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Lew Sandy, MD
Chair, Clinical Episode Payment Work Group
Health Care Payment Learning and Action Network
PaymentNetwork@MITRE.org

Re: Comments on Draft Elective Joint Replacement White Paper

Dear Dr. Sandy:

Thank you for the opportunity to provide comments on the clinical episode payment (CEP) workgroup's paper on elective joint replacement. The Pacific Business Group on Health (PBGH) is a non-profit organization that leverages the strength of its 65 members—who collectively spend $40 billion a year purchasing health care services for more than 10 million Americans—to drive improvements in quality and affordability across the U.S. health system.

Moving toward value-based payment methodologies like orthopedic bundles has long been a cornerstone of our members' strategy for lowering health care spending while improving the quality of care their employees receive. As part of that effort, PBGH currently administers the Employers Centers of Excellence Network (ECEN), a nationwide travel surgery program for joint replacements that features episodic payments to hospitals, physicians, and post-acute care providers. To date, ECEN participants have paid four hospital systems more than $30 million in bundled payments for 1,120 hip and knee replacement surgeries.

PBGH also has several years of experience administering one of the first and most comprehensive joint replacement data registries in the country. Founded in 2009, the California Joint Replacement Registry (CJRR) serves as an important public resource for comparative effectiveness research and evidence-based decision-making. CJRR is a "Level 3" registry that includes patient-reported outcome data as well as payer, provider, clinical, surgical, laboratory, pharmacy, and device information. It has recently been incorporated into the nationwide American Joint Replacement Registry.

Both CJRR and ECEN—as well as other PBGH member initiatives—have generated significant insights in orthopedic bundle design, quality measurement, and patient experience that can be brought to bear on the LAN's framework for joint replacement document. It is with these lessons in mind that PBGH and its members offer the following feedback:

1. Appropriateness of Care. The paper needs to more clearly define what constitutes "appropriate care" and ensure that this definition represents a suitable threshold. Our ECEN experience suggests that there are a number of cases where joint replacement is sought by a patient or referred by their treating physician that are determined to be inappropriate or in some cases not necessary. For Lowe's, a participating ECEN employer, 15% of cases referred for surgery were told by a Center of Excellence that a joint replacement was not the appropriate course of treatment at that time. The Bree Collaborative cites additional components for determining appropriateness: 1) disability due to osteoarthritis despite conservative therapy, 2) documented

conservative therapy for at least three months, and 3) evidence of osteoarthritis according to standardized radiographic criteria.

2. Prospective Bundled Payment vs. Retrospective Reconciliation. The workgroup's recommendation to pursue retrospective reconciliation through fee-for-service rather than prospective payment is not very aspirational. Hospitals and surgeons have more opportunity to innovate in how they deploy professional staff, choose technology, and engage with outpatient and home-based services when they have full flexibility within a budgeted payment amount. Prospective bundles are indeed spreading in the hip and knee replacement market; for instance, ECEN uses a pre-negotiated rate for DRG 469 and 470 that includes pre-op diagnostics, facility and professional fees, implants, post-op clearance, and initial physical therapy.

   The LAN paper recognizes prospective bundled payment "may serve as a foundation for greater innovation in the quality and coordinated care delivery needed to make episode payment successful" but concurrently conveys a strong bias towards retrospective fee-for-service reconciliation. At the top of page 19, the report states that the prospective method "works most effectively when care is delivered via an integrated health system." This is overly simplistic. The prospective method is undoubtedly easier to implement in integrated settings; however, its impact would be greater—and therefore more "effective"—in non-integrated systems by incentivizing collaboration and coordination across providers and care settings.

   While the report concludes that retrospective payment is "the most practical approach at present," there is value in the CEP workgroup advancing a stronger view about the importance of testing prospective models that change the underlying financial incentives to motivate care redesign. Many of the early Medicare BPCI adopters reported savings through reduced post-acute care utilization and steerage to providers with deeper contractual discounts. Prospectively negotiated bundles could lead to more targeted action to reduce care variation, optimize patient safety, and promote provider engagement.

3. Patient-Reported Outcomes Measures and Quality Scorecards. Requiring providers to report and achieve benchmark levels on patient-reported outcome and functional status measures (PROs) in order to receive payment under an orthopedic bundled payment scheme is prudent. We concur with the need to prioritize PROs and measure longitudinal patient outcomes. The Core Quality Measures Collaborative Orthopedic Measures do not go far enough in this regard. The paper states that the use of functional status tools is relatively new and that there may not be enough information on where quality thresholds should be set. In fact, the Hip disability and Osteoarthritis Outcome Score (HOOS) and Knee injury and Osteoarthritis Outcome Score (KOOS) have been widely used and validated. Each of the Employers Centers of Excellence hospitals collect patient-reported outcomes. Effective risk adjustment and comparative presentation of quality and outcome metrics is now widespread in other industrialized nations, including the United Kingdom, Sweden, Norway, and Australia. The California Joint Replacement Registry, now working with the American Joint Replacement Registry, published initial quality results in its 2014 Annual Report.

   Not only is quality information needed to communicate and engage with patients, but ***better*** quality information to inform improvement activities and consumer choice of provider. We note the absence of any meaningful emphasis in the workgroup paper about improving quality information

and longitudinal measurement of functional outcomes. Rather than suggesting that quality measurement "may" include up to 12 months of data, it "should" include such measures. Encouraging broader participation in and reporting to clinical registries and embedding such data collection in current workflows are essential to improving care and reducing unwarranted variation.

4. Patient Population and Risk Adjustment. The paper states that appropriate risk and severity adjustment to price are "critical… if the episode is to be attractive to providers." If attractiveness to the provider is the litmus test, the bundled payment is not likely to be much differentiated from fee-for-service. We note that this paper is focused on elective joint replacement and that aggressive appropriateness criteria should be applied at the outset. With screening criteria such as BMI levels already in place as well as use of optimal care guidelines pre- and post-surgery, there is already risk mitigation. Risk adjustment should not serve as a back door for insufficient patient safety management and avoidable complications. Alternatively, using a risk corridor or basic stop-loss mechanism may be more appropriate for managing undue insurance risk. Patient exclusion processes are equally likely to incent "reverse cherry-picking" that increases surgical volume and inclusion of low-risk patients in the bundle, a bundle that has been priced for the whole population at the outset.

5. Alignment with Benefit Design. We strongly recommend revisiting the workgroup's decision not to endorse the importance of tying benefit changes to payment reforms. Employers (e.g., all of the ECEN participants, Boeing and Intel with their ACOs) rely on aligning payment with benefit design to make the APMs like CEP work.

6. Fraud and Abuse Waivers. It is important to acknowledge that fraud and abuse waivers are needed to enable gainsharing. The BPCI Initiative has demonstrated the importance of gainsharing in the design of successful bundled payment programs. While gainsharing helps to align care delivery incentives through financial benefits, it is often viewed under federal policy as inappropriate remuneration that raises fraud and abuse concerns. Waivers of these policies are key to forging the alignment between providers—hospital and physicians—necessary for successful coordination under bundled payment programs. If providers continue to be subject to existing regulations, participants in joint replacement models may need more than just waivers; new safe harbors from certain laws should be developed that eliminate potential liability due to the public policy benefits of better aligned care and cost reductions.

7. Implementation Toolkit. Many of the purchasers we spoke with reported that providing explicit language, talking points, or instructions for employers who want to encourage their carriers to adopt this type of prospectively negotiated, comprehensive joint replacement bundle could increase the uptake and impact of the CEP workgroup's recommendations. A "gold standard" and set of metrics with which to evaluate the orthopedic bundles offered by carriers and TPAs would also be helpful. We strongly advise the group to develop a short implementation toolkit for commercial purchasers as part of the white paper.

To augment the listed resources in Appendix D, we also offer the following materials developed from our experience in implementing the joint registry:

Shared Decision-Making Tools: Impact of decision and communication aids on patient knowledge, efficiency of decision making, treatment choice, and patient and surgeon experience.

Patient Assessment Tools: The California Joint Replacement Registry Selecting a Tool for Evaluating Patient-Reported Outcomes. This report provides a literature review of the most commonly-used PRO questionnaires, as well as the use and performance criteria considered by CJRR in selecting an instrument. Additional information on implementation experience has also been published.

Thank you again for the opportunity to provide feedback to the CEP workgroup on this important framework document. We look forward to continuing to engage public and private purchasers in the workgroup's activities, and continue to strongly support the LAN's broader effort to increase value across the U.S. health system.

Please contact me should you require any additional information or clarification.

Sincerely,

David Lansky, PhD
President and CEO