified as ineligible for the CCJR program due to coverage status. As an example, from the BPCI program, when the CMS beneficiary eligibility files lag and it is later discovered that the beneficiary is no longer eligible for BPCI (e.g., the beneficiary has moved to Medicare Advantage or become eligible under the ESRD benefit). HFMA strongly believes that, in these instances, the waiver should continue to apply even if it’s discovered that the beneficiary is no longer eligible for a CCJR episode as a result of a change in benefit status. **We ask that CMS in the final rule clearly state that waivers will continue to apply under these circumstances.**

Waivers Available to Other Entities Bearing Risk in Under Medicare Fee-For-Service: HFMA believes that the payment waivers that CMS proposed to apply within the MSSP for those providers who take risk should apply to the CCJR model. Similar to MSSP, these CCJR participants have both financial incentives and quality measurement thresholds that hold them accountable for the overall cost and outcomes associated with the episode. Thus, there is less risk that the payment waivers will result in increased spending or poorer outcomes. Specifically, we urge CMS to finalize the following waivers as for CCJR participants:

- Hospital discharge planning requirements that prohibit hospitals from specifying or otherwise limiting the information provided on post-hospital services should be relaxed. If hospitals are held responsible financially for overall episode costs, they must be able to select, based on quality data, their preferred post-acute partners and develop steerage relationships with them. HFMA believes that beneficiaries should still retain full choice. However, CMS should use a tiered network model similar to benefit designs that are widely used in commercial health plans. If a beneficiary chooses to remain in the CCJR participant’s network CMS will reduce out of pocket cost sharing for that individual for the related post-acute stay. **HFMA believes the ability to increase (or decrease) referrals to a post-acute care provider is a more effective and administratively simpler mechanism for aligning incentives across the care continuum than sharing savings (or less likely sharing losses as discussed below).**

8. An episode is canceled if a beneficiary is readmitted for MS-DRG 469 or 470, dies during the anchor hospitalization, or initiates an episode under one of the BPCI models.

Concerns about “stinting” on care can be addressed under the current regime of Civil Monetary Penalties. Given that CMS proposes to collect and monitor both quality measures and post-acute episode spending, it has the data necessary to identify and pursue bad actors.

- The homebound requirement for home health, which requires that a Medicare beneficiary be confined to the home to receive coverage for home health services.

Patient Incentives Related to Prevention or Adherence: HFMA appreciates CMS’s efforts to waive the *Beneficiary Inducements Civil Monetary Penalty* and the *Federal Anti-Kickback Statute* related to the provision of items and services provided to CCJR episode beneficiaries for free or less than fair market value, as part of care received under the CCJR and as part of a treatment goal such as prevention or adherence to a treatment regimen. However, the administrative burden imposed on hospitals that opt to provide free or reduced cost items or services related to CCJR is considerable.

The proposed rule requires hospitals to:

- Document the provision of any item or service in excess of \$10. **HFMA strongly recommends increasing the threshold to \$50.**
- Retrieve any technology item provided worth more than \$50 from the beneficiary. It will cost hospitals more to pick up the technology item than the item is worth. **HFMA strongly recommends increasing the threshold to \$500.**

Direct Patient Financial Incentives: In addition to CMS reducing a CCJR beneficiary’s post-acute cost sharing (as discussed above), HFMA believes the waivers addressing patient incentives promulgated as part of the MSSP should apply to CCJR participants as well. This waiver would waive primary care copays. Doing so would encourage beneficiaries within an episode to seek the appropriate follow-up care that would not only help reduce readmissions, but also allow patients to be discharged to a lower level of post-discharge care

Pre-Admission Home Evaluation Services: Home Health Agencies (HHAs) are prohibited from performing free pre-operative home safety assessments for patients scheduled to undergo surgery. A waiver of this policy would result in more informed post-acute care plans, a decreased likelihood of falls and readmissions, and a more patient-centered care plan. HHAs are especially adept at working with clinicians to assess the patient’s care needs, including his or her ambulatory limits or other functional impairments, and should not be prevented, under the CCJR, from working collaboratively to generate a care plan at the pre-admission stage that helps transition the beneficiary to the lower cost community-based setting.

Transition Planning: Additionally, HFMA believes the *Federal Anti-Kickback Statute* should be waived to allow CCJR participants, including, without limitation, home health providers, to assist with discharge planning for beneficiaries and coordinate care transitions. For instance, better transition planning, in particular the assessment of readiness for in-home care services or other lower cost settings, is critical to the success of this population, since patients prefer to recover in their communities, and to CCJR participants, who are best positioned, along with discharge planners and patient’s families, to help identify the most clinically appropriate and cost-effective post-hospital setting for the patient. Current restrictions that prevent active coordination in transition planning obstruct the CCJR’s goals of ensuring that patients are discharged to the setting that best suits their needs.

Appeals Process:

CMS proposes that hospitals provide a written notice of any error in a calculation within 30 days of receiving a reconciliation report. HFMA finds this timeframe problematic. We continue to hear from BPCI participants that they continue to experience issues with the data files and reconciliation reports they receive from the contractors administering the program. The monthly data feeds from CMMI regularly omit data elements that are used by the contractor to identify and reconcile episodes to target prices. Without these data elements, it is impossible to replicate the reconciliation results calculated by CMMI. Participants are left to hope the contractor did not make an error in reconciling the data. This practice would not be acceptable in a commercial episodic payment contractual arrangement.

Given these data issues and the amount of time it will take hospitals to replicate CMS's results, HFMA believes CMS should allow hospitals an initial 180 days to file an appeal. This timeframe is similar to the timeframe afforded hospitals to appeal adjustments in the Medicare Cost Report. A document that in many respects is far less complicated than replicating CMS's reconciliation for the CCJR program.

Additionally, **CMS needs to provide CCJR participants with all data, methods, and underlying calculations necessary to replicate the reconciliation results.** This check is necessary to ensure that inadvertent errors did not occur (as will happen from time to time) when the contractor reconciled actual episode prices to targets. The ability to replicate the reconciliation results also helps maintain a transparent and open relationship among the CCJR participant, CMS, and CMS's contractor.

Alignment with Ongoing State Efforts: Currently, three states (Arkansas, Tennessee, and Ohio) have implemented (or are implementing) bundled payment programs that include a LEJR episode. These efforts to implement bundled payment include the state Medicaid plan and commercial health plans. In at least one state that HFMA is aware of (Arkansas), the episode definition is consistent (duration, responsible entity, included services/conditions) across all participating payers.

Unfortunately, the episode described in the CCJR proposed rule is not consistent with these state level efforts. **In the Metropolitan Statistical Areas (MSAs) in Arkansas, Tennessee, and Ohio that are included in the CCJR final rule, HFMA believes that CMS should align its episode definition with that of the state Medicaid plan.** Doing this would reduce the number of episode definitions for the same procedure, decreasing both the complexity and cost providers would encounter as they attempt to manage LEJR episodic payment. It would also reduce overlapping, independent efforts at care redesign that both hospitals and orthopedic groups would be simultaneously undertaking (potentially independently). Further, it would allow CMS to experiment with episode definitions outside of those it developed as part of either CCJR or BPCI.

Administrative Burden:

HFMA continues to hear from participants that the BPCI program entails a significant volume of administrative work, which drains time and resources from patient care activity. Examples cited include:

- Overlapping reporting requirements related to updating program implementation plans and data requested by Lewin in an attempt to identify best practice/shareable care protocols.
- Meeting monthly with program monitors.

CMS proposed in the CCJR proposed rule that any CCJR collaborator be required to permit site visits from CMS or one of its contractors for program evaluation purposes.

HFMA is deeply concerned about the administrative burden posed by the various overlapping evaluation efforts. Given that this is not a voluntary program HFMA believes that CMS must make a concerted effort to limit site visits to the minimum necessary to understand the impact of the program. Further, CMS must compensate hospitals on an hourly basis for the time their staff spends on administrative activities resulting from CMS evaluation efforts. Further, HFMA believes it is highly inappropriate for CMS to require CCJR collaborators to be required to permit site visits. The additional burden will limit the pool of willing collaborators.

Proposed Financial Arrangements:

The CCJR proposed rule makes hospitals the primary risk-bearing entity for LEJR episodes for qualifying Medicare beneficiaries. However, hospitals would be permitted to enter into gain/risk sharing arrangements with physician groups and post-acute providers referred to hereafter as “CCJR collaborators.”

HFMA appreciates CMS encouraging hospitals to enter into gain/risk sharing agreements with CCJR collaborators in their markets. However, we are concerned that these arrangements are inadequate to fully align financial incentives across the care continuum to catalyze care process redesign and coordination.

While in theory, gain/risk sharing arrangements should align financial incentives across the care continuum, a surprisingly small percentage of HFMA’s members who participate in the BPCI program currently use these agreements with their “collaborators” beyond orthopedic surgeons. Based on feedback from our BPCI participating members, HFMA attributes the underutilization of gainsharing to three things:

- 1) The complexity of CMS’s framework (which is identical to CCJR) and the related administrative burden imposed on BPCI participants if they initiate a gainsharing arrangement.
- 2) A lack of clearly articulated safe harbors from the myriad of fraud and abuse regulations implicated by gainsharing arrangements.
- 3) Outside of large orthopedic groups, few collaborators have a sufficient volume of cases for the gainsharing to be a financially meaningful incentive.

And we are unaware of any agreements that share both up and downside risk. In the current environment, there is no compelling reason for a collaborator to enter into a downside risk-sharing arrangement. If a hospital attempts to mandate that an orthopedic group enters into a risk-sharing agreement, the group will be referring their cases to a competing hospital. Further, hospitals cannot “steer” patients away from post-acute settings that refuse to enter into downside risk arrangements.

HFMA urges CMS to make the following improvements to the provisions related to financial arrangements in CCJR.

- 1) Reduce the administrative reporting requirements currently imposed on organizations using gainsharing arrangements.

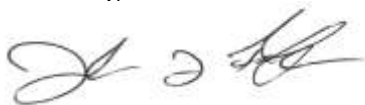
- 2) Work with the Office of Inspector General (OIG) to provide the waivers from related fraud and abuse regulations.
- 3) Allow for gainsharing on commercial and Medicaid episodic payment arrangements that are similar to CCJR to increase the volume of cases on which hospitals can share gains with CCJR collaborators.

Further, HFMA believes it is inappropriate to mandate participation in a program that holds one provider type (hospitals) responsible for the actions of other provider types without those provider types having exposure to some degree of financial risk related to cost and quality outcomes. If CMS is unwilling or unable to hold these organizations responsible for their contribution to the outcome, HFMA believes CMS needs to provide hospitals with the waivers discussed above related to discharge planning requirements.

HFMA looks forward to any opportunity to provide assistance or comments to support CMS's efforts to refine and improve the CCJR payment model. As an organization, we take pride in our long history of providing balanced, objective financial technical expertise to Congress, CMS, and advisory groups.

We are at your service to help CMS gain a balanced perspective on this complex issue. If you have additional questions, you may reach me or Richard Gundling, Vice President of HFMA's Washington, DC, office, at (202) 296-2920. The Association and I look forward to working with you.

Sincerely,



Joseph J. Fifer, FHFMA, CPA
President and Chief Executive Officer
Healthcare Financial Management Association

About HFMA

HFMA is the nation's leading membership organization for more than 40,000 healthcare financial management professionals. Our members are widely diverse, employed by hospitals, integrated delivery systems, managed care organizations, ambulatory and long-term care facilities, physician practices, accounting and consulting firms, and insurance companies. Members' positions include chief executive officer, chief financial officer, controller, patient accounts manager, accountant, and consultant.

HFMA is a nonpartisan professional practice organization. As part of its education, information, and professional development services, HFMA develops and promotes ethical, high-quality healthcare finance practices. HFMA works with a broad cross-section of stakeholders to improve the healthcare industry by identifying and bridging gaps in knowledge, best practices, and standards.

Links to Prior Comment Letters Related to BPCI:

www.hfma.org/Content.aspx?id=32061
<http://www.hfma.org/Content.aspx?id=31072>
<http://www.hfma.org/Content.aspx?id=1279>