June 23, 2019

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

Dear Administrator Verma:

LeadingAge and our partners, the Visiting Nurse Associations of America and ElevatingHOME, on behalf of our 6,000 non-profit members who provide housing, health care and personal assistance to older persons and persons with disabilities, appreciate the opportunity to comment on the proposed rules related to Comprehensive Care for Joint Replacement (CJR) Model Three-Year Extension and Changes to Episode Definition and Pricing.

The mission of LeadingAge is to be the trusted voice for aging. The members of LeadingAge and partners impact the lives of millions of individuals, families, employees and volunteers every day. Our over 6,000 members and partners include nonprofit organizations representing the entire field of aging services, 38 state associations, hundreds of businesses, consumer groups, foundations and research centers. LeadingAge is a 501 (c)(3) tax-exempt charitable organization focused on education, advocacy and applied research.

Our comments reflect the perspective of providers of skilled nursing facilities (SNFs) and home health agencies who provide critical post-acute care services as part of this model, many of whom participated in and successfully led a Model 3 bundle under the Bundled Payments for Care Improvement initiative.

Overall, we are supportive of CMS’s efforts via Center for Medicare and Medicaid Innovation (CMMI) to continue testing alternative payment models (APMs) for the care of older adults. We agree that delivering care in a more integrated manner where providers communicate, coordinate and collaborate around addressing an individual’s needs can result in better outcomes and lower costs. However, key to successful integration is reimagining how we pay for care and services to incentivize these new approaches.

**Proposed Target Prices**

Upon initial review, the proposal to use one-year of claims data for setting target prices during the extension period made considerable sense as it should better reflect the recent Medicare payment changes (e.g. the shift to Patient Driven Payment Model for SNFs). However, with the advent of anomalous utilization and expenditures during the COVID-19 pandemic, we wonder if this approach still makes sense and offers accurate pricing. We appreciate the efforts to incorporate the number of chronic conditions a patient has and their age into the risk adjustment calculations to more accurately account for the resources required to care for these individuals. As CMS/CMMI consider further risk
adjustment approaches for CJR and other APMs, we think it would be beneficial for consistency in risk adjustment factors utilized by Medicare for consistency across programs. Ideally, we want to align risk adjustment across models where it makes sense using the most appropriate factors including an ability to adapt for changes in condition instead of relying too heavily on past behavior as the key predictor of the future, particularly to account for changing clinical practice patterns, and accounting for numbers of chronic conditions an individual has.

We support the extension of the SNF 3-day inpatient stay waiver for the new outpatient procedures being added to the CJR program. This is an important protection for beneficiaries by ensuring their eligibility and Medicare payment for necessary SNF care and it ensures SNF providers are also eligible for Medicare reimbursement.

**Require gainsharing with providers who help generate gains**

While we were pleased to see that CMS is proposing to lift the 50% cap on gainsharing payments, we are disappointed that it is limited to just “when the recipient of these payments is a physician, non-physician practitioner, physician group practice (PGP), or non-physician practitioner group practice (NPPGP).”

Our members’ experiences with these models is that the models still do not fully align financial incentives across all providers who participate in the care delivered through the model. More specifically, post-acute care (PAC) providers rarely see gainsharing in models, like the CJR model, even though SNFs and home health agencies are redesigning care and playing a key role in ensuring patients can return home sooner and remain there without a rehospitalization. This proposed change would likely further exacerbate the disparate treatment of PAC providers in comparison to physicians regarding gainsharing payments.

These bundled, episodic models are successful through a focus on redesigning care by appropriately shortening length of stay when SNF care is needed and substituting one type of care for another such as bypassing a SNF and discharging a patient directly home or with home health care. While these approaches are appropriate for some patients, the reason bundled participants redesign care this way are more likely the result of how SNFs and home health agencies are paid under Medicare fee for service. SNFs are paid for each day they provide service; unlike hospitals, which are paid a flat rate per case. Therefore, fewer SNF days results in fewer dollars spent. In addition, home health care episodes cost less than a SNF stay so, where possible and appropriate, it makes financial sense under a bundle to make this substitution of care. This allows bundled participants to spend under the target price resulting in gains. However, the PAC providers are rarely, if ever, sharing in the gains generated by these care pattern changes and instead merely get referrals that come with additional expectations that don’t bolster their revenue but diminish it through fewer covered days and fewer admissions for SNFs and more complex patients in home health.

Most APMs, including the CJR model, have permissive language that bundled participants can opt to share gains with other providers but are not required to do so. Nonetheless, we believe this is a fundamental flaw of this and other APMs. As CMMI continues to refine all APMs, we encourage CMMI to look more closely at, and attempt to fix, this flaw related to gainsharing across care providers. Providers who contribute to the gains should be sharing in them. This is rarely the case beyond physicians. The reality is until we truly shift how we pay providers we may be able to achieve cost
reductions in care but to what end if the PAC providers revenue diminishes to the point that they can no longer afford to operate.

One of our members articulated to us, “The only concern I can share with you is that extending the CJR program continues to cut post-acute out of the equation. We cannot own or manage the bundle; hospitals are not sharing the savings; and in those cases that do come to SNFs, we do the work to safely move the patient to a lower cost setting as quickly as possible yet share in none of the benefits of doing so. These programs continue to discount the work and costs that post-acute providers put into improving outcomes and decreasing costs, yet we get nothing for it.” As a former Bundled Payment for Care Improvement Model 3 participant, this provider organization is very familiar with managing care across sites of service, while improving outcomes and lowering costs.

We support continued testing of new models but encourage CMMI/CMS to test models that:

1. Integrate services across the constellation of services recognizing that an individual’s needs are not confined to services paid for by Medicare.
2. Allow other providers besides just hospitals and physicians to lead such models including PAC and long-term service and support providers.
3. Align financial incentives to ensure all providers participating in a beneficiary’s care are held accountable for the outcomes but also financially rewarded when they achieve the desired outcomes.

LeadingAge has been actively advocating for and working to design new alternative payment models that PAC (and in some cases, long term services and supports) providers can lead. We appreciate CMMI staff working with us and our other association partners to achieve the goal of a new APM led by these providers. We look forward to CMMI adopting such a model in the near future so these providers can demonstrate their ability to bend the cost curve and deliver quality care while remaining financially viable. We are interested in continuing these conversations with CMMI/CMS.

Again, LeadingAge appreciates the opportunity to submit comments on the proposed rule. Please do not hesitate to contact me if you wish to discuss any of these comments or further discuss potential alternative payment models.

Sincerely,

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