August 17, 2023

Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
P.O. Box 8013
Baltimore, MD 21244-8013

Re: Request for Information: Episode-Based Payment Model (CMS-5540-NC)

Dear Administrator Brooks-LaSure:

The Health Care Transformation Task Force (HCTTF or Task Force) appreciates the opportunity to comment on the Centers for Medicare and Medicaid's (CMS) Request for Information: Clinical Episode Payment Model (RFI).

The Task Force is a multistakeholder consortium that supports accelerating the pace of transforming the delivery system into one that better pays for value. Representing a diverse set of organizations from various segments of the industry – including providers, payers, purchasers, and patient advocacy organizations – we share a common commitment to transform our respective businesses and clinical models to deliver a health system that achieves equitable outcomes through high-quality, affordable person-centered care. We strive to provide a critical mass of policy, operational, and technical support that, when combined with the work being done by CMS and other public and private stakeholders, can increase the momentum of delivery system transformation.

CARE DELIVERY: HCTTF'S VISION FOR THE FUTURE OF CLINICAL EPISODE MODELS IN MEDICARE

The RFI asks a series of comprehensive questions designed to inform Medicare's future clinical episode models. The Task Force's letter responds to many of those questions; however, responses to individual questions fail to provide a clear and complete vision for the meaningful role that clinical episode models can play to drive more effective value transformation in Medicare. This section reflects the Task Force's broader vision for the desired direction of clinical episode models.

Key issues raised by the RFI include the use of mandatory vs voluntary episodic payment models, the types of services and conditions included in episodes, and the length of episodes. The Task Force believes that total-cost-of-care (TCOC) models with an effective primary care component are the most promising vehicle for holistically serving the needs of Medicare beneficiaries, and that episodic models function best when implemented in concert with TCOC

models. With that said, HCTTF recognizes that specialist engagement in TCOC models has been low and that there are specific conditions and services where medical professionals are not well positioned to lead such models. The Task Force views the strategic use of episodic models as a valuable tool for increasing institutional provider and medical professional engagement in value-based care models.

The RFI indicates that CMS is considering implementing mandatory clinical episode models. The Task Force believes mandatory models can serve an important role in driving model participation; we will support mandatory models on a case-by-case basis based on their design and impact. It is our understanding that CMS's intent is to mandate clinical episode models that will likely focus on hospitals not otherwise actively engaged in value-based models. We generally support this goal. With that said, the Task Force urges CMS not to mandate a clinical episode model in markets or regions where there is already significant participation in voluntary value-based models or for providers who are ill-equipped or under-resourced to support the burden of implementing this type of payment model. Even in markets with less value-based penetration, hospitals and medical professionals meaningfully engaged in TCOC models by virtue of ACO participation should be given the opportunity to opt out of a mandatory model.

The Task Force offers an alternative approach to balancing the interests of mandating model participation while not creating an unreasonable risk that the model's participants may fail in a manner that negatively impacts the access to or quality of care. While a new CMMI model may mandate participation for specific providers, it can still offer choice to those providers within the model design. For example, the new model is likely to cover a multitude of episode types, as the RFI portends a program with more episodes than the CJR model but with less than the BPCIA program. Within this construct, a mandatory model could require participation in a reasonable number of specific episodes most important to CMS, while providing the participant with the choice to participate in more episodes otherwise available under the model. Other possible permutations are likely for allowing a degree of participant choice inside a mandatory clinical episode model.

In discussion with Task Force members, we find that clinical episodes typically fall into three categories: (1) acute medical episodes; (2) surgical episodes; and (3) condition-based episodes. Acute medical episodes present the most serious short-term clinical risk but can also be of the shortest duration. Surgical episodes are most common within the Medicare clinical episode models, with effective management of post-acute care and readmission avoidance being most critical to participant success. Condition-based episodes are longitudinal in nature and create the greatest potential for overlap and conflict with TCOC models which also seek to manage and coordinate care. In our response to the RFI questions, we highlight the importance of CMS prioritizing greater alignment across models with an emphasis on: (1) clearly defining when a condition-based episode is warranted over a TCOC model, and (2) developing clear pathways for nesting acute and surgical bundles within existing TCOC models whenever possible.

The RFI indicates that CMMI is considering imposing a 30-day episode length "to better align episodic and longitudinal, population-based incentives, thereby strengthening communication, collaboration, and coordination by providers at all points of a patent's journey through the health care system." We presume that CMS believes the current 90-day episode

length is too long in many instances to effectively reengage and coordinate with the patient's health care ecosystem. The Task Force agrees with this sentiment, as we believe there is no one-size-fits-all solution when it comes to episode length. A 90-day length is not appropriate in all situations, and we agree that 30-day episode lengths are more appropriate than 90 days in many instances. We believe a clear, rigorous standard should be established to determine which episodes should be assigned a 30-day length.

The Task Force believes conditions and services appropriate for a 30-day episode should be easily identified, distinct, of sufficiently high volume to create accurate target prices, and should have a substantial portion of costs associated with the service occur during the first 30 days. Under this standard, acute medical episodes appear to present the best opportunities for the shortest durations, but that is not absolute and may not ring true in every instance. For example, treatment for acute medical conditions such as sepsis, stroke, or even a heart attack sometimes requires longer than 30 days for specific patients and clinical situations.

In the Task Force's view, CMMI should seek to provide adequate linkage and incentives that drive the nesting of a clinical episode within a TCOC model. The combination of the two approaches should best align the goals to lower the cost of care for clinical episodes while the TCOC management ensures such clinical episodes are only used when necessary and appropriate. We urge that the focus of any future CMMI model - particularly a mandatory model – be to find the sweet spot of a carrot and stick approach that either incentivizes or requires specialists to better engage and/or affiliate with TCOC model participants in a meaningful way and that complements rather than conflicts with the ACO model.

The other issues and questions CMS is considering under the "care delivery and incentives structure alignment" section of the RFI reflect over a decade of learning about the opportunities and challenges inherent in any alternative payment model. Many of these questions, particularly those pertaining to supporting provider participants, promoting patient-centered care, supporting multi-payer alignment, engaging specialists, and building effective HIT infrastructure, are addressed later in these comments.

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Responses to Other Specific RFI Sections

I. Clinical Episodes

- **Which of the clinical episode categories, tested in either BPCI Advanced or CJR, should be considered for, or excluded from, this next episode-based payment model?**
- **Should CMS test new clinical episode categories?**
- **How many clinical episode categories or service line groupings should be tested?**
- **Are there particular types of items or services that should be excluded from clinical episodes?**
- **Are there other considerations for selection criteria that are of interest to other payers?**

Rather than offering specific clinical episode categories or service lines, the Task Force strongly recommends that CMMI incorporate the following guidelines to identify the episodes or service lines that are best suited for use in a mandatory model:

- Include only episodes with a well-defined triggering event with costs of that event and subsequent services attributed to an accountable entity.
- Include only episodes conducive to accurate benchmark setting and common enough or sufficient volume to justify including in a mandatory model.
- Include only episodes that have been found to generate savings without harming quality or improving quality without increasing spending.
- Focus on acute services, for example: total hip/knee arthroplasty, spinal fusion, stroke/transient ischemic attack, sepsis, where a beneficiary has a time-limited relationship with a provider to address a specific issue. The principal goal of the bundle should be to improve quality and address issues with quality, unexplained variations in cost, and efficiency.
- Elements unrelated to the episode initiation should be excluded from the clinical episode evaluation. The participant should be rewarded, however, for implementing and achieving various elements of evidence-based care through transition, such as medication reconciliation and timely follow-up appointments.

Participants in these models would be responsible for managing costs and quality within the bundle – or total cost of care for that patient for the duration of the episode – but would not be eligible to serve as accountable entities for overall beneficiary care.

The Task Force believes that chronic care episodes may be too complex to implement at the start of the mandatory model but supports CMS continuing to iterate on how chronic conditions could be included at a later point. As part of this consideration, the Task Force suggests CMS explore the use of clinical condition categories (CCCs) as the basis for any potential chronic condition episodes. We discussed this concept in detail as part of a set of recommendations for aligning the alternative payment model portfolio that HCTTF sent to CMS in April of 2022. Basing episode payment models on CCCs would serve to reduce adverse selection, incentivize collaboration between primary care providers and specialists, and create broadscale availability of advanced APM for specialty care providers.[1]

- **Should CMS consider alternatives to a 30-day episode length? If so, include evidence to support this marker as the most appropriate transition point from the hospital to the primary care provider.**

In general, the Task Force is concerned that a 30-day episode may not be long enough to appropriately account for a procedure and the post-acute care needs of the patient, particularly if skilled nursing facility or rehabilitative services are required. Our recommendation to CMMI is to take a "one size does not fit all" approach, and to design the episode length to the care cascade that comprises the clinical episode in a way that allows for comprehensive, coordinated care and guards against unnecessary readmission risks.

[1] A Playbook for Medicare Specialty Bundles Fina.pdf (wsimg.com)

II. Participants

- **Should different participants be accountable for different clinical episodes? For example, if both hospitals and physician group practices (PGPs) are participants in the episode-based payment model, should hospitals be accountable for a certain clinical episode category (for example, congestive heart failure) or a certain clinical episode type (for example, medical episodes vs. surgical episodes) as compared to PGPs?**

In line with the recommendations offered above regarding the clinical episode design, the Task Force recommends that initially, the clinical episode(s) selected for a mandatory model may be best suited for hospital participants. Additional recommendations related to this are described in more detail below, as they relate to health equity. However, as the program evolves, our members are supportive of designing a model that also engages Physician Group Practices (PGPs), depending on the clinical episode.

Related to the recommended guidance above, the Task Force recognizes that hospital participants will need to coordinate with other entities. We recommend that CMMI promote alignment by creating incentives for hospital participants to have demonstrated meaningful relationships, defined referral pathways, and clear coordination plans with PGPs and/or ACOs where available, to ensure a successful return to the patient's established source of primary care as the episode is ending. These relationship incentives should also extend to community agencies as appropriate, (e.g. substance use disorder, mental health agencies). For those patients without an established medical home, or source of primary care, there should be explicit incentives within the episode model that incentivize specialists' involvement in ensuring their patients have access to a continuous primary care relationship.

- **Given that some entities may be better positioned to assume financial risk, what considerations should CMS take into account about different types of potential participants, such as hospitals and PGPs?**

Because of the mandatory nature of the model, the Task Force recommends there be an ample glidepath for assuming financial risk and reiterates that hospitals can be the focus for initial participation but should not be the exclusive participant type.

- **Should CMS continue using precedence rules to attribute clinical episodes to a single accountable entity or consider weighted attribution for multiple accountable entities?**

Task Force members are not in consensus regarding a single accountable entity versus weighted attribution. However, there is agreement among our members that there must be direct responsibility for whichever entity is formally responsible for the episode, and/or taking risk to collaborate across the care team. This may be operationalized in several ways, for

example, by CMS sharing data across all entities that are contributing to the patient's episode of care.

III. Health Equity

- **What risk adjustments should be made to financial benchmarks to account for higher costs of traditionally underserved populations and safety net hospitals?**

HCTTF fully supports the emphasis on health equity that CMS has placed at the core of new payment model design efforts. We recommend CMMI leverage strategies such as health equity plan requirements and benchmark adjustments. Regarding benchmark adjustments, unlike in ACO REACH where CMS offsets the increase in benchmarks for beneficiaries with high ADI by lowering benchmarks for lower-risk patients, the Task Force recommends that CMS modify target prices to account for underutilization in a way that does not reduce payments elsewhere in the model. This would guard against introduction of potential inaccuracies and inadvertently creating new inequities in payment. However, health equity policies around clinical episode models should be realistic regarding the resources that should be devoted to equity issues depending on the length of the episode.

In previous letters to CMS, the Task Force highlighted issues with APM design that negatively impact the ability of models to address equity and have offered recommendations to address them. Many of those recommendations are directly applicable to a mandatory episode-based payment model. Specifically, we note that the providers most often caring for communities impacted by inequity (rural practices/hospitals, safety net practices/hospitals, critical access hospitals, federally qualified health centers, community clinics, and small practices) lack the investment resources (e.g. for interoperability infrastructure, staff recruitment, and workflow redesign) and risk tolerance for most APMs; this needs to be addressed if this is to be a mandatory model.

- **Should episode-based payment models employ special adjustments or flexibilities for disproportionate share hospitals, providers serving a greater proportion of dually eligible beneficiaries, and/or providers in regions identified with a high ADI, SVI, or SDI?**

A mandatory model should include flexibilities for Disproportionate Share Hospitals, hospitals that serve a greater proportion of dually eligible beneficiaries and/or Low-Income Subsidy (LIS) beneficiaries, as well as providers in regions identified with a high ADI, SVI, or SDI score. In addition, the Task Force recommends exploring other data elements around which to develop flexibility, such as surveying patients to understand their living situations (e.g. living alone or with family), and patients experiencing homelessness or residential instability. Finally, CMMI should consider such indices as the frailty index, which can be used as a proxy for individuals with additional social risk factors.

- **What other factors could be considered for providers who serve underserved beneficiaries or beneficiaries who experience social risk factors?**

An important factor to consider is that current benchmarking approaches generally fail to adequately account for equity in that they rely to some degree on historic spending and utilization as a proxy for appropriate levels of care. This is not a realistic expectation for individuals and communities that are underserved by the health care system and further entrenches historic inequities.

We urge CMMI to continue leveraging a multi-faceted approach to advancing equity including equity plan requirements, benchmarking strategies that adjust for beneficiary and community level equity, risk adjustment methodologies tailored to providers working in underserved communities, demographic data collection, and quality measurement strategies that encourage the closing of health equity gaps.

- **Can measure stratification among patient subgroups and composite health equity measures improve how CMS identifies and quantifies potential disparities in care and outcomes?**

Measure stratification by race, ethnicity, language, gender, sexual orientation and gender identity, disability, and other demographic factors, is absolutely critical to identifying, quantifying, and addressing disparities in care and outcomes. Research indicates that when unstratified by patient subgroups, quality metrics that indicate positive trends are masking enormous gaps in care and outcomes.

- **What metrics should be used or monitored to adjust payment to assure health disparities are not worsened as an unintended consequence?**

These efforts should be grounded on the establishment of reasonable expectations for the cost of providing efficient and high-quality care in a manner that adjusts for the historic underinvestment in some communities and demographic groups.

To improve equity in relation to APM alignment and specialist care, CMMI could target models to communities with shortages of primary care providers and specialists and develop measures to monitor equity issues in the treatment modalities that beneficiaries receive, patient experience, and outcomes.

IV. Quality Measures and Multi-Payer Alignment

- **Which quality measures, currently used in established models or quality reporting programs, would be most valuable for use across care settings?**

The Task Force urges CMS to incorporate screening measures for health-related social needs and referral patterns for concerns related to health equity. Measures should not be administratively burdensome to providers, should be easy to collect, and should include those most important to patients and clinicians. As with BPCI-A, participants should have options to report quality via administrative claims-based measures or via registry reported measures. CMS should also use standardized tools for screening and other interoperability standards. New quality measures should be phased in or include sufficient implementation time to support provider and payer success without unreasonable implementation and operational costs.

The Task Force also believes CMMI should prioritize the use of quality measures to support health equity improvements. The CDC reports that people from racial and ethnic minority groups experience higher rates of illness and death across a range of conditions, including diabetes, hypertension, obesity, asthma, and heart disease, when compared to white patients. Similar disparities exist for individuals of minoritized sexual orientation and gender identity groups. We urge CMS to prioritize the stratification of measures to address where inequalities are starkest and incentivize equity improvements.

Examples of reasonable measures to consider for an episode-based payment model are listed below. CMS should ensure that the selected measures are relevant to the care furnished in the episode, including the condition as well as the patient population. Challenges with quality measurement in the CJR and BPCI-A models include measures not being tailored enough to the model, and participants feeling like there is not a lot that they can do to drive care improvements under the model.

- Depression screening, either upon admission or as part of the follow up plan.
- Advanced care planning, so that patients' wishes for care at end of life and who of their loved ones they would like involved in those care decisions are better understood.
- Hospital acquired conditions (HACs), never events such as wrong-site surgery, unintended retention of a foreign object after surgery/procedure, and patient death or serious injury associated with a medication error (wrong drug, dose, patient, time, rate, preparation, or route).
- Return to hospital, as measured by readmission or ED visit during the episode.
- Return to primary care as measured by a follow up visit seven days post discharge from acute or post-acute care (if transitioned to PAC), with additional payment if a TCM visit is documented.

To support success in primary care transition following a specialty-led episode of care CMS should hold both specialists and primary care providers accountable. One way to encourage accountability for quality outcomes is to develop a narrower set of quality measures focused on outcomes that are clearly within a provider's control (i.e., infections, revisions of procedures, post-acute care, patient experience). Additionally, CMS should require specialists and primary care providers to participate in an HIE or other trusted data exchange mechanism that supports real-time ADT notifications to primary care physicians. This will aid in a successful transition, especially for patients who do not have an established primary care provider.

- **What PRO measures should CMS consider including in this next episode-based payment model?**

The Task Force urges CMS to support a stepwise approach that first supports establishing a patient-reported outcome measure (PROM) infrastructure before measuring health systems on their PROM performance. CMS should commit to helping providers to effectively use the PROM information to improve care. Efforts to advance the use of PROMs should include looking at ways to improve the timeliness of collection and analyses of data and taking action to

address issues raised. Additionally, PROMs design, testing, implementation, and evaluation should be conducted through a health equity lens. CMS should seek to minimize manual chart abstraction as this adds administrative burden for providers.

Existing PRO measures CMS should consider including in this next episode-based payment model are listed below. While we suggest that CMS implement measures that can be used across programs, as outlined in the General Health Related Outcomes Measures section below, we have also included additional measures specific to different episodes.

General Health Related Outcomes Measures:

- Veterans RAND Survey- 12-questions that focus on the patient's ability to do certain tasks and any physical/emotional impairment in everyday tasks and social activities. The questions ask about the patient's functionality as compared to four weeks prior, as well as compared to a year prior. These measures are part of voluntary reporting in the CJR model.
- Patient Reported Outcomes Measurement Info System (PROMIS)- PROMIS measures are relevant across all conditions for the assessment of symptoms and functions. These measures are part of voluntary reporting in the CJR Model.

Hip Injury Measures with or Without Osteoarthritis:

- Hip Disability and Osteoarthritis Outcomes Score- 40-question questionnaire recommended when there are symptoms of hip disability, with or without osteoarthritis. The questionnaire assesses five subcategories: pain, symptoms and stiffness, activities of daily living, function in sports and recreational activities, and quality of life. These measures are part of voluntary reporting in the CJR model.
- Oxford Hip Score- 12-item PRO specifically designed to assess function and pain for patients undergoing hip replacement surgery

Knee Injury Measures with or Without Osteoarthritis:

- Knee Injury and Osteoarthritis Outcome Score- developed to assess a patient's opinion about their knee pain and associated problems. It contains 42 questions that assess pain, function in daily living, function in sport and recreation, and knee-related quality of life. These measures are part of voluntary reporting in the CJR model.
- Oxford Knee Score- 12-item PRO designed to assess function and pain after total knee replacement surgery.

Mental Health Measure:

- Patient Health Questionnaire (Mental Health)- various surveys to assess anxiety, depression, PTSD, and substance use. The PHQ-9 is also used to assess depression.

Breast Surgery Measure:

- Breast Q PROM- PROM for use in cosmetic and reconstructive breast survey that covers quality of life and patient satisfaction. There are independent modules for breast reduction/mastopexy, augmentation, and breast cancer. There are also several

domains for each module: psychological well-being, physical well-being, sexual well-being, satisfaction with breasts, experience of care, and satisfaction with outcome.

General Cancer Therapy Measure:

- Functional Assessment of Cancer Therapy- covers breast bladder, brain, colorectal, central nervous system, cutaneous t-cell lymphoma, cervix, esophageal, endometrial, gastric, head & neck, hepatobiliary, lung, leukemia, lymphoma, melanoma, multiple myeloma, nasopharyngeal, ovarian, prostate, vulva. It includes 37 items and measures five domains of health-related quality of life in cancer patients: physical, social, emotional, functional well-being, and a cancer subscale depending on the type of cancer.

In addition to the use of PROMs, CMS should consider including PREMs.

- **The CAHPS for the Merit-based Incentive Payment System (MIPS) includes questions to assess the degree to which shared decision-making has been implemented in the outpatient setting. How can CMS most effectively measure these activities in the hospital setting.**

To measure patient experience and care coordination, CMS should look outside of the existing Care Transition questions in the CAHPS survey. The historical trend is flat, and this domain is the lowest among all HCAHPS domains. The suspected root cause of why this measure has not received greater responses is patient interpretation of the question wording and recall bias. CMS should partner with patient advocacy groups to test patient and family-centered care and patient experience questions.

CMS should be more specific in asking patients about whether they were involved in the development of their treatment plan and post- discharge plan, whether their discharge instructions were clearly understood, and whether their family and caregivers were involved in decision making processes around their care. CMS should consider allowing larger sample sizes of patients to respond to the survey, rather than restricting based on the number of clinicians in a practice, to combat declining response rates.

- **What supports can this new model provide for decreasing the burden of data collection?**

As noted throughout this letter, the Task Force suggests CMS focus on the quality measurement and accountability design of this model to address health equity, via increased and improved collection of R/E/L/G/SOGI data. Below are specific recommendations for how to address this challenge.

The Task Force fully supports efforts to improve and increase the collection of SDOH data. The proposed expanded billing codes for SDOH screening and community integration will create greater consistency in data collection, decrease the burden of data collection, and help with the potential to automate data systems around SDOH. CMS should first use measures that

payers can pull from common claims data before turning to other measures. For clinical measures, CMS should align on the use of digital quality measures and minimize manual chart abstractions. CMS can provide leadership with other payers who all currently have individual data submission processes.

We urge that any SDOH screening instruments go through rigorous cross-cultural validation before being implemented. Without such validation, there is the potential to under- or over- report unmet need in certain communities, and inadvertently develop or exacerbate existing disparities within communities. To decrease burden of data collection, CMS can start by supporting the creation of educational resources that help providers make the case to patients for why these data are being requested, and for what purposes they will be used. While stakeholders understand that these data are critical to the ability to develop meaningful interventions and policies that help patients, several Task Force members note that personal information is being asked of patients, without the requisite time spent providing patients with a clear rationale. When a provider codes a patient's social drivers of health codes via an EMR or other form of collection, that screening and result will show up on the patient's after-visit summary, which many patients may find concerning. The process of improving patient-reported data requires a foundation of trust; we encourage CMS to consider its role in addressing this need.

While CMS should invest in strategies to improve more robust self-reporting of R/E data at point of service, we urge CMS to consider being the primary collector of this type of person-level data through the Medicare enrollment process or other targeted CMS data collection initiatives or partnerships.

Another way that CMS can help improve collaboration between hospitals, primary care doctors, and specialists is to provide easier access to notifications related to admissions, discharges and transfer (ADT) information. Access to this information is often gained through third party vendors at a significant cost to ACOs or medical professionals. While Health Information Exchanges (HIEs) may be a more beneficial source, they are not ever present or functional everywhere.

We urge CMS to modify the HIPAA Eligibility Transaction System (HETS) to allow access to all eligibility inquiries for ACO-assigned beneficiaries and to develop a proactive, real-time notification system for ACOs when beneficiary eligibility is requested. Through its operation of the HETS, CMS could provide Medicare providers with real-time knowledge of beneficiary visits to medical professionals, hospital admissions, emergency department visits, and specialist encounters. This information could supplement current ADT feeds and allow ACOs to better track their patients while accessing the delivery system.

- **How can registries, electronic health records, and other quality reporting systems reduce the reporting burden for participants?**

The Task Force urges CMS to continue working with ONC to establish data exchange supports that allow CMS to access Electronic Health Record (EHR) data. Additionally, providers find it inefficient and burdensome to have to collect and report on different, voluminous sets of measures from other payers. The Task Force believes that value-based arrangements are best

served by a parsimonious set of measures applied consistently across payers and population types. If CMS streamlines quality measures across one program but not all, providers are still burdened by capturing every measure required by each different program. To effectively reduce burden on providers, alignment across MA, Medicaid, commercial, duals and traditional Medicare is necessary.

- **What approaches are providers currently utilizing that would create opportunities for payer alignment?**

Some approaches that Task Force provider members are currently utilizing to establish payer alignment are outlined below:

  - One Task Force provider member developed a standard data file strategy for use with health care payers. This strategy included details on the format for data files and the data elements to include. Frequency could vary across payers to accommodate for the limitations of legacy systems. This provider incorporated the standard file format as part of negotiations with new payers. Contracts would require regular monthly meetings between staff responsible for data systems on both the payer and provider side to discuss operations and identify/address issues promptly. The contracts also included defined penalties for failing to meet the terms of the data sharing requirements. Finally, this provider sought a dedicated contact at each payer organization to serve as a touchpoint for addressing technical assistance needs.
  - Another Task Force provider convened major payers and providers in their market to develop an aligned commercial strategy for patient attribution. This effort was informed by participant experiences with the CMS Pioneer ACO model. This aligned attribution methodology addressed how service types, provider types and pharmaceutical prescribing impacted patient attribution. The aligned methodology improved transparency and predictability in attribution for payers and providers. The process focused on collaboration rather than competition and required a multidisciplinary and collaborative approach including representatives from data, contracting, legal, and quality measurement experts.
  - A third Task Force provider member developed a health care payer performance report that it used as a unform template for identifying strengths and areas for improvement during communications with payers. The report included notes on overall health plan performance across areas like clinical operations, practice operations, billing, data and reporting, credentialing, and provider enrollment. The provider shared the report with payers and used it to highlight best practices and identify opportunities to partner and improve. The provider also issued a full multi-payer report with blinded results to allow plans to compare themselves to other plans.

- **Are there opportunities to reduce provider burden across episodes through multi-payer alignment of quality measures and social risk adjustment?**

Providers find it inefficient and burdensome to have to collect and report on different, voluminous sets of measures from multiple payers. The Task Force believes that value-based

arrangements are best served by a parsimonious set of measures applied consistently across payers and population types. Alignment in this area is both desirable and potentially achievable for providers across MA, Medicaid, commercial, duals and traditional Medicare, and across payment models. Alignment of measures across payers more effectively drives care improvements and makes measurement more meaningful for physicians. In addition to aligning quality measures across payers and programs, CMS should prioritize alignment of the mechanisms and approaches to measurement such as how data are collected, transmitted, aggregated, and scored.

To reduce provider burden through multi-payer alignment of quality measures, one Task Force provider member developed an aligned set of quality measures in coordination with several payers in their region. This collaborative effort involved negotiations over the course of years and allowed all payers involved to weigh in before any measures were finalized. The aligned measure set agreement included details on the specific measures to be used, performance targets, comparison groups, patient population, appeals rights, and reporting timelines. The final measure set included 20 measures that incorporated process, outcome and patient reported outcomes measures.

V. Payment Methodology and Structure

- **How should CMS balance the need for predictable, achievable target prices with the need to create a reasonable possibility of achieving net Medicare savings?**

The Task Force has been consistent in highlighting the need for greater APM adoption to achieve lasting shifts in the trajectory of health care spending. To this end, we encourage CMS to prioritize the broad uptake of episode-based payment models by creating predictable glide paths from low to higher risk arrangements over time (consistent with the strategy of creating greater onramps for providers in MSSP). Furthermore, the experience of our members has shown that the greatest potential for improvements in quality and reductions in costs comes from aligning incentives across episodic and total cost of care models.

The Task Force believes there are two primary pathways for achieving net Medicare savings on episode-based models: (1) improving the efficiency of care delivery within the episode (thus reducing the per-unit/episode cost of care compared to a counterfactual), and (2) avoiding unnecessary episode utilization by helping to navigate patients to lower intensity interventions as appropriate. The first strategy is often the primary focus of CMS model evaluations of cost savings. The success of this strategy depends on CMS identifying an appropriate set of services to include in the episode, setting a reasonable episode length, establishing sustainable target prices, and developing a quality measure strategy that safeguards patient care. As CMS well knows, successfully balancing all of these elements into a single model that is sustainable for providers and generates net savings for CMS can be challenging.

Our members encourage CMS to focus on testing a small subset of clinical services within an episode-based model with a focus on tailoring each episode to the standards of care for a given service or condition. Our members note that in prior episodes there have been instances where payment methodologies have discouraged the delivery of guideline concordant care and

attribution methodologies have created disincentives for ACOs to seek out and coordinate with specialists in episode-based models.

We encourage CMS to reconsider any plans to only create 30-day episodes. While a 30-day episode may be appropriate for some acute services, we believe there are several instances where this time window is too short. CMS should assess each of the target conditions or services and develop episodes with a length that reflects the typical course of care. For example, oncology bundles should not focus on a 30-day course of treatment because that is not aligned to the standard of care.

Finally, HCTTF believes the second mode of achieving savings (avoiding unnecessary care) is an underappreciated opportunity for CMS to achieve savings while maintaining achievable target prices. By incorporating a proactive strategy for avoiding unnecessary services, CMS could focus on gaining broad participation in episodic models designed to prioritize high-quality, coordinated care initially and achieve savings over a longer time horizon. To achieve this, we encourage CMS to focus on designing ACO benchmarks and episode target prices in a manner that incentivizes coordination. Allowing for nesting of bundled payments within TCOC models (specifically ACOs) will allow ACO providers to help patients both avoid unnecessary care and help direct them to high quality and efficient care options when intervention is needed.

- **How should CMS balance participants' desire to receive reconciliation results as close as possible to the performance period, while also allowing for sufficient claims runout to finalize the results and minimize the administrative burden of multiple reconciliations?**

HCTTF recognizes the challenges in managing data systems that would allow for rapid reconciliation. Our members note that this challenge is further compounded by the fact that many episode-based models involve claims from a variety of facilities and providers – including post-acute/SNF services – adding complexity to the and time to the claims process. These lengthy delays greatly reduce the ability of episodic models to impact provider behavior because any shared savings or losses occur too long after the provision of care for participating providers to clearly connect clinical actions with financial results.

CMS has made efforts to improve reconciliation timelines in prior models, including the use of provisional reconciliation results for some ACO participants. We encourage CMS to continue experimenting with these concepts in episode-based models. We also encourage CMS to consider other opportunities for allowing model participants to manage cash-flow and timing to create stronger incentives for participating providers. Potential approaches could include the use of a prospective PMPM payment for some service types and/or a multiplier applied to future claims. These cash flow strategies should be paired with recurring provisional data feeds to help model participants monitor performance (with the clearly communicated caveat that the data is not final) and a reconciliation at the end of the year.

- **How should risk adjustment be factored into payment for episode-based payment models?**

Risk adjustment is critical to the success of episode-based models and should be capable of accounting for the variability in the complexity and severity of patients being seen by different providers. Our members note that episode inclusion and exclusion criteria have created winners and losers based principally on the severity of patients a provider or facility treats. This is a particular concern for large tertiary care centers and sub-specialists that treat complex patients referred from across their region/nationally.

HCTTF members encourage CMS to continue refining the use of concurrent risk adjustment that CMS is experimenting with in other models and apply those learning to episode-based models. Furthermore, CMS should continue to use sophisticated claims-based risk adjustment, similar to BPCIA. This should include both HCC count & HCC weights as covariates. Ideally, episodic models appropriately aligned with TCOC models should result in improved management of lower risk patients and a greater focus on higher risk patients within episodes. Therefore, we encourage CMS to not establish a cap on HCC growth.

The Task Force notes that it can be challenging for providers to address social risk factors within the context of episodic models (especially short 30-day episodes). Yet, we still believe it is important to account for this in risk adjustment. We encourage CMS to incorporate validated measures/indices of social risk factors into the risk adjustment methodologies for episodic models. At minimum, this should include incorporating dual eligibility, disability & LIS status. In addition, CMS should investigate the use of other health related social need data collected through the model if such data can be captured in a consistent manner that balances the value of the information with the burden of data collection.

- **How can risk adjustment be designed to guard against preferential selection of healthier patients (that is, cherry picking)?**

CMS has traditionally used coding intensity factors and risk score caps to guard against risk score gaming and retroactive reviews to catch "cherry picking." Task Force members note that, if risk adjustment is done correctly, there should be no incentive to drop sicker patients. Furthermore, as we note in the question above, appropriately aligning episodic models with TCOC models should result in improved management of lower risk patients within the TCOC model and a greater focus on higher risk patients within episodes.

That said, we believe CMS should implement robust data monitoring to track trends in the demographics and severity of patients being treated to identify preferential selection and combat the negative impacts on equity. HCTTF members note that this is an additional reason to prioritize the alignment of episode-based models with total cost of care models (given the stronger incentives for managing overall patient care).

- **What risk factors, including clinical or social, should be considered?**

In prior letters, the Taks Force has stressed the need for CMS to focus on incorporating both clinical and non-clinical risk factors into the design on payment models. We are encouraged by recent CMS efforts to adjust for social factors in the ACO REACH and MSSP models and encourage continued efforts to refine these methodologies and apply them across all APMs.

Effectively addressing social factors within episodic models is challenging given the condition/service specific focus of these models and time limited nature of interaction between providers and patients. This is a further reason for CMS to prioritize aligning episode-based models with TCOC models and carefully consider when a 30-day episode may be appropriate versus a longer timeframe.

We recommend that CMS incorporate/test adjustments for the following:

- Demographic factors: age, sex, REL/SOGI, disability
- Clinical factors: Chronic Conditions
- Social Factors: SDI or some other measure of community social vulnerability

We recommend that CMS collect data elements consistently across all models. CMS should commit to using the data within three years for the purposes of quality measurement or risk adjustment. If CMS cannot explicitly adjust payment based on these factors it should at a minimum gather data to monitor variations in care access, experience, and outcomes based on these factors to monitor health equity. If CMS cannot use the data or determines that specific data elements are not significant, the Agency should discontinue collecting that data.

- **Which non-claims-based variables could be used to improve risk adjustment and address health equity, and how can CMS ensure that they are collected uniformly and documented consistently?**

In prior communications to CMS, the Task Force highlighted several non claims-based measures CMS should consider in the design and operation of APMs. Risk assessments are often focused on income and education as defining characteristics for health disparities; however, these variables do not adequately capture health equity issues that do not correlate to income or education.

We recommend that CMS evaluate the effects of APMs on patients, stratifying outcomes by race, ethnicity, and other demographics. The Task Force encourages the mandated collection of race, ethnicity, and other demographics data in all future alternative payment models, as well as the use of a standardized set of evaluation metrics.

CMS should evaluate episode payment models to identify potential unintended consequences (on both patients and providers) resulting from bundled payment rates not accounting for the needs of underserved patients who may be receiving care at a later stage of their condition/disease. (The UCLA Williams Institute and the Fenway Institute offer best practices for accurately collecting Gender Orientation and Sexual Identity information from patients.) Furthermore, we encourage CMS to consider other factors that impact the quality and cost of care for patients receiving care under episodic models. Specifically, our members have highlighted the importance of addressing home safety issues as a critical strategy for improving care by reducing fall risk for recovering patients as well as transportation barriers that interfere with ongoing treatment for some conditions like ESRD and cancer care.

VI. Model Overlap

- **How can CMS allow beneficiary overlap with ACO initiatives yet ensure Medicare is not double-paying incentives for the same beneficiary?**
- **Should the approach to prevent double-paying incentives differ depending on whether the participating entity is part of an ACO or particular type of ACO (for example, low revenue ACOs vs. high revenue ACOs, or one-sided vs. two-sided risk ACOs)?**

In April of 2022 HCTTF sent CMS a set of recommendations for aligning the alternative payment model portfolio. In that letter we discussed a range of issues including potential strategies for addressing model overlap and double-payment concerns. While recommendations were written with a focus on voluntary models, we believe many of the same principles would apply to the models CMS is contemplating under this RFI. To this end we are highlighting the following recommendations from our earlier letter.

First, CMS should adopt a policy of "do no harm" to providers willing to accept full accountability for the cost and quality of a patient's care. CMS should also focus on setting a clear, consistent, and predictable beneficiary attribution policy supported by financial arrangements that: (1) allows providers delivering complimentary care to mutually benefit under their respective models, and (2) strives to minimize cross-model gaming opportunities that drive adverse incentives such as participant selection bias or freeriding.

The Task Force believes that CMS efforts to align ACOs and specialty focused bundled payment models should favor providers willing to accept greater levels of responsibility for the cost, quality, and coordination of a beneficiary's care. To accomplish this, we urge CMS to implement a hierarchical model alignment policy using the following approach.

- **Beneficiaries aligned to high-risk ACO models (i.e., MSSP Track E, Enhanced Track, and ACO-REACH):** Under a hierarchical model arrangement, when a beneficiary is aligned to a high-risk ACO– such as those in MSSP Enhanced or ACO-REACH – that relationship would take precedence over any other payment model. The ACO would retain beneficiary attribution, and the responsibility for the cost of care would be reconciled under the ACO benchmark. **To encourage provider alignment, CMS should allow high-risk ACOs two options for engaging with specialists**.
    - **Option 1**: ACOs could elect to participate in bundled payment models designed and operated by CMS. In this scenario, the ACO would identify a set of bundled payment arrangements and a list of participating specialists for CMS to apply the bundled payment arrangement to. The ACO would retain beneficiary attribution, CMS would make direct payments to providers under the bundled payment model, and all bundled payment spending would be reconciled against the ACO TCOC benchmark.
    - **Option 2**: ACOs could opt-out of CMS designed episodes. ACO aligned beneficiaries would not be eligible for any other payment models. Instead, ACOs may choose to contract directly with specialists, receive funds from CMS, and manage downstream payments. ACOs would have the latitude to design these contracts giving them full flexibility to negotiate the details of the payment arrangement (e.g., electing to design

bundled payment models or enter into sub capitation agreements). ACOs would also have the discretion not to enter into any downstream contracts.

Under both options, the ACO would keep responsibility for the TCOC of all attributed patients whether they received care from a specialist contracted with the ACO or an outside provider. This approach would allow more advanced ACOs to fully align specialists through contracting and support less advanced ACOs by allowing them to outsource the complexity of designing a custom model for specialists to CMS. ACOs would have an incentive to coordinate care as the TCOC risk bearing entity and duplicate shared savings issues would be avoided by virtue of all beneficiary spending being reconciled against the ACO's TCOC benchmark under both options.

- **Beneficiaries aligned to low and moderate risk ACO models (i.e., MSSP Tracks A-D):** In situations where a beneficiary is receiving care from a provider under a low or moderate risk ACO model, CMS should advance APM alignment by establishing a model overlap policy that preferences models based on the nature of the clinical condition covered by the model and the degree of responsibility the provider is accepting for beneficiary care coordination, cost, and quality.

  The goal of this policy should be to limit the potential for gaming opportunities across models, align patients to providers best suited to address their clinical needs, encourage care coordination, and incentivize providers to transition to higher-risk arrangements over time. These models should utilize strong incentives for specialist engagement through collaborative care agreements focused on practical activities such as data sharing through health information exchanges, payment for e-consults, and shared accountability for patient measures such as seven-day post discharge appointments. Under this policy, beneficiary attribution would work as follows:

  - **Beneficiary with Chronic Condition:** While the Task Force believes that the challenges with designing chronic care episodes make them too complex for inclusion as part of a mandatory model, we support CMS continuing to explore how chronic conditions focused episodes should be implemented. Assuming that CMS will eventually seek to implement chronic condition episodes, we offer the following recommendations for managing model overlap issues.
    - When a beneficiary with a chronic condition receives care under both a low or moderate risk ACO and a relevant chronic-condition model, alignment preference would go to the chronic condition model provider when the specialist serves as the central coordinating point of care for beneficiaries (such as ESRD) and is willing to accept greater risk for the total cost of care and quality. The goal of this policy would be to encourage specialists in chronic-condition models to take accountability for beneficiaries with conditions that could most benefit from their expertise.
    - CMS would need to establish a threshold to preclude alignment of low-acuity beneficiaries to chronic-condition models due to on-off or intermittent consultations.

        - Additionally, because beneficiaries often have multiple chronic conditions, CMS would need a process for determining the most appropriate accountable provider when a beneficiary could qualify for alignment to an ACO and multiple chronic-condition model.
    - **Beneficiary with Condition that Aligns to Procedural Episode:** When a beneficiary is receiving care from a low or moderate risk ACO model and receiving treatment from a provider participating in a procedure focused episode, beneficiary alignment would remain with the ACO model.
- **Beneficiaries not aligned to any ACO:** When a beneficiary is not receiving care from any ACO provider but is receiving care from a provider in another APM, then attribution would default to the other APM (with chronic-condition models taking precedence over procedural episodes)

HCTTF does not support using the high/low revenue distinction and has called on CMS to end this method for classifying ACOs in past comments. The high/low revenue distinction creates unnecessary complexity within the program and is a disincentive for ACOs to include specialists in their ACOs. We strongly encourage CMS to end the use of the high/low revenue distinction. We do support stratifying ACOs by the degree of risk they are willing to accept.

The Task Force believes that CMS' efforts to align ACOs and specialty focused bundled payment models should favor providers willing to accept greater levels of responsibility for the cost, quality, and coordination of a beneficiary's care. To accomplish this, we urge CMS to implement a hierarchical model alignment policy using the following approach.

The Task Force supports nesting of bundles (and possibly shadow bundles as appropriate) and providing a TIN-NPI participation option to help with the curation of a high value highly engaged set of specialists. As noted above, we believe combining the objectives of a TCOC model and a clinic episode model is the most effective way to steward Medicare Trust Fund dollars and is most likely to provide the best and most desirable patient outcomes.

- **What are the implications of allowing beneficiary overlap for model evaluation?**

Task Force members believe that model overlap may make it more difficult to directly attribute changes in cost and quality to any single model. With that said, we should also note that the rate of change in the health care sector (public and private payer policies, clinical standards of care, etc.) also presents challenges to evaluation, and it is not possible to control for all of these factors. For example, the transition of many services into ambulatory surgical centers and outpatient settings, the push for site neutral payments, and the decision by CMS to shift many services and procedures off the "inpatient only" list have all impacted provider behavior inside and outside of bundled payment models. Also well documented are the spillover effects from CMS and private payer APMs that influence provider behavior with all beneficiaries regardless of their attribution to a model.

We recommend CMS seek to develop natural experiments within any episode-based model to evaluate this impact. For example, a model could be designed with two tracks: (1) intentional overlap (episodes nested within an ACO or in another arrangement that explicitly

links specialists and PCPs in TCOC models), and (2) non-overlap (limited to episode participants that are independent of ACOs and do not intend to formally partner with specialty practices).

CMS may also consider if overlap policies and model evaluations should vary based on condition or service type (chronic conditions that require specialist care vs. acute conditions that require a time limited service/procedure). The model evaluation process should also examine the impact of increased collaboration between specialists and primary care on quality outcomes and patient experience.

- **How should CMS create a reciprocal overlap policy that incentivizes efficiency by the participant while the ACO is incentivized to use the participant for episodic care?**

To promote alignment across provider types, **CMMI could leverage model participation requirements by** creating incentives for hospital participants to have demonstrated meaningful relationships, defined referral pathways, and clear coordination plans with PGPs and/or ACOs where available, to ensure a successful return to the patient's established source of primary care as the episode is ending. These relationship incentives should also extend to community agencies as appropriate, (e.g. substance use disorder, mental health agencies). These incentives, in combination with aligned quality measures and benchmarking methodologies, could be designed to: (1) encourage specialists to refer lower acuity patients to population-based models, and (2) encourage population-based models to transition to higher-risk payment arrangements and accept greater accountability for the costs and quality of care for the beneficiaries they serve. We believe the new Making Care Primary's use of e-consults to facilitate ambulatory co-management should be a policy that is adopted in future clinical episode models.

- **What risks or rewards should we include to drive collaboration? What resources or data should CMS provide participants to ensure there is collaboration with ACO providers for shared beneficiaries?**

Under a mandatory model, ACO participants or ACOs that that affiliate with specialty practice participants (and vice versa) could be incentivized by being offered a glide path to two-sided risk arrangements. Allowing for upside-only arrangements for a certain time period provides a strong incentive to forge broader partnerships and to make these affiliations work while immediate two-sided risk arrangements are likely to have the opposite effect.

We also believe that many parts of the country are currently saturated with voluntary models, which is a good thing, and CMS should be thoughtful about what areas of the country they impose mandatory models. Task Force members believe a mandatory model option should be used to drive greater overall participation in APMs and should not be deployed where provider partners have already developed and are operating value-based arrangements on their own volition.

There is also a need for CMMI models to address the foundational infrastructure necessary to facilitate primary and specialty care collaboration, including common cost and

quality dashboards/data feedback and technical assistance around the implementation of or participation in a neutral patient-centered data utility or health information exchange.

- **What resources or data should CMS provide ACOs to ensure collaboration with participants for shared beneficiaries? How does this differ when the participant is not part of the ACO?**

The Task Force supports condition-level data sharing and development of condition-based metrics/measures, which would help in isolating key data metrics for ACOs and specialty practices to focus on. Similarly, the Task Force supports CJR model-like approach that incentivizes the collection and use of evidence-based patient-reported outcomes and experience measures. Again, requiring participation in a neutral data sharing utility to share and access common data is important for collaboration, regardless of participation in an ACO.

- **How can CMS leverage this episode-based payment model to incentivize participants to join an ACO if not already a part of one?**

As noted above, one incentive that can be used to incentivize specialty practice participants to join an ACO is to afford them a glide path to two-sided risk by offering an upside-only track for a certain time period to help establish and refine the necessary arrangements to be successful.

- **Conversely, how can this episode-based payment model incentivize ACOs to partner with participants?**

Similar to the answer to the prior question, a glide path to two-sided risk would also help the ACO in the model's early stages and provide time to develop and operationalize sustainable arrangements for the latter stages of the model when two-sided risk is triggered. We believe the overall policy goal should encourage effective collaborations to drive high quality care rather than seek to save the Medicare Trust Funds expenditures in the model's early years.

- **What levers, such as benefit enhancements or waivers, could be used to support participants to close the care loop back to primary care/ACOs?**

Primary Care Cost Sharing Waivers: Permitting cost-sharing waivers as a way to encourage regular use of primary care services.

Flexibility in Post-Acute Care Payments: Permitting flexibility in the rates and structure of post-acute care payments would allow APM participants to tailor the use of post-acute services to increase the proportion of patients that could efficiently be treated outside of an inpatient setting. For example, members identified home health services as an area where this concept could be applied. Home health services are currently paid as an all or nothing benefit; a waiver in this case would allow providers participating in an APM to negotiate different rates for home care – such as smaller payments for shorter/more frequent home health visits – that better

address patient needs. Also, explicitly allowing post-acute providers to accept less than the Medicare fee-for-service payment rates in APM arrangements would add flexibility that fosters clinical decision making that is less affected by cost considerations.

Beneficiary Inducement Rules around Home Assessments: Some Task Force members have been advised that home safety checks or structural modifications prior to surgery foster a prompter return to home qualify as beneficiary inducements. A waiver of beneficiary inducements in these cases would allow APM participants to proactively access a patient's home environment prior to surgery and help ensure that the patient has the best chance of being able to recover at home rather than in an inpatient or SNF setting where costs are higher and there is an increased risk of facility acquired infections. The Task Force stands ready to further support CMS' efforts to improve waivers for all APM participants to achieve the desired outcomes of improved patient care and lower health care spending. Our recommendations are intended to facilitate increased waiver uptake among model participants and to improve the impact of future CMMI models.

Post Discharge Home Visit Waiver: Task Force members explicitly cited the importance of the post discharge home visit waiver to their ACO work. Members commended CMS for adjusting the waiver to clarify requirements and offer greater flexibility under the Next Generation ACO model as compared to a similar (but less clear) waiver available under the Pioneer ACO program. However, some questions remain regarding the professionals qualified to bill under this waiver. Specifically, CMS should clarify whether paramedics and community health workers could qualify to provide services and bill under this waiver. Care Management Home Visit Waiver (Next Generation ACO) Members stated that this waiver, when used in conjunction with the post discharge home visit waiver, was effective in improving care. We recommend that CMS retain this waiver in combination with the post discharge home visit waiver for current and future models.

- **How can CMS design this model to spur ACOs to engage specialty care providers for episodes of care that may not be included in this model?**

Policies that ensure adequate payment on both sides of collaborative care arrangements between specialists and primary care through e-consults or other forms of collaboration and engagement are critically important.

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The Task Force appreciates the opportunity to respond to the Episode-based Payment Model Request for Information. Please contact HCTTF Executive Director Jeff Micklos (jeff.micklos@hcttf.org) with any questions.

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