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SUBMITTED ELECTRONCIALLY VIA
http://www.regulations.gov

Seema Verma
Administrator
Centers for Medicare & Medicaid Services,
Department of Health and Human Services,
Attention: CMS–5529–P
Mail Stop C4–26–05
7500 Security Blvd.
Baltimore, MD 21244-1850

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

Dear Administrator Verma:

The American Geriatrics Society ("AGS") greatly appreciates the opportunity to provide comments to the Centers for Medicare & Medicaid Services (CMS) on the proposed rule to extend the Comprehensive Care for Joint Replacement (CJR) model (CMS–5529-P).[1]

The AGS is a not-for-profit organization comprised of nearly 6,000 physician and non-physician practitioners ("NPPs") who are devoted to improving the health, independence and quality of life of all older adults. The AGS provides leadership to healthcare professionals, policy makers, and the public by implementing and advocating for programs in patient care, research, professional and public education, and public policy. Our mission is to improve the health, independence, and quality of life of all older people.

As the healthcare providers for older adults, particularly those with multiple chronic and complex conditions, we appreciate CMS's efforts to reform the Medicare payment systems to better incentivize well-coordinated, patient-centered care. In this CJR rule, CMS proposes significant changes to the CJR model, including expanding the definition of an 'episode of care' to include procedures furnished in the hospital outpatient department, and changing the pricing methodology, among other revisions. In particular, CMS proposes to shift the price-setting methodology from using three years of data to using just one year.

[1] CMS. Medicare Program: Comprehensive Care for Joint Replacement Model Three-Year Extension and Changes to Episode Definition and Pricing. 85 Fed. Reg. 10516, February 24, 2020.

In general, we applaud CMS for evaluating how the CJR model should be refined to reflect the evolution of care delivery patterns and recent changes in Medicare payment policy. However, we strongly urge CMS to reconsider whether the model should be continued at this time. The nation is in the midst of an unprecedented public health emergency (PHE) responding to the novel coronavirus pandemic, COVID-19, which has caused serious complications for older adults and those with underlying health conditions. The US health care system is currently focused on treating COVID-19 patients, and CMS has urged facilities and clinicians to curtail non-emergent, elective services in order to avoid exposing patients to the virus and to conserve vital medical supplies.[2] Many, but not all of the services in the CJR model may be considered elective procedures and be affected by this guidance.

CMS has already acknowledged that the crisis will affect the CJR model. In a separate interim final rule making changes in Medicare and Medicaid policies and regulations in response to the PHE, CMS extends the current CJR model through March 31, 2021, and broadens the extreme and uncontrollable circumstances policy for participants.[3] However, in addition to the impact on the current model, AGS is concerned that the COVID-19 PHE fundamentally undermines the viability of the extended CJR model. The extended model is planned for three years, through December 31, 2023, and, as proposed, would use one year of data as the basis for the target price calculation in each of the performance years. Data from 2020 are expected to be the basis for target prices in performance year 7.

It is impossible to predict what that data will look like in the future, but given the significant and prolonged disruption in typical care patterns caused by the pandemic, we expect the utilization for 2020 to be substantially different than previous years in ways that are unrelated to the incentives of the payment model. It is doubtful that CMS will be able to draw any meaningful conclusions from the model with target prices for one out of the model's three years reflecting such extreme and anomalous experience. If, despite these concerns, CMS chooses to pursue the extended model, we strongly recommend that CMS continue to use the current methodology of setting target prices based on three years of data, to mitigate the effect of this PHE on the model pricing.

Even without the impact of the COVID-19 pandemic, it is not clear that CMS would be able to isolate the impact of the model from recent changes in Medicare payment policy which allow the CJR procedures to be done in outpatient sites of care. During the performance period of the current model, CMS removed many CJR procedures from the inpatient only list, allowing them to be performed in the hospital outpatient department for the first time. As described in the proposed rule, CMS estimates that costs per episode under the CJR model decreased 3.7 percent in the first two performance years (2016 and 2017). However, analysis of lower extremity joint replacement spending outside of the model shows a decrease of 8 percent in national spending per case from 2014 and 2017. It is not clear how CMS can identify changes that can be attributed to the model design and further shifts in site of service

[2] CMS. Non-Emergent, Elective Medical Services, and Treatment Recommendations. 4/07/2020. https://www.cms.gov/files/document/cms-non-emergent-elective-medical-recommendations.pdf

[3] CMS. Medicare & Medicaid programs; Policy and Regulatory Revisions in Response to the COVID-19 Public Health Emergency. 85 Fed. Reg. 19263, April 6, 2020.

are likely in the future. Total knee arthroplasty procedures were recently added to the list of services that Medicare will cover when performed in an ambulatory surgical center (ASC); CMS recognizes that total hip arthroplasty may also be covered in the ASC setting at some future time. The proposed model includes hospital outpatient department services, but does not include ASC services. Given the fluidity in site of service, even with the proposed revisions to the model design and methodology, AGS is concerned that it may not be possible to differentiate changes in cost due to the incentives of the model from changes driven by the ongoing transition in the care setting for these services.

In summary, AGS recommends that CMS not finalize the extended model because of anticipated anomalies caused by the COVID-19 PHE. If CMS does finalize an extended CJR model, we urge CMS to maintain the current methodology which relies on three years of claim data to determine the target price.

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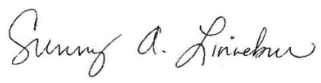
Thank you for the opportunity to submit these comments and for your attention to these concerns. We would be pleased to answer any questions you may have. Please contact Alanna Goldstein, agoldstein@americangeriatrics.org.

Sincerely,



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