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

Subject: [CMS-5529-P] Medicare Program: Comprehensive Care for Joint Replacement Model Three-Year Extension and Changes to Episode Definition and Pricing; Federal Register / Vol. 85, No. 36 / February 24, 2020 / Proposed Rules.

Dear Ms. Verma:

On behalf of the more than 145 voluntary and public hospitals in four states that make up the acute care membership of the Greater New York Hospital Association (GNYHA), we appreciate this opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS) proposed rule for the Comprehensive Care for Joint Replacement (CJR) Model Three-Year Extension and Changes to Episode Definition and Pricing. Our comments are below and address the following topics:

- Participation requirements
- Combining inpatient and outpatient episodes
- Risk adjustment
- Quality measurement
- Target price methodology

If you have any questions or would like further information, please contact Rebecca Ryan (212-506-5514/rryan@gnyha.org) or John Gravina (212-258-5309/jgravina@gnyha.org).

Sincerely,

Elisabeth R. Wynn
Executive Vice President, Health Economics & Finance

GNYHA Comments on the Proposed Three-Year Extension of the CJR Model and Changes to Episode Definitions

Program Year (PY) 5 Extension

GNYHA appreciates CMS's recognition of the hardships hospitals are facing during the COVID-19 public health emergency (PHE). By broadening the extreme and uncontrollable circumstances policy to cover the COVID-19 PHE and thus capping episode payments at the target price, the financial risk is mitigated for CJR participants during a particularly difficult time. This is especially important for COVID-19 "hotspot" areas, such as the New York metropolitan region, where providers have incurred extraordinary expenses in responding to the pandemic, while experiencing massive revenue losses due to cancelled elective surgeries and to changes in consumer demand for health care services. In fact, our large academic health systems report losing between $350 – $450 million per month *each* during this period. The three-month extension of PY 5 will also help mitigate what will surely be an atypical baseline and performance period.

Comments on the Proposed Model Extension for Years 6-8

GNYHA offers several recommendations on CMS's proposed Model extension for an additional three-years and changes to the episode definitions based on our analysis of available data, as described in detail below.

Participation Requirements

Nearly all of GNYHA's member hospitals are located in Metropolitan Statistical Areas selected by CMS to participate in CJR. Although we have some issues with the current Model's specifications, such as the lack of appropriate risk adjustment, many of our members have performed well in CJR. Over the first three years of the program, participants in New York, New Jersey, and Connecticut had the highest per-episode bonus payments among the 33 CJR-participant states.

Regardless, GNYHA continues to oppose mandatory episode-based payment models (EPMs), including CJR, because many hospitals do not have sufficient resources to succeed under these models. Significant resources are required to build the necessary infrastructure or hire employees to perform new care coordination functions. In addition, we have expressed concern that certain clinical episodes are inappropriate for an EPM because they would impose excessive risk due to factors outside of a hospital's control.

Given our concerns about the appropriateness of mandatory EPMs, and in light of the financial challenges facing hospitals during the COVID-19 pandemic (and will continue to face for a protracted period after), we urge CMS to convert CJR to a voluntary model for the proposed extension period.

Allow Voluntary Participants to Continue in the Model

CMS proposes to restrict participation during PYs 6-8 to include only those hospitals who are currently required to participate in CJR, which would prohibit current voluntary participants from future participation (i.e., those who opted to remain in the program when they had the opportunity to drop out in January 2018). CMS estimates that it would achieve savings by prohibiting voluntary CJR participants from continuing

their participation in the proposed three-year extension and acknowledges that the estimated savings are due to the success of voluntary participants in the Model. In other words, CMS believes that those hospitals who opted to remain in CJR were more likely to succeed in lowering episode costs and therefore achieve shared savings.

Inherent in CMS's savings estimate is a flawed assumption that voluntary participants will continue to generate the same "savings" after their participation in the Model ends. GNYHA member hospitals are committed to patient safety and quality of care but eliminating the Model's financial incentives could limit some participants' ability to continue to invest in the level of discharge planning and patient follow-up required to manage patients across the continuum of care. These investments include hiring employees to engage in efforts that go beyond the typical responsibilities of an acute care hospital. For some participants, these non-reimbursable costs will be difficult to sustain without the Model's shared savings incentive. Maintaining the additional administrative overhead would be especially challenging during the current PHE, which as described above, has significantly strained hospital finances.

Additionally, CMS assumes that there are other opportunities available for hospitals interested in bundled payment programs for lower extremity joint replacement (LEJR) episodes. CMS states that it anticipates that any participant hospital interested in pursuing voluntary participation in a bundled payment model would have already applied to Bundled Payments for Care Improvement (BPCI) Advanced (BPCI-A). However, many voluntary hospitals did not apply to participate in BPCI-A due to their participation in the CJR program, and CMS is not planning for additional BPCI-A application opportunities. In other words, a hospital that applied for BPCI-A for another episode type could add the LEJR bundle after 2020, but a hospital that is not participating in BPCI-A at all would not have the option to join the program. This is especially limiting for specialty hospitals that perform joint replacements that might not have been eligible to participate in BPCI-A for other episode types, or for hospitals that were unable to take on the additional financial risk inherent in BPCI-A. Restricting participation in the proposed CJR extension to mandatory hospitals would leave many hospitals without an option to participate in a bundled payment program for LEJR episodes.

Voluntary CJR participants have invested significantly in the CJR program and their successes have resulted in substantial savings for Medicare. This investment can be seen clearly in their quality results. In PY 3, 32.6% of voluntary participants had "excellent" quality, compared to 18.6% across all participants. Success should not be viewed as a Model flaw—in fact, it is the opposite—and these participants should not be excluded from future participation in the Model simply because they have performed well. CMS should welcome continued interest from all participants, especially during such challenging times.

Lastly, CMS states that 1) the cost of evaluating the small number of voluntary Model participants for years 6-8 would exceed the benefits given the small sample size and 2) that excluding such hospitals would minimize the effects of selection bias in evaluating the changes proposed for the three-year extension. We disagree that the costs would outweigh the benefits of such a program evaluation. The CJR program is meant to incentivize efficient quality care for recipients of Total Hip Arthroplasty (THA) and Total Knee Arthroplasty (TKA) and has succeeded in doing so among voluntary participants. Removing these participants would be a step backwards in CMS's goal to expand EPMs. In addition, if CMS is concerned about selection bias, it should simply exclude the voluntary hospitals retrospectively from the larger sample

for evaluation purposes. Moreover, removing these facilities from the program and introducing them into the pool of control, hospitals could potentially introduce a separate bias as these facilities have already been incentivized to improve their care processes.

Thus, CMS should allow voluntary participants to continue in the Model during the proposed three-year extension.

Combining Outpatient and Inpatient Episodes

CMS proposes to add outpatient joint replacements to the CJR program by grouping them with the applicable diagnosis-related group (DRG)-based inpatient episodes to calculate target prices. Specifically, outpatient TKA—which is currently the only type of outpatient LEJR surgery reflected in the available claims data (based on 2018)—would be grouped with DRG 470 without hip fracture. **For the reasons outlined below, GNYHA opposes this approach and instead recommends that CMS establish separate target prices for inpatient and outpatient LEJR episodes.**

GNYHA Analysis

To evaluate CMS's proposal, GNYHA developed an analytic dataset of LEJR episodes from the 2018 Medicare Limited Data Set claims file that mirrors the CJR program methodology. This includes a 100% sample for institutional claims and a 5% sample for professional claims.

Our analysis revealed the following comments and concerns with CMS's proposal:

- *Episode spending varies significantly by inpatient and outpatient TKA episodes.* As shown in Table 1, our analysis indicates substantial differences exist in the average payments for inpatient and outpatient episodes for TKA without hip fracture, as well as by region. Our analysis was limited to TKA procedures because claims data for outpatient THA is not yet publicly available.

Table 1. Inpatient (IP) versus Outpatient (OP) Average Episode Payments for TKA without Hip Fracture

	IP Episodes	OP Episodes
Total	$22,088	$17,280
GNYHA Member Hospitals	$22,842	$18,291
Region		
1 New England	$22,635	$19,856
2 Middle Atlantic	$22,262	$17,830
3 South Atlantic	$22,779	$17,413
4 East North Central	$22,024	$16,827
5 East South Central	$22,275	$15,590
6 West North Central	$20,452	$16,374
7 West South Central	$23,286	$17,324
8 Mountain	$21,273	$16,812
9 Pacific	$21,353	$18,681

Source: GNYHA analysis of 2018 Medicare claims data from the Limited Data Set.

- *CMS's proposal would result in a target price that is inappropriately low for more complex inpatient stays.* We compared episode payments by the length of stay (LOS) of the index admission to the average

payment for an outpatient TKA episode (see Table 2). These preliminary results indicate that while the average spending associated with a TKA episode originating in the outpatient setting may be similar to inpatient episodes with a zero- or one-day LOS, the difference in average payment is drastically different when compared to inpatient episodes with a two- or three-day LOS, which account for the majority of episodes. Therefore, CMS's proposal would result in a target price that is inappropriately low for more complex inpatient stays.

Table 2. Average Estimated Payment per TKA Episode w/o Hip Fracture by IP/OP Status and LOS

	LOS	Average Payment	# Episodes	Difference from OP Average	% of IP Episodes
OP Episodes	N/A	$17,280	62,947	$0	N/A
IP Episodes	0-1 Day	$18,090	82,693	-$810	30%
	2 Days	$20,813	101,737	-$3,532	37%
	3 Days	$26,308	71,378	-$9,028	26%
	4 Days	$28,428	11,257	-$11,147	4%
	5 Days	$30,237	3,435	-$12,957	1%
	6 Days	$33,493	1,643	-$16,213	1%
	7 Days	$37,206	851	-$19,925	0%
	8 Days	$36,554	400	-$19,274	0%
	9 Days	$35,969	203	-$18,688	0%
	10 Days	$47,301	115	-$30,021	0%

Source: GNYHA analysis of 2018 Medicare claims data from the Limited Data Set.

Therefore, CMS's proposal could lead to inappropriate incentives for hospitals to shift surgeries from the inpatient to the outpatient setting. We are also concerned that the variation in the percentage of episodes performed on an inpatient versus outpatient basis by hospital could result in regional average episode spending targets that are unrealistic for hospitals performing relatively more inpatient procedures than other hospitals.

Risk Adjustment

Since the CJR Model's inception, GNYHA has urged CMS to incorporate appropriate risk adjustment in its target price calculations. The current adjustment for the presence or absence of hip fracture is an imprecise proxy for the many variables that effect costs and clinical outcomes. To address stakeholders' concerns about insufficient risk adjustment, CMS proposes to incorporate two risk-adjustment variables at the episode level: the number of Hierarchical Condition Category (HCC) conditions ("counts") and beneficiary age.

To evaluate the robustness of CMS's proposal, we tested whether CMS's proposed risk adjustments (i.e., HCC counts and age) were sufficient to ensure comparability between inpatient and outpatient episodes. Specifically, we fit a model regressing the difference between the log of the estimated episode cost and the log of the estimated episode target price (which we will refer to going forward as "excess costs") on the setting of the anchor service (inpatient or outpatient), age group, HCC count, and the interaction of anchor admission setting and HCC count. Our findings, presented in Table 3, indicate that the relationship between excess costs and HCC counts varies significantly between episodes that originated in the inpatient versus

outpatient setting. Therefore, additional risk adjustment must be incorporated, especially if CMS rejects our recommendation to establish separate target prices for inpatient and outpatient episodes.

Table 3. Results of Linear Regression of Log Excess Costs on Setting, Age, Dual Eligibility, HCC Group, and HCC Group/Setting Interaction for Proposed DRG 470 Episodes*

Independent Variable	Estimate	Ratio**	P-Value
Intercept	-0.2392	0.7873	< .0001
Setting			
Inpatient	Ref.	1.0000	Ref.
Outpatient	-0.1741	0.8402	< .0001
Age			
Age < 65 Years	Ref.	1.0000	Ref.
Age 65-74	0.0002	1.0002	0.9460
Age 75-84	0.0932	1.0977	< .0001
Age 85+	0.2620	1.2996	< .0001
HCC Count Groups			
No HCCs	Ref.	1.0000	Ref.
1 HCC	0.0607	1.0625	< .0001
2 HCCs	0.1192	1.1266	< .0001
3 HCCs	0.1750	1.1913	< .0001
4+ HCCs	0.2721	1.3127	< .0001
Dual Eligibility			
Non-Dual	Ref.	1.0000	Ref.
Dual Eligible	0.1330	1.1423	< .0001
HCC Count X Outpatient Interaction			
1 HCC X Outpatient	-0.0312	0.9693	< .0001
2 HCC X Outpatient	-0.0740	0.9287	< .0001
3 HCC X Outpatient	-0.0904	0.9135	< .0001
4+ HCC X Outpatient	-0.1703	0.8434	< .0001

*Log Excess Costs=Log Estimated Episode Cost-Log Estimated Target Price.
**The ratio is calculated as the exponentiated estimate.

Next, we ran models that included variables that CMS tested but ultimately did not include in its proposed model, including HCC "groups" (i.e., groupings of clinically similar HCCs) and dual eligibility status to evaluate CMS's proposal to exclude the variables. Table 4 presents the results of our approximation of CMS's proposed risk adjustment model, which are comparable to CMS's results with the exception of the effect of dual eligibility.

Table 4. Results of Linear Regression of Excess Costs on Age, Dual Eligibility, and HCC Count Group*

Independent Variable	Estimate	Ratio**	P-Value
Intercept	-0.2632	0.7686	< .0001
Age			
Age < 65 Years	Ref.	1.0000	Ref.
Age 65-74	-0.0114	0.9887	0.0006
Age 75-84	0.0789	1.0821	< .0001
Age 85+	0.1385	1.1486	< .0001
HCC Count Groups			
No HCCs	Ref.	1.0000	Ref.
1 HCC	0.0480	1.0492	< .0001
2 HCCs	0.0907	1.0950	< .0001
3 HCCs	0.1271	1.1356	< .0001
4+ HCCs	0.1687	1.1838	< .0001
Dual Eligibility Status			
Non-Dual	Ref.	1.0000	Ref.
Dual Eligible	0.1277	1.1362	< .0001

*Excess Costs=Log Estimated Episode Cost-Log Estimated Target Price.
**The ratio is calculated as the exponentiated estimate.

Based on these results, we are concerned that the proposed risk adjustment model ignores the variation in the impact on costs of different HCCs. By adjusting only for the *count* of HCCs, CMS assumes that all conditions equally impact the cost of care. While the count of HCCs is important, the *relative* costliness of each condition within a condition category is equally, if not more, important. In fact, controlling only for the number of HCCs contradicts the underlying assumptions in the CMS-HCC model of how diagnoses relate to costs. The CMS-HCC model was developed for the Medicare Advantage program and accounts for both the impact of individual HCCs and for the HCC count. To demonstrate the relative difference in costliness across different conditions, we regressed excess costs on several HCC groups, controlling for age and dual eligibility (see Table 5).

Table 5. Results of Linear Regression of Log Excess Costs on Setting, Age, Dual Eligibility, and HCC Group for Proposed DRG 470 Episodes*

Independent Variable	Estimate	Ratio**	P-Value
Intercept	-0.078	0.9246	< .0001
Setting			
Inpatient	Ref.	1.0000	Ref.
Outpatient	-0.199	0.8195	< .0001
Age			
Age < 65 Years	Ref.	1.0000	Ref.
Age 65-74	-0.004	0.9958	0.2189
Age 75-84	0.084	1.0876	< .0001
Age 85+	0.245	1.2777	< .0001
Dual Eligibility			
Non-Dual	Ref.	1.0000	Ref.
Dual Eligible	0.131	1.1400	< .0001
HCC Group			
Severe infection, other infectious diseases (CC 1, 3-7)	0.048	1.0491	< .0001
Metastatic cancer, acute leukemia and other severe cancers (CC 8-14)	0.048	1.0495	< .0001
Diabetes mellitus (DM) or DM complications (CC 17-19, 122-123)	0.056	1.0581	< .0001
Quadriplegia, other spinal cord disorders/injuries (CC 70-74, 103-104, 189-190)	0.179	1.1962	< .0001
Myasthenia Gravis/Myoneural Disorders (CC 75, 81)	-0.022	0.9784	0.0615
Dementia or other specified brain disorders (CC 51-53)	0.177	1.1940	< .0001
Major psychiatric disorders (CC 57-59)	0.093	1.0974	< .0001
Acute myocardial infarction (CC 86-87)	0.165	1.1790	< .0001
Specified heart arrhythmias (CC 96-97)	0.043	1.0439	< .0001
Stroke (CC 99-100)	0.367	1.4431	< .0001
Vascular disease and complications (CC 106-109)	0.059	1.0603	< .0001
Renal failure (CC 135-140)	0.067	1.0692	< .0001
Decubitus ulcer of skin (CC 157-161)	0.372	1.4505	< .0001
Trauma, other injuries (CC 166-168, 170-174)	0.309	1.3625	< .0001
Hypertensive heart disease (CC 94,95)	0.011	1.0114	< .0001
Depression (CC61, CC62)	0.040	1.0411	< .0001
Profound Intellectual Disability/Developmental Disorder (CC64-CC68)	0.131	1.1395	< .0001
Osteoarthritis of hip or knee (CC 42)	-0.156	0.8551	< .0001
Multiple sclerosis mononeuropathy, other neurological conditions/injuries (CC 77, 81)	0.059	1.0604	< .0001
Chronic obstructive pulmonary disease (COPD) (CC 111)	0.069	1.0718	< .0001
Pneumonia (CC 114-116)	0.036	1.0369	0.4620
Dialysis status (CC 134)	0.314	1.3682	< .0001
Urinary tract infection (CC 144)	0.116	1.1226	< .0001

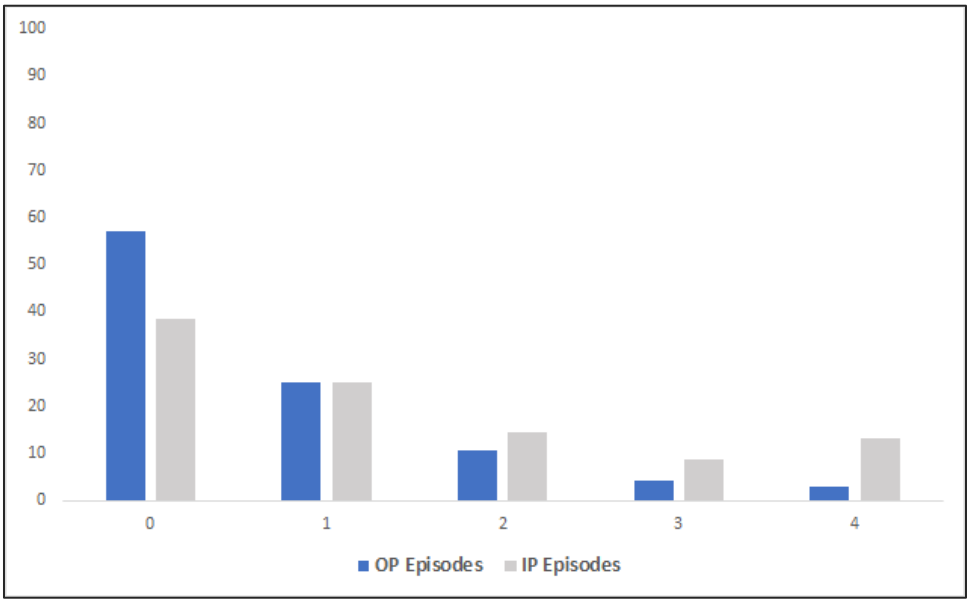
*Log Excess Costs=Log Estimated Episode Cost-Log Estimated Target Price
**The ratio is calculated as the exponentiated estimate

Our analysis clearly shows the estimated coefficients vary greatly across HCC groups. For example, our analysis showed that the hypertensive heart disease group leads to a 5% increase in excess costs, while HCCs in the decubitus ulcer of the skin group are associated with a 12% increase in excess costs. **Therefore, GNYHA urges CMS to implement a model that accounts for the impact of both individual HCCs and the type of HCCs in each episode.**

In addition, we analyzed the systematic differences in the reporting of ICD-10-CM codes across inpatient and outpatient claims to understand how provider coding differences could impact the HCC counts between the two settings, irrespective of true differences in the severity of illness. We were interested in this question because inpatient reimbursement is dependent on ICD-10-CM codes (including comorbidity/complication codes), while outpatient and physician services are generally reimbursed through Current Procedural Terminology (CPT) or Healthcare Common Procedure Coding System (HCPCS) (CPT/HCPCS) codes, with the latter not impacted by the presence of ICD-10-CM codes. The purpose of this analysis was to evaluate whether there is potentially systematic risk in CMS's proposal to adjust solely for HCC counts, without establishing separate inpatient and outpatient targets.

Figure 1 provides the percentage of outpatient and inpatient episodes that reflect the number of HCC categories (as proposed by CMS for inpatient episodes relative to outpatient episodes). This clearly illustrates that outpatient episodes are far more likely to include claims that are assigned zero HCCs. Therefore, simply adjusting by HCC count is insufficient to ensure comparability across setting. To address this concern, CMS should account for the difference between inpatient and outpatient episodes by either stratifying by the setting of the anchor service when developing its risk adjustment model or by including both the setting and the interactions between setting and measures of severity of illness as variables in a non-stratified model.

Figure 1. Percentage of Episodes Reflecting Various HCC Count Groups



Beneficiary Age Adjustment

GNYHA supports CMS's proposal to risk-adjust the target price calculations for beneficiary age. Adjustments of TKA/THA spending for age aligns with the current body of evidence and is consistent with the risk adjustment model used by CMS to adjust its own measure of risk standardized payment associated with a 90-day episode of care for elective primary TKA and/or THA.

Dual Eligibility Adjustment

Although CMS considered including dual eligibility as a proxy for socioeconomic status in the CJR program, it did not ultimately propose to include such an adjustment because its analysis did not indicate a statistically significant relationship between dual eligibility and excess costs. However, as indicated in Table 3, our analysis showed a statistically significant relationship between these two variables. **GNYHA encourages CMS to engage in further analysis of the relationship between socioeconomic status and excess costs.** We note that CMS has acknowledged that dual eligibility is an important factor associated with the likelihood of readmission for Medicare beneficiaries undergoing these procedures by risk-adjusting for dual eligibility (through stratification) in the Hospital Readmissions Reduction Program, which includes a measure of readmissions for THA and TKA.

Request for Comments on a Fixed Effects Model

CMS requests comment on moving to a fixed effects model for purposes of risk adjustment, and the implications such a change would have on CMS's ability to build checks into its risk adjustment process. We believe that the provider community lacks the necessary information to meaningfully comment on such a change. If CMS would like substantive comments on a model that is different than the model proposed, CMS should provide the details of such a model.

High Episode Spending Cap

CMS currently imposes a high episode spending cap during reconciliation to limit participants' responsibility for catastrophic episode spending amounts beyond their control. Assuming a normal distribution of CJR episode costs, the cap is set at two standard deviations above the regional mean episode price identifying high episode spending that qualifies as statistical outliers. Under these assumptions, the threshold would cap approximately 2.5% of episode costs.

CMS states in the proposed rule that CJR episode costs have not demonstrated a normal distribution and a higher-than-expected number of episodes are being capped. Therefore, during the three-year extension period, CMS proposes to set the high episode spending cap equal to the 99th percentile of costs as derived from the performance year's regional spending data during the model's extension period.

GNYHA opposes this change—CMS's proposed high episode spending cap is arbitrary and the agency provides no clear rationale for decreasing the number of episodes that can be capped to 1%.

Quality Measurement

Discount Rates

When calculating episode target prices for reconciliation, CMS applies a standard discount that it takes for Medicare savings before evaluating whether the participating hospital reduced episode expenditures. In the current Model, CMS reduces the discount factor from 3 percentage points for hospitals who achieve a composite quality score (CQS) of "Good" or "Excellent" by 1 percentage point and 1.5 percentage points, respectively. CMS proposes to further reduce the standard discount for PYs 6-8 from 3 percentage points to 1.5 percentage points for hospitals with a "Good" CQS and by 3 percentage points—i.e., eliminating the discount entirely—for hospitals with an "Excellent" CQS.

However, CMS states in the proposed rule that it is proposing these adjustments to the discount factors to partially offset the negative impact of some of its other proposed changes on participants:

> *"…the composite quality score adjustment for performance years 1 through 5, with a maximum potential for a 1.5 percentage point reduction to the discount factor, could potentially force the target amounts calculated under the proposed methodology…under an appropriate actual cost amount, which is not the intent of the model."*

Without access to the full data set that CMS used to develop its proposals, we have no way to evaluate whether the reduced discount factors are appropriate and the extent to which they help mitigate some of the negative financial implications of the other proposed changes to the target price calculations.

Patient-Reported Outcomes (PRO) Measure

CMS proposes to increase thresholds for successful submission of PRO for PYs 6-8 progressing from a threshold of at least 80% or 200 procedures up to 100% or at least 1,000 procedures. GNYHA believes any increase to the reporting thresholds is unreasonable. While facilities that are reporting may include a high percentage of procedures, this number reflects facilities that have opted to report. Facilities that have not started collection may choose not to invest resources in collecting PRO data given the high bar required for success.

The number of CJR participants that successfully report PRO data is consistently low because the required data collection is complex and burdensome. In PY 3, only 10% of CJR participants received CQS credit for reporting PRO data, and we have heard anecdotally that some participants who previously reported have stopped due to the increasing thresholds. **At a minimum, CMS should maintain the PY 3 thresholds of at least 70% or 100 procedures for the TKA/THA PRO measure going forward.**

Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) Survey

CMS proposes to continue to use the HCAHPS measure as part of the CQS for PYs 6-8. GNYHA has previously expressed concerns about the appropriateness of the HCAHPS measure given that it is based on a survey of all patients rather than patients in CJR episodes. CJR participants should be evaluated based on quality of care components that they can impact through care redesign.

We also remain concerned that CMS is penalizing hospitals more than once for performance on a single measure by using the HCAHPS measure, among others, in multiple hospital pay-for-performance programs.

Target Price Calculation

Baseline Data Period

CJR target prices are based on three years of baseline data and are updated every other year. Initially, CMS used three years of data to allow for sufficient claims data to reasonably calculate targets. CMS proposes to update the target price calculation to use one year of baseline claims data and update targets each year.

GNYHA urges CMS to postpone implementing a one-year baseline period given the COVID-19 crisis. CMS has announced its intent to exclude claims data from the period affected by COVID-19. We agree with this; however, as the pandemic is affecting different states at different times, it would be more prudent to incorporate additional data from a longer time period to smooth any impact of COVID-19 on costs and

claims data. We note that CMS would also need to maintain the existing trend factor during the postponement period.

Aside from our concerns about data fluctuations in 2020 due to the COVID-19 PHE, we generally support eventually moving to one reconciliation period to reduce administrative burden and reduce the potential for secondary reconciliations that result in takebacks (thereby providing more certainty for providers). We also believe that moving to a one-year baseline period would allow for a better comparison between baseline periods in which no THA procedures were performed on an outpatient basis to performance periods in which THA was removed from the inpatient only list. Similar logic applies to the addition of TKA to the ambulatory surgical center (ASC) covered procedures list beginning in 2020, which could create inconsistencies between the baseline and performance data for CJR episodes performed in the inpatient or outpatient hospital setting—i.e., assuming that some lower acuity episodes would move from the hospital to the ASC setting and thus increase the case mix of the CJR episodes in the performance year.

Trend Factor

CMS proposes to add a trend factor to the target price methodology in response to changing practices in joint replacement. The proposed market trend factor is the regional mean cost for episodes during the PY divided by the regional mean cost for episodes during the target price base year with separate factors by Medicare Severity DRG and fracture status. CMS also explored using the median cost instead of the mean.

GNYHA supports CMS using the *median* cost to calculate the market trend factor. CMS describes the episode costs as not normally distributed, so a non-parametric measure of central tendency is more appropriate.