September 8, 2015

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

Re: Medicare Program; Comprehensive Care for Joint Replacement Payment Model for Acute Care Hospitals Furnishing Lower Extremity Joint Replacement Services; Proposed Rule [CMS-5516-P]

Dear Acting Administrator Slavitt:

AMDA - The Society for Post-Acute and Long-Term Care Medicine (AMDA) appreciates the opportunity to comment on the Centers for Medicare & Medicaid Services (CMS) Proposed Rule for Medicare Program; Comprehensive Care for Joint Replacement (CCJR) Payment Model for Acute Care Hospitals Furnishing Lower Extremity Joint Replacement Services. AMDA is the professional society of nursing home medical directors, nursing home attending physicians, and other professionals practicing in the post-acute and long-term care (PA/LTC) continuum. We work to ensure excellence in patient care and to promote the delivery of quality PA/LTC medicine.

AMDA supports detailed comments submitted by the umbrella physician organizations. We agree with the goals that are essential to the success of any new Alternative Payment Model (APM) and that CMS should support the following principles in the development of a revised CCJR proposal and in the development of other APMs:

1. Enable physician-identified improvements in care that cannot currently be implemented due to barriers created by current payment systems;
2. Provide adequate, predictable resources to support the delivery of high-value care to all patients;
3. Hold physicians and other providers accountable only for aspects of costs and quality that they can influence or control;
4. Allow voluntary participation by all interested physicians in all parts of the country;
5. Support physician leadership in redesigning care delivery;
6. Offer flexibility to support different organizational arrangements among providers; and
7. Design and implement the program in a collaborative approach between CMS and physicians.
Likewise, we concur with comments that stress the notion that it is essential to recognize that it is not the payment model that will improve care; it is the physicians and other health professionals who are most likely to improve care. Rather than CMS implementing a new payment model and “testing” it to see if the payment model improves care, greater benefits and fewer unintended consequences will occur if new payment models are specifically designed with physician input to ensure the model removes existing barriers to better care and avoids creating new barriers.

Implementation of a bundled payment program for joint replacement in Medicare should be designed to remove the current barriers to better care and give physicians and other providers adequate flexibility and sufficient resources to improve care and assume accountability for outcomes they can control. Unfortunately, the design of the CCJR payment model that CMS has proposed does not achieve these goals. The proposed model does not give physicians and other providers the necessary flexibility to significantly redesign care, and it places providers at risk for costs they cannot control.

AMDA recommends that other entities beyond acute care hospitals be permitted to take responsibility for bundles, as is occurring under the current BPCI initiatives, in the future. Leaving physicians and other entities (e.g., skilled nursing facilities) out of the equation will predictably result in less robust and nimble approaches to these care models. Acute care hospitals have varying effectiveness in improving the efficiency of care and should not bear the sole responsibility under the CCJR moving forward.

Further, we agree with detailed comments submitted by Altarum Institute’s Center for Advanced Illness. In particular, we want to stress that the NPRM APM is written with a primary focus on Medicare beneficiaries with elective replacement of hips or knees. Our concern is that patients with hip fractures are being integrated into the document discussion (e.g., p. 41201, section I.A.). These patients are being swept into the care population as if irrelevant (see, e.g., p. 41278, section II.D.2.a.(1) – the document states, “Both hip and knee arthroplasty procedures improve the function and quality of life of patients with disabling arthritis…” which is true, but ignores the devastating situation of fractures).

The post-hip-fracture patient population is generally a much frailer and medically complex group than those healthy enough to receive elective total joint replacements, and a population that AMDA members frequently care for in the PA/LTC setting. The costs of an episode of care for a hip fracture patient who receives an arthroplasty to repair the fracture will predictably be much higher than for an elective joint replacement, both in covered medical services and in non-covered long-term care supports and services. These patients require comprehensive care plans, interdisciplinary care teams, careful attention to every transition, goal setting, access to palliative care, and often complicated advance care planning and surrogate decision-making. The proportion of fractures in the hip replacement mix will vary among hospitals (again, information that CMS could examine and make public), making a serious reason for variation in costs and complications among hospitals, which will not be addressed with risk adjustment in the current plan. Therefore, a hospital that has traditionally served a substantial population of frail elders will be seriously disadvantaged and might seek to reduce its traditional commitment to this population in various ways, all of which are contrary to the interests of the frail elders.
AMDA agrees with the Altarum Institute and recommends that CMS remove the post-hip fracture arthroplasty population from calculations of bundles relating to joint replacements, as it is a completely different population. If CMS chooses to retain this population, then substantial changes in the requirements, the quality metrics, and the financing need to be explored with data and resolved.

Thank you for the opportunity to comment on these important issues. AMDA looks forward to working with CMS on improving care delivery and payment models for joint replacement and for other types of patient health needs. If you have any questions or wish to discuss this issue further, please contact Alex Bardakh, Director Public Policy and Advocacy, at abardakh@amda.com or 410-992-3132.

Sincerely,

Naushira Pandya, MD, FACP, CMD
President