Congress of the United States
Washington, DC 20515

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Mr. Andrew Slavitt
Acting Administrator
Centers for Medicare & Medicaid Services
Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, D.C. 20201

Patrick Conway, M.D., MSc
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Dear Mr. Slavitt and Dr. Conway:

CMS recently proposed the Comprehensive Care for Joint Replacement Model (CCJR), a new episode-based payment model for lower extremity joint replacement (LEJR) that would apply to 75 Metropolitan Statistical Areas (MSA's) for five years. The CCJR proposed payment model represents a significant change for beneficiaries and providers because it constitutes the first mandatory Medicare episode payment model promulgated under CMS' CMMI authority. Other CMS proposed models, including the Bundled Payments for Care Improvement (BPCI) on which the CCJR model was based, have all been voluntary. Given this substantial change for Medicare beneficiaries and providers, we raise certain questions and ask that you delay the implementation of the CCJR payment model for at least one year.

HHS has a goal of tying 85 percent of all traditional Medicare payments to quality or value by 2016 and 90 percent by 2018 through programs such as Hospital Value Based Purchasing. To be sure, increasing value by means of improved outcomes and reduced cost is a goal that we all share. As a result, the questions below relate not to the goal itself but, rather, how the Centers for Medicare and Medicaid Services (CMS) seeks to achieve it.

1. We recognize the uniquely positive influence that patient choice has in achieving quality, responsiveness, effectiveness, and efficiency of healthcare services. Systems that foster patient choice have proven to work, whereas those that supplant patient choice with centralized control have often led to shortages, rationing, and poor outcomes. If it ultimately places post-acute care (PAC) funding with hospital control, the CCJR model would likely create a strong incentive for hospitals to acquire post-acute care facilities and orthopedic surgery practices, or preclude independent practices from performing surgeries at the hospital. There is a considerable body of evidence suggesting that healthcare market consolidation can have deleterious effects on patients, providers, and taxpayers.[1] It also appears likely that hospitals would be compelled to

[1] Between 1998 and 2012, there were 1,113 mergers and acquisitions involving a total of 2,277 hospitals. Mergers have nearly doubled in recent years. There were 95 hospital mergers in 2014, 98 in 2013, and 95 in 2012. Compare that with

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restrict the provision of additional services by Medicare beneficiaries' physicians in order to mitigate the risk that hospitals will face under the CCJR program. What safeguards are incorporated into the proposed CCJR model, and are under consideration in any possible future iteration, that would guard against hospital-driven vertical integration or other forms of market consolidation that could lead to higher costs? Consequently, what protections are incorporated into the proposed CCJR model to maintain a patient's freedom to choose their provider, course of treatment, and medical services?

2. We are concerned that patients requiring higher-cost complex surgeries (such as hip fractures and ankle replacement procedures) or who suffer from multiple chronic conditions may find it more difficult to find hospitals willing to serve them, since the greater risk of complications or the higher level of post-acute care associated with their condition would be logically viewed by hospitals as increasing their risk under the proposed CCJR model. Additionally, since the CCJR model excludes "non-elective" joint replacement surgeries (many of which involve complex hip fractures) from its quality framework, but otherwise maintains such cases for "target price" and episode expenditure purposes, this could potentially place too much emphasis on the cost of these vulnerable patients' post-acute care without adequate consideration of their outcomes and the quality of care they receive. What safeguards are incorporated into the proposed CCJR model to ensure that patients with complex surgeries or chronic conditions would have access to the full spectrum of hospitals, physicians, and post-acute care providers under CCJR that they are able to access today?

3. Small and rural hospitals are a crucial resource for numerous communities. The risk placed on hospitals by CCJR, as well as the oversight and administrative responsibilities that hospitals would have to bear for 90 days post-discharge may be so burdensome that small and rural hospitals may have little option other than to be subsumed into larger systems or refrain from offering lower extremity joint replacement surgeries. What safeguards are incorporated into the proposed CCJR program to address the specific needs and circumstances of small and rural hospitals?

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50 mergers in 2005, and 54 in 2006. American Hospital Association, *Trendwatch Chartbook 2012: Trends Affecting Hospitals and Health Systems*, http://www.aha.org/research/reports/tw/chartbook/index.shtml. See also: Glenn Melnick and Emmett Keeler, "The Effects of Multi-Hospital Systems on Hospital Prices," *Journal of Health Economics*, Vol. 26 (2007), pp. 400–413. See also: Martin Gaynor, "What Do We Know About Competition and Quality in Health Care Markets?" National Bureau of Economic Research *Working Paper* No. 12301, June 2006, http://www.nber.org/papers/w12301.pdf In 2005, only a quarter of physician medical practices were owned by hospitals. By 2008, the majority of physician practices were hospital owned. Gardiner Harris, "More Doctors Giving Up Private Practices," *The New York Times*, March 25, 2010. (See also House Committee on Ways and Means, Hearing on Health Care Industry Consolidation, September 9, 2011 and House Committee on Small Business, Subcommittee on Investigations, Oversight, and Regulations, "Health Care Realignment and Regulation: The Demise of Small and Solo Medical Practices?" July 19, 2012.) In 2014, the share of doctors who have an ownership stake in their practice was estimated to be down to about one-third, and only 2 percent of newly licensed physicians were seeking a solo practice. David Rotham, "Hospital Networks Need a Hippocratic Oath," *The New York Times,* March 6, 2014. See also: Xu T, Wu AW, Makary MA. The Potential Hazards of Hospital Consolidation: Implications for Quality, Access, and Price. *JAMA.* Published online August 13, 2015.

4. This CCJR model requires sophisticated coordination of care that will demand additional providers within the post-acute setting to collaborate with hospitals to define and monitor a patient's care plan.[2] The CCJR proposed rule indicates that forcing post-acute care providers to invest in Electronic Health Records (EHRs) will accomplish the needed coordination, as hospitals that rely on post-acute care providers without EHRs may not be eligible for reconciliation payments in the future. How would this mandatory approach within the CCJR model prevent forced relationships between providers based on the meaningful use of EHRs, rather than allowing these choices to be based on who provides the best quality of care, keeps patients the safest, and does the best job of coordinating with the hospital and other providers?

5. The total amount of gainsharing payments for a calendar year paid to an individual physician, nonphysician practitioner, or physician group practice who is a CCJR collaborator cannot exceed a cap equal to 50 percent of the total Medicare approved amounts under the Physician Fee Schedule (PFS) for services furnished to the participant hospital's CCJR beneficiaries during a CCJR episode by that physician, non-physician practitioner, or members of the physician group practice. Why are you limiting gainsharing payments to providers who will be responsible for much of the care-redesign required in this model? Additionally, why are post-acute care providers not meaningfully included in the CCJR bundle to ensure quality care is provided over the entire continuum of care?

In light of the January 1, 2016 effective date proposed by the Agency, we request your response to these questions no later than October 1, 2015. The CMS proposal represents a significant change to our healthcare delivery system which could have a negative impact on patient choice, access and quality. Given the fact that the proposed rule will not be finalized until almost the year's end, it will give physicians, hospitals and post-acute providers little or no time to prepare for this abrupt shift in payment for these high-volume procedures and the changes in care delivery that they will require. As a result, we ask that you seriously reconsider the CCJR payment model. At a minimum, we ask that you delay the implementation of the CCJR payment model for at least one year.

Yours truly,

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[2] CMS assumes that hospitals will enter sharing arrangements with post-acute care providers. See pg. 41297 of the CMS proposed CCJR rule.

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