June 6, 2024

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Re: The Transforming Episode Accountability Model (TEAM) as Proposed in the CY 2025 Inpatient Prospective Payment Systems Proposed Rule *(CMS-1808-P)*

The Health Care Transformation Task Force (Task Force) appreciates the opportunity to share recommendations on the Transforming Episode Accountability Model (TEAM), as proposed in the Calendar Year (CY) 2025 Inpatient Prospective Payment Systems (IPPS) Proposed Rule (CMS-1808-P) (Proposed Rule). The Task Force believes these recommendations will help the Centers for Medicare & Medicaid Services (CMS) achieve the goal of increasing specialist engagement in value-based care (VBC), as well as ensuring that all Medicare patients are in accountable care relationships by 2030.

The Task Force is a collaborative that supports accelerating the pace of delivery system transformation to better pay for the value of care received. Representing a diverse set of organizations from various segments of the industry – including providers, payers, purchasers, and consumer/patient advocacy organizations – we share a common commitment to transform our respective businesses and clinical models to deliver better health through high quality care at reduced costs. 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.

The Task Force has previously articulated support for mandatory models on a case-by-case basis. As proposed, there are elements of TEAM that the Task Force supports. However, our members have concerns about the financial methodology. In particular, the combination of the 30-day episode length and the 3% CMS discount would set more aggressive financial targets than any previous voluntary or mandatory episode-based model. As described in this letter, the proposed policy would require hospitals to achieve up to 17% savings in the 30-day post-discharge period to realize a positive incentive payment. This degree of cost reduction to simply break even is unreasonable for a mandatory model – particularly for the rural and safety net hospitals that are required to participate.

Our comments address each aspect of the proposed TEAM model design, including: (1) participation and eligibility (sections I-IV), (2) financial methodology (V-VIII), (3) quality and health equity (IX-X), (4) alternative payment model elements (XI-XIV), and (5) additional design elements (XV-XVIII). We believe these recommendations will strengthen TEAM, which is especially important for a mandatory model. These recommendations are offered in the spirit of collaboration, with the goal of helping CMS design a model that advances access, quality, and equity.

## PARTICIPATION & ELIGIBILITY

### I. Mandatory Participation by CBSA

CMS proposes that TEAM will be a mandatory model, with participation determined based on each hospital's core based statistical area (CBSA), which are roughly analogous to ZIP codes. CMS stratified all CBSAs into 17 groups, based on four factors: (1) proportion of safety net hospitals, (2) past exposure to CMS bundles, (3) average historical spending, and (4) the number of hospitals in the CBSA. Within each of the 17 strata, CMS proposes to randomly select the CBSAs that will be required to participate. For most of the strata, between 20 to 33% of the CBSAs would be selected for TEAM participation. However, one of the 17 strata specifically identifies CBSAs with the highest proportion of safety net hospitals, and 50% of these CBSAs would be selected. All hospitals in the selected CBSAs would be required to participate in TEAM (unless they meet narrow exclusion criteria). CMS proposes to release the list of selected CBSAs in the CY2025 IPPS final rule in August 2024.

The Task Force understands that the randomized participation design will substantially increase participation in the model and allow for rigorous evaluation. **The Task Force appreciates that CMS intends to give hospitals required to join TEAM (TEAM participants) approximately 15 months' notice. However, the Task Force and its members have significant concerns about the inclusion of safety net and rural hospitals, as discussed below.**

### II. Safety Net and Rural Hospitals

CMS proposes to include hospitals that treat high proportions of historically underserved patients, including safety net hospitals, rural hospitals, Medicare-dependent hospitals, sole community hospitals, and essential access community hospitals. CMS proposes that these hospitals will have greater stop-gain/stop-loss protections, as discussed below in the Financial Methodology section. CMS also will exempt hospitals that meet a proposed low volume exclusion policy, which would exclude hospitals with fewer than 41 episodes across all Clinical Episode categories over the three-year baseline period.

The Task Force and its members have significant concerns with this proposal to include safety net and rural hospitals. Safety net and rural hospitals generally have very low operating margins and are at higher risk of closure.[1] In addition, the patients they serve may not have access to alternative providers due to financial or geographic constraints. As a result, the TEAM model may have unintended negative consequences for these hospitals and the patients they serve. The downside financial risk under TEAM could ultimately jeopardize the hospital's financial viability, which in turn impacts access to care – both in terms of the service lines available within the

[1] Topchik et al., "Unrelenting Pressure Pushes Rural Safety Net Crisis into Uncharted Territory." *The Chartis Group*. February 13, 2024. https://www.chartis.com/sites/default/files/documents/chartis_rural_study_pressure_pushes_rural_safety_net_crisis_into_uncharted_territory_feb_15_2024_fnl.pdf

hospital and, in the most extreme cases, hospital closure. These potential outcomes would clearly harm patient access to care and potentially exacerbate equity issues.

**The Task Force recommends that CMS revise several elements of the TEAM model design that would adversely impact safety net and rural hospitals:**

1. **The financial risk is set too high**: Under the TEAM model's financial methodology (discussed in greater depth below), all participating hospitals will face 100% downside risk for the Clinical Episodes included in the model. While safety net and rural providers could opt for greater stop-loss/stop-gain protection (Track 2 of the financial methodology), this option does not change the fact that the hospitals would still be required to assume 100% downside risk. **The Task Force recommends that CMS introduce additional design elements to provide additional financial protections for safety net and rural providers. Ideally, rural and safety net providers would have no downside risk throughout the model. At minimum, rural and safety net hospitals should have lower levels of downside risk than were proposed in Track 2, more protective stop gain / stop loss limits, and a lower "CMS discount" of no more than 1%** (representing the savings CMS takes off the top of the Clinical Episode target price).

2. **The low volume exclusion is set too low:** The TEAM low-volume threshold is the lowest that CMS has ever proposed. In the Bundled Payments for Care Improvement Advanced (BPCIA), CMS set the low-volume threshold at 41 episodes during the four-year baseline period (averaging at least 10 episodes per year) *for a given clinical episode*. Similarly, the Comprehensive Care for Joint Replacement (CJR) Model had a low-volume threshold of 20 episodes over the three-year baseline for lower-extremity joint replacement episodes. In contrast, the TEAM threshold is set at fewer than 31 episodes in the baseline *aggregated across all Clinical Episodes*. With volumes this low, the TEAM participant's results would be driven by low-volume variation, and it would not be possible to meaningfully determine their financial and quality performance. **Thus, the Task Force recommends that CMS raise the low-volume threshold to a minimum of 31 episodes in the baseline for each Clinical Episode (rather than all Clinical Episodes in aggregate). TEAM participants should only be accountable for the Clinical Episodes that meet the low-volume threshold in the baseline.**

3. **There is insufficient risk adjustment for patient- and hospital-level factors:** The TEAM model does not include sufficient risk adjustment for patient- or hospital-level factors, as discussed in greater detail below. In contrast, BPCIA included sophisticated risk adjustment that CMS proposes not to adopt for TEAM. CMS's stated rationale is that including sufficient risk adjustment, though more accurate, would be confusing for participants. The Task Force and its members disagree with this approach because we believe hospitals are capable of understanding that appropriate risk adjustment is essential to producing fair target prices. **The Task Force strongly recommends that CMS adopt more sophisticated risk adjustment for TEAM, such as the adjustment applied under BPCIA. It is essential that CMS adjust for patient-level factors on clinical and social risk (*e.g.*, patients who live in nursing homes or experiencing homelessness), as well as hospital level factors (*e.g.*, safety net status).**

4. **There is unmet need for up-front investment:** The TEAM model does not include any up-front investment, which is particularly important for rural or safety net providers. Notably, CMS has acknowledged the need for up-front investment payments in other models, such as the Medicare Shared Savings Program (MSSP) Advanced Investment Payment. Without up-front investment, rural and safety net providers may be unable to make essential investments in care management, data and analytics infrastructure, and support for patients' health-related social needs. **The Task Force recommends that CMS incorporate an up-front investment for rural and safety-net providers. Ideally, those hospitals should not be required to pay back this investment, even from their shared savings. At minimum, if hospitals would be required to pay back this investment from future shared savings, the hospitals should be held harmless if they do not achieve sufficient savings to pay back the investment during the model performance period.**

CMS has stated their desire to include safety net and rural hospitals in TEAM in order to include more historically underserved patients in the model and increase equitable outcomes. Given these goals, it is imperative that CMS avoid unintended consequences that may inadvertently harm patient access, quality, and health equity. To avoid these negative outcomes, CMS should better account for the fact that safety net and rural providers lack the financial resources to make up-front investments or bear losses under VBC models.

## III. Model Overlap with Population-Based Models

CMS proposes to allow overlap between TEAM and population-based models, including both "total cost of care" models that include downside risk all Part A and B spending, as well as other "shared savings models" that may or may not include downside risk. Specifically, this proposed policy would allow overlap with MSSP Accountable Care Organizations (ACOs), the Enhancing Oncology Model, Making Care Primary, the States Advancing All-Payer Health Equity Approaches and Development (AHEAD) Model, and future population-based models that the Center for Medicare and Medicaid Innovation (CMMI) may offer. Unlike BPCIA and CJR, CMS proposes not to recoup any savings between these models. This means that it would be possible to simultaneously earn shared savings in TEAM and in another overlapping model, even for patients that were attributed to both models, without any offset/recoupment requirement.

**The Task Force strongly supports the proposed policy to allow overlap between TEAM and population-based models without recoupment.** This policy will incentivize coordination between ACOs and specialists, supporting CMMI's goals for specialist engagement in VBC, as well as alignment between episode-based and population-based models. The policy will also support TEAM participants, by simplifying the attribution process and increasing episode volume. TEAM participants will know which patients are attributed to the model in real time, without retrospective carve outs due to ACO alignment – which was a key problem under BPCIA and CJR. This policy will also increase TEAM episode volume, which will then provide greater financial predictability for TEAM participants, given that low-volume variation is a key challenge for episode-based models.

CMS is considering adding a requirement that TEAM participants notify ACOs of any shared patients. **CMS could support effective collaboration between hospitals, specialists and primary care providers by increasing easy access to admission, discharge and transfer (ADT) notifications.** 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 data source, they are not ever present or functional everywhere.

The Proposed Rule does not clearly state how ACO expenditures will be calculated for overlapping TEAM episodes. The Task Force recommends that CMS calculate ACO spending based on the fee-for-service claims submitted for TEAM episodes rather than TEAM episode target prices. This will avoid duplicative incentives across programs, allowing ACOs to clearly understand and track their performance throughout the performance period.

CMS also proposes to increase alignment between ACOs, specialists, and primary care providers (PCPs) by requiring TEAM participants to determine the patient's PCP status and refer patients to a PCP as part of the discharge planning process for the initial admission for the Clinical Episode. **The Task Force supports this requirement to connect patients to PCPs, because it recognizes the important role of PCPs in providing continuity of care to their patients in all settings, both directly and by coordination of care with other health care professionals. To ensure continuity and alignment across care settings for patients, we encourage CMS to clarify that TEAM participants ensure the PCP referral is consistent with the beneficiary's PCP status recorded at initiation of the hospitalization or procedure.**

## IV. Other Inclusion / Exclusion Criteria

The Task Force responds to several questions that the Proposed Rule raised about the proposed inclusion/exclusion criteria. Specific feedback is requested on the following topics:

1. The Task Force believes that ACOs that participate in full-risk ACOs, such as the MSSP Enhanced Track or REACH ACOs, should be allowed to have their participating hospitals opt out of TEAM. This would recognize the fact that these ACOs already bear risk for all of the episodes included under TEAM. Allowing the opt-out would both support ACOs already taking on risk, as well as encourage other ACOs to enter full-risk tracks.

2. The Task Force believes that current CJR & BPCIA participants should be allowed to opt in to TEAM, even if their CBSA is not selected by CMS. In addition, the Task Force believes that CMS should allow other hospitals to opt in, including those that previously participated in BPCIA. Many hospitals have years of experience in CMS episodes, representing investments in care management, clinical quality improvement, preferred networks of post-acute care providers, data systems and analytics, and other forms of population health infrastructure. Allowing these hospitals to opt into TEAM would allow them to continue investing in VBC and population health. It also sends the wrong signal for BPCIA participating hospitals to go right back to FFS after sometimes 12 years of participation in previous episode-based models.

3. Conversely, the Task Force believes that AHEAD hospitals should be allowed to opt out of TEAM. These hospitals will be voluntarily assuming global budgets for hospital services, including the Clinical Episodes in TEAM. If CMS required AHEAD hospitals to join TEAM, it would fragment the incentives under AHEAD by introducing different pricing methodologies for a subset of patients, who would otherwise be included under the AHEAD global budget.

The underlying belief behind these recommendations is that CMS should encourage hospitals to continue investing in VBC, whether based on their previous experience in models like CJR and BPCIA, or due to their willingness to take on risk under new innovative models such as AHEAD or just begin to participate because the time is now right for them to do so.

## FINANCIAL METHODOLOGY

### V. Risk Arrangements

CMS proposes the following three risk tracks under TEAM which provide an optional glide path before assuming financial risk:

- **Track 1:** No risk for the first year of the model. Available to all participating hospitals.
- **Track 2:** 100% risk with 10% stop gain/stop loss for years 2-5. Available to safety, rural, Medicare-dependent, sole community and essential access hospitals. Quality adjustment would increase savings by ≤10% and mitigate losses by ≤15%.
- **Track 3:** 100% risk with 20% stop gain/stop loss, for years 1-5. Available to all hospitals, optional in year 1. Quality adjustment would increase savings or mitigate losses by ≤10%.

**The Task Force appreciate that CMS is offering a glide path before hospitals must assume risk, particularly in a mandatory model.** We believe this policy will support hospitals as they implement the model. In addition, as discussed above, **the Task Force believes that Track 2 does not provide sufficient financial protections for safety net and rural hospitals, which could unintentionally harm access, quality of care, and health equity. Ideally, CMS should eliminate downside risk for rural and safety net hospitals for the duration of the model.**

### VI. Clinical Episodes, Episode Length & CMS Savings

CMS proposes five Clinical Episodes for inclusion in TEAM, all of which are surgical procedures:

- Lower extremity joint replacement (LEJR)
- Surgical hip & femur fracture treatment (SHFFT)
- Spinal fusion
- Coronary artery bypass graft (CABG)
- Major bowel procedures

Similar to BPCIA and CJR, these procedures would be defined by DRGs and HCPCS codes, with nearly all Part A and B spending included. All these procedures were previously included in BPCIA, and CJR included LEJR and SHFFT. CMS is considering adding medical episodes through future rulemaking. CMS is also proposing to keep the CMS discount at 3%, which represents the savings that CMS takes off the top of the Clinical Episode target price – based on the episode's total cost of care, including the index admission or procedure. The key difference from previous models is that episodes would be 30 days long, rather than 90 days.

**The Task Force generally supports including these surgical episodes.** As the Task Force shared in previous comments, surgical episodes may be appropriate for episode-based models in part because the procedure is an appropriate clinical trigger. If CMS decides to expand TEAM to include medical episodes in future rulemaking, CMS should focus on acute medical episodes with similarly clear starting points triggered by an admission (e.g., stroke, AMI, sepsis) and avoid exacerbations of chronic conditions that are often hard to predict during the hospitalization. For example, patients with congestive heart failure (CHF) patient diagnosed with acute renal failure and given that DRG, but CHF is the patient's primary condition. ACOs are best suited to manage their chronically ill beneficiaries and coordinate with community specialists in prevention of these episodes. In addition, CMS should only include episodes that have high volumes, high variability in spending, and opportunities to improve post-discharge care patterns.

**However, the Task Force has concerns about the fact that CMS adopted a one-size-fits all approach to episode length, without making corresponding changes to the financial methodology.** The decision to apply 30-day episodes to all Clinical Episodes has two key implications: (1) the clinical care patterns associated with each Clinical Episode, and (2) the impact of the episode length on the financial methodology.

From a clinical perspective, the Task Force is concerned that a 30-day episode may not be long enough to appropriately account for the post-acute care (PAC) for patients with each of these Clinical Episodes. Rather than adopting a uniform episode length, the Task Force recommends that CMMI assess the PAC patterns for each Clinical Episode and select an episode length that aligns with the clinical needs for patients receiving a given procedure.

In terms of the financial implications, TEAM's proposed target price methodology requires participants to achieve all cost savings during the 30-day post-discharge period, because the cost of the index DRG or procedure that triggers the episode is a fixed dollar amount. While a hospital may realize internal cost savings during the index admission, this will not result in a lower DRG or HCPCS reimbursement. Therefore, any internal cost savings will not impact the total cost of care from a model evaluation perspective. Instead, any cost savings must come from reducing post-discharge spending relative to the benchmark period.

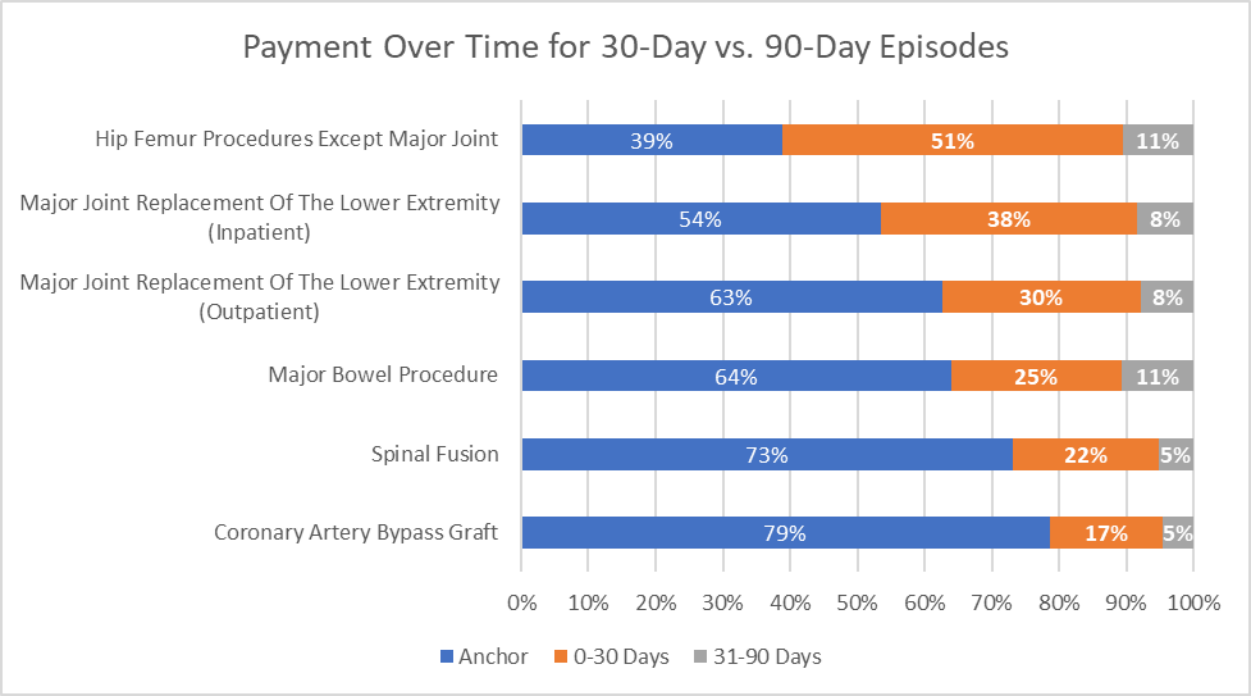
**The CMS proposal to reduce the episode length but retain the same 3% CMS discount will make the TEAM financial targets more difficult to achieve than either BPCIA or CJR.** This is because the savings CMS requires off the top is based off the total cost of the episode, including both the index admission or procedure, as well as the post-discharge spending. Because CMS proposes to reduce the total among of post-discharge spending, the index DRG or procedure becomes an even larger proportion of the total spending – and therefore even more savings must be achieved within the 30-day post-discharge period.

This will be most problematic for Clinical Episodes with high-cost index admissions relative to their post-discharge spending, such as CABG and spinal fusion. Figure 1 illustrates this concern, showing the proportion of total cost of care that is driven by the index admission or procedure relative to post-discharge spending for TEAM clinical episodes. Figure 2 illustrates the degree to which post-discharge spending must be reduced to achieve the 3% savings to CMS off the top.

For spinal fusion, the index admission represented 73% of the total cost of care under a hypothetical 90-day episode. To break even, hospitals would need to reduce post-discharge spending by 11% to break even over 90 days. For 30-day episodes as proposed under TEAM, the required spending reduction rises to 13%. This math is more extreme for CABG, because the index admission would account for 79% of the total cost of care under a hypothetical 90-day episode. As a result, hospitals would have to reduce post-discharge spending by 14% within 90 days – and this rises to 17% under 30-day episodes.

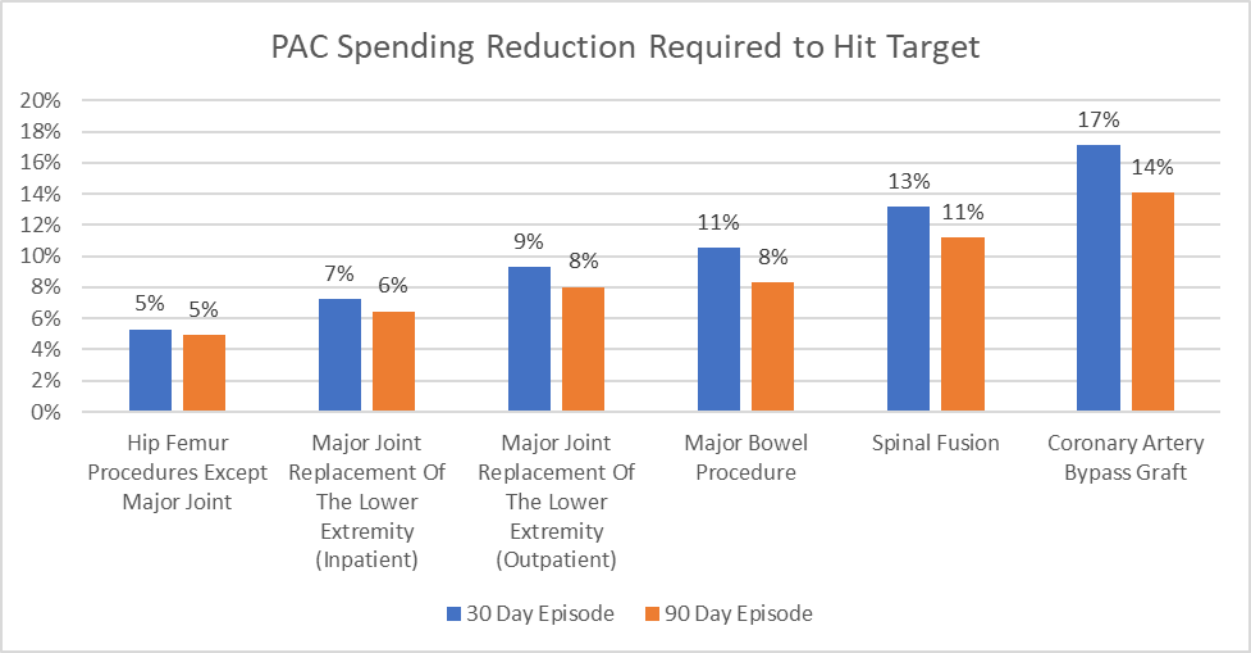
**The Task Force strongly opposes the proposed financial methodology, because the 30-day episode length, combined with the 3% CMS discount, would create the most aggressive financial target that CMS has ever adopted in either a mandatory or voluntary episode-based model. If CMS decides to retain the proposed 30-day episode length, then the CMS discount should be reduced to 2%. Unless CMS makes this change, the TEAM financial methodology will require a more aggressive post-discharge spending reduction than both BPCIA and CJR – which is especially egregious for a mandatory model that includes rural and safety net hospitals.**

**Figure 1: Payment Over Time for TEAM Clinical Episodes**




Source: AAMC / DataGen analysis, 2024. Data from the CMS Standard analytic file, 2020 Q1-2022 Q3.

**Figure 2: Post-Discharge Spending Reduction Needed to Hit Target for TEAM Clinical Episodes**




Source: AAMC / DataGen analysis, 2024. Data from the CMS Standard analytic file, 2020 Q1-2022 Q3.

## VII. Target Price Methodology: Baseline & Prospective Trend

CMS proposes to establish a prospective target based on a 100% regional benchmark, using methodology similar to CJR. As described above, the target would include nearly all Part A and B spending, with limited exceptions for specific DRGs and hemophilia drugs. CMS would use a weighted, rolling three-year baseline period to determine the historic regional benchmark, calculate the prospective trend, and set each hospital's target price. For example, the 2026 performance year would be based on a 2022-2024 baseline, weighted at 17% for 2022, 33% for 2023 and 50% for 2024. The years and their corresponding weights would roll forward each year. CMS stated their belief that this rolling baseline would adequately adjust for the ratchet effect, in which participants must continually find new ways to save money, because previous savings are baked into the new baseline.

However, unlike BPCIA and CJR, the targets would not have a retrospective trend applied, unless variation was greater than 5% above or below the prospective target, in which case the retrospective adjustment would be capped at +/-5%. Also, unlike previous models, CMS would not update the targets mid-year to account for changes in inpatient and outpatient payment rates. CMS stated that updating the target mid-year to reflect new prices would be more accurate but confusing to participants.

**The Task Force strongly opposes the proposal to exclude target price adjustment to reflect current pricing.** This proposal would harm participants by applying previous prices that are no longer current – and are often lower than the updated price, effectively creating an apples-to-oranges comparison. As a result, the actual costs incurred under the episodes in the later part of

the year would have higher costs than those predicted by the outdated prices. In addition, Task Force members believe that participants can understand that target prices should be as accurate as possible, including the need for targets to reflect the current price for services.

**The Task Force supports the proposal to exclude specific DRGs and high-cost hemophilia drugs. In addition, the Task Force recommends that CMS expand the list of excluded drugs to include other high-cost drugs.** Consistent with the hemophilia exclusions, CMS should exclude any drugs that have a mean cost of more than $25,000 per episode, including drugs for oncology and other conditions. This exclusion is necessary due to the high cost of these drugs, combined with the large annual price increases that many high-cost drugs experience.

**In addition, the Task Force and its members are broadly supportive of administratively set benchmarks. We appreciate that CMS acknowledges the downward ratchet effect created by benchmarking methodologies dependent on historical spending.** The current approach threatens to make benchmarking strategies untenable in the long term because participants must continuously find new ways to save money. Left unchecked, this could create a race to the bottom, especially for episodes like LEJR that already have over a decade of cost reductions. We do not agree with CMS' conclusion that a three-year, rolling baseline will sufficiently address the ratchet effect, especially since the baseline period would encompass the period in which comparable BPCIA and CJR episodes were already being tested. To better mitigate the ratchet effect, we recommend that CMS test innovative approaches to incorporate administratively set benchmarks into the TEAM methodology, as well as in other models.

## VIII. Target Price Methodology: Risk Adjustment

CMS proposes to apply retrospective adjustments to the targets based on the case mix for patients that triggered TEAM episodes. The proposed risk adjustment would account for each patient's age bracket, the number of Hierarchical Condition Categories (HCCs) with a 90-day look-back, and their social risk. Social risk would be defined as a single, binary variable based on whether a patient has any of the following: dual eligibility, low-income subsidies, and lives in region with a state Area Deprivation Index (ADI) above 0.8 or a national ADI above the 80$^{th}$ percentile. However, CMS proposes not to account for other patient-level characteristics currently included in BPCIA's risk adjustment, such as whether a patient lives in a nursing home prior to an episode. Similarly, CMS proposes not to account for whether a surgical episode, such as CABG, was planned or due to an emergency. Lastly, CMS proposes not to account for hospital-level characteristics, such as whether a hospital is a safety net or rural.

**The Task Force believes that target prices should be as accurate as possible for all participants. Therefore, we support more sophisticated risk adjustment, such as the adjustment made under BPCIA.** The Task Force and its members believe that TEAM should adequately risk adjust for the following characteristics:

- **Patient-level clinical risks:** The Task Force supports CMS' proposal to apply retrospective adjustments based on patient case mix. However, the CMS proposal does not include numerous relevant variables that are incorporated in the risk adjustment for

BPCIA. **One of the most concerning omissions is whether a surgical episode such as CABG was planned or due to an emergency.** This is a meaningful clinical difference that drives patient complexity and the need for more intensive care patterns, which in turn increases cost. **Another significant omission from the proposed risk adjustment is whether a patient lived in a nursing home prior to the episode. Patients who previously lived in a nursing home will return to a nursing home after discharge, which may be charged to Medicare for up to 60 days – substantially driving up post-episode spending.** This care pattern reflects appropriate care delivery for known clinical risks, which are outside the control for TEAM participants. The CMS proposal to omit this relevant clinical data from the risk adjustment would penalize hospitals that care for the sickest patients, potentially leading to unintentional consequences that harm patient access, quality of care, and equity. Lastly, CMS should account for both HCC weights and counts in the risk adjustment, as well as HCCs captured during the episode, as is done in BPCIA. CMS should also use a one-year look back for HCCs, comparable to Medicare Advantage risk adjustment methodologies. **The Task Force urges CMS to risk adjust for all clinical data elements in TEAM as they do in the BPCIA methodology, especially whether a patient lived in a nursing home prior to the episode and whether a surgery was due to an emergency.**

- **Patient-level social risks:** The Task Force strongly supports CMS' proposal to account for social risk factors, including patient-level factors (*e.g.*, dual eligibility and low-income subsidy status) and validated geographic indices *(e.g.*, national and state ADI). In addition, **the Task Force recommends that CMS incorporate other relevant patient-level data that CMS collects, such as whether a patient has a disability, is experiencing homelessness, inadequate or unstable housing** (*e.g.,* Z59.00, Z59.01 and Z59.02, Z59.10, Z59.11, Z59.12, Z59.19, Z59.811, Z59.812, and Z59.819).

- **Hospital characteristics**: The Task Force recommends that CMS adjust for hospital-level characteristics, including safety net status, rural/urban location, size, and teaching status. This will further increase the accuracy of the targets. However, should ensure that rural and safety net hospitals do not receive any target price reductions as a result of this methodology.

Collectively, these recommendations would improve the accuracy of TEAM target prices for all participants. That will in turn support clinician buy-in, while mitigating potential negative consequences for patient access, quality, and equity.

## QUALITY & HEALTH EQUITY

### IX. Quality Measurement

CMS proposes to include three Hospital Inpatient Quality Reporting (IQR) measures starting in the first year of TEAM (2026):

- **Readmissions:** Hybrid Hospital-Wide All-Cause Readmission Measure with Claims and Electronic Health Record Data (CMIT ID #356)

- **Patient Safety:** CMS Patient Safety and Adverse Events Composite (CMS PSI 90) (CMIT ID #135)
- **Patient-Reported Outcomes:** Hospital-Level Total Hip and/or Total Knee Arthroplasty (THA/TKA) Patient-Reported Outcome-Based Performance Measure (CMIT ID #1618).

The readmissions and patient safety measures would be applied to all episodes, while the patient-reported outcome measure would be specific to LEJR. However, CMS acknowledged the concern that the readmissions and patient safety measures apply to all patients treated by the hospital rather than being specific to TEAM Clinical Episodes. The agency indicated that these measures were chosen to due limited specialty-specific measures with readily available data.

CMS also seeks input on whether three new hospital harm measures on the 2023 Measures Under Consideration (MUC) List would be a better alternative to PSI-90, including:

- Falls with Injury (MUC2023-048)
- Postoperative Respiratory Failure (MUC2023-050).
- 30-day risk standardized death rate among surgical inpatients with complications (Failure-to-Rescue) (MUC2023-049)

If finalized, two of these new measures would be voluntary electronic Clinical Quality Measures (eCQMs) (falls with injury and postoperative respiratory failure), while the third is claims-based (30-day risk standardized death rate). These eCQMs will initially be pay-for-reporting measures under IQR, which is typically a precursor to later adoption as pay-for-performance measures under other CMS programs. For TEAM, CMS is considering replacing PSI-90 with these measures would potentially beginning in 2027, one year after the three measures would be added to IQR as voluntary eCQMs. CMS is also seeking feedback about the potential for other specialty-specific patient-reported outcomes.

CMS proposes that these measures would be used to calculate a composite quality score (CQS) that would adjust the TEAM shared savings or shared losses. Like BPCIA, each measure is weighted according to the volume of applicable episodes. The measures would be scaled based on relative national performance, with a fixed baseline (calendar year 2025). The resulting percentile performance would be applied to either increase savings or mitigate losses for TEAM participants.

**The Task Force appreciates that CMS is seeking to use existing IQR measures to decrease the administrative burden for TEAM participants. However, we are concerned that the readmissions measure and PSI-90 are not specific to TEAM episodes.** As a result, the measures cannot assess quality for patients treated under TEAM. The same issue applies to the alternative hospital harm measures. Even if patients treated under TEAM had zero readmissions or adverse events, this would not move the needle on the hospital-wide measures due to the relatively small volume of TEAM episodes.

**In addition, the Task Force has concerns about the proposed measures themselves.** The hybrid readmissions measure is currently in the first mandatory reporting period for IQR, and many hospitals are unable to extract the required data from their EHRs. The PSI-90 measure includes many adverse events that are generally not linked to TEAM episodes. The new IQR measures that CMS is concerning as alternatives to IQR are untested, meaning there may be

reporting challenges and benchmark data is not available to support quality improvement efforts. In the Proposed Rule, CMS acknowledges this uncertainty by proposing that the new IQR measures be voluntary. However, if CMS incorporates the new eCQMs into TEAM, these measures would functionally become mandatory pay-for-performance measures prematurely.

**Instead of the proposed quality measures, CMS should consider alternatives such as registry-based data, which is available for all TEAM Clinical Episodes except major bowel procedures.** CMS should adopt a similar approach to BPCIA, in which participants may select registry-based measures rather than claims-based measures. Registries provide clinical outcome data for patients treated by a given hospital and physician, making it highly specific to the TEAM Clinical Episodes. Even without one-to-one matching between TEAM episodes and the patients in the registry (which represents all patients with a given condition treated by that hospital/physician), using registry data would create a closer link between TEAM clinical outcomes and the proposed claims-based measures. In addition, the registries provide national benchmarks for this outcome data, and many hospitals already report to registries, minimizing any additional burden.

**The Task Force supports the use of the patient-reported measure for LEJR.** We encourage CMS to continue developing condition-based measures, including patient-reported outcome measures (PROMs) and patient-reported experience measures (PREMs). To support the implementation of PROMs and PREMs, CMS should establish requirements that align with survey best practices. For example, the timing of the survey should closely follow the delivery of care and CMS should ensure sufficient sample sizes to meaningfully assess results (*e.g.,* by aggregating across years or providers, as needed). If CMS establishes response rate requirements, these should be in line with survey best practices (*e.g.,* 50% response rates are considered excellent). **In addition, the Task Force recommends that CMS stratify all measures by patient-level factors, such as demographic data discussed below, to identify potential gaps in care. We recommend that CMS consider adopting upside-only incentives to close these gaps.**

## X. Health Equity

CMS proposes to incorporate health equity in the TEAM financial methodology and reporting requirements. As discussed previously in this comment letter, the proposed financial methodology would (1) offer lower risk tracks for safety net and rural hospitals, and (2) apply health equity risk adjustments to the target prices. In our comments above, we generally support these two proposals, but believe CMS should apply greater financial protections and more sophisticated risk adjustment to adequately support the patients served by rural and safety net hospitals.

In addition to the financial components of the model, CMS proposes three reporting requirements related to health equity:

- **Health equity plans:** TEAM participants would submit annual health equity plans. The plan would be voluntary in the first year (2026) and mandatory thereafter.
- **Demographic data collection:** TEAM participants would be required to collect patient-reported demographic data. Like the health equity plans, this would be voluntary in the first year and mandatory thereafter.

- **Health-related social need (HRSN) screening:** TEAM participants would be required to screen for four out of five domains, including: (1) housing instability, (2) food insecurity, (3) transportation difficulties, (4) utility assistance needs, and (5) interpersonal violence. Participants would report on which domains they chose to screen for, the screen positive rate, and their processes for referring patients to resources to address identified needs.

The Task Force strongly supports CMS' proposal to incorporate key health equity elements into TEAM, including the annual health equity plan. For the demographic data collection and HRSN screening, we believe these are good first steps to obtaining the data needed to identify gaps in care for underserved populations. CMS should support these efforts by separately paying for data collection and screening. In addition, CMS should commit to validating this data and incorporating the data into financial methodologies and quality measurement.

The Task Force supports HRSN screening but recommends that CMS streamline reporting requirements for TEAM participants. Beginning in 2024, CMS requires all hospitals – not just TEAM participants – to report on all five HRSN domains (housing, food, transportation, utilities, interpersonal violence) as part of IQR. Under TEAM, CMS proposes that TEAM participants report on four of the five domains, which is redundant with the IPPS reporting requirements. Instead, CMS should align the TEAM requirements with the IQR and use the IQR data to obtain this information from TEAM participants.

The Task Force also acknowledges that, while patient-reported data is the gold standard, this information is sensitive and patients may not be fully compliant due to a lack of understanding about the rationale for collecting the data. To increase patient engagement and decrease the burden of data collection, CMS should create 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. 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.

For all demographic and HRSN data, the Task Force strongly recommends that CMS align the coding and documentation requirements with national standards, such as those developed by the Gravity Project and United States Core Data for Interoperability (USCDI). After selecting a standard, CMS should give hospitals sufficient time to implement changes to the data infrastructure and workflows.

In addition, CMS should advance the adoption of these standards by working with electronic health record (EHR) vendors to advance the adoption of USCDI Version 3, which includes categories of data elements that capture health status (including health concerns, functional status, disability status, and mental function), demographics (including race, ethnicity, tribal affiliation, sexual orientation, gender identity and preferred language), and other HRSNs, so this data can be appropriately requested via the Application Programming Interfaces (APIs) from EHRs.

## Alternative Payment Model Elements

### XI. CMS Quality Payment Program

CMS proposes that all TEAM participants be considered Alternative Payment Model (APM) participants under the CMS Quality Payment Program. In addition, TEAM participants would be considered Advanced APM Participants if they: (1) are in Risk Tracks 2 or 3, and (2) attest to their compliance with Certified Electronic Health Record Technology. TEAM participants would be required to submit quarterly lists of the clinicians with whom they work and/or gainshare. Clinicians on these lists would be assessed for Qualified APM Participant (QP) status. In addition, CMS is seeking comments on how to promote interoperability without creating duplicative requirements.

**The Task Force supports the CMS proposals related to Advanced APM and QP status.** In addition to the financial incentives available to Advanced APMs, this designation also comes with key non-financial incentives, such as reduced reporting requirements under the Merit Based Incentive Program (MIPS). However, starting in 2025, CMS will require APM participants to report on the MIPS Promoting Interoperability requirements. This change will increase the reporting requirements on APM participants, making them equivalent to providers operating exclusively under fee-for-service. **The Task Force recommends that CMS not require TEAM participants to report on the MIPS Promoting Interoperability requirement, which could present a key non-financial disincentive to APM participation.**

### XII. Waivers

CMS proposes to include two care delivery waivers in TEAM, including: (1) the skilled nursing facility (SNF) three-day waiver and (2) telehealth waivers. CMS did not include waivers related to home visits that were offered under previous models (*e.g.*, waivers for the homebound requirement or the incident-to billing), stating that these waivers were omitted because they were rarely used under other models.

**The Task Force strongly supports the CMS proposal to offer SNF three-day and telehealth waivers, because they are essential to increasing access, equity, and high-quality care. In addition, the Task Force and its members believe that CMS should further expand the waivers available under TEAM, to offer greater flexibly to participants and consistency across models.** Ideally, CMS should offer a standard set of waivers in all APMs to streamline requirements across models and increase equitable access for all beneficiaries. In addition to telehealth and SNF three-day waivers, the standard set of waivers should include:

- **Patient cost-sharing waivers:** Allow providers to waive patient cost-sharing for select services or patient populations, as allowed under ACO REACH. This is especially important for patients with HRSNs, and the services designed to address these needs, such as community health integration services.
- **Post-discharge home visit waivers:** Task Force members have experience using home-visit waivers available to some ACOs. These ACOs cited the importance of making post-discharge home visits available to many high-risk patients, not only those that are

homebound, as allowed under the waiver for the homebound requirement. In addition, the ACOs also used team-based care approaches to allow non-physician clinicians to deliver home-based assessments, as allowed under the incident-to billing waiver. In addition, CMS should offer the Care Management Home Visit waiver offered under the Next Generation ACO Model, which allowed paramedics and community health workers to deliver home-based services. While these waivers may not be used by all participants, their inclusion would support TEAM participants in the delivery of team-based care, to increase patient access, quality, and equity.

- **Beneficiary inducement rules for home visits:** Some Task Force members have been advised that home visits prior to surgery may qualify as beneficiary inducements. From a clinical perspective, however, home safety checks or structural modifications prior to surgery could foster a prompter and safer return home, which would be responsive to patient preferences and reduce avoidable spending. CMS should offer a waiver of beneficiary inducements in these cases to 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. Without these waivers, APM participants must continue to rely on inpatient or SNF settings, where costs are higher and there is an increased risk of facility acquired infections.
- **Flexibility in PAC payments:** In cases where patients need care in SNFs, inpatient rehab or other PAC facilities, APM participants should be offered the flexibility to negotiate rates and payment structures. This would allow APM participants to create partnerships with PAC providers to deliver high-quality, seamless care to patients within innovative VBC arrangements. Task Force 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. In addition, explicitly allowing PAC 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.

In addition to supporting TEAM participants by offering these waivers, CMS should also consistently offer these waivers across all models to increase consistency – thus allowing model participants to deliver the same standard of care across patient populations, not only those in a single model.

## XIII. Gainsharing

CMS proposes that TEAM participants be allowed to gainshare with other entities, explicitly stating that the APM safe harbor laws apply to TEAM participants. CMS proposes that the terms of gainsharing agreements could not consider the volume of services delivered by a gainsharing partner. In addition, CMS proposes to establish caps on shared losses, but not on shared savings. The cap would be set at 50% of shared losses across all entities. The cap for most individual entities would be set at 25%, except for ACOs, which would have a cap of 50%.

**The Task Force thanks CMS for allowing gainsharing through TEAM and explicitly clarifying that APM safe harbor laws apply. However, we do not support the 50% cap on shared losses.** The Task Force has long supported gainsharing as a mechanism to better encourage alignment between bundled payments and ACOs. CMS previously acknowledged the need for greater flexibility in gainsharing, by eliminating the cap in CJR and not applying a cap under BPCIA. The Task Force believes that eliminating the cap proposed for TEAM – both overall and at the entity level – would further strengthen integration between ACOs and specialists in episode-based models. In addition, eliminating the cap would provide rural and safety net hospitals with more financial protection through partnerships with ACOs or other risk-bearing entities.

**In addition, the Task Force and its members are concerned that the proposed policy would not allow gainsharing contracts to take volume of services into account.** Without tying gainsharing agreements to volume, it would not be possible to link the size of the gainsharing payment to the partnering organizations' level of involvement in TEAM.

## XIV. Beneficiary Incentives

CMS proposes to allow TEAM participants to provide in-kind incentives that are directly linked to the patient's clinical care or disease prevention, documented and collectively worth under $1,000 per patient. CMS proposes a documentation requirement to apply to any item or service worth at least $25, including recording the patient, date, and the item or service. In addition, CMS proposes that TEAM participants must retrieve any item worth more than $75 and document efforts to retrieve the item. As with gainsharing, CMS explicitly stated that APM safe harbor laws apply.

**The Task Force supports beneficiary incentives as a means of improving patient care, particularly for historically underserved populations.** Beneficiary incentives can directly support patients in managing their health and preventing further disease development (*e.g.*, by providing blood pressure cuffs and other medical devices). The incentives can also support patients with health-related social needs (*e.g.*, by providing transportation to and from medical appointments).

However, many Task Force members are concerned that some APM participants do not use beneficiary incentives because the documentation requirements are too strict. In particular, the requirement to retrieve items worth more than $75 represents large costs to the provider, who must make multiple efforts to track down the item to request its return. This also represents a burden to patients, who may need to make additional trips to the provider to return this item – in addition to losing the benefit of the item, such a device that the patient was using the manage their condition. The Task Force and its members believe there is minimal risk that this benefit would be abused, since the in-kind donations must be made within the APM participant's operating budget – and thus there is a built-in disincentive to spend unnecessarily. **The Task Force recommends that CMS streamline the documentation requirements by increasing the $25 price point that requires documentation to $100. In addition, the Task Force recommends that CMS eliminate documentation requirements that place added burden directly on patients, such as the requirement that patients return any item over $75.**

## Additional Design Elements

### XV. Reconciliation

CMS proposes to conduct a single reconciliation with at least six months of claims runout, to be paid in Q3 of the year following each performance year. CMS states that the single reconciliation is intended to balance the need for sufficient claims runout, while minimizing the burden of multiple reconciliation cycles for the same performance period.

The Task Force recognizes the need for sufficient time for claims runout, given the number of facilities and provider types involved in total cost of care models. However, delayed results reduce the ability of episodic models to impact provider behavior due to the long delay between delivering care and receiving reconciliation results. **The Task Force believes that CMS' proposal to offer a single reconciliation with at least six months of runout helps close the timing gap relative to BPCIA and CJR. In addition, CMS could consider other ways to shorten the data lag.** For example, CMS has previously made efforts to improve reconciliation results, such as providing provisional reconciliation results to some ACO participants. The Task Force encourages CMS to continue experimenting with these concepts in episode-based models, to help participants manage cash-flow and timing.

### XVI. Data

CMS proposes to provide beneficiary-level and summary data to participants, with appropriate data protections in place. The beneficiary level data would include episode summaries, indicators for excluded episodes, diagnosis and procedure codes, and enrollment and dual eligibility information for beneficiaries that initiate episodes in TEAM.

**The Task Force strongly supports CMS' proposal to provide beneficiary-level data, which is essential to help TEAM participants improve quality of care under the model.** This data allows participants to identify their patient populations, assess their care patterns to identify quality improvement opportunities, and select high-quality PAC providers with which to form partnerships. The Task Force recommends that the beneficiary-identifiable data include data from all claim types (*e.g.*, inpatient, SNF, home health, inpatient rehab, inpatient psych, hospice), with sufficient beneficiary identifiers and episode identifiers to link data sources across all claim types. In addition, CMS should provide all variables used for the purposes of risk adjustment and target price calculations. This data will allow TEAM participants to fully assess episodes, make informed predictions for reconciliation results, and validate CMS calculations.

### XVII. Beneficiary Notification

CMS proposes that TEAM participants give patients a beneficiary notification letter written by CMS. CMS would require that the letter be delivered prior to discharge (for inpatient episodes) or no later than the day of the procedure (for outpatient episodes).

The Task Force shares CMS' goals of using beneficiary notification to engage patients and strengthen their relationships with clinicians. The Task Force believes the proposed timing for delivering the beneficiary notification letters is operationally feasible based on the experience in BPCIA and CJR. However, our members are concerned that the standardized beneficiary engagement letters required under previous models have not achieved the intended goal. Task Force members have heard from patients that the standard notification language is confusing, does not resonate with them, and can increase mistrust in the health care system. Therefore, **the Task Force recommends that CMS allow TEAM participants to edit the standard notification templates to customize it to the specific hospital, provided that all required core elements are included.**

## XVIII. Decarbonization

CMS proposes to incorporate an optional Decarbonization and Resilience Initiative for TEAM participants. Participants that volunteer for this initiative would report annually on four domains of emissions: (1) organizational questions, (2) building energy metrics, (3) anesthetic gas metrics, and (4) transportation metrics. The building energy metrics and reporting process were designed to align with ENERGY STAR Score for Hospitals, which would minimize the reporting burden for TEAM participants because many hospitals already participate voluntarily in this initiative. CMS would set the metrics and reporting requirements for the other three domains, drawing on the Sustainable Healthcare Certification requirements by The Joint Commission and guidance from the National Academy of Medicine.

**The Task Force and its members support CMS' proposal to test the Decarbonization and Resilience Initiative on a voluntary basis.** This approach balances the importance of addressing the impact of climate change on health, while also recognizing the need to pilot new initiatives. This initiatives' voluntary nature will help CMS and TEAM Participants troubleshoot any potential challenges and evaluate its effectiveness.

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The Task Force appreciates the opportunity to provide feedback on TEAM in the CY 2025 IPPS Proposed Rule. Please contact HCTTF Executive Director Jeff Micklos (jeff.micklos@hcttf.org) or Senior Director Theresa Dreyer (theresa.dreyer@hcttf.org) with questions related to these comments.

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