CALIFORNIA HOSPITAL ASSOCIATION
Providing Leadership in Health Policy and Advocacy

June 23, 2020

Seema Verma
Administrator
Centers for Medicare & Medicaid Services
Hubert H. Humphrey Building
200 Independence Avenue, S.W., Room 445-G
Washington, D.C. 20201

SUBJECT: CMS-5529-P Medicare Program; Comprehensive Care for Joint Replacement Model Three-Year Extension and Changes to Episode Definition and Pricing; Proposed Rule, Federal Register (Vol. 85, No. 36), February 24, 2020

Dear Administrator Verma:

On behalf of our more than 400 hospital and health system members, the California Hospital Association (CHA) appreciates the opportunity to submit comments on the Centers for Medicare & Medicaid Services' (CMS) proposed rule to extend and modify the Comprehensive Care for Joint Replacement (CJR) model.

CHA appreciates the effort the agency put into issuing the proposed rule. However, since its publication, the COVID-19 public health emergency (PHE) has greatly altered the health care system's landscape. While we continue to support the development of alternative payment models that incentivize high-quality, efficient, and coordinated patient care, we are concerned that the COVID-19 PHE will significantly impact whether CJR model participants can be successful and adapt to the proposed changes of the extended model. **In light of the unprecedented challenges hospitals are currently facing, we urge CMS to reconsider the proposed rule and end the CJR model as scheduled at the end of performance year 5.**

CMS recently acknowledged the impact of the COVID-19 PHE on the CJR model when it issued an interim final rule extending the CJR model performance year 5 by three months (to March 31, 2021) and applied the extreme and uncontrollable circumstances policy to episodes impacted by the pandemic. In the interim final rule, CMS extended the model to ensure operational continuity for hospitals simultaneously dealing with COVID-19 challenges. However, the duration of the COVID-19 PHE — as well as its lasting impacts — are currently unknown. Preparing for changes to a mandatory payment model will be a challenge for hospitals for the foreseeable future.

In addition, CMS applied its extreme and uncontrollable circumstances policy to all episodes (with or without fracture) that have dates of anchor hospitalization admissions on or within 30 days of the date that the emergency period begins, as well as those that occur during the emergency period. Under the policy, actual episode payments will be capped at the applicable target price as determined for that

episode. CMS finalized this policy in anticipation of declines in volume of procedures performed under the CJR model during the PHE, as elective operations are being sharply limited. However, hip replacement episodes for fractures will continue to trigger episodes, and the model's post-discharge period will overlap with the PHE period for some beneficiaries whose episodes were triggered prior to March 2020. Without the application of the extreme and uncontrollable circumstance policy, participant hospitals would be financially disadvantaged during the financial reconciliation process for high episode costs unrelated to the model itself, but rather the increasing health care costs during the PHE. CHA supports this policy and urges CMS to further hold hospitals harmless from performance-related penalties for the entire 2020 performance year.

CHA is concerned that the COVID-19 PHE will have long-lasting impacts on the health care system that cannot be anticipated at this time. Notably, the cancellation of elective surgeries will not only affect episodes for participants initiated during the PHE, but the claims data to set target prices for future years of the model if extended. Should CMS extend the model, it would have to make significant changes to its proposed payment methodologies to reflect the impacts of the COVID-19 PHE in future performance years. **Therefore, we believe it would be appropriate to end the model as scheduled — either on December 31, 2020, or March 31, 2021, as finalized in the interim final rule — and evaluate the five-year model to inform the development of future hospital-initiated voluntary payment models.**

CHA has long opposed mandatory participation in alternative payment models — rather, we support voluntary models that allow hospitals to determine which most closely align with their organization's unique strategic goals. In the proposed rule, CMS notes that the Bundled Payments for Care Improvement Advanced (BPCI Advanced) model is a voluntary model that tests the same total knee arthroplasty (TKA) and total hip arthroplasty (THA) diagnosis-related groups (DRGs) as the CJR model under its lower extremity joint replacement (LEJR) bundles, including outpatient TKA procedures as of January 1, 2020. **Should CMS end the CJR model as scheduled, it should open an additional round of BPCI Advanced applications, allowing CJR participants to voluntarily continue participation in an advanced payment model while selecting the episodes most appropriate for their strategic goals, which could include the selection of LEJR episodes.**

However, should CMS proceed in extending the CJR model, we offer the following comments on specific provisions of the proposed rule.

Proposed Three-Year Extension of CJR Model
CMS proposes to extend the CJR model for an additional three years — through December 31, 2023 — beyond its current five-year timeline. However, this extension would apply only to hospitals in the 34 metropolitan statistical areas (MSAs) in which participation was mandatory. The model would end as currently scheduled on December 31, 2020, for all hospitals participating in the 33 voluntary MSAs, as well as all low-volume and rural hospitals that have elected to participate in mandatory MSAs.

CHA has long been supportive of voluntary participation in alternative payment models and we are disappointed in CMS' proposal to end the model for voluntary participants. Hospitals that decided to say in the program voluntarily — despite the financial risks — have shown their commitment to the goals of care transformation under the CJR model and have invested significant time and resources in improvements that have directly benefited patients. Should the model end for these participants,

several incentives that promote coordinated care — such as Medicare program waivers and gainsharing agreements — would be unavailable to these hospitals, as well as the clinicians and post-acute care facilities that hospitals partner with in their communities. **Should the agency move forward in extending the CJR model for three additional program years, we urge CMS to continue to allow voluntary participation for current model participants.**

Episode of Care
CMS proposes to change its definition of an "episode of care" to address the fact that TKA and THA procedures were recently removed from the inpatient-only list and are now being performed in both outpatient and inpatient settings. Specifically, CMS would include outpatient TKAs and THAs as episode triggers for CJR. For purposes of calculating episode target prices, CMS proposes to create a CJR episode category that would blend outpatient TKA and outpatient THA episodes with non-hip fracture inpatient TKA and THA episodes to create a single target price. CMS refers to this as a "site-neutral" MS-DRG 470 price. Outpatient THAs performed for hip fracture treatment would be grouped with MS-DRG 470 with inpatient THA hip fracture episodes. Current approaches to price setting would remain unchanged for episode categories based on MS-DRGs 469 with or without hip fracture and MS-DRG 470 with hip fracture.

CHA has previously urged CMS to evaluate the inclusion of outpatient TKA in CJR in response to its removal from the inpatient-only list so as to not disadvantage inpatient hospitals, should the volume of less-complex procedures shift to the outpatient setting. We appreciate that CMS has responded to these comments and proposed a methodology to include outpatient episodes in the model. However, we remain concerned that the COVID-19 PHE will have impacts beyond anticipation that will affect CJR participants' ability to adapt to program changes at this time.

Target Price Calculation
The CJR model currently uses three years of historical baseline data to calculate initial target prices; the three-year baseline data are updated every other year. For the first three performance years, CMS blended three years of hospital-specific and regional data to mitigate concerns that some hospitals would not have sufficient historical volume to reliably calculate target prices. However, since performance year 4, target prices have been entirely based on aggregated regional spending data. CMS now believes that one year of data is sufficient to calculate target prices and therefore, for performance years 6 through 8, proposes to use the most recently available one year of data available prior to the start of the performance year to calculate target prices. Specifically, CMS proposes to base performance year 6 target prices on episode baseline data from 2019, performance year 7 target prices on episode baseline data from 2020, and performance year 8 target prices on episode baseline data from 2021. **CHA is concerned that the utilization of a single year of data, even at the regional level, can result in variation that is inappropriate for setting reliable target prices. We urge the agency to consider an alternative methodology.**

Notably, the removal of TKA from the inpatient-only list was effective beginning January 1, 2018, and removal of THA effective beginning January 1, 2020. CMS states that, by using only 2019 data for performance year 6 target prices, the agency will be able to capture spending patterns associated with the movement of TKA into the outpatient setting, as well as other practice trends during that year. However, the agency will not have any baseline data on outpatient THA episodes until 2020, which as proposed would be utilized for performance year 7. Furthermore, we are concerned that the COVID-19

PHE will significantly impact the baseline data for 2020 and possibly 2021. **Should CMS move forward in extending the model, we urge the agency to detail how it will address changes in the THA/TKA trends to account for a significant reduction in elective procedures and overall increased health care spending, especially in those regions most impacted by the COVID-19 PHE.**

Reconciliation
CMS proposes to change the high-episode spending cap used at reconciliation. Currently, CMS caps the spending amount of episodes at two standard deviations above the mean. However, CMS now proposes to change the methodology to cap episode spending at the 99th percentile. The agency believes that the high-episode spending cap is being applied too often and this change would more accurately represent the cost of infrequent and potentially non-preventable complications. However, for a subset of elective LEJR patients – despite optimal care being provided prior to surgery – unexpected and severe complications occur. The spending cap is necessary to protect hospitals from incurring undue penalties because of these complications and we do not believe the proposed cap at the 99th percentile is adequate for doing so. **CHA opposes this proposal.**

CMS proposes to move from two reconciliation periods (conducted two and 14 months after the close of each performance year) to one reconciliation period conducted six months after the close of each performance year. The agency has determined that the full 14 months is not necessary to sufficiently capture claims run out and overlap with other models, and that six months is adequate for capturing episode costs. **CHA agrees that one less reconciliation would reduce administrative burden for hospitals and the agency alike and supports this proposal.**

Quality Measurement: Patient-Reported Outcome Measure
CMS proposes to retain an optional patient-reported outcome (PRO) measure that enables hospitals to increase their composite quality score. However, CMS proposes to increase the data completeness thresholds for the PRO measure such that by the last year of the extension, hospitals must report on 100% of eligible cases. Hospitals report that it can be challenging to reach current thresholds and there is no credit given for partial survey completions. **CHA does not believe that a 100% data completeness threshold is appropriate and does not support this proposal.**

Eliminating the 50% Cap on Shared Payments
CJR participant hospitals are permitted to engage in financial arrangements with a variety of providers and suppliers with whom they partner in delivering care under the CJR model. CMS currently imposes a cap on gainsharing, distribution, and downstream distribution payments made to physicians, non-physician practitioners, physician group practices, and non-physician practitioner group practices. However, CMS responds to previous commenters who have argued the cap is arbitrary and inhibits hospital-practitioner collaboration. In the proposed rule, CMS states that its analysis of claims data does not indicate negative effects on beneficiary access to care due to the various types of CJR financial arrangement. For performance years 6-8, CMS proposes to eliminate the 50% cap on gainsharing payments, distribution payments, and downstream distribution payments whenever the payment recipient is a physician, non-physician practitioner, physician group practice, or non-physician practitioner group practice. **CHA supports this proposal and agrees that it will reduce regulatory burden.**

CHA appreciates the opportunity to comment on the proposed rule. If you have any questions, please contact Megan Howard, senior policy analyst, at mhoward@calhospital.org or (202) 488-3742.

Sincerely,

/s/
Anne O'Rourke
Senior Vice President, Federal Relations