



March 28, 2016

To: The Health Care Plan Learning and Action Committee (HCPLAN)

From: AMGA

Re: Comments in Response to HCPLAN's "Elective Joint Replacement" Draft White Paper

On behalf of AMGA, we appreciate the opportunity to comment on the Health Care Payment Learning and Action Network's (HCPLAN) "Accelerating and Aligning Clinical Episode Payment Models: Elective Joint Replacement, Draft White Paper." AMGA, founded in 1950, represents more than 450 multi-specialty medical groups and integrated delivery systems representing about 177,000 physicians who care for one-in-three Americans. Our member medical groups participate in the Center for Medicare and Medicaid Services' Comprehensive Care for Joint Replacement (CJR), in the agency's Bundled Payments for Care Improvement (BPCI) demonstrations, and in various commercial bundled payment arrangements. AMGA has a strong interest in the success of both the Medicare program and private payers' bundled payment initiatives.

AMGA's sees the same problems present in the HCPLAN's white paper draft outline of "the adoption of clinical episode-based payment models" "for elective joint replacement" (or for lower extremity joint replacement, or LEJR) as we saw in Medicare's CJR demonstration. Several substantive issues are either unaddressed or addressed inadequately. AMGA's comments are limited to five comparable issues or problems: underlying payment; overuse; care coordination; quality measurement or including the use of the Unique Device Identifier (UDI); and, profit sharing.

Underlying Payment

Like the Medicare CJR demonstration, the white paper does not address underlying payment reform. Under "episode price" the white paper simply states, "price should be based on the performance of the better performers in a particular market." As in Medicare's CJR demonstration, a finite list of reimbursements for LEJR-related services and procedures is assumed and simply bundled for the white paper's proposed 120 day LEJR episode. Paying providers exactly the same neither encourages, nor allows for, care innovation. As Harold Miller noted in his 2015 report, "Bundling Badly: The Problems with Medicare's Proposal for Comprehensive Care for Joint Replacement," "in a true episode payment system, the providers have the flexibility to deliver services that they could not bill for under the fee for service structure, knowing that they will ultimately be paid for those services when the reconciliation occurs." Providers are left unable to innovate by providing services that reduce costs, not just improve savings. Like the Medicare CJR demo, the white paper's design outline is simply another pay for performance effort.

Overuse

There is substantial LEJR overutilization, which is made evident by unwarranted variation. Researchers at Dartmouth's Institute for Health Policy and Clinical Practice have shown regional LEJR variation per 1,000 Medicare beneficiaries can range from two to seven episodes for hip replacement and from four to sixteen episodes for knee replacement. There also exists substantial variation within regions and by race. These problems are compounded by the fact that LEJR episodes account for the largest dollar amount (\$25 billion) and highest percentage (6.3 percent) of annual 30-day-episode Medicare spending. Beyond the recommendation under "Episode Definition" that there needs to be evidence of a functional status assessment and the use of a shared decision aid to "support the appropriateness of the episode," AMGA recommends there needs to be demonstrated use of appropriate evidence based clinical guidelines. We also recommend that payers carefully monitor utilization to better assure appropriate use. Absent these checks, LEJR episode expenditures could perversely decrease episode spending while at the same time increase aggregate spending.

Care Coordination

Care coordination is not one of the white paper's 10 "recommendation" subtopics. Care coordination is only mentioned within the context of the white paper's LEJR 120 care episode. This is disappointing since healthcare is already too fragmented. We also know that nearly 75 percent of seniors, who are most likely to receive a LEJR procedure, suffer from two or more chronic conditions and that nearly four in ten suffer from four or more chronic conditions. The white paper ignores the fact these patients are more likely than not co-morbid. This means these patients simultaneously have other, or additional, on-going care needs. The white paper final draft should include a discussion of how the joint replacement episode will be coordinated with other providers, such as Accountable Care Organization providers, to treat patients with simultaneous or ongoing chronic care needs. We also encourage the white paper work group and staff to consider the use of patient navigators throughout the entire 120-day episode, since many CMS Acute Care Episode (ACE) demonstration participants made product use of their services.

Quality Measurement

The use of implantable medical devices, particularly artificial hip and knee replacements can cause substantial iatrogenic harm. Causes of joint replacement failure include mechanical loosening, osteolysis, infection, instability, peri-prosthetic fracture, and implant failure. These can lead to, among other consequences, cerebral and nervous system impairment, bone deterioration and amputation. If a hip or knee implant fails, a second replacement has a higher failure rate than a primary replacement; these surgeries require more technical expertise, are significantly more expensive, and fewer surgeons have the ability to perform second or "revision" replacement surgeries, which limits access to these procedures in some regions.

AMGA strongly supports the use of the quality metrics identified in the paper. However, it is disappointing the white paper does not recommend the use of the FDA's Unique Device Identification (UDI) system, particularly because the CMS ACE demonstration providers used cheaper surgical implants, equipment and materials in both the orthopedic and cardiovascular DRGs to produce the greatest cost savings. The white paper should support Department of Health and Human Services Secretary Sylvia Burwell's advocacy for incorporating UDIs in support of the FDA's Sentinel Initiative. This effort also is supported by the American Joint Replacement Registry, HL7 (Health Level Seven International), AARP, Duke Medicine, Geisinger, Intermountain Healthcare, The Leapfrog Group, the Pacific Business Group on Health, The Pew Charitable Trusts, Premier, and numerous others.

Profit Sharing

Under "payment flow," the white paper discusses prospective versus retrospective payment and recommends, "at this point in time," the latter. Per our "underlying payment" comment above, providers should be given a choice in how they are reimbursed. Providers more able to accept risk and more willing to innovate to reduce costs should be given the opportunity to do so.

For several reasons, we also recommend that the white paper outline a protocol whereby profit sharing is achieved. There is no evidence to support the view that the "accountable entity" or "quarterback" will simply "opt" to profit or gain share. Most ACE demonstration providers did not do so. Profit sharing would enable the "accountable entity" to share risk with providers formally involved in the care episode, particularly post-acute providers where LEJR care costs most widely vary. Profit sharing should include non-episode providers in cases where the patient is receiving simultaneous or ongoing care. Profit sharing should also include the patient to incent self-activation. Profit sharing also avoids the perception, or reality, that in a world where providers are caring for the whole person and addressing population health needs, bundled payment arrangements fragment or silo care, are redundant, and competitive. Bundled payment arrangements should create synergy between and among providers.

Thank you for offering AMGA an opportunity to comment. We look forward to continuing to work with the HCPLAN to evolve further bundled payment arrangements. If you have any questions please do not hesitate to contact David Introcaso, Ph.D., Senior Director for Regulatory and Public Policy, at dintrocaso@amga.org.

Thank you.



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