September 8, 2015

Mr. Andrew Slavitt
Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Hubert H. Humphrey Building
200 Independence Avenue, S.W.
Washington, DC 20201

Submitted via www.Regulations.gov

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

Dear Acting Administrator Slavitt:

The National Association of ACOs (NAACOS) is the largest organization of Medicare Shared Savings Program (MSSP) ACOs representing approximately 150 MSSP and Pioneer ACOs. NAACOS is a member-led and member-owned non-profit organization that works on behalf of ACOs across the nation to improve the quality of Medicare delivery, population health and outcomes, and health care cost efficiency.

NAACOS is pleased to submit the following comments and recommendations in response to the Comprehensive Care for Joint Replacement (CCJR) Payment Model for Acute Care Hospitals Furnishing Lower Extremity Joint Replacement (LEJR) Services proposed rule (the "proposed rule").

Summary

We believe the CCJR will adversely affect and undermine the MSSP due to the failure of CMS to integrate the CCJR payment model with the MSSP. The proposed rule will:

1. Incentivize care "carve-outs" at the expense of population health and decrease the value of ACOs;
2. Shift cost savings away from ACOs to CCJR hospitals, thereby compromising the MSSP's ability to lower Medicare cost growth;
3. Incentivize overutilization of LEJR and increase costs;
4. Increase costs for post 90-day CCJR episode care for ACO beneficiaries by incentivizing bundlers to postpone care until after the 90-day episode;
5. Undermine ACO care coordination and population health efforts;
6. Undermine ACO patient engagement and shared decision making; and
7. Undermine ACO quality performance.

NAACOS believes that CMS should modify the CCJR to recognize the value provided to Medicare beneficiaries and the Medicare program through the MSSP and other CMS ACO programs. The CCJR should not undermine the key delivery system reform contained in the Affordable Care Act by minimizing the potential impact ACOs can have on achieving the Triple Aim.

Accounting for Overlap with Shared Savings Programs

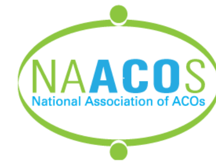
NAACOS believes that CMS must pursue policies that enable the harmonious coexistence of delivery system reform payment models and programs. As CMS stated in the proposed rule, "it is important to simultaneously allow beneficiaries to participate in broader population-based and other total cost of care models, as well as episode payment models…such as CCJR."[1] The presence of one program cannot be to the direct detriment of another model. Providers are at different stages in their ability to manage risk and varied payment models enable providers to elect models appropriately suited to their individual capabilities and constraints. However, with the mandated CCJR model, the growing number of different risk-based payment models within the same markets presents significant challenges to CMS, stakeholders, and as a result, Medicare beneficiaries. Providers, who have chosen to participate in risk-based payment models, are at risk of losing volume and seeing their savings siphoned off to other programs. We are equally concerned about the same overlap issues in the current Bundled Payment for Care Improvement (BPCI) Program at CMMI. The table below summarizes the current BPCI and CCJR overlap policy of CMS.

Table 1: Current CMS Policies for BPCI and CCJR

CCJR Overlap Issue	Program			
	BPCI LEJR Episode	**BPCI Non-LEJR Episode**	**MSSP (Aligned Hospital)**	**MSSP (Non-Aligned Hospital)**
Program Precedence	BPCI LEJR	No precedence	No precedence	No precedence
Attribution of Savings	N/A	Not specified	CCJR	CCJR
CCJR Discount Factor	N/A	Not specified	CMS recoups CCJR discount paid out as MSSP savings	No adjustment

As depicted in the table above, CMS proposes that hospitals that are part of an MSSP ACO or other shared savings model would still be required to participate in CCJR, and that CCJR savings

[1] 80 Fed. Reg. 41252 (July 14, 2015).



would be attributed to CCJR and counted as regular performance period payments for the MSSP and other shared savings models. In effect, an MSSP ACO would have little chance of scoring savings for any patient in a bundled payment episode, and as bundled payment programs grow, MSSP savings would diminish, putting the model at risk.

NAACOS encourages CMS to pursue policies that enable the integration of these programs. Integration is essential for both providers and beneficiaries, and as a strategy to limit duplicative administrative costs. NAACOS agrees that when an overlap occurs, it is appropriate to attribute savings to a bundled program as it has a shorter duration and is initiated by a major procedure involving an inpatient hospitalization. However, this does not mean that a portion of those savings cannot be shared among the organizations caring for the patients. We also believe that providers who have already voluntarily devoted resources to a different risk-based model should be afforded some protection. This issue becomes especially critical when an ACO's attributed beneficiary triggers a CCJR episode at a non-aligned hospital. The table below summarizes our recommendations for how CMS should treat the overlap with both the BPCI and most importantly the CMS ACO programs.

Table 2: NAACOS Recommendations for CMS Policies for BPCI and CCJR

CCJR Overlap Issue	**Program**			
	BPCI LEJR Episode	**BPCI Non-LEJR Episode**	**MSSP (Aligned Hospital)**	**MSSP (Non-Aligned Hospital)**
Program Precedence	BPCI LEJR	**BPCI Non-LEJR Episode**	No precedence	**MSSP**
Attribution of Savings	N/A	**N/A**	CCJR	**MSSP**
CCJR Discount Factor	N/A	**N/A**	CMS recoups CCJR discount paid out as MSSP savings	**N/A**

<u>NAACOS recommends that related MSSP ACOs and CCJR hospitals have the option to be excluded from the demo or otherwise allow the hospital and ACO to share the savings.</u>
CMS proposes that CCJR hospitals that are aligned with an MSSP ACO would still be required to participate in CCJR. CCJR savings would be attributed to the CCJR payment model and counted as regular performance period payments for the MSSP (i.e., the ACO would be credited with no savings for any patient in a bundled payment episode and CMS would recoup CCJR discounts paid out as MSSP savings). NAACOS recommends where the CCJR hospital is a participant in an MSSP ACO, CMS should allow the MSSP participants to exclude themselves from the CCJR program. However, if they chose to enter the program, CMS could alter its proposed gainsharing rules to allow some funds to be shifted back to the ACO that assisted in achieving savings through contractual agreements.

NAACOS recommends that unrelated MSSP ACOs take precedence over a CCJR hospital. CMS proposes that for hospitals that are not aligned with an MSSP ACO, savings would still be attributed solely to CCJR. In effect, with the CCJR increased or decreased claims costs being adjusted out of the MSSP ACO performance costs, the ACO would have no chance of scoring savings for any patient in a CCJR episode. As the program grows to cover additional bundled payments beyond LEJR, MSSP savings will further diminish, putting the entire MSSP at risk of collapse. This recommendation should be adopted by CMS for three key reasons among many. First, CMS should be promoting models that enhance population health, not disease-focused silos of care. At the very least, CMS should not promote disease-focused models to the direct detriment of population health models, such as ACOs. Second, the BPCI initiative already tests a system where the bundler takes precedence over the ACO with respect to attribution of savings. Adopting our recommendation would provide CMS with an invaluable direct comparison of the two attribution methods. Because CCJR and the BPCI are operated through the Innovation Center, it is imperative that CMS include meaningful variables from which to compare models. Third, ACOs face an immediate financial threat by being excluded from sharing in any savings associated with the CCJR. ACOs have devoted substantial resources to implementing a different risk-based model and should be afforded some protection. We acknowledge that this additional precedence rule could create confusion for non-aligned hospitals in markets with Medicare ACOs. As such, NAACOS recommends that CMS provide hospitals with lists of patients prospectively and tentatively assigned to Medicare ACOs in their metropolitan statistical area (MSA) or provide access to a CMS maintained database of prospectively or tentatively assigned MSSP, Pioneer and Next Generation beneficiaries.

Absent the adoption of our recommendation above, NAACOS recommends that CMS require unaligned CCJR hospitals to sign agreements with ACOs in their MSA to work together to care for Medicare beneficiaries and to develop gain sharing agreements. ACOs should be permitted to share in some of the savings associated with CCJR patients that involve ACO-assigned beneficiaries. The proposed rule provides no incentive for CCJR/ACO collaboration, which threatens the continuity of care for ACO beneficiaries who experience a 90-day bundled episode of care. As we have seen with the BPCI initiative, hospitals have not involved the ACOs, except when the hospital is part of the ACO. Working together is defined as having a written contract in place that defines the role each organization will play in the post-acute care and includes a commitment to jointly develop a patient care plan that recognizes all of the comorbidities and post-bundle care requirements. In situations where the CCJR hospital is treating an ACO-assigned beneficiary and the ACO is not aligned with the hospital, we offer these four recommendations:

1. The CCJR hospital should document use of appropriate evidence-based clinical practice guidelines.
2. The CCJR hospital should document in writing a 90-day care plan developed in cooperation with the assigned beneficiary's ACO primary care provider/s.
3. The CCJR hospital should document that it has used an evidence-based decision aid that informed the patient's shared decision making.

4. CMS should require or allow the relevant ACO the option of participating in CCJR gainsharing. This would help spread CCJR risk beyond the CCJR hospital, move ACOs incrementally in the direction of participating in down side risk, and help reduce overutilization.

With respect to BPCI, CMS proposes that LEJR hospital participants would be excluded from CCJR for the remainder of their BPCI performance period, but they would be required to enter CCJR once the BPCI performance period concludes. NAACOS is concerned by the prospect of requiring hospitals and beneficiaries to automatically transition from one program to the other. As currently proposed, some BPCI participants may be required to enter CCJR in performance year 4 under 100% regional pricing. NAACOS recommends that CMS give BPCI participants the option to extend their participation in BPCI for an additional three-year period rather than transitioning to CCJR. Because BPCI is a widespread program and manages risk for a number of conditions beyond LEJR, NAACOS supports the proposal that BPCI LEJR episodes would take precedence over CCJR episodes. However, NAACOS recommends that this precedence rule be extended to all BPCI episodes to cover those occasions in which a patient could simultaneously be in a CCJR episode and a non-LEJR BPCI episode (such as congestive heart failure). In these scenarios, there is no accurate way to fairly attribute savings between CCJR and BPCI.

NAACOS believes that is imperative that CMS pursue a larger strategy for dealing with the potential overlap of different delivery system reform payment models and programs. The absence of a broader plan for integrating and transitioning between different risk-based models will force the continued adoption of patchwork solutions, which enhance the complexity of the nation's health system. NAACOS stands ready to work with CMS to develop and implement such an important strategy.

CCJR Undermines the Principles of ACOs

For MSSP ACOs, the proposed CCJR creates a lost opportunity cost for the ACO and the Medicare program. Under CCJR, the MSSP loses potential savings that could have been derived through less intensive or expensive treatment provided by the ACO. The CCJR will ensure that LEJR procedures are instead performed. This is a significant concern because LEJR surgeries constitute the most prevalent condition in the Medicare program with over one million episodes annually. LEJR accounts for the largest dollar amount ($25 billion) and highest percent (6.3%) of 30-day episode Medicare spending.[2] Not surprisingly LEJR also constitutes the largest number of BPCI Model 2 care episodes. This presents negative financial consequences for MSSP ACOs. While the CCJR holds ACOs harmless if CCJR episode costs exceed the CCJR hospital's target price, all 90-day CCJR episodes (i.e., their target prices) are added to ACO benchmarks indiscriminately. Since the CCJR episode ends at 90 days, any and all post 90-day related claims costs are added to the ACO's benchmark.

[2] Allen Dobson, et al. "Medicare Payment Bundling: Insights from Claims Data and Policy Implications, Analyses of Episode-based Payment," Dobson-DaVanzo (October 26, 2012).

Recent MSSP performance year two (PY2) results demonstrate that the MSSP has struggled to produce a large number of successful provider participants and meaningful savings. The PY2 results show in part:

- Approximately the same percent of ACO participants earned shared savings in PY2 as did in PY1 (26% and 24%, respectively).
- Total earned shared savings of $411 million among 333 ACO participants in PY2 was comparatively less than total earned shared savings of $315 million among 220 ACO participants in PY1.
- Average earned shared savings among 92 ACO awardees in PY2 was substantially lower than in PY1. In PY2 per awardee savings averaged $3.7 million. Average earned shared savings among 52 awardees in PY1 equaled $6.05 million.
- Only 27% of all PY2 ACOs fell within their minimum savings rate (MSR) compared to 54% of all ACOs in PY1. However, in PY2 46% of all ACOs, or 152, fell below their negative MSR compared to only 20%, or 42, of all ACOs in PY1.
- In PY2, more experienced ACOs (2012 ACOs) did comparatively better than first year ACOs (2014) and the ACO community in sum improved on quality measures and performed comparatively better compared to FFS providers. However, since quality scores are punitive only, ACOs earning shared savings did not receive 50% of all savings. Rather, they received 42%, or $315 million, out of a total of $806 million. CMS retained the balance of $491 million.

The MSSP remains at best a mixed success. It is reasonable to question whether the program, which is considered the ACA's flagship Medicare payment reform initiative, can continue to grow at the rate it has to date with yet another bundled payment demonstration competing against it. MSSP participation has already begun to decline. The 2015 ACO class was 28% smaller than the 2014 class (89 versus 123), and we estimate 50-60 of the 2012-13 class will leave the program in 2016. Launching the mandatory CCJR demonstration further threatens the viability of the MSSP, only a few years after its inception.

CCJR Incentivizes Overutilization of LEJR and Increases Costs

Research conducted by the Dartmouth Institute for Health Policy and Clinical Practice shows regional variation for LEJR namely THA (Total Hip Arthroplasty) and TKA (Total Knee Arthroplasty) per 1,000 Medicare beneficiaries is substantial. Excess volume, evinced by unwarranted variation by region, can be as great as four times and does not appear to be declining in part because LEJR volume is increasing. According to Dartmouth, hip replacement varies from 1.8 to 7.2 episodes per 1,000 Medicare beneficiaries. Knee replacement episodes vary from 4.0 to 15.7 per 1,000 beneficiaries. Mandating CCJR participation within MSAs to dampen variation will therefore not solve the problem.[3]

[3] Elliott S. Fisher, et al., "Trends and Regional Variation in Hip, Knee and Shoulder Replacement," a Dartmouth

Research shows the number of patients in need of LEJR, defined as clinically appropriate for surgery, exceeds the rate of replacement surgery by a factor of more than ten.[4] CMS in the proposed rule makes no mention of how it will attempt to address already substantial, unwarranted variation, including disparities. The proposed rule does not require CCJR hospitals to demonstrate use of evidence-based clinical guidelines such as for osteoarthritis treatment, nor the use of patient decision making tools.

Since the proposed CCJR mandates participation and incentivizes THA and TKA procedures by paying CCJR hospitals a bonus when there is a difference between episode claims costs and the episode's target price, the demo's effect will be to contribute to excess volume. One way to do this is for CCJR hospitals to increase the volume of their THA and TKA procedures without major complications or co-morbidities (MS-DRG 470) at least to the extent the savings from these less complex cases can offset more likely financial losses from complicated and co-morbid THA and TKA patients (MS-DRG 469). Another way is to up-code less complicated cases (DRG 470) to more complicated cases (DRG 469). It is not understandable that CMS leaves this likely scenario effectively unaddressed. CMS states it will evaluate utilization, specifically "regional variations" (FR pg. 41298), but this analysis will be completed retrospectively or after the fact. As proposed the CCJR will create a boomerang effect in that the demonstration will worsen the problem of excess volume and cost for Medicare, which is the problem CMS presumably is trying to address.

Additional Comments

Inadequate Authority to Mandate CCJR Demonstration

We question if CMS has the authority under ACA Section 3021 to mandate the CCJR demonstration as proposed. CMS certainly does not have authority to implement a demonstration that harms the MSSP. Section 3021 establishes the Innovation Center, which is designed to test innovative payment models and delivery system reforms. The MSSP was established by statute as a permanent Medicare program, not a demonstration or model to be tested. CCJR would harm the MSSP and derail a permanent Medicare program in order to test unproven bundled payments.

Proposed Start Date of CCJR Should be Moved Back

CMS proposes that the CCJR performance period would last five years and begin on January 1, 2016. NAACOS recommends CMS delay the start date of CCJR until at least October 1, 2016 to give CMS and all affected stakeholders adequate time to prepare. Additionally, because the

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Atlas Surgery Report," (April 6, 2010) and "Preference-Sensitive Care," A Dartmouth Atlas Project Topic Brief (January 1, 2007).

[4] G. A. Hawker, et al., "Determining the Need for Hip and Knee Arthroplasty: The Role of Clinical Severity and Patients' Preferences," Medical Care (2001): 206-218.

CCJR as proposed will have a detrimental impact on MSSP ACOs, additional time is needed for ACOs to reevaluate their participation in the MSSP.

National and Regional LEJR Benchmarking Concerns

In MedPAC's August 19, 2015 CCJR comment letter, the Commission noted there exists considerable variation nationally in the cost of LEJR surgeries. As a result MedPAC argued, "Transitioning to regionally based target prices, as opposed to nationally based targets, will continue to allow large differences in spending across the country." MedPAC has previously argued for regionally established MSSP targets as well. NAACOS has been very cautious in supporting the incorporation of regional spending into any advanced payment model and has concerns here to. NAACOS believes CMS and stakeholders need to assess well in advance the effects such models will have on existing program participants and the selectivity they might bring to future participants. While the CCJR's ambitious adoption of regional pricing may benefit some, it will hurt others and allow little time to modify the underlying care processes. Further, in a mandatory program, it could lead high cost providers to adopt untested care changes that could threaten the outcomes for the patient. Forcing care process changes with unrealistic financial penalties must be avoided, and we encourage CMS to work with stakeholders to establish thoughtful and data/evidence-driven transition timelines before rules are promulgated.

Beneficiary Incentives

The evaluation of the Medicare Acute Care Episode demonstration showed that Medicare beneficiaries were largely unaware of the demonstration. We welcome CMS' proposal to provide in-kind patient engagement incentives. However, we believe CMS should think beyond "items of technology" to include social and supportive services, such as homemaking, meals, personal care services, and transportation. These services are important as Medicare typically does not reimburse for, and the government inadequately funds, social services and supports.

Conclusion

We believe the CCJR will threaten the viability of the MSSP and it calls into question CMS' commitment to the success of ACOs.

- The CCJR demo does not account for the care an ACO-assigned beneficiary is receiving. Thus, a CCJR hospital that is unaligned with an ACO will not necessarily be aware their patient is receiving ACO care.
- The CCJR has the potential to increase volume, causing ACOs to incur added benchmark claims costs indiscriminately while simultaneously losing opportunity savings.
- MSSP participation will decline coincidentally with the decline in MSSP savings potential. Absent the CCJR, ACOs would have managed LEJR care for assigned beneficiaries since the MSSP already manages Medicare beneficiary Part A and B utilization spending.
- The CCJR hospital should be actively collaborating with ACOs and any and all other

providers in coordinating all the CCJR patient's care needs. The CCJR as proposed, however, does not recognize this reality nor ensure the CCJR hospital coordinates with the patient's ACO. This will undermine an ACO's ability to both provide and/or coordinate care for the ACO's patients.

- Ironically, the CCJR will exacerbate Medicare's fragmented care crisis and have the effect of making ACOs less "accountable."

Thank you for your consideration of our comments,

Clifton Gaus
CEO