NAUH
NATIONAL ASSOCIATION OF URBAN HOSPITALS

September 4, 2015

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Box 8103
Baltimore, MD 21244

Subject: 42 CFR Part 510 [CMS–5516–CN] RIN 0938–AS64
Medicare Program; Comprehensive Care for Joint Replacement Payment Model for Acute Care Hospitals Furnishing Lower Extremity Joint Replacement Services; Corrections

Attention: CMS-5516-P

To Whom it May Concern:

I am writing on behalf of the National Association of Urban Hospitals (NAUH) to convey our views on the proposed Comprehensive Care for Joint Replacement Model (CCJR) described in the *Federal Register* (Vol. 80, No. 134, pp. 41198-41316) on July 14, 2015.

NAUH supports the goals espoused by the CCJR model. We appreciate the continuing efforts of the Centers for Medicare & Medicaid Services (CMS) and the Center for Medicare and Medicaid Innovation (CMMI) to explore new approaches to improving the health care delivery system in ways that will improve the quality of care, improve the health of communities, and reduce health care costs. The CCJR model was clearly developed in this spirit.

While we support these goals and believe the CCJR model has great promise, NAUH has a number of specific concerns about the program as proposed:

1. the savings assumptions of the proposed CCJR model
2. assigning virtually all risk to hospitals
3. the breadth of services for which the lead provider is at financial risk
4. the program's lack of socio-economic risk adjustment
5. the inclusion of non-elective surgeries

We address each of these issues below.

The Savings Assumptions of the Proposed CCJR Model

NAUH believes the savings assumptions underlying the CCJR model are overly optimistic. They appear to be based on the savings produced by other demonstration programs launched by CMMI, but there is an important distinction between those initiatives and CCJR: those programs were all voluntary. Every provider that participated did so by choice, based on its own assessment of the likelihood it could succeed

21351 Gentry Drive, Suite 210, Sterling, VA 20166
Phone: 703-444-0989, Fax: 703-444-3029
www.nauh.org

and profit from its participation but also knowing that if it found it could not thrive under the model it could withdraw.

CCJR is very different: it is mandatory, it encompasses 25 percent of the nation's hospitals, and participants that struggle to achieve the program's goals will not have the option of leaving the program.

Based on the program's structure and approach, it appears the CCJR model is based primarily on the Bundled Payments for Care Improvement (BPCI) initiative introduced by CMMI in 2011. Participation in that program was voluntary: when CMMI introduced BPCI, the providers that volunteered to participate in it did so because they believed they had the infrastructure – established programs, relationships with other providers, information technology systems, and more – they needed to succeed and profit by participating. Even so, even with their confidence, they understood that if they found they were underperforming, they knew they had the option of withdrawing from the program – and some eventually did exactly that.

That, in NAUH's view, was a reasonable approach to take at the experimental stage, and BPCI and other programs have produced savings and imparted valuable lessons. Despite this, NAUH believes it is unreasonable to expect a mandatory program with far more participants to produce the same level of financial benefits as a self-selected group of participants that could withdraw from a program at any time. Consequently, NAUH believes the savings expectations of CCJR are too optimistic and aggressive. We do not object to the program or many aspects of its basic structure but we do believe that far too many participants will have very little chance of achieving the savings goals established for CCJR and far too many will suffer serious financial penalties. NAUH therefore urges CMS to develop more modest goals that better reflect what can reasonably be expected from a very different participant pool than the programs the agency has launched on a demonstration basis since the Affordable Care Act's passage.

Assigning Virtually All Risk to Hospitals

NAUH disagrees with the CCJR initiative's intention to require hospitals to assume virtually all of the financial risk for the care associated with the surgical procedures covered by the program. In the BPCI program the lead provider could be acute-care hospitals, skilled nursing facilities, physician group practices, home health agencies, inpatient rehabilitation facilities, or long-term-care hospitals, but under the proposed CCJR initiative, only acute-care hospitals may fill this role.

We object to the degree of responsibility assigned to hospitals under the CCJR model because generally speaking, hospitals are only responsible for about half of the costs associated with the joint replacements the program covers. Absent readmissions, hospitals have limited influence over the other, non-surgical costs associated with joint replacement, such as post-acute care, rehabilitation, home care, doctor visits, and more. Hospitals have little influence over the post-surgical care physicians prescribe and in many cases even physicians must defer to the wishes of their patients (such as whether a joint replacement patient will be discharged to a post-acute-care facility or just go home). While hospitals can theoretically negotiate with some of those other providers to share risk (and potential reward) with them, from a practical perspective it appears more likely that other providers will only be willing even to talk seriously about assuming risk after they have seen others enjoy the financial benefits of doing so. For now, at least, hospitals would be on their own.

The Breadth of Services for Which the Lead Provider is at Financial Risk

As described above, NAUH objects to the degree to which hospitals alone would bear virtually all of the financial risk associated with the CCJR initiative. We are especially concerned about some of the

individual services for which the program proposes hospitals assume such risk.

Specifically, NAUH sees no reason hospitals should be responsible for inpatient psychiatric services or hospice care needed by patients who have recently undergone joint replacement surgery. These are not customary post-surgical services for patients who have undergone joint replacement, they can be extremely expensive, and they fall well outside any reasonable post-surgical responsibilities hospitals have for their patients. In addition, to the degree that such services are needed by joint replacement patients, they are most likely to be needed by patients whose joint replacement was necessitated because of a serious injury. As we will address below, we believe the joint replacement services required by such patients should be excluded from the purview of the CCJR model.

NAUH recognizes that there is a degree to which CMS proposes making providers responsible for such services as part of a broader effort to encourage hospitals to pay closer attention to the patients for which they provide joint replacement services and to make more of an effort to avoid serving those who might reasonably be considered poor candidates for such surgery. Hospitals already seek to do this, although the primary responsibility for such decisions ultimately rests with the patient, the patient's family, and the surgeon – none of whom would bear any financial responsibility for their decisions under the CCJR model. Between the lack of control hospitals have over these decisions and the likelihood that joint replacement patients who require post-surgical inpatient psychiatric care or hospice care do so because of a serious injury they have suffered, NAUH urges CMS to reconsider the list of services for which participating hospitals will be responsible for all associated costs.

The Program's Lack of Socio-Economic Risk Adjustment

Inherent in the design of the CCJR initiative is a belief that all patients are equal, but as an association that represents hospitals that care for especially large numbers of low-income patients, NAUH knows that assumption is simply not true. Often, these patients have had only periodic and episodic contact with the health care system, and when they turn to us for care, they have numerous medical problems that need to be addressed that fall outside of the primary diagnosis for their cases – even when that primary diagnosis calls for joint replacement. In addition, these patients frequently pose challenges that go well beyond their immediate medical conditions. Frequently, urban safety-net hospitals serve low-income patients who lack the resources to follow their discharge instructions; often, there is no one at home capable of helping them through their period of very, very limited mobility or to help them get to the facilities where they will undergo physical rehabilitation. Together, these factors – the medical problems and social challenges – require both additional treatment and additional outreach. They cannot all be addressed overnight, and in many cases, they require the investment of additional resources to address. A growing body of research supports the view that low-income patients pose special challenges that often make them more difficult to serve: concerns raised by MedPAC and the National Quality Forum; reports published in the *New England Journal of Medicine*, *Health Affairs*, and by the U.S. Department of Health and Human Services' own Agency for Healthcare Research and Quality; and just last week, a new study published by the California Department of Public Health's Office of Health Equity.

Under the CCJR initiative, hospitals and hospitals alone would be responsible for the costs associated with the additional services needed to meet the health care needs of this challenging patient population. Urban safety-net hospitals take this responsibility seriously and routinely expend those additional resources, and they do so willingly. They do not, however, want to be forced into a demonstration program in which they not only must invest those resources but also must be prepared to be penalized financially for doing so – for doing their job.

Under these circumstances, NAUH urges CMS to add a socio-economic risk-adjustment component to the CCJR model. Such a step would make the program much fairer and enable urban safety-net hospitals to

compete – and this program is explicitly designed as a competition among hospitals – with other hospitals on a more level playing field. Without that, the playing field will be severely tilted – against urban safety-net hospitals and others like them.

The Inclusion of Non-Elective Surgeries

NAUH believes the CCJR model should encompass only elective joint replacements. The cost of many non-elective joint replacement procedures – reattachments, procedures undertaken as a result of fractures, and others – may not vary much from elective replacements but the post-surgical care is often far more complex, far more resource-intensive, and as a result, far more costly. Under the CCJR model, however, they would be treated the same as elective surgeries, and as a result, hospitals that perform more of such procedures – those with more active emergency departments, those with trauma units, those that serve older communities where broken hips are more common and more dangerous – would find themselves caring for a higher proportion of patients who require more intensive post-surgical care, as would hospitals with relatively modest orthopedic surgery practices that perform most of their procedures on an emergency basis; in fact, the average cost of post-acute care for joint replacement associated with hip fractures is more than twice that of a typical elective hip replacement. As noted above, most of these post-surgical costs are already beyond hospitals' control, yet under the proposed model it would be hospitals and hospitals alone that would bear all of the financial risk for caring for such patients. NAUH believes this is unfair and urges CMS to limit the CCJR model to non-elective joint replacement procedures.

About the National Association of Urban Hospitals

The National Association of Urban Hospitals advocates for adequate recognition and financing of private, non- profit, urban safety-net hospitals that serve America's needy urban communities. These urban safety-net hospitals differ from other hospitals in a number of key ways: they serve communities whose residents are much older and poorer; they are far more reliant on Medicare and Medicaid for revenue; they provide far more uncompensated care; and unlike public safety-net hospitals, they have no statutory entitlement to local or state funds to underwrite their costs. NAUH's role is to ensure that when federal officials make policy decisions, they understand the implications of those decisions for these distinctive urban safety-net hospitals. NAUH pursues its mission through a combination of vigorous, informed advocacy, data-driven positions, and an energetic membership with a clear stake in the outcome of public policy debates.

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NAUH appreciates the opportunity to present these comments to CMS and invites questions about the issues we have raised.

Sincerely,

Ellen J. Kugler, Esq.
Executive Director