Society of Hospital Medicine
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September 8, 2015

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

Dear Acting Administrator Slavitt:

The Society of Hospital Medicine (SHM) submits the following comments on CMS-5516-P Medicare Program; Comprehensive Care for Joint Replacement Payment Model for Acute Care Hospitals Furnishing Lower Extremity Joint Replacement Services.

SHM represents the nation's nearly 48,000 hospitalists, who are experts in primary care for hospitalized patients. In this role, they provide a significant amount of care to Medicare and Medicaid beneficiaries, ensuring safe and efficient delivery of care during hospital stays and transitions in and out of the hospital. SHM strongly supports exploring alternative payment models designed to improve quality of care and efficiency, including bundled payments.

Many hospitalist groups nationwide are preparing for, or are currently taking on risk and participating in the Center for Medicare and Medicaid Innovation's (CMMI) Bundled Payment for Care Improvement Initiative (BPCI). In joint replacement episodes, hospitalists frequently manage or co-manage patient care with specialists, and provide pre-operative and post-operative care. With significant hospitalist involvement in current bundled payment efforts, and their role in caring for joint replacement patients, the Comprehensive Care for Joint Replacement (CCJR) model, as proposed, raises significant concern.

CCJR Model Threatens to Marginalize Physicians

We are deeply concerned that under the CCJR program, CMS/CMMI has discounted the importance of physician-led healthcare redesign by placing control of the bundle fully into the hands of the hospital. The CCJR program mandates hospital control of the clinical, financial and care incentives, thereby running the risk of leaving physicians disengaged. We strongly believe it is imperative that CMS/CMMI recognize the critical nature of strong physician engagement and of the physician's role in creating the successful care redesign that we all hope to see from bundled payments and other provider risk models.

Furthermore, physician gainsharing and CCJR risk sharing arrangements are too limited and physicians should be granted the opportunity to participate more meaningfully in any savings generated.

Physicians are a necessary component of any care delivery model, and cannot be marginalized in new alternative payment models. In its current form, the CCJR sends the wrong signal and risks triggering the disengagement of physicians who may otherwise be willing to invest their time, effort and resources into new alternative payment arrangements. Allowing physician groups to take risk for episodes of care that they manage must be an integral part of the equation and the CCJR proposal does not create this opportunity.

Mandatory Bundle is Premature

SHM strongly believes that the proposed CCJR model is premature. Physicians and hospitals alike are beginning to successfully create care redesign programs under the BPCI model, and it is clear that both hospitals and physicians are truly embracing this effort. However, many hospitals and physician practices are not prepared to successfully enter into a bundled payment model on their own. This is evidenced by the large number of organizations that did not enter into current BPCI models, and by the wide reliance on convener organizations as partners for those organizations that did decide to enter into current models. With this in mind, the implementation timeframe for CCJR is overly aggressive, forcing hospitals to take on risk that they neither prepared for, nor desired. If a significant number of those organizations fail to manage that risk, and therefore suffer financially under the CCJR, the experience will damage the otherwise promising enthusiasm generated by current *voluntary* BPCI participants. Even worse, hospitals who are forced to take risk under CCJR could start turning away patients for joint surgery, or otherwise dramatically change the way they select patients for surgery. The unintended consequences to patients as a result of such desperate measures may incur a consumer backlash against the concept of episode-based-payments.

Rather than risk backlash against bundled payment initiatives overall just to test the CCJR concept, CMS/CMMI should formally evaluate more BPCI data prior to implementing a new model. Most notably, CMS should look at actual cost savings and quality improvements, and undertake a serious assessment of the relative strengths and weaknesses of physician-led versus hospital-led bundled payment programs. Any evaluation should also take into account various care redesign efforts and impacts on patient/beneficiary outcomes.

Recommendations

SHM strongly recommends delaying implementation of the CCJR bundle until more hospitals and provider groups are comfortable with, and capable of, taking on risk. This will also allow more data to be available for purposes of comparing the results of hospital and provider group initiated models, and only then, should those models be implemented in a way that better balances control of the model between physicians and hospitals.

Should the CCJR program proceed as scheduled, we strongly recommend that the following changes be made to allow physicians to fully participate, and to ensure physician engagement in the program:

- Allow physician groups in the 75 identified MSAs to voluntarily take risk on patients whom they admit for surgery, and thereby lead the effort to provide their own patients with better, more

cost effective care, and better outcomes. All joint cases admitted to a given hospital that do not fall under a physician group that has taken risk, can then be assigned to the pool of patients for which the hospital takes risk. It also ensures that the physician populations caring for these patients do not feel marginalized in the new mandatory program as they will have been given first opportunity to take risk, if they so desire.

- Allow physician groups to enter into risk sharing arrangements with hospitals who end up bearing risk on the episode beyond the 50% cap.

SHM encourages CMMI and CMS to work on expanding bundled payment programs, including BPCI, and improve the climate for both facilities and physician practices to enter into risk-sharing arrangements by:

- Recognizing physicians who enter risk sharing agreements in CCJR, BPCI and other CMMI programs as participating providers in the Alternative Payment Model (APM) pathway under MACRA beginning in 2019.
- Ensuring that physician BPCI participation takes precedence over CCJR or similar models, if implemented.
- Including specific and broad fraud and abuse waivers related to the civil monetary penalty law, the anti-kickback statute and the physician self-referral law. Without clear safeguards in place from the inception, both hospitals and physicians may be reticent to enter into mutually-beneficial risk sharing or gainsharing arrangements.

Conclusion

SHM appreciates the opportunity to provide comments on the proposed Comprehensive Care for Joint Replacement Payment Model for Acute Care Hospitals. If you require any additional information or clarification, please contact Josh Bowell, Director of Government Relations at jboswell@hospitalmedicine.org or 267-702-2632.

Sincerely,

Robert Harrington, Jr., MD, SFHM
President, Society of Hospital Medicine