

April 24, 2020

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

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

Dear Ms. Verma:

On behalf of our nearly 5,000 member hospitals, health systems and other health care organizations, our clinician partners – including more than 270,000 affiliated physicians, 2 million nurses and other caregivers – and the 43,000 health care leaders who belong to our professional membership groups, the American Hospital Association (AHA) appreciates the opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS) proposed extension of and modifications to the Comprehensive Care for Joint Replacement (CJR) model.

Our members support the health care system moving toward the provision of more accountable, coordinated care and are continuing to redesign delivery systems to increase value and better serve patients. The AHA believes that bundled payment models could help further these efforts to transform care delivery through improved care coordination and financial accountability; indeed, many hospitals have become deeply invested and achieved success in the CJR model over the past four years. **As such, our members support the proposed extension of the model for an additional three years, but only on a voluntary basis.** Hospitals and health systems that have been required to participate in this model have fulfilled their obligation; they should now have the option to stop participation if they do not believe it will benefit their patients. In addition, because we have long been supportive of voluntary participation in alternative payment models as a pathway to potentially improve care coordination and efficiency, **we strongly urge CMS to extend the program for all hospitals – including those currently participating on a voluntary basis.**



In addition, hospitals and health systems, as well as CMS, are currently focused on defeating COVID-19 as their predominant activity. This virus will have a dramatic impact on the health care system, including on CJR-related care. Because its implications will be far-reaching and difficult to predict, maintaining the model as-is in 2020 will be impractical. **As such, we urge CMS to hold hospitals harmless from performance-related penalties for the 2020 performance year. We also urge to you to make appropriate adjustments, for the 2020 and 2021 performance years as a start, to address the impact of COVID-19 on financial expenditures, performance scores and risk adjustment.**

Payment Methodology. CMS currently uses three years of historical data to calculate hospital target prices. It set this policy because it was concerned that using less data would not generate stable prices. However, as of performance year four of CJR, target prices are based entirely on historical data across an entire region, rather than across individual hospitals, which has mitigated the agency's low volume concerns. Thus, the agency proposes to use one year of data – the most recent available – to set target prices.

We note that CMS's use of three years of data not only helped general stable target prices, but also helped ensure that a hospital did not have to compete against its own best performance. The use of regional pricing also helped in this regard, but five years into this model, the country as a whole has seen significant improvements in cost and quality. Using only the single most recent year of data to calculate target prices will reflect these gains to the maximum extent possible, essentially penalizing regions by having their success make future savings more difficult to achieve. **Thus, we ask CMS to reconsider this proposal and instead look to other policies that do not rely on only the single most recent year of data.** For example, CMS could use 2019 data to calculate target prices for each of the three years of the extended model. We are concerned about using 2020, and possibly 2021, data as a baseline due to the COVID-19 pandemic (see also below).

However, to be clear, no matter the adjustments CMS makes, programs that are designed to achieve savings for the Medicare program year after year will see diminishing returns over time. Providers in low-spending areas will first begin to encounter such limited opportunities for additional gains in efficiency, but **eventually, the agency will no longer be able to continue decreasing target prices for providers without putting quality of care at risk.**

Risk Adjustment. As a means of risk adjustment for the model, CMS currently sets four separate target prices for each hospital: for diagnosis-related groups (DRGs) 469 and 470, for patients with and without hip fractures. However, the agency states that given its proposal to include outpatient THA and TKA procedures in the model, it believes additional risk adjustment is warranted. Thus, it also proposes to incorporate data on CMS hierarchical condition category (HCC) condition count and beneficiary age into the target price calculation. CMS proposes to use five CMS-HCC condition count variables

to account for the expected marginal cost of treating beneficiaries with zero, one, two, three or four or more CMS-HCCs. It proposes four age categories: less than 65, 65 to 74, 75 to 84 and 85 or older. **The AHA supports this proposal.**

Discount Amounts. In order to determine any shared savings, CMS currently compares a hospital's actual spending to its target price minus a percent discount that varies depending on its quality score. Hospitals keep any savings they achieve in excess of this percent discount, again subject to quality performance. For the extension of the model (performance years six through eight), CMS proposes changes to the discount amounts, which would provide more favorable factors for higher quality scores. **The AHA supports this proposal.**

Reconciliation. CMS proposes to change the high-episode spending cap used at reconciliation. Under this policy, 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 this change would more accurately represent the cost of infrequent and potentially non-preventable complications. **The AHA opposes this proposal.** For a subset of elective lower-extremity joint replacement 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, but a cap at the 99th percentile is inadequate for doing so. **We urge CMS to maintain the current cap set at two standard deviations above the mean.**

CMS also 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 AHA supports this change and agrees that six months is adequate for capturing episode costs, and that one less reconciliation would reduce administrative burden for the agency and hospitals alike.**

Waivers. We urge CMS to consider an additional waiver to provide participating hospitals with maximum flexibility to identify and place beneficiaries in the clinical setting that best serves their short- and long-term recovery goals. Specifically, waiving the post-acute care transfer policy when beneficiaries are discharged to home health agencies (HHAs) that commit to coordinating with their hospital partners would help support care transitions without penalizing CJR hospitals. This waiver could be restricted to agencies performing well on cost and quality criteria.

Pandemic and Extreme and Uncontrollable Circumstances Policy. On April 6, CMS published an interim final rule with comment period that ensured that CJR's "extreme and uncontrollable" circumstances policy applies to the COVID-19 pandemic. **The AHA supports this policy.**

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However, as hospitals are focused on defeating COVID-19 and using every resource at their disposal to do so, we urge CMS to more broadly consider steps to ensure the pandemic does not derail the CJR model. A crisis of this magnitude is already putting significant strain on clinical resources, staff and finances alike. Our members report that currently, their CJR volume consists entirely of emergent hip fractures, the most costly of the CJR cases. They also anticipate that when the pandemic ends and elective TKA and THA patients return, those patients may have an increased need for care compared to if their treatment had not been delayed. The implications will be far-reaching and difficult to predict. **As such, we urge CMS to hold hospitals harmless from performance-related penalties for the 2020 performance year and make appropriate adjustments to address the impact of COVID-19 on financial expenditures, performance scores and risk adjustment.** In addition, the long-term impact on performance measures and baselines for future years must be considered. Hospitals on the path to value need to know that they will not be penalized for it.

We appreciate your consideration of these issues. Please contact me if you have questions or feel free to have a member of your team contact Joanna Hiatt Kim, vice president of payment policy, at (202) 626-2340 or jkim@aha.org.

Sincerely,

/s/

Thomas P. Nickels
Executive Vice President