



## AMERICA'S ESSENTIAL HOSPITALS

September 8, 2015

Mr. 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

**Ref: CMS-5516-P: Medicare Program; Comprehensive Care for Joint Replacement Payment Model for Acute Care Hospitals Furnishing Lower Extremity Joint Replacement Services**

Dear Mr. Slavitt,

Thank you for the opportunity to submit comments on the above-captioned proposed rule. America's Essential Hospitals appreciates and supports the Centers for Medicare & Medicaid Services' (CMS') work to encourage improved care delivery across the entire health care industry. However, mandatory participation in the Comprehensive Care for Joint Replacement (CCJR) Model might have a negative impact on essential hospitals—those dedicated to serving the most vulnerable. To this end, America's Essential Hospitals asks CMS to consider the unique challenges inherent in caring for these patient populations when finalizing this rule.

America's Essential Hospitals is the leading association and champion for hospitals and health systems dedicated to high-quality care for all, including the most vulnerable. Filling a vital role in their communities, our more than 250 member hospitals provide a disproportionate share of the nation's uncompensated care and devote approximately half of their inpatient and outpatient care to Medicaid or uninsured patients. Nearly half of patients at essential hospitals are racial or ethnic minorities who rely on the culturally and linguistically competent care that essential hospitals are best able to provide. Our members provide this care while operating on margins substantially lower than the rest of the hospital

industry—with an aggregate operating margin of -3.2 percent, compared to 5.7 percent for all hospitals nationwide.<sup>1</sup>

Through their integrated health systems, essential hospitals offer the full range of primary through quaternary care, including trauma care, outpatient care in their ambulatory clinics, public health services, mental health services, substance abuse services, and wraparound services critical to vulnerable patients. Many of the specialized inpatient and emergency services they provide are not available elsewhere in their communities.

The high cost of providing so much complex care to low-income and uninsured patients leaves essential hospitals with limited resources, propelling them to find increasingly efficient strategies for providing high-quality care to their patients. Essential hospitals are constantly engaging in robust quality improvement initiatives, which range from reducing patient harm by preventing falls and bloodstream infections to reducing readmissions. They also focus on improving the patient experience by breaking down language barriers and engaging patients and families. For example, an essential hospital implemented a two-pronged strategy that targeted both inpatient and outpatient clinical settings to reduce 30-day diabetes readmissions among its diverse patient population. Inpatient strategies included designating a physician champion and developing an electronic using electronic health record (EHR) to readily identify high-risk patient in need of ancillary services.

But improving care coordination and quality while maintaining a mission to serve the most vulnerable is a delicate balance. Some members are participating in alternative payment models such as the Medicare Shared Savings Program (MSSP) and have invested in becoming part of an accountable care organization (ACO). However, our members have faced challenges finding the resources necessary for ACO participation, which includes upgrading technology, process redesign, personnel changes, care coordination, quality measurement, risk management, compliance, network development, governance, and legal restructuring. These same resource constraints will likely affect essential hospitals that have been selected and would be required to participate in the proposed CCJR Model.

**For these reasons, and as detailed below, America's Essential Hospitals does not support the testing of a payment model through required hospital participation and urges CMS to address concerns outlined in the following comments prior to finalizing the proposed rule.**

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<sup>1</sup>Reid K, Roberson B, Landry, C, Laycox S, Linson M. Essential Hospitals Vital Data: Results of America's Essential Hospitals Annual Characteristics Survey, FY 2013. America's Essential Hospitals. March 2015. <http://essentialhospitals.org/wp-content/uploads/2015/03/Essential-Hospitals-Vital-Data-2015.pdf>. Accessed August 2015.

1. CMS should not require participation in the CCJR Model.

CMS is proposing to require participation in a payment model that bundles Medicare payments to selected acute care hospitals for hip and knee replacement surgery with payment provided retrospectively through a reconciliation process. An episode of care would begin with an eligible Medicare beneficiary's inpatient admission to a participating hospital for a procedure assigned to either Medicare-severity diagnosis-related group (MS-DRG) 469 or 470.<sup>2</sup> The episode of care would last from the date of admission through 90 days after the date of discharge from the hospital and includes the surgical procedure and inpatient stay, as well as all related care covered under Medicare Parts A and B within the 90 days after discharge.

The proposed CCJR model is largely based on bundled payment models currently being tested by CMS, such as the Bundled Payments for Care Improvement (BPCI) initiative. However, participation in the BPCI initiative and other episode-based, bundled payment models, is voluntary. And CMS wants more participants who can help the agency better understand the effects of bundled payment models on a broader range of Medicare providers. Thus, **the proposed rule would be the first time CMS has required participation in a bundled care model by preselected hospitals.** Through mandatory participation, CMS seeks to obtain information representing a wide and diverse group of hospitals that might not otherwise opt-in to such a payment model. The results will help inform the agency of how such a payment model might function if more fully integrated within the Medicare Program. **America's Essential Hospitals does not support mandatory participation in a demonstration payment model, such as the CCJR Model.**

2. CMS should consider factors related to a hospital's capability and readiness to implement care redesign activities when selecting hospital participants for inclusion in the CCJR Model.

CMS proposes to require participation of all hospitals, with limited exceptions, paid under the Inpatient Prospective Payment System (IPPS) that are physically located in a county in a metropolitan statistical area (MSA) selected through a stratified random sampling methodology. In its selection of CCJR MSAs and hospital participants, CMS considered important factors, but ultimately did not use those factors in the agency's selection process. Those factors included the degree to which a market might be more capable or ready to implement care redesign activities, such as ACO penetration and experience with other bundling efforts.

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<sup>2</sup>MS-DRG 469 is Major Joint Replacement or Reattachment of Lower Extremity with Major Complications or Comorbidities (MCC) and MS-DRG 470 is Major Joint Replacement or Reattachment of Lower Extremity without MCC.

Additionally, CMS did not incorporate any MSA-level demographic measures in its selection process, including distributions of population by age, gender, or race; percent of population dually eligible; percent of population with specific health conditions or other demographic composition measures. These factors vary not only between MSAs, but also by hospitals within an MSA and could impact a hospital's chances of success in the CCJR Model. Specifically, these factors highlight the unique difficulties essential hospitals face in providing care to vulnerable populations and might unfairly hinder the success of such hospitals in the model. **We urge CMS to use such factors in its methodology for selecting hospital participants prior to finalizing the list of MSAs included in the proposed rule.**

The proposed rule also places financial risk solely on participant hospitals—as the episode initiators—based on CMS' assumption that, “[i]n comparison to other health care facilities, hospitals are more likely to have resources that would allow them to appropriately coordinate and manage care throughout the episode.” In making such an assumption, CMS fails to recognize that not all hospitals may in fact have these resources. In particular, the financial preparations essential hospitals would have to make—while currently operating on margins substantially lower than the rest of the hospital industry—would be difficult, if not impossible. Should essential hospitals perform more poorly in the CCJR Model, they would be unfairly penalized. They would not receive any reconciliation payment and would be responsible for repayment to Medicare simply due to a lack of resources other hospitals have to build a care coordination infrastructure and thus, inexperience with bundled payment models. For these reasons, **we urge CMS to consider the financial burden on certain hospitals when selecting participants for inclusion in the CCJR Model.**

3. CMS should only include in the model reliable and valid measures that are risk-adjusted for sociodemographic factors and specific to lower extremity joint replacement procedures to provide an accurate representation of hospital quality of care and patient experience without unduly penalizing essential hospitals.

For those CCJR hospital participants that meet or exceed a minimum measure threshold for all quality measures in each performance year and show that actual episode spending was less than the target price set by CMS, the agency would issue a reconciliation payment. Hospitals would be eligible to receive reconciliation payments beginning in performance year one and continuing through each of the five years of the model. A hospital that does not meet all quality thresholds would not receive any reconciliation payments and, in the event that its actual episode spending exceeded the target price, the hospital would be responsible for repayment to Medicare.

The three quality measures selected by CMS are currently reported in the hospital Inpatient Quality Reporting (IQR) Program:

- Hospital-level, all-cause risk-standardized readmission rate (RSRR) following elective primary total hip arthroplasty (THA) and/or total knee arthroplasty (TKA) (NQF #1551)
- Hospital-level risk-standardized complication rate (RSCR) following elective primary THA and/or TKA (NQF #1550)
- Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey measure

For each of performance years one through three, a participant hospital's results for each measure must be at or above the 30th percentile of the national hospital results calculated under the IQR Program.

America's Essential Hospitals has concerns about these measures, in particular the complication and readmission measures for THA and/or TKA, as neither measure is risk-adjusted for socioeconomic factors and therefore do not accurately represent the quality of care provided by essential hospitals. We also disagree with CMS' proposed inclusion of a hospital-level measure (the HCAHPS survey) to evaluate patient experience for specific surgical procedures. **CMS should select a set of measures that are closely related to the procedures targeted in the CCJR episode of care, to assist hospitals as they work to improve the quality of their care for these procedures and to benefit the public by accurately reflecting the care being offered by hospitals.**

- a. CMS should risk-adjust for sociodemographic factors in the quality measures included in the CCJR Model.

**CMS should ensure the methodology for calculating a participant hospital's quality threshold includes adequate risk-adjustment for socioeconomic factors.** Outcomes measures, especially readmissions measures such as the proposed readmission measure for THA/TKA, do not accurately reflect hospitals' performance if they do not take into account socioeconomic factors that can complicate care.

Factors outside of hospitals' direct control, such as homelessness, income level, education, and primary language, can influence patient health care outcomes. Patients who do not have a reliable support structure upon discharge are more likely to be readmitted to a hospital or other institutional setting. The current methodology used in calculating THA/TKA readmission measures in other Medicare programs (e.g., Hospital Readmissions Reduction Program) does not incorporate appropriate risk-adjustment that accounts for socioeconomic status,

language, insurance status, postdischarge support structure, and other factors that make providing care to vulnerable populations uniquely difficult.<sup>3</sup>

In its June 2013 report to Congress, the Medicare Payment Advisory Commission (MedPAC) underscored the connection between socioeconomic status and readmission rates, emphasizing the strong correlation between a hospital's share of low-income Medicare patients and its readmission rate.<sup>4</sup> Due to the disproportionate effect of readmission penalties on hospitals treating a larger share of low-income patients, MedPAC suggests that in calculating a penalty, hospitals be compared to a peer group of hospitals with a similar share of low-income patients. This type of change requires Congress to take legislative action to make changes to the HRRP. However, nothing precludes CMS from using this suggestion—or a similar model—when assessing hospitals on readmission measures under other programs. **In fact, the CCJR Model presents a unique opportunity for CMS to test the impact of the inclusion of socioeconomic variables in hospital quality measures.**

Hospitals should not be punished for their readmission rates when high readmission rates are associated with lower mortality rates and good access to inpatient hospital care. By not taking into consideration the full range of differences in patients' backgrounds that might affect readmission rates, readmission measure calculations will inevitably be skewed against hospitals providing essential care to people who are minorities, those who have sociodemographic challenges, and those who are uninsured. **America's Essential Hospitals urges CMS to only include measures that are risk-adjusted for factors relating to a patient's background—socioeconomic status, language, and postdischarge support structure—in the CCJR Model.**

- b. CMS should not include the HCAHPS survey as a quality measure in the CCJR Model.

The HCAHPS survey is one method of formally recognizing that patient experience is central to health care, shifting quality metrics from the provider to the patient perspective. However, the inclusion of this survey in the CCJR Model could negatively affect essential hospitals if used as a quality threshold that hospitals must meet to receive reconciliation payments. Research has shown a greater likelihood of low HCAHPS scores reported from patients admitted via the emergency department (ED), as patient-provider interactions often are more

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<sup>3</sup>Nagasko EM, et al. Adding Socioeconomic Data to Hospital Readmissions Calculations May Produce More Useful Results. *Health Affairs*. 2014; 33(5): 786-791.

<sup>4</sup>See, e.g., Medicare Payment Advisory Commission. Report to Congress, Medicare and the Health Care Delivery System. June 2013. [http://www.medpac.gov/documents/reports/jun13\\_entirereport.pdf](http://www.medpac.gov/documents/reports/jun13_entirereport.pdf). Accessed August 2015.

limited due to the stressful nature of the ED.<sup>5</sup> Hospitals with higher ED volumes may score lower on the HCAHPS despite the fact that their quality may be the same or better than other hospitals, including those with lower ED volumes. An essential hospital, with higher ED volumes and potentially lower HCAHPS scores, may fail to meet this quality threshold under the CCJR Model and be ineligible to receive reconciliation payments for reasons unrelated to the quality of care provided to their surgical patients.

Additionally, the HCAHPS survey is overly broad, assessing overall hospital experience. Conversely, the CCJR Model is designed to examine and evaluate the relationship between care coordination, cost of services, and quality of outcomes for a narrowly defined subset of procedures. Therefore, to capture meaningful patient experience data, the measure chosen for the CCJR Model should also be narrowly defined and focused on the procedures captured in the model's episode of care (i.e., lower extremity joint replacements). For these reasons, **CMS should not include the HCAHPS survey in the CCJR Model.**

4. CMS should adopt an alternative to the proposed quality thresholds that aligns with current quality reporting and provides hospitals that do not meet the thresholds the opportunity to receive reconciliation payments while continuing their quality improvement efforts through an improvement plan.

As proposed, in order to receive a reconciliation payment, a CCJR participant hospital would be required to achieve actual episode spending below the target price for a performance year and perform at or above the 30th percentile of the IQR Program in all three required quality measures in performance years one through three. This threshold would increase to 40th percentile in performance years four and five.

America's Essential Hospitals does not support the use of such arbitrary thresholds. Such thresholds are not meaningful, particularly for the specific measures chosen for the CCJR Model. For example, a hospital may continue to fall short of meeting the threshold for the readmissions measure even while it reduces its excess readmissions if the national readmission rate continues to improve. In fact, MedPAC has noted that the manner in which the readmission penalty is calculated in other quality programs is counterintuitive because improvements in readmission rates nationally can result in higher penalties for individual hospitals.<sup>6</sup>

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<sup>5</sup>Kahn SA, Iannuzzi JC, Stassen NA, et al. Measuring satisfaction: factors that drive hospital consumer assessment of healthcare providers and systems survey responses in a trauma and acute care surgery population. *The American Journal of Surgery*. 2015 May;81(5):537-43.

<sup>6</sup>See, e.g., Medicare Payment Advisory Commission. Comment Letter to CMS on FY 2013 IPPS Proposed Rule. June 2012. [http://medpac.gov/documents/comment-letters/06222012\\_medpacfy2013ipps\\_comment.pdf?sfvrsn=0](http://medpac.gov/documents/comment-letters/06222012_medpacfy2013ipps_comment.pdf?sfvrsn=0). Accessed August 2015.

- a. CMS should adopt an alternative to the percentile thresholds for quality measures that utilizes interval estimates to categorize hospital quality performance and should not unduly penalize essential hospitals for their inability to meet percentile thresholds.

CCJR participants would not be eligible for reconciliation payments if they fail to meet the specified thresholds for all quality measures beginning in performance year one. Participants whose episode spending was higher than the target price would not be required to repay Medicare in performance year one; repayment would be phased-in in year two, with full implementation in performance years three through five. Hospitals would need to perform at or above the 30th percentile in all three quality measures to receive a reconciliation payment. This is a very high bar. Using current data from Hospital Compare, we determined fewer than 25 percent of essential hospitals would meet the threshold for eligibility to receive reconciliation payments. Regardless of whether those hospitals are successful in achieving actual episode spending below their target price throughout the performance year, they would be barred from a reconciliation payment.

Additionally, we examined how many members would have been eligible for reconciliation payment if the thresholds were set at or above the 20th percentile, and we found only slight improvement.<sup>7</sup> The effect of the quality thresholds, as proposed, is to substantially limit the number of participants eligible to receive reconciliation payments. This is counter to the underlying incentive of the CCJR Model—to drive delivery improvement efforts and outcomes through shared savings.

Establishing appropriate quality thresholds is crucial to the success of the CCJR Model, especially among essential hospitals. Essential hospitals with high readmissions rates but low mortality rates would not meet the quality thresholds as proposed and would be ineligible to receive reconciliation payments. These hospitals will be disadvantaged even while demonstrating quality of care and lower actual episode costs versus the target. The CCJR Model cannot achieve its goal to promote care coordination through cost-effective care practices by setting quality thresholds at percentiles that unduly penalize certain hospitals and that are based on measures that are not risk adjusted for sociodemographic factors.

**America's Essential Hospitals urges CMS to adopt interval estimates, similar to those used on Hospital Compare, for the two claims-based quality measures in the CCJR Model—readmissions and/or complications following elective primary THA and/or TKA. Adopting intervals will help ensure hospitals**

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<sup>7</sup>Estimated using the July 2015 release of CMS' Hospital Compare. HCAHPS metrics were estimated utilizing the top-box score of the "Overall Hospital Rating" as a proxy measure. Measure dates for this metric are 10/01/2013 through 9/30/2014. Measure dates for readmissions and complications were 7/1/2011 through 06/30/2014 and 4/1/2011 through 03/31/2014, respectively.



are assigned to appropriate performance categories. Currently, the readmission and complication measures related to elective THA and/or TKA are reported in a way that compares individual hospital rates to the national rate using interval estimates (i.e., confidence intervals) and hospitals are assigned to categories: “No Different than National Rate,” “Better than National Rate,” and “Worse than National Rate.”<sup>8</sup> In adopting a similar threshold based on these categories for the CCJR Model, CMS would be able to identify those hospitals performing as or better than expected.

America’s Essential Hospitals urges CMS to adopt a threshold whereby reconciliation payments would be issued to hospitals that are within the categories of “No Different than National Rate” and “Better than National Rate.” These hospitals would still be required to show reduced actual episode spending compared to their target price, as written in the proposed rule. However, we feel it is important that hospitals falling within the “Worse than National Rate” category, that have also shown a reduction in spending compared to target price, also receive reconciliation payments. However, these hospitals would be required to develop and implement an improvement plan.

**We urge CMS to adopt an interval estimate-based approach and an improvement plan, as described further below, for hospitals that fall within the “Worse than National Rate” category.**

- b. CMS should adopt an improvement plan for CCJR hospital participants that do not meet the quality thresholds but otherwise show reduced spending in the CCJR episode of care. This will allow such hospitals to receive reconciliation payments that will assist in their continued care coordination efforts and demonstrated improvement over time.

CMS states that an important purpose of the proposed quality measures for the CCJR Model is “to provide transparent information on hospital performance ... and to ensure that care quality is either maintained or improved.” Creating a barrier to reconciliation payments by using unattainable thresholds is counter to fostering system improvement and continuing effective best practices. A hospital with poor quality outcomes is arguably in greater need of reconciliation payments to support care coordination efforts. **We urge CMS to adopt an alternative that allows for hospitals that have shown reduced spending (i.e., total episode spending less than target price) but have not yet met the quality thresholds to receive reconciliation payments, subject to implementation of an improvement plan and measurable improvement over time.**

An improvement plan should include a written step-by-step plan of action developed by the participant hospital in response to its initial inability to meet the

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<sup>8</sup>Hospital Compare. 30-day unplanned readmission and death measures. <https://www.medicare.gov/hospitalcompare/Data/30-day-measures.html>. Accessed August 21, 2015.

quality thresholds. CMS should assist in defining the scope of a hospital's action plan, setting improvement benchmarks, and outlining a time frame in which the hospital must demonstrate quality improvement. We urge CMS to use an individual hospital's performance as a benchmark for quality improvement over time, allowing each respective hospital to show measurable improvement in outcomes specific to that hospital's performance. A hospital that does not improve over time should not be eligible for reconciliation payments. However, forcing hospitals to improve practices while removing the opportunity to receive reconciliation payments to assist financially in such efforts is setting them up for failure. CMS should provide participant hospitals the incentive, through reconciliation payments, to integrate redesign practices and gain experience with the CCJR Model. **We urge CMS to provide robust guidance and technical support in the implementation of a hospital's improvement plan related to the CCJR Model.**

Additionally, CMS proposes to provide historical and ongoing claims data representing care furnished during the CCJR episodes of care in recognition of the importance of allowing hospitals the opportunity to analyze, prospectively, detailed beneficiary-level information, as well as regional aggregate expenditure data. In doing so, hospitals will be better able to estimate acute inpatient and post-acute spending within the CCJR episode of care, evaluate practice patterns, and adequately structure care pathways. America's Essential Hospitals supports CMS' proposed data sharing for participants within the CCJR Model. This data sharing in conjunction with an improvement plan will allow hospitals to share best practices and improve practices, ultimately leading to aggregate improvement across hospitals in the model.

We urge CMS to afford providers ample time to evaluate data obtained through participation in this new payment model. The success of the CCJR Model lies in the ability of a hospital to assess current care coordination practices, determine if alternatives exist that might be more appropriate, and ultimately improve on practices over time. This improvement process requires a financial commitment on the part of hospital participants. Thus, hospitals' ability to receive reconciliation payments, without excessive barriers, is crucial for redirecting savings back into care redesign, coordinated care processes, and improved patient outcomes.

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America's Essential Hospitals appreciates the opportunity to submit these comments. If you have any questions, please contact Erin O'Malley, Director of Policy, at 202-585-0127.

Sincerely,

/s/

Bruce Siegel, MD, MPH  
President and CEO