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Submitted via the Federal eRulemaking Portal: http://www.regulations.gov/

The Honorable Seema Verma Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-5529-P

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

Dear Administrator Verma:

Vizient, Inc. appreciates the opportunity to comment on the Centers for Medicare & Medicaid Services (CMS) proposed rule, "Comprehensive Care for Joint Replacement Model Three Year Extension and Modifications to Episode Definition and Pricing" (CMS-5529-P) (hereinafter, "Proposed Rule"), as many of the proposed policies have a significant impact on our members and the patients they serve.

Background

Vizient, Inc. provides solutions and services that improve the delivery of high-value care by aligning cost, quality and market performance for more than 50% of the nation's acute care providers, which includes 95% of the nation's academic medical centers, and more than 20% of ambulatory providers. Vizient provides expertise, analytics and advisory services, as well as a contract portfolio that represents more than $100 billion in annual purchasing volume, to improve patient outcomes and lower costs. Vizient has earned a World's Most Ethical Company designation from the Ethisphere Institute every year since its inception. Headquartered in Irving, Texas, Vizient has offices throughout the United States.

Recommendations

First and foremost, Vizient is sensitive to the needs of hospitals and the disruptions our health care delivery system has and will continue to experience in the wake of COVID-19. Given these changes, we appreciate CMS's decision, as noted in the Interim Final Rule (CMS-1744-IFC), to extend the Comprehensive Care Joint Replacement (CJR) model for performance year (PY) 5 by three additional months and the change to the

extreme and uncontrollable circumstances policy to account for the COVID-19 pandemic. Vizient encourages CMS to modify this Proposed Rule to align with the changes noted in the Interim Final Rule. While CMS notes in the Interim Final Rule their desire to continue the CJR model, we do encourage CMS to regularly review the appropriateness of the programmatic changes, including whether any additional extensions may be warranted, or further rulemaking is required. As more is learned about the impact of COVID-19, CMS may also need to consider further expansion of the extreme and uncontrollable circumstances policy and potentially consider if any other financial safeguards would be appropriate.

Vizient appreciates CMS's efforts to test the CJR model to support better and more efficient care for beneficiaries undergoing hip and knee replacements. In addition, Vizient is aware of the regulatory changes for certain outpatient lower extremity joint replacement (LEJR) procedures which prompted CMS to change this model. While we appreciate CMS's efforts to adapt the model to include more settings, we believe additional factors should be considered and modifications are necessary to ensure the model is appropriately applied in inpatient and outpatient settings. Among the additional considerations and recommendations provided below, Vizient emphasizes our concern that the Proposed Rule fails to take in to account the substantial increase in APC 5115 (Level 5 Musculoskeletal Procedures) payment rates for 2020. In addition, we provide recommendations related to the target price calculation and reconciliation process.

As the CJR model is extended, Vizient believes it is important for healthcare providers' engagement to be considered by CMS. Given the extension and lag between when care is provided and results learned, Vizient is aware of providers who are losing interest in the model. To enhance motivation, Vizient recommends CMS provide more immediate results to health care providers where possible.

Lastly, Vizient appreciates CMS's efforts to align several components of the CJR model with Bundled Payments for Care Improvement Advanced (BPCIA) model as it can both help reduce administrative burden and enhance the understanding of each model. Vizient encourages the agency to continue to identify opportunities to streamline and simplify the extended CJR model and consider communicating the agency's long-term plans regarding the model.

Episode Definition

Grouping outpatient procedures with MS-DRG 470

Vizient appreciates CMS's consideration of including outpatient (OP) procedures in the CJR model because OP Total Knee Arthroplasty (TKA) and Total Hip Arthroplasty

(THA) were removed from the inpatient only (IPO) list in the CY 2018 and CY 2020 Outpatient Prospective Payment System (OPPS) final rules, respectively. The Proposed Rule groups inpatient procedures with outpatient procedures by adding OP THA episodes with hip fracture to "MS-DRG 470 with hip fracture" and OP TKA and OP THA without hip fracture to "MS-DRG 470 without hip fracture". Like CMS, Vizient believes a "single blended target price could potentially underestimate spending on some inpatient episode and likewise, could potentially overestimate spending on some outpatient episodes".[1] However, we are also concerned that CMS's proposed grouping and related justification may not adequately address cost variability between inpatient and outpatient settings. To reduce potential issues that may arise due to this grouping, Vizient encourages CMS group OP procedures separately from IP procedures.

For example, CMS indicates "Consistent with our goal for site neutrality… we do not want to create separate prices for inpatient and outpatient CJR episodes."[2] Vizient agrees with CMS that financial incentives should not dictate where a patient receives care. However, Vizient strongly believes decisions regarding the type and site of care should be left to the patient and their provider to decide. CMS does not have experience testing bundled OP CJR episodes and, as such, the agency's proposal to provide the same reimbursement for both inpatient and outpatient episodes is premature and could undermine the clinical judgment of providers. CMS should not put its goals of site neutral policies over the need to effectively adapt the model to include OP procedures to support better and more efficient care. Therefore, Vizient recommends CMS separate IP and OP procedures under the model and clarify that in extending the model, CMS is maintaining the same goals as with prior CJR model years.

Partial knee replacements

Should CMS continue to expand the model to include OP THA and TKA, Vizient suggests CMS continue excluding partial knee replacements, as these procedures were excluded from the CJR model originally and are more commonly performed in an outpatient setting.

[1] 85 FR 10516 at 10519
[2] 85 FR 10516 at 10519

Target price calculation

Change to one year of baseline data

Vizient believes target price calculations serve as an important starting point for participating hospitals to be aware of in the CJR model. CMS proposes to shift the baseline data used to determine the target price from the 3 most recent years of claims data to the most recently available one year of data. While Vizient does not disagree with this proposed change for IP procedures under the model, we are concerned OP procedure data that relies on one year of baseline spending may skew the baseline given CMS's desire to impose blended pricing.

The 2018-2020 national unadjusted CMS reimbursement rates for Total Knee Replacement show a significant increase ($10,122.91 in 2018[3] to $11,900.71 in 2020[4] for APC 5115) and Vizient is concerned this increase is not considered by CMS. For example, CMS states, "given the remaining difference in post-acute spending, as well as the higher amount paid by Medicare for an inpatient procedure billed under the IPPS as opposed to an outpatient procedure under the OPPS" but does not reference the OPPS rates and the variability in those rates. While Vizient agrees OP episodes are typically less costly than IP episodes, we are concerned the increase in OP reimbursement for 2020 is not reflected in the Proposed Rule and therefore, may be overlooked by CMS.

Regional spending

For Performance Years 6-8, CMS proposes to continue basing episode targets on 100 percent regional spending. Vizient agrees with this decision, but does encourage CMS to consider whether the size of the regions need to be modified based on previous years' findings and/or if there is significant market variability within a single region. If so, CMS should make appropriate changes to resolve such issues.

[3] Centers for Medicare & Medicaid Services, 2018 CN Addendum B, available for download at: https://www.cms.gov/apps/aha/license.asp?file=/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Downloads/CMS-1678-CN-2018-OPPS-Addendum-B.zip, last accessed April 13, 2020.
[4] Centers for Medicare & Medicaid Services, 2020 CN Addendum B, available at: https://www.cms.gov/apps/ama/license.asp?file=/files/zip/cy2020-cn-opps-addendum-b.zip, last accessed April 13, 2020.

Reconciliation

CMS proposes to modify the reconciliation process for the CJR models by having a single reconciliation period, modifying the methodology used in deriving the high episode spending cap amount during reconciliation, adding a market trend factor adjustment and modifying the discount factor to better recognize providers who have "good" or "excellent" CJR composite quality score categories, among other changes. For CMS's additional consideration, Vizient is aware that hospitals are less engaged with the model when they have reduced costs but still owed money. While CMS is making several changes to the model impacting payment, Vizient encourages CMS to consider whether opportunities exist to encourage provider interest by reducing circumstances where providers owe money and/or identifying additional strategies to maintain providers' interest over the remainder of the model.

Retrospective market trend factor

Vizient is concerned that, as proposed, the retrospective market trend factor would perpetuate issues stemming from the grouping of inpatient and outpatient procedures together. CMS proposes that the market trend factor would be the regional/MS-DRG/fracture mean cost for episodes occurring during the performance year divided by the regional/MS-DRG/fracture mean cost for episode occurring during the target price base year. As noted elsewhere in our comments, we do not believe it is appropriate to blend IP and OP procedures, and as a result, believes CMS needs modify several aspects of the proposed model, including the market trend factor (which relies on the proposed MS-DRG) to correct this issue. Should CMS modify the grouping, Vizient recommends CMS revise the market trend factor as well as other portions of the Proposed Rule that are reliant on the proposed grouping.

In addition, Vizient emphasizes the importance of participants being able to quickly respond to issues learned throughout the models and predict their financial performance. Given the retrospective nature of the adjustment, Vizient is concerned participants may have fewer opportunities to track and improve performance and that financial predictability may be lost. Vizient encourages CMS to reconsider the necessity of this proposed change.

Composite quality score: Coding

As payment models reward providers for quality, the need to accurately and consistently record the care provided to patients becomes even more important. Yet, Vizient is aware of variability in coding practices, including acuity, in various hospitals that may ultimately be favoring those who are more proficient in coding. As such, Vizient

encourages CMS to provide additional resources to help healthcare providers more effectively record the care provided in a manner that complements the demands of new payment models.

Risk factor adjustment

Vizient applauds CMS for its efforts to better account for patient-specific factors in the CJR model. Specifically, CMS proposes risk adjustment methodology that considers age and the patient's CMS-Hierarchical Condition Category condition count. For the benefit of this adjustment to come to fruition, a hospital must effectively record and maintain information related to the patient's chronic conditions. Ideally, this would not be a concern. However, as previously stated, there is considerable variability in the content of patients' medical records which may result in a hospital not capturing all of the patient's conditions. Since the likely outcome would be underreporting of chronic conditions, Vizient is concerned the potential benefit of the risk factor adjustment may not be fully realized by hospitals who have less sophisticated health record systems or those who do not consistently and accurately code information to the record. Vizient encourages CMS to provide education to providers participating in the model and practitioners to better ensure they are aware of this change once finalized.

As CMS considers moving forward with enhancements to risk factor adjustment, we encourage the agency to consider other variables (e.g., patient demographics, dual eligibility status) to further refine the model.

Three-year extension

Vizient thanks CMS for considering alternative payment models and seeking feedback from stakeholders to refine those models as they may become permanent. Given CMS's intent to extend the CJR model by 3 years, Vizient encourages CMS to clarify the agency's long-term plans for the model. Vizient believes such clarity will help maintain interest in the model and provide stability for participating hospitals.

In addition, Vizient encourages CMS to permit inclusion for those participants in voluntary Metropolitan Statistical Areas (MSAs) for PY 6-8. As proposed, CMS would prevent voluntary participation in the extended model and believes BPCIA would be an attractive alternative. However, given these participants are already engaging in the model, Vizient encourages CMS to provide bundled payment options for participants, rather than steering participation toward a specific model.

Beneficiary notifications

Consistent with CMS's efforts to reduce provider burden, Vizient believes providing additional time for beneficiary notifications related to CJR participation and financial obligations would be beneficial. Providing notice on the same day can be challenging as there may be delays in determining which beneficiaries may qualify as CJR beneficiaries.

Request for comment on New LEJR-Focused Models That Would Include Ambulatory Surgical Centers (ASCs) and That Could Involve Shared Financial Accountability

Vizient appreciates the opportunity to provide feedback regarding a new LEJR-focused model that would include ASCs and could involve shared financial accountability. Vizient has two key considerations for CMS regarding the inclusion of ASCs. First, creating the target price would be more challenging since there is even more variation in reimbursements for ambulatory surgical centers compared to IP settings. This variation may require significantly different risk adjustment, and other adjustments, that may effectively result in different payment models. Second, determining appropriate attribution of patients to either physician or facility may be confusing and potentially contentious, especially given past experiences with the BPCI and BPCIA for joint replacement where most patients are attributed to physicians, whereas in CJR, patients are attributed to the hospital. Vizient encourages CMS to consider these points and clarify how it prefers these models to advance particularly because several aspects seem to be merging.

While CMS notes that is considering new LEJR-focused models that would include ASCs, we urge CMS not to add procedures performed in ASCs to the CJR model as this would perpetuate our previously stated site neutrality concerns. In reviewing the Proposed Rule, CMS does not contemplate including ASC procedures in the CJR model, however, we reiterate the importance of continued exclusion.

Conclusion

Vizient welcomes CMS's extensive discussion of options and its emphasis on requesting comments, which provides a significant opportunity for stakeholders to inform the agency on how specific proposals will impact our members.

Vizient membership includes a wide variety of hospitals ranging from independent, community-based hospitals to large, integrated health care systems that serve acute and non-acute care needs. Additionally, many are specialized, including academic

medical centers and pediatric facilities. Individually, our members are integral partners in their local communities, and many are ranked among the nation's top health care providers. In closing, on behalf of Vizient, I would like to thank CMS for providing us the opportunity to comment on this important proposed rule. Please feel free to contact Jenna Stern at (202) 354-2673 or jenna.stern@vizientinc.com, if you have any questions or if Vizient may provide any assistance as you consider these issues.

Respectfully submitted,

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