April 24, 2020

VIA ELECTRONIC SUBMISSION

Seema Verma
Administrator
Centers for Medicare & Medicaid Services
7500 Security Blvd
Baltimore, MD 21244-1850

Re: CMS-5529-P Medicare Program: Comprehensive Care for Joint Replacement Model Three-Year Extension and Changes to Episode Definition and Pricing

Dear Administrator Verma:

The Health Care Transformation Task Force (HCTTF or Task Force) appreciates the opportunity to comment on the Centers for Medicare and Medicaid Services (CMS) proposed rule 5529-P addressing proposed changes to the Comprehensive Care for Joint Replacement (CJR) model (Proposed Rule).

The Task Force is an industry consortium representing a diverse set of organizations from various segments of the industry – including providers, health plans, employers, and consumers – all committed to adopting payment reforms that promote a competitive marketplace for value-based health care and allow health care organizations to move from a system that incentivizes volume of services to one that rewards value of care. Our member organizations aspire to have 75 percent of their business in value-based arrangements by the end of 2020. We strive to provide a critical mass of policy, operational, and technical support from the private sector that, when combined with the work being done by CMS and others, can increase the pace of delivery system transformation.

Our members have developed, operated, and participated in various alternative payment models, including Bundled Payments for Care Improvement (BPCI), BPCI Advanced, the Oncology Care Model, and CJR. We believe these models present key opportunities for providers to invest in improving quality and reducing health care expenditures. We applaud CMS's commitment to the ongoing refinement of bundled payment models and encourage continued efforts to expand opportunities for organizations to take on more advanced risk and accountability for total cost of care and outcomes for Medicare beneficiaries.

Below, HCTTF offers general comments on the Proposed Rule as well as feedback on the specific program changes that CMS highlighted for feedback.

I. General Comments

HCTTF commends the ongoing efforts of CMS to update the CJR model in response to changes in the standards and practice of lower extremity joint replacement (LEJR) procedures. In response to CMS proposed rule 5516-P, we encouraged CMS to engage with stakeholders with prior experience in LEJR models to identify specific issues with model designs that could impact operations. We appreciate the outreach effort that this Proposed Rule represents, and the effort made to explain the reasoning behind many of the methodological changes in the proposed rule. Overall, **the Task Force supports the decision to incorporate outpatient hip and knee arthroplasty into the CJR model and the proposal to extend the model for an additional three years to test changes to the methodology.**

We encourage CMS to offer CJR participants clear guidance on the issue of model overlap as well as inclusion and exclusion criteria for beneficiary eligibility. With that in mind we note that the Proposed Rule does not include information on beneficiary eligibility with regard to the Center for Medicare and Medicaid Innovation Direct Contracting Model. **We recommend that CMS amend 42 C.F.R. 510.205 to clarify beneficiary exclusion criteria when attribution cold be made to the Direct Contracting model.** Alternatively, CMS may consider incorporating broader language clarifying eligibility when attribution could be made to multiple Alternative Payment Models more generally. Additionally, **we urge CMS to avoid creating arbitrage opportunities when considering overlap with other models.** To this end CMS should ensure the costs of an episode are measured the same way in benchmarking and in performance years across models. For example, if an episode is priced in one model and the episode overlaps with another model then the episode in the other model should use either actual costs in both benchmark and performance or the episode price in both benchmark and performance.

The Task Force appreciates the action CMS has taken in Interim Final Rule CMS-1744-IFC to clarify the application of the CJR Extreme and Uncontrollable Circumstance (ECU) Policy in relation to the COVID-19 pandemic. As stated in CMS-1744-IFC, the EUC policy applies from 30 days before the Public Health Emergency (PHE) until the termination of the PHE. Our members expect that few new episodes will be initiated during the PHE and a sharp increase in demand for services after the PHE ends. Consequently, the Task Force urges CMS to consider extending the ECU policy to 90 days after the end of the PHE. We also encourage CMS to consider the long-term impacts of COVID-19 on CJR as part of this rulemaking, possibly through an interim final rule with comment period. Ideally, this IFR would cover adjustments to CJR due to expected changes in utilization patterns and spending in 2020 (and potentially beyond) which will affect target pricing, benchmarking, and quality data. CMS should also clarify how the EUC and any other provisions that limit downside risk during the Public Health Emergency (PHE) will impact providers Qualifying APM Participant status and discuss any anticipated impacts of COVID-19 on the CJR model evaluation which is critical to determining the impacts of the proposed program changes and overall model success.

Below, HCTTF provides comments on the specific provisions of the Proposed Rule as well as feedback on strategies to address some of the long-term issues that may be created by COVID-19.

II. Feedback on Provisions of Proposed Rule

a. Episode Definition

HCTTF supports the proposal to include outpatient total knee arthroplasty (TKA) and total hip arthroplasty (THA) in the CJR episode definition. As stated in our general feedback we view this change as allowing the model to keep pace with the changing standards of care and clinical practices across the

country. Additionally, we do not oppose the proposal to freeze the hip fracture and episode exclusion list.

That said, we urge CMS to provide more information as it relates to the methodology for the proposal to group the outpatient TKA and THA procedures together with the MS–DRG 470 without hip fracture historical episodes in order to calculate a single, site-neutral target price for this category of episodes. Some Task Force members have concerns about the variation in complexity between patients treated in inpatient vs. outpatient settings and the comparability in costs between TKA and THA. TKA was approved for outpatient care in 2018 and may be performed by ambulatory surgery centers (ASC), whereas THA in outpatient settings was just approved in 2020 and cannot be conducted within an ASC at this time. As discussed in the Proposed Rule, this change will result in a shift of low complexity cases to outpatient care and an increase in the average overall complexity of patients receiving inpatient procedures. Additionally, because outpatient THA was just approved for 2020, some members expressed concerns about the adequacy of data to make an informed decision on the comparability of THA and TKA costs in the outpatient setting. Consequently**, we encourage CMS to ensure that any changes to the CJR model payment policy account for the range of patient complexity and underlying operating costs for sites treating more complex patients in order to avoid unnecessarily penalizing high quality providers caring for complex patients.**

b. Target Price Calculation

The Proposed Rule states that CMS intends to shift from using three years of baseline data to a single year of data to calculate target prices. The justification provided for this change is that: (a) the shift from using hospital-specific to regional historic data for establishing target prices has addressed the volume concerns that inspired the initial decision to use three years of baseline data; (b) the use of a single year of data would result in more accurate target prices as it would incorporate the recent policy changes allowing outpatient THA and TKA procedures; and, (c) this change would simplify the model methodology.

The Task Force generally supports efforts to simplify the methodology for alternative payment models; however, our members have differing opinions on the proposed shift from three years of baseline data to a single year of data. Some Task Force members are concerned that recent regulatory changes, including the removal of THA and TKA from the inpatient only list, application of the 2-midnight rule, and addition of Ambulatory Surgery Centers as an eligible site of service for TKA, are likely to impact utilization and price trends increasing volatility in target pricing. These concerns notwithstanding, the expected effect of the COVID-19 PHE on the utilization of elective services (which comprise the bulk of THA and TKA without fracture) will likely render 2020 data unrepresentative of typical care patterns. **If CMS is committed to moving to the use of a single year of data we request that CMS exclude or adjust the 2020 data from the methodology due to the likely quality and comparability issues resulting from the PHE and request that CMS clearly explain how it intends to adjust for factors highlighted above this would incorporate into the target price calculation.**

The Proposed Rule outlines a change to the high spending cap methodology from the current approach of setting the cap at two standard deviations above the regional mean episode price to the 99th percentile of each MS–DRG and hip fracture combination for each region. This proposed change would reduce the number of episodes that fall under the high spending cap thus increasing the potential risk for model participants to incur losses. While supportive of two-sided risk models, the Task Force

also recognizes the potential for this change to disproportionately impact model participants who are providing quality care to a high-risk population. CMS should factor in the potential impact on these participants and utilize appropriate risk adjustments to ensure that changes to the high spending cap do not result in a penalty for those caring for the most complex patients.

c. Reconciliation

The Proposed Rule outlines a provision to transition from two CJR payment reconciliations at two and then 14 months after the close of a Performance Year, to a single reconciliation at six months after the close of the Performance Year. HCTTF supports this proposal, however, the transition from the current two-part reconciliation to the new single reconciliation could result in cash flow challenges for model participants. **We request that CMS provide additional clarity on the transition period and consider strategies to mitigate any cash flow issues. We also urge CMS to incorporate details on the planned approach for claims data sharing during the proposed model extension into the final rule; monthly routine claims data sharing is essential to participant efforts to monitor their performance and improve the quality of care.**

The Task Force appreciates the detail that CMS provided regarding the risk adjustment factors considered in the regression analysis that resulted in the selection of the CMS–HCC condition count and age bracket risk adjustment factors. Task Force members are concerned that this change, when coupled with the move to a single reconciliation, could leave model participants with little time to react to how these new factors impact their payments. **We urge CMS to provide model participants with data on how these adjustments would have impacted their prior years payments to assist them in preparing for the extended model period. The Task force also urges CMS to publicly release more details on the regression analysis that identified the CMS-HCC condition count and age bracket as the most impactful adjustment factors.** This information would be valuable data for Medicaid and commercial payers developing episode-based models and would promote further alignment across Medicare, Medicaid, and commercial payment models.

CMS proposes the addition of a market trend factor intended to adjust for recent variations in the underlying structure of a given market. This trend factor would be calculated at the time of reconciliation using the ratio of performance period spending to baseline period spending and applying the resulting ratio to the target price. Task Force members expressed concern with this proposal, noting that the application of the trend factor at reconciliation essentially creates a retrospective target price making it impossible for model participants to use their prospective target price to gauge their performance during the year. Furthermore, some members who participated in BPCI Model 2 noted that the implementation of a national trend factor in that model resulted in unexpectedly high downward adjustments to target prices, even for high performing participants, making it difficult to remain in the model. **We urge CMS to consider methodologies to incorporate trend factors directly into the target price on a prospective basis while retaining reasonable shared savings potential for both CMS and model participants.**

d. Elimination of 50 Percent Cap on Gainsharing

The Task Force supports the proposal to eliminate the 50 percent cap on gainsharing payments, distribution payments, and downstream distribution payments. HCTTF has long supported gainsharing as a mechanism to better encourage synchronization between bundled payment models and other

APMs. We believe the proposed elimination of the gainsharing cap will help further strengthen provider collaboration.

e. Quality Measures and Reporting

The Task Force supports the proposal to increase the quality score adjustment to a 1.5 percentage point reduction to the applicable discount factor for participant hospitals with "good" quality performance and a three-percentage point reduction to the applicable discount factor for participant hospitals with "excellent" quality performance.

Task Force members raised concerns about the ongoing reliance on HCAHPS quality measures for the CJR model, in particular flagging issues with the time lag between care delivery and measurement results and the lack of actionable provider-level data to drive quality improvement. We recommend CMS identify and propose a list of outcome-focused quality measures that can be used to inform actionable recommendations to improve LEJR quality. Task Force members also noted that Patient-Reported Outcome (PRO) measures are resource intensive to collect and present a significant financial investment for most participants. Consequently, **we encourage CMS to reconsider the feasibility of the proposed 100 percent reporting requirement for successful THA/TKA voluntary data submission. We also urge CMS to provide feedback in the final rule on the status of patient reported outcome (PRO) data collected as part of the CJR model and what progress has been made toward developing a suitable PRO measure for LEJR procedures. Finally, we urge CMS to incorporate health equity into the model evaluation approach by stratifying outcome measure data by race, ethnicity, and socioeconomic status.**

f. Three Year Model Extension

In general, HCTTF supports the proposal to extend the CJR model by three years to test the impacts of the methodology changes. CMS notes that this extension would only apply to those participant hospitals with a CMS Certification Number (CCN) primary address in the 34 mandatory MSAs. **We encourage CMS to keep model participation open to current CJR voluntary participants through the three-year extension period.** CJR has proven to be a promising model thus far and opening the model extension to continued voluntary participation would promote ongoing participation in APMs.

III. Request for Comment on New Model Concept

In recognition of the ongoing shift of joint replacement from the inpatient setting to ambulatory surgical centers (ASC), the proposed rule sought input on how to best design a future bundled payment model focused on LEJR procedures performed in ASC settings. The Task Force offers the following responses to the prompts CMS provided:

1. How could a new model better recognize the role of the surgeons and clinicians in LEJR episodes?
    - In general, the Task Force believes the role of surgeons is already well recognized in most episode-based models given that their services are often used to initiate an episode. We would encourage CMS to incorporate mechanisms to encourage shared accountability into any new LEJR model. This could include explicit requirements for partnerships and improved coordination between providers as a prerequisite for eligibility to participate in the model

2. Who should participate in the model and should the reconciliation payment and/or repayment obligations be shared between the facility and the rendering surgeon to better encourage collaboration?
    - HCTTF encourages CMS to mirror the approach used in some of its earlier bundled payment models by allowing for broader participation among hospitals and physician group practices. Consistent with our earlier comments on the proposed changes to CJR, we would encourage CMS to support the use of gainsharing and loss-sharing arrangements as a vehicle to incentivize engagement and collaboration across providers and facilities.

3. Are there any other clinicians who should share directly in the financial accountability?
    - Generally, the Task Force views the surgeon as the appropriate primary point of financial accountability for LEJR procedures; however, the model should have the flexibility to allow for gainsharing arrangements between surgeons, other providers, and the support staff who contribute to efficient and high quality care.

4. In general, would a prospective bundled payment or a retrospective target price benchmarked payment model approach work best?

    The Task force views prospective payments arrangements as preferable to retrospective payment arrangements for bundles payment models. Presumably, ASCs would be treating the lowest acuity LEJR patients with less variation in patient risk factors allowing for the development of relatively predictable prospective payment methodology. Regardless of the payment model approach, the methodology should be clearly defined, reflect current spending trends, adjust for extreme events, and offer participants achievable savings goals.

5. What types of quality measures would participants need to track and report?
    - Task Force members have concerns with the current reliance on HCAHPS quality measures for many CMS models due to the delay in measure results and lack of actionable provider level information. We recommend that CMS move away from the reliance on HCHAPs measures and focus on measures that assess the functional outcomes of LEJR. In the area of patient reported outcomes, CMS should consider the incorporation of the hip disability and osteoarthritis outcome score (HOOS) and knee injury and osteoarthritis outcome score (KOOS) surveys. CMS should also consider the incorporating a measure to monitor for poor outcomes post LEJR such as the ASC-4 all-cause hospital transfer/admission measure collected as part of the CMS Ambulatory Surgical Center Quality Reporting Program.

6. Should the model be ASC specific or site neutral such that inpatient, outpatient and ASC service sites would be paid the same rate, regardless of where the procedure was performed?
    - The Task Force believes payment methodologies should be focused on encouraging high quality care for beneficiaries in the most appropriate setting. To this end we urge CMS to consider the potential for unintended consequences created by both site-specific and site neutral payment policies in the model design process. Site specific payment policies may create incentives for the treatment of low acuity patients in more complex settings than

are required to deliver quality care. Conversely a site neutral payment policy may create incentives to treat complex patients in a care setting better suited for low acuity cases. As low risk THA and TKA procedures shift from the IP setting to OP and ASC settings, we encourage CMS to ensure that any LEJR model payment policy accurately adjusts for the range of patient complexity and underlying operating costs needed to maintain different sites of care when operating efficiently.

The HCTTF appreciates the opportunity to provide feedback on the direction of the CJR model and future LEJR models under development. We look forward to continuing to support CMS efforts to achieve sustainable change in value-based payment and care delivery, a goal that requires alignment between the private and public sectors and engagement with payers, providers, purchasers, and patients. Please contact Joshua Traylor (Joshua.Traylor@hcttf.org | 202.774.1579) with any questions or comments on this letter.

Sincerely,

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