

April 23, 2020

Seema Verma  
Administrator  
Centers for Medicare & Medicaid Services  
Department of Health and Human Services  
Attention: CMS-5529-P  
P.O. Box 8013  
Baltimore, MD 21244-1850

File Code: CMS-5529-P

Re: Comprehensive Care for Joint Replacement Model Three-Year Extension and Changes to Episode Definition and Pricing

Dear Administrator Verma:

On behalf of the Healthcare Financial Management Association's (HFMA's) 53,000 members, I would like to thank you for the opportunity to comment on the recently proposed Comprehensive Care for Joint Replacement Model Three-Year Extension and Changes to Episode Definition and Pricing (hereafter the proposed rule) as published in the February 24, 2020, *Federal Register*. As an organization, HFMA's members are strong supporters of efforts to transition the payment system from one that rewards the volume of services delivered to one that rewards the value of care delivered. Through our [Value-Project Research](#), HFMA has provided its members with strategies and best practices to help their organizations succeed under alternative payment models like the CJR.

HFMA members commend CMS's continued leadership in transition to value and are greatly appreciative of the in-depth analysis of issues and alternatives related to extending the CJR program in the proposed rule. Below please find HFMA members' comments related to the:

- Episode Definition
- Target Price Calculation
- Reconciliation Process
- Composite Quality Score Adjustment
- COVID-19

**Episode Definition:** CMS proposes to revise the CJR model's episode definition for model performance year 6 (episodes starting on or after October 4, 2020) and future years to include total knee arthroplasty (TKA) and total hip arthroplasty (THA) *anchor procedures*. For proposed performance year 6 and subsequently, episodes would be triggered by either a TKA or THA anchor procedure (outpatient) or an anchor hospitalization (inpatient), and would include, respectively, a 90-day post-procedure or post-discharge period.

CMS proposes to create a CJR episode category that would blend outpatient TKA and THA episodes with inpatient TKA and THA episodes, all without hip fractures, to create a single target price. CMS refers to this as a “site-neutral” MS-DRG 470 price.

HFMA members strongly object to including outpatient TKA/THAs in the episode definition to create a “site-neutral” target price for episodes anchored by MS-DRG 470 without hip fracture at this juncture. We have three specific concerns.

First, CMS did not analyze the actual spending for episodes with a TKA procedure performed in the outpatient setting. Instead of using actual outpatient episode spending to make this decision, CMS used MS-DRG 470 as a proxy to identify beneficiaries undergoing inpatient TKAs who were most likely to have been candidates for outpatient TKAs. Their TKA episode spending patterns were compared to those for simulated CJR outpatient TKA episodes. Therefore, we do not believe that CMS can definitively state that spending for uncomplicated inpatient and simulated outpatient episodes is “highly similar.” CMS’s finding is not surprising, given that it is comparing “apples to apples” when it should be comparing “apples to oranges.”

Second, we remain deeply concerned that TKA/THA procedures for healthier patients are being shifted into an outpatient setting, leaving sicker, more costly cases to be performed in the inpatient setting. The “weight” for MS-DRG 470, like all MS-DRGs, is a blended historical average of all Medicare patients who have this procedure. Given the process CMS uses to set weights for MS-DRGs, there is a two-year lag (FY20) before the inpatient payments reflect the increased acuity of the 75% of TKA patients whose procedures were performed in the inpatient setting. This means that hospitals were under-paid in 2018 and 2019 for providing a medically necessary service to Medicare beneficiaries. Meanwhile, orthopedic surgeons have gained more comfort with performing TKA/THA procedures in the outpatient setting. As a result of increased comfort levels, coupled with additional changes in Medicare payment policy (i.e., removing THA from the inpatient-only list in the FY20 OPPS final rule), Medicare payments for MS-DRG 470 will not fully compensate hospitals for the cost of care for a sicker, more complex patient population. Therefore, target prices for lower extremity joint replacement (LEJR) episodes – particularly if CMS moves forward with incorporating outpatient cases – will also fail to accurately reflect the total cost of care.

Third, we are aware that Bundled Payments for Care Improvement- Advanced (BPCI-Advanced), the Center for Medicare & Medicaid Innovation’s (CMMI’s) voluntary bundled payment model, incorporates outpatient LEJR procedures into the definition and target price of MS-DRG 470 cases without hip fracture to create a “site neutral” target price. We believe that is appropriate, given that BPCI-Advanced is a voluntary program and participants can not only choose to participate but can choose what episodes to participate in. They also have the option of adding additional episodes or “dropping” episodes at prescribed points during their participation. **Due to the mandatory nature of the CJR program, we do not believe it is appropriate to compel participants to participate in a model that includes an inaccurately priced episode.**

Given the lack of relevant comparative analysis and ongoing concerns about chronically insufficient payment for MS-DRG 470, HFMA members strongly recommend that CMS delay including outpatient episodes in the definition and target price for MS-DRG 470 without hip fractures to create a site-neutral target price. **Once the MS-DRG 470 payment accurately reflects the acuity of the remaining uncomplicated LEJR procedures performed in the inpatient setting and CMS uses actual claims experience to compare the cost of inpatient episodes to outpatient episodes and can definitively say that post-acute spending is similar, then HFMA members believe it will be appropriate to incorporate outpatient LEJR episodes into the definition and target price of MS-DRG 470 without hip fraction to create a “site-neutral” target price.**

Currently, in the proposed rule, the “site-neutral” target price would be based on the regional average, adjusted for local wage differences. **Once CMS incorporates outpatient episodes into the target price, it will need to also incorporate a hospital-specific adjustment to the target price to reflect differences in site of service for LEJR procedures.** As CMS rightly reminds readers in the proposed rule, “(T)he decision to admit a patient is a complex medical judgment that is made by the treating physician”. HFMA members cannot dictate to the orthopedic physicians, most of whom are not employed by the hospital, the site of service they will use to perform LEJR procedures. Without a hospital-specific site-of-service adjustment to the target price, HFMA members are concerned that CMS’s proposed methodology to create a site-neutral target price for MS-DRG 470 without hip fractures using claims data aggregated at the regional level will create an unearned windfall for hospitals whose orthopedic physicians are less traditional (or have healthier patients) in their practice patterns while penalizing those hospitals whose orthopedic physicians are more conservative (or have sicker patients) for factors beyond their control.

**Target Price Calculation:** The rule proposes to make changes to the number of years of data used to establish the target price and change the high episode spending cap mechanism.

**Number of Years of Data:** The CJR model currently uses three years of baseline data to calculate initial target prices with the three-year baseline data updated every other year. CMS chose this policy because it wanted to ensure that it had sufficient historical episode volume to reliably calculate target prices. For performance years six through eight, the rule proposes to use the most recently available year of data available prior to the start of the performance year to calculate target prices rather than the three years of data currently used. CMS believes that this would be the more appropriate baseline period on which to set target prices given the removal of TKA/THA from the inpatient-only list, along with the national shift in LEJR spending.

HFMA members strongly disagree with the proposed change to use one year of claims data to set target prices. First, using three years of data at the regional level will create additional stability in pricing due to the number of procedures included in the regional average compared to using a single year. Second, HFMA members are concerned this policy change will accelerate what many already describe as a race to the bottom (which will be exacerbated by the use of the market trend factor discussed below). While in theory more efficient providers may benefit from regional pricing in general, conversations with these providers indicate that they believe they have achieved much of the possible savings by reducing unnecessary variation in care delivery. **Therefore, HFMA members strongly recommend continuing to use three years of claims data.**

**If CMS finalizes using one year of data adjusted by the market trend factor to set target prices, HFMA members strongly recommend CMS limit the year-to-year payment-rate-increase-adjusted target price decrease by implementing a cap of 1% on changes in utilization-related pricing factors.**

***High Episode Spending Cap:*** CMS incorporated a high episode spending cap policy as part of the CJR model to prevent participant hospitals from being held responsible for catastrophic episode spending amounts that they could not reasonably have been expected to prevent. The high cost episode cap is set at two standard deviations above the regional mean episode price for calculating the target price and for comparing actual episode payments during the performance year to the target prices.

CMS proposes to change its method of deriving the high episode amount applied to initial target prices by setting the high episode spending cap at the 99th percentile of historical costs. **HFMA supports this change and believes it is appropriate to bring the model in line with BPCI-Advanced.**

**Reconciliation Process:** Among the changes to the reconciliation process included in the proposed rule, HFMA members would like to provide feedback on the use of a single reconciliation period, incorporation of episode risk adjustment factor and the transition to a market trend factor.

***Single Reconciliation Period:*** For each of performance years six through eight, CMS proposes to conduct one reconciliation six months following the end of the performance year. **HFMA members strongly support this provision as it will reduce the administrative burden associated with being required to participate in the model.** It will also simplify participating hospitals' communications with the physicians with whom they have gainsharing agreements.

***Episode Risk Adjustment Factors:*** CMS proposes to include CMS Hierarchical Condition Category (HCC) condition count and beneficiary age as additional risk adjustment methodology for performance years six through eight into CJR pricing. HFMA has long believed CMMI's various episodic payment models have suffered from insufficient risk adjustment.<sup>1,2,3,4,5</sup> **Therefore, HFMA is strongly supportive of efforts to include additional risk adjustment mechanisms.** While our members believe HCC count may be a reasonably accurate predictor of cost for individuals with three or more HCCs, we question the accuracy of HCC count to adjust price for individuals with less than three HCCs. For example, consider two patients, each with one HCC. Patient A has diabetes without complications (HCC 19). Patient B has dementia with complications (HCC 52). Patient B is more likely to require institutional post-acute care and Patient B's case will therefore likely be more expensive. Additionally, exogenous factors that drive episode spending are not accounted for by simply using age and HCC count cohorts to adjust target prices. **Therefore, we strongly recommend CMS use a more sensitive risk adjustment mechanism in the CJR model. To be consistent (where appropriate) with other episodic payment models, we believe CMS should use the same risk adjustment model that is currently used in BPCI-Advanced<sup>6</sup> program.** In addition to the patient-

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<sup>1</sup> [HFMA Comments on Bundled Payments for Care Improvement initiative](#), May 21, 2012.

<sup>2</sup> [HFMA Comments on CMS Bundled Payments for Care Improvement initiative](#), May 12, 2015.

<sup>3</sup> [HFMA Comments on CMS's CCJR Payment Model Proposed Rule](#), September 17, 2015.

<sup>4</sup> [HFMA Comments on CMS's Advancing Care Coordination Through EPMs Proposed Rule](#), October 5, 2016.

<sup>5</sup> [HFMA Comments on CMS's EPM IFR](#), April 21, 2017.

<sup>6</sup> CMS Bundled Payments for Care Improvement Advanced, [Target Price Specifications, Model Year 3](#), August 2019.

specific HCC and (expanded) patient demographics, the model includes a number of factors beyond the hospital's control that influence episode spending. A table including the model's elements is provided below.

### Patient Characteristics Categories used to Risk Adjust BPCI-Advanced Target Prices

Risk Adjuster Category	Data Source/Input	Specifications
<b>Hierarchical Condition Category (HCC)</b>	Inpatient, Outpatient and Part B Carrier Claims	HCC flags are constructed using Version 22 of the CMS Medicare Advantage Risk Adjustment software <sup>10</sup>
<b>HCC Interactions</b>	<b>Inpatient, Outpatient and Part B Carrier Claims</b>	HCC flags are interacted with each other and other demographic characteristics as used in the Post-acute Care Payment Reform Demonstration, Relative Resource Use and Part C Models
<b>HCC Severity</b>	<b>Inpatient, Outpatient and Part B Carrier Claims</b>	Count of HCCs for a given beneficiary, categorized into four groups: 0, 1-3, 4-6, 7+
<b>Recent Resource Use</b>	<b>Inpatient, Outpatient and Part B Carrier Claims</b>	Flags to indicate whether there was an inpatient hospitalization (besides inpatient rehabilitation facility [IRF] or long-term care hospital [LTCH] or any post-acute care (inpatient LTCH, SNF, home health care, or IRF stay) in the 90-day period prior to the Clinical Episode
<b>Demographics</b>	<b>Enrollment Database (EDB) and Common Medicare Environment (CME)</b>	Includes age, disability as the reason for Medicare entitlement, and dual eligibility for Medicare and Medicaid
<b>Long-Term Institutional</b>	<b>Long-Term Minimum Data Set (MDS)</b>	Indicates whether the beneficiary was institutionalized in a long-term care facility within 90 days of the Clinical Episode start date
<b>MS-DRG/Ambulatory Payment Classifications (APCs)</b>	<b>Inpatient and Outpatient Claims</b>	MS-DRGs are acquired from inpatient claims and mapped from the baseline period to the Model Year to ensure consistency across years. APCs are based on HCPCS and are mapped from the baseline period to the Model Year

Risk Adjuster Category	Data Source/Input	Specifications
<b>Clinical Episode Category-Specific Adjustments</b>	<b>Inpatient Claims</b>	Clinical Episode category-specific risk adjusters such as indicators for fracture and knee arthroplasty in the Major Joint Replacement of the Lower Extremity Clinical Episode, hemorrhagic stroke indicator in the Stroke Clinical Episode, indicators for fistula and ulcerative colitis in the Inflammatory Bowel Disease Clinical Episode, and interactions between an indicator for the anchor discharge occurring in or after FY18 and indicators for spinal fusion MS-DRGs for the Spinal Fusion Clinical Episode category

**Changes to the Trend Factor Calculation:** CMS proposes to calculate a market trend factor at the time of reconciliation by calculating the ratio of performance period spending to baseline period spending and applying the resulting ratio to the target price. As a result, CMS would no longer apply the national update factor and biannual Medicare prospective payment and fee schedule update methodology it currently applies to historical episode spending to trend prices forward prospectively. CMS would apply this trend factor after the beneficiary-level, risk-adjusted target prices are normalized. CMS believes that the absence of a national trend factor has led to artificially inflated target prices.

**HFMA members strongly disagree with this change.** First, incorporating a market trend factor does not allow for participants in the model to know their base target price prospectively – i.e., in advance of a model year. And given that the market trend factor is a “black box” calculation, it is difficult, if not impossible to know, what changed in the target price calculation between the start of a performance year and the actual results. Beyond making it impossible to accurately project a hospital’s financial results related to participating in a compulsory model, it strains a hospital’s relationship with the physicians – orthopedic surgeons, in particular – with whom it has entered into gainsharing agreements to improve outcomes for Medicare beneficiaries.

Many hospitals attempt to project the available gainsharing payments to physicians to maintain their engagement. However, when the projected gainsharing payments evaporate due to a market trend factor that hospital staff cannot explain, it sows distrust among partners, making it harder to collaborate to improve outcomes for Medicare beneficiaries. HFMA members were strongly supportive of the BPCI-Advanced model in part because it eliminated this design flaw. We are incredibly frustrated that CMS would ignore lessons learned in prior iterations of similar payment models by introducing a market trend factor into the CJR program.

Second, the use of a market trend factor, coupled with using a single year of data to calculate target prices will force providers to compete against themselves in the current year. This makes it harder for hospitals to generate savings, share in the efficiencies they are creating for the Medicare program and cover their costs for participating in a program designed to improve outcomes for Medicare beneficiaries and reduce Medicare spending. **As such, HFMA members strongly recommend that CMS eliminate the use of a market trend factor and retain the annual updates to target prices to account for changes in the underlying payment systems that factor into the total cost of care for an episode.**

**Composite Quality Score Adjustment:** CMS proposes to increase a participant hospital's ability to reduce the 3-percentage point discount factor as a result of the composite quality score. It believes that this is appropriate because the target prices would be more accurate and that all participant hospitals would be at financial risk during performance years six through eight.

Specifically, CMS proposes that, for performance years six through eight, a 1.5 percentage point reduction be applied to the 3 percentage point discount factor for participant hospitals with good quality performance, defined as composite quality scores that are greater than or equal to 6.9 and less than or equal to 15.0. Additionally, CMS proposes that a 3-percentage point reduction be applied to the 3-percentage point discount factor for participant hospitals with excellent quality performance, defined as composite quality scores that are greater than 15.0. That is, for participant hospitals with excellent quality performance, the 3-percentage point discount factor would effectively be eliminated for the applicable performance year.

**HFMA members applaud CMMI's efforts to increase the rewards offered to high quality, cost efficient hospitals. We strongly support this change.**

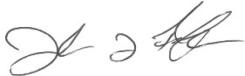
**COVID-19-CJR:** On March 30<sup>th</sup> CMS issued an interim final rule with comment period (IFC) providing regulatory flexibility across a number of areas to support hospitals and other providers as they respond to the COVID-19 pandemic. HFMA members sincerely thank CMS for its continued leadership during this crisis. One of the provisions in the IFC expands the CJR extreme and uncontrollable circumstances policy by applying certain financial safeguards to participant hospitals that have a CMS Certification Number (CCN) primary address that is located in an emergency area for episodes that overlap with the emergency period. Accordingly, all participant hospitals are located in the emergency area and qualify for applicable financial safeguards during the emergency period.

CMS states that for a fracture or nonfracture episode with a date of admission to the anchor hospitalization that is on or within 30 days before the date that the emergency period begins or that occurs through the termination of the emergency period actual episode payments are capped at the target price determined for that episode. CMS is also implementing a three-month extension to CJR performance year 5 such that the model will now end on March 31, 2021, rather than ending on December 31, 2020. **HFMA strongly supports these provisions and will provide additional comments after it has had the opportunity to review the IFC with its members.**

HFMA looks forward to any opportunity to provide additional assistance or comments to CMS as they drive the transition to alternative payment models. As an organization, we take pride in our long history

of providing balanced, objective financial technical expertise to Congress, federal agencies and advisory groups. If you have additional questions, you may reach me or Richard Gundling, Senior Vice President of HFMA's Washington, DC, office, at (202) 296-2920. The Association and I look forward to working with you.

Sincerely,



Joseph J. Fifer, FHFMA, CPA  
President and Chief Executive Officer  
Healthcare Financial Management Association

#### About HFMA

HFMA is the nation's leading membership organization for more than 53,000 healthcare financial management professionals. Our members are widely diverse, employed by hospitals, integrated delivery systems, managed care organizations, ambulatory and long-term care facilities, physician practices, accounting and consulting firms and insurance companies. Members' positions include chief executive officer, chief financial officer, controller, patient accounts manager, accountant and consultant.

HFMA is a nonpartisan professional practice organization. As part of its education, information and professional development services, HFMA develops and promotes ethical, high-quality healthcare finance practices. HFMA works with a broad cross-section of stakeholders to improve the healthcare industry by identifying and bridging gaps in knowledge, best practices and standards.