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April 22, 2020

Seema Verma, MPH
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Hubert H. Humphrey Building, Room 445-G
200 Independence Avenue, SW
Washington, DC 20201

Re: File code CMS-5529-P

Dear Ms. Verma:

The Medicare Payment Advisory Commission (MedPAC) welcomes the opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS's) proposed rule entitled "Medicare Program: Comprehensive Care for Joint Replacement Model Three-Year Extension and Changes to Episode Definitions and Pricing" in the *Federal Register*, vol. 85, no. 36, pages 10516 to 10550 (February 24, 2020). We appreciate CMS's ongoing efforts to develop, administer, and improve alternative payment models, particularly given the many competing demands on the agency's staff.

The Comprehensive Care for Joint Replacement (CJR) model is an alternative payment model for fee-for-service Medicare beneficiaries undergoing lower extremity (hip and knee) joint replacements (LEJRs) in the hospital inpatient setting. Hospitals are held accountable for all spending associated with the initial hospital stay and Part A and Part B services during the 90 days after discharge from the hospital. Hospitals that keep 90-day complication rates down, meet a minimum threshold for patient experience, and keep their spending below a target price can retain a portion of the difference as savings. All hospitals in 34 metropolitan statistical areas (MSAs), except low-volume and "rural" hospitals, are currently required to participate in the CJR model, and hospitals in another 33 MSAs have the option of participating.[1] Low-volume and rural hospitals in all 67 of these MSAs also have the option of participating.

The fifth and final year of the CJR model was scheduled to run through 2020 at the time this proposed rule was published, but it has since been extended by three months in a subsequent interim final rule with comment period. In the proposed rule that is the subject of this letter, CMS proposes to extend the CJR model by three years for those hospitals that are currently mandated to participate and to make a number of technical changes to the model. We appreciate

[1] A hospital in an urban area can apply to be reclassified as a "rural" hospital if it meets any of the criteria listed in 42 CFR §412.103. Rural classification can allow a hospital to access the 340B drug discount program.

CMS's efforts to improve the model and comment on a number of these technical changes. However, from a broader perspective, the evidence supporting the efficacy of bundled payments for LEJRs in terms of reducing episode spending without harming quality is already quite strong, but these models typically have not generated savings for the Medicare program (after accounting for shared savings payments to providers). This large body of evidence leads us to suggest that CMS focus on ways to generate net savings for Medicare so that the CJR model can be expanded nationally and help improve the long-term sustainability of the program.

At the conclusion of the proposed extension, the CJR model will have been operating for eight years. This experience is in addition to previous bundling demonstrations, such as the Acute Care Episode demonstration and the Bundled Payments for Care Improvement (BPCI) initiative, and other ongoing bundling demonstrations (e.g., BPCI Advanced). Cumulatively, this will give CMS more than two decades worth of experience implementing and evaluating bundled payments for LEJR and other conditions. To date, the results of bundled payments for some clinical conditions have been mixed and further testing is likely necessary. However, bundled payments demonstrations for LEJR have consistently lowered Medicare expenditures per episode, without negatively affecting the quality of care or increasing utilization. A CMS-sponsored evaluation found that, over the first two years of the CJR model, Medicare expenditures per episode decreased 3.7 percent faster than a comparison group;[2] another academic study found a similar relative decline of 3.1 percent over two years.[3] Despite this success, the CJR model and other bundled payment demonstrations typically do not generate net savings for the Medicare program after accounting for shared savings payments to participating hospitals.

The Commission therefore believes that CMS should focus on changes to the model that could generate net savings for the Medicare program instead of redistributing all of them back to providers. CMS could take various steps to increase the likelihood of savings being generated, such as increasing the episode target price discount factor from 3 percent to 5 percent or increasing the percentage of losses for which hospitals are responsible.[4]

The Commission understands that CMS is limited in its ability to expand the CJR model nationwide because the demonstration has not yet generated savings for the Medicare program. However, the history of LEJR demonstrations suggests that modest changes to the model (i.e., retaining a greater share of episode savings for the Medicare program) would result in net savings for Medicare. The Commission believes the CJR model should ultimately be expanded nationally and, with modest changes, it will meet the expansion criteria at the end of the

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[2]The Lewin Group. 2019. *CMS Comprehensive Care for Joint Replacement Model: Performance Year 2 evaluation report*. Prepared for Centers for Medicare & Medicaid Services under contract no. HHSM-500-2014-00033I.
[3]Barnett, M., A. Wilcock, J. M. McWilliams, et al. 2019. Two-year evaluation of mandatory bundled payments for joint replacement. *New England Journal of Medicine* 380, no. 3 (January 17): 252–262.
[4] CMS applies a 3 percent discount to target episode prices to help generate program savings. However, the effective discount is lower than 3 percent because hospitals with good or excellent quality can earn back some of the discount. In the first two years of the model, more than three quarters of hospitals earned back some of the discount. CMS proposes allowing hospitals to earn back a higher share of the discount in the three-year extension, further lowering the effective discount.

proposed three-year extension. As an interim step towards national expansion, CMS should consider instituting the CJR model in a larger number of areas, such as the 67 MSAs that were originally included in the model.

The remainder of this letter comments on technical changes, which can be summarized as follows:

- We support adding LEJR procedures performed in outpatient hospital departments to the CJR model and setting site-neutral target prices for inpatient and outpatient episodes.
- We support adding LEJRs performed in ambulatory surgical centers (ASCs) to the model but suggest setting lower target prices for ASC episodes than for inpatient and hospital outpatient episodes.
- We support using national rather than regional target prices.
- We favor updating episode target prices using the new "market trend factor" only when it will *reduce* target prices.
- We support CMS's proposal to eliminate the 50 percent cap on gainsharing payments.

Adding LEJRs performed in hospital outpatient departments to the model

CMS proposes to include total knee arthroplasty and hip arthroplasty procedures performed in hospital outpatient departments in the CJR model's episodes of care. The agency gives two rationales for this proposal: (1) excluding these outpatient procedures from the CJR model could give hospitals a financial incentive to perform them in the more expensive inpatient setting because they would be part of a bundled payment in the inpatient setting, which would allow hospitals to receive reconciliation payments if they keep spending below the target price; and (2) excluding these outpatient procedures from the CJR model would reduce the generalizability of results from the model's evaluation because hospitals in the model would have a financial incentive to perform these procedures in inpatient settings but hospitals in the comparison group would not.

CMS proposes to create site-neutral target prices for episodes that would be the same for procedures performed in inpatient and outpatient settings. A site-neutral policy would be consistent with the BPCI Advanced voluntary bundled payment model, which has a site-neutral price for LEJR episodes performed in hospital inpatient and outpatient settings. It would also be consistent with CMS's policy to equalize payment rates for clinic visits at excepted off-campus outpatient departments with physician fee schedule payment rates for clinic visits at non-excepted off-campus outpatient departments. [5]

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[5] Excepted off-campus outpatient departments are those that are excepted from the rules of Section 603 of the Bipartisan Budget Act of 2015, and non-excepted off-campus outpatient departments are those that must follow the rules of Section 603.

CMS proposes to use different methods to create site-neutral target prices for the four episode categories in the CJR model (Medicare severity–diagnosis related group (MS–DRG) 469 with hip fracture, MS–DRG 469 without hip fracture, MS–DRG 470 with hip fracture, and MS–DRG 470 without hip fracture). The target price for MS–DRG 470 without hip fracture episodes would be based on historic spending for outpatient total knee arthroplasty episodes, outpatient hip arthroplasty episodes without hip fracture, and inpatient episodes for MS–DRG 470 without hip fracture. The price for this episode category would include outpatient total knee arthroplasty episodes because spending on these episodes most closely resembles spending on MS–DRG 470 without hip fracture inpatient episodes. The price for this category would also include outpatient hip arthroplasty episodes without hip fracture because the cost of outpatient hip arthroplasty and outpatient total knee arthroplasty tend to be similar, which is why these procedures are assigned to the same comprehensive ambulatory payment classification system group (5115) in the outpatient prospective payment system. The target price for the other three episode categories would continue to be based on historic spending for only inpatient episodes.

Comment

The Commission supports CMS's proposal to include total knee arthroplasty and hip arthroplasty procedures performed in hospital outpatient departments in the CJR model based on the rationale stated in the proposed rule. Including these outpatient procedures in the CJR model would make this model consistent with the BPCI Advanced model, which includes both inpatient and outpatient LEJR episodes. We also support setting a site-neutral target price that would apply to episodes in both the inpatient and outpatient settings. The Commission has long supported site-neutral payment policies where appropriate.[6,7] We agree with CMS's proposal to base the target price for MS–DRG 470 without hip fracture on a blend of historic spending for outpatient total knee arthroplasty episodes, outpatient hip arthroplasty episodes without hip fracture, and inpatient episodes for MS–DRG 470 without hip fracture because of the cost similarity of these episodes.

Adding LEJRs performed in ambulatory surgical centers to the model

Because lower joint procedures are transitioning into ASCs, CMS seeks comment on how to design a future bundled payment model focused on LEJR procedures performed in ASCs. CMS recently added total knee arthroplasty procedures to the list of ASC-covered procedures, and continued improvements in medical technology and surgical techniques might make ASCs an appropriate setting for hip arthroplasty procedures in the future. CMS asks whether a new model should pay ASC-specific rates or site-neutral rates that would be the same across settings (inpatient, hospital outpatient department, and ASC).

[6] Medicare Payment Advisory Commission. 2012. *Report to the Congress: Medicare payment policy*. Washington, DC: MedPAC.
[7] Medicare Payment Advisory Commission. 2014. *Report to the Congress: Medicare payment policy*. Washington, DC: MedPAC.

Comment

We support including ASCs in the CJR model because it is important to have a consistent payment structure for LEJR procedures across settings. In addition, including ASCs in the model would create additional opportunities to reduce spending for LEJR episodes.

Although we support setting site-neutral target prices for episodes in both the inpatient and outpatient settings, we support setting lower target prices for ASC episodes than for inpatient and hospital outpatient episodes. We agree with CMS's proposal to base the target price for MS–DRG 470 without hip fracture for hospital episodes on a blend of historic spending for certain outpatient and inpatient episodes because spending for these episodes is similar (see above). However, because Medicare's facility payment rates for procedures are much less in ASCs than in inpatient and hospital outpatient settings (and we continue to lack cost data from ASCs that could be used to establish the costs of the services they provide), a target price for LEJR episodes that is based on an average of spending for inpatient episodes, hospital outpatient episodes, and ASC episodes would probably result in a price that is too low for inpatient and hospital outpatient episodes and too high for ASC episodes. Underpaying hospitals for LEJR episodes in areas of the country without ASCs could create an access problem if hospitals are unwilling to treat LEJR patients.

Therefore, CMS should create separate target prices for episodes that occur in ASCs (to account for the lower facility payment rate for ASC procedures) and episodes that occur in inpatient or hospital outpatient settings (to account for the higher payment rates for hospital outpatient and inpatient procedures). However, the portion of the target price that is related to spending for providers other than a hospital or an ASC (e.g., clinicians and post-acute care providers) should be the same across settings because the payment rates for these service do not vary based on the facility setting in which the procedure was performed. The aggregate target price for each setting should be subject to the episode-specific risk-adjustment policy that CMS proposes to adopt because this policy would help account for patient-specific risk factors that are beyond the control of providers.

Retaining regional target prices

CMS currently sets the target prices for LEJR episodes based on the average LEJR episode spending in a region. CMS proposes to continue to set regional target prices but asks for feedback on whether to switch to national target prices.

Comment

The Commission supports setting national, not regional, target prices for LEJR episodes (although these national target prices should be adjusted to reflect local or regional input costs, consistent with other Medicare payment systems). National target prices would be consistent with the establishment of prices under all other prospective payment systems in Medicare. Data presented by CMS shows a $3,500 difference in average episode prices across regions in 2018—

a difference that has gradually increased since 2016. National target prices would incentivize providers in high-cost areas to reduce post-surgical service use and would reward providers in low-cost areas with larger shared savings payments than providers in high-cost areas. While switching to national target prices in a voluntary model might increase the risk that providers in high-cost areas drop out of the model, CMS is proposing to convert the CJR model to a mandatory-only model in its final three years, so there is no risk of national target prices prompting drop-outs. Further, the mandatory design would present CMS with a valuable opportunity to see what kind of utilization patterns occur in high-cost areas when providers are faced with strong incentives to reduce spending and cannot simply opt out of a model.

Updating target prices using a "market trend factor"

Broadly speaking, LEJR episode target prices are currently set based on average episode spending in a region over the past three years (with prior years' data trended forward using a national update factor). CMS then discounts target prices by 3 percent to try to generate savings for the Medicare program, although participants can reduce the size of this discount (and effectively raise their target prices) based on their performance on quality measures. Target prices are recalculated every other year based on the newest claims data. Target prices are also adjusted during the performance year to reflect annual updates to various Medicare prospective payment systems and fee schedules.

CMS proposes to use a new approach to set target prices that would include more high-cost cases and improve risk adjustment. CMS also proposes adjusting target prices using a "market trend factor" that would take into account regional changes in episode spending in the performance year relative to two years prior. One of the rationales for adopting this market trend factor is it would allow CMS to capture more recent spending trends in its target prices (including spending trends *in the performance year itself*). CMS explains that its current approach has resulted in target prices that have not accounted for the nationwide reductions in LEJR episode spending that occurred from 2014 to 2017. CMS implies that because it sets target prices every other year, and it does not factor in the current performance year's spending trends, target prices may have been easier to meet than they would have been if the market trend factor adjustment had been in place.

Comment

The market trend factor will lower target prices during periods when episode costs have been declining, but it will raise target prices in periods when episode costs have been increasing. Although CMS notes that LEJR episode spending for non-CJR participants declined from 2014 to 2017, there is a risk that LEJR episode spending could revert to increased year-over-year spending—for example, if physicians started using more expensive implant devices or increased the intensity or volume of services they provide during an episode. There is already reason to believe that the period of declining spending on LEJR episodes may have come to an end: CMS notes that non-CJR participants in 8 out of 10 regions in the country exhibited *increased* spending on LEJR episodes from 2017 to 2018 (the most recent years they analyzed). If LEJR

episode spending continues to increase in future years, then adopting the proposed market trend factor would raise target prices compared to what they would be if the market trend factor were not applied. A higher target price would mean CMS would have to pay more CJR participants shared savings payments, and fewer participants would owe CMS shared losses—thus reducing the model's likelihood of generating net savings for Medicare.

To prevent increases in Medicare spending under the CJR model, the Commission favors applying the market trend factor in a one-sided manner—only when it *decreases* the target price. In years when the market trend factor would *increase* the target price, CMS should not apply the market trend factor and instead only update LEJR target prices to reflect updates to Medicare payment systems and fee schedules (consistent with the model's current approach). Otherwise, the update could capture spending trends that reflect increasing service intensity and volume—changes in practice patterns the program should not encourage.

Eliminating the 50 percent cap on gainsharing payments

The CJR model allows participant hospitals to enter into financial arrangements with other providers and accountable care organizations (ACOs) to share in the financial risk and rewards of the CJR model. CMS believes that these arrangements promote accountability for the quality and cost of CJR beneficiaries.

Arrangements between participant hospitals and other entities (including physicians, other clinicians, group practices, and ACOs) are called "sharing arrangements," and the payments made by participant hospitals to these providers and ACOs are termed "gainsharing payments." Gainsharing payments are composed of reconciliation payments (Medicare makes reconciliation payments to a hospital if the hospital's average actual episode spending is below the target price and the hospital meets quality thresholds), internal cost savings, or both.

Under current rules, the total amount of gainsharing payments for a performance year paid to clinicians or group practices must not exceed 50 percent of the total Medicare payments under the physician fee schedule for items and services provided by those clinicians or group practices to CJR beneficiaries during CJR episodes that occurred in the same performance year ("the 50 percent cap"). CMS capped the total amount of gainsharing payments to guard against the potential risks of stinting, patient steering, and denial of medically necessary care that could arise from these financial arrangements.

CMS proposes to eliminate the 50 percent cap on gainsharing payments for episodes that begin on or after January 1, 2021, for the following reasons:

- CMS's monitoring of hospitals participating in the CJR model and analysis of CJR claims data does not suggest that the financial arrangements in the model have reduced beneficiaries' access to care.
- Hospitals and other entities incur an administrative burden to monitor their compliance with the cap policy.

- The cap policy constrains the ability of hospitals and other entities to design financial arrangements that will change physicians' behavior.
- The CJR model contains other restrictions on financial arrangements that are sufficient to prevent these arrangements from harming patients. For example, the model prohibits arrangements that induce clinicians to reduce or limit medically necessary services.
- Eliminating the 50 percent cap will make the CJR model more consistent with the BPCI Advanced model, which would reduce confusion and create a more level playing field between the models. In 2018, CMS allowed BPCI Advanced participants to execute an amendment that would eliminate the 50 percent cap on the shared payments of reconciliation payments.

Comment

Although the Commission previously supported CMS's inclusion of the 50 percent cap on gainsharing payments in the CJR model, we now support CMS's proposal to eliminate the cap to reduce the administrative costs that hospitals and other entities incur to monitor their compliance with the cap policy. Currently, if a hospital has a sharing arrangement with clinicians or group practices that involves gainsharing payments, the hospital needs to obtain data on physician fee schedule payments received by the clinicians or group practices for services they provided to CJR beneficiaries during CJR episodes, sum the fee schedule payments for each clinician or group practice, and ensure that the gainsharing payments do not exceed 50 percent of total fee schedule payments. This requirement imposes an administrative burden that makes it more difficult for hospitals and other entities to provide gainsharing payments. In addition, eliminating the 50 percent cap would make the CJR model more consistent with the BPCI Advanced model, which should simplify CMS's oversight of the models.

However, CMS should continue monitoring the quality of care and the mix of patients who receive LEJR surgery to ensure that eliminating the cap on gainsharing payments does not lead to lower quality or patient selection. The most recent evaluation report of the CJR model, which covers the model's first two performance years, examined the impact of the model on patient selection and quality.[8] If CMS decides to eliminate the 50 percent cap on gainsharing payments, the agency should use the methods used in this evaluation report to closely monitor whether this policy change has an effect on patient selection or reduces quality. If CMS finds that eliminating the cap is associated with patient selection or lower quality care, the agency should reinstate the cap if it decides to expand the model nationwide.

For example, the evaluation report analyzed whether there was an increase in the share of lower-cost patients within one of the episode case-mix categories by examining changes in patients' age, sex, race, Medicaid eligibility, disability status, health status, and prior health use.[9]

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[8] The Lewin Group. 2019. *CMS Comprehensive Care for Joint Replacement Model: Performance Year 2 evaluation report*. Prepared for Centers for Medicare & Medicaid Services under contract no. HHSM-500-2014-00033I.

[9] Under the model, there are separate target prices for four episode case-mix categories that are determined by fracture status (elective or fracture) and Medicare severity–diagnosis related group (470 or 469).

Increasing the proportion of lower-cost patients within an episode category would make it easier for hospitals to reduce episode spending below the target price. The report found some evidence that the health of CJR patients in the least complex elective episode category (LEJR surgery without major complications or comorbidities) improved, on average, relative to the comparison group, which could indicate patient selection or induced demand. CMS should use this approach to evaluate whether eliminating the cap on gainsharing payments affects patient selection.

The report also evaluated whether the model had an impact on outcomes and quality, as measured by the readmission rate, emergency department visits, mortality, self-reported pain, patients' overall satisfaction with recovery, care management, and care transitions. The report found no statistically significant differences between CJR participants and the comparison group in these measures. CMS should use this approach to analyze whether eliminating the cap on gainsharing payments impairs quality or outcomes.

MedPAC appreciates the opportunity to comment on the important policy proposals crafted by the Secretary and CMS. The Commission also values the ongoing cooperation and collaboration between CMS and MedPAC staff on technical policy issues. We look forward to continuing this productive relationship. If you have any questions, or require clarification of our comments, please feel free to contact James E. Mathews, MedPAC's Executive Director, at (202) 220-3700.

Sincerely,

Francis J. Crosson, M.D.
Chairman