MODEL COMMENT LETTER
ON CMS' TRANSFORMING EPISODE ACCOUNTABILITY MODEL (TEAM)
PROPOSED RULE

These are model comments to guide AHA members in crafting their own comments to the Centers for Medicare & Medicaid Services. ***All comments must be received no later than 5 p.m. ET June 10, 2024.***

To send electronically: go to http://www.regulations.gov. Follow the instructions for "Submit a Comment" and enter the file code CMS-1808-P to submit comments on this proposed rule.

[LETTERHEAD]

[DATE]

The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
Hubert H. Humphrey Building
200 Independence Avenue, S.W., Room 445-G
Washington, DC 20201

RE: CMS-1808-P, Medicare and Medicaid Programs and the Children's Health Insurance Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Policy Changes and Fiscal Year 2025 Rates; Quality Programs Requirements; and Other Policy Changes, (Vol. 89, No. 86), May 2, 2024.

Dear Administrator Brooks-LaSure:

On behalf of [name of hospital], we appreciate the opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS') proposed Transforming Episode Accountability Model (TEAM) that was included in the inpatient prospective payment system (PPS) proposed rule issued April 10. The comments here are specific to the proposed TEAM. [Insert "We will be issuing separate comments on the agency's proposed changes to the inpatient and long-term care hospital PPS" if your organization plans to comment on either of those proposals].

The proposed new mandatory TEAM payment model would bundle payment to acute care hospitals for five types of surgical episode categories: coronary artery bypass graft, lower extremity joint replacement, major bowel procedure, surgical hip/femur fracture treatment and spinal fusion. It would make acute care hospitals responsible for the quality and cost of all services provided during select surgical episodes, from the date of inpatient admission or outpatient procedure through 30-days post-discharge. This includes services covered under both Medicare Part A and Part B, including physician, post-acute care, therapy, clinical laboratory, Part B drugs and biologicals, and other medical services and supports. It would run for five years and require participation for inpatient prospective payment system (PPS) hospitals in certain core-based statistical areas that would be selected at a later date.

Our hospital/health system supports the health care system moving toward the provision of more accountable, coordinated care. As such, we are in the process of redesigning delivery systems to increase value and better serve patients [Insert areas in which you are participating in value-based care and alternative payment models, such as the Comprehensive Care for Joint Replacement (CJR) and Bundled Payments for Care Improvement Advanced (BPCI-A) models]. **However, we are deeply concerned about the proposed TEAM. Specifically, we strongly recommend that CMS make TEAM voluntary, lower the 3% discount factor and make several changes to problematic design elements.**

ALLOW VOLUNTARY PARTICIPATION

The proposed rule would mandate TEAM participation for all acute care inpatient PPS hospitals in select geographies. However, mandatory participation is neither feasible nor advisable. Many hospitals are neither of an adequate size nor in a financial position to support the investments necessary to transition to mandatory bundled payment models. [For example, at our hospital, the five types of surgical procedures proposed for inclusion in TEAM comprised x% of inpatient PPS payments in FY 2023 — a staggering amount that doesn't even include the outpatient payments that would be part of the model.] Migrating this volume of procedures to mandatory bundles across multiple service lines in such a short timeframe would be untenable. [Insert detailed examples of processes and procedures that will need to be changed or created to support the proposed model, how long these will take, and their effect on your financial situation]. **We urge CMS to make model participation voluntary.**

Additionally, participants should have the ability to select individual clinical episodes, as opposed to requiring participants to take on risk for large, clinically diverse bundles of episodes. Analysis from the AHA indicates that for four out of the five proposed bundles, over 72% of costs are incurred during the anchor hospitalization or outpatient procedure, leaving little savings opportunities in post-acute care. [Insert examples of specific challenges that some of the clinical episodes could present to your hospital.] **As such, we urge CMS to allow organizations to select the episodes for which they feel can best impact cost savings.**

LOWER THE 3% DISCOUNT FACTOR

The proposed rule includes a 3% discount factor. This means that CMS will take 3% in cost savings right off the top, regardless of whether the episode achieves cost savings. There is less opportunity for savings in this model given that for each of the five clinical episode categories, the majority of episode spending is accounted for by the anchor hospitalization or outpatient procedure. In fact, three of the five episodes have at least three-quarters of spending accounted for by the anchor hospitalization or outpatient procedure. This will become even more true over time, as target prices decline further, and hospitals must compete against their own best performance. CMS must provide hospitals with a fair opportunity to achieve enough savings to garner a reconciliation payment. **We recommend that a discount factor of no more than 1% be applied.**

REVISE SEVERAL CRITICAL DESIGN ELEMENTS

TEAM has several problematic design elements. In crafting the proposed rule, CMS places too much risk on providers with too little opportunity for reward in the form of shared savings, especially considering the significant upfront investments required. A more appropriate balance is needed. **Thus, we urge CMS to make significant model design changes, including those identified below. If CMS cannot do so, the agency should not finalize the model.**

- Modify the Risk Adjustment Factors. As proposed, CMS' TEAM risk adjustment factors are insufficient to adequately account for differences in patient complexity and resource use across hospitals. Indeed, such a lack of a robust risk-adjustment methodology penalizes hospitals treating the sickest, most complicated patients. **At a minimum, the risk adjustment factor should capture complication or comorbidity flags from the anchor hospitalization, hierarchical condition codes (HCC) flags prior to the**

hospitalization as well as hierarchical condition codes flags for 36 months prior to the hospitalization (as opposed to the 90 days proposed). Additionally, target prices should be adjusted based on more granular factors than just Medicare-severity diagnosis-related group (MS-DRG). There is a high degree of variability in the clinical complexity of cases even within MS-DRGs, such as for emergent and elective and fracture and non-fracture cases. In addition, in some instances outpatient procedures are included in the same episode categories as inpatient. All these cases can vary significantly in terms of complexity, care pathways and recommended post-discharge treatment. [Provide data from your hospital's experience, if possible, on different factors that affect episode spending, such as type of procedure (e.g., elective vs emergent), patient age, comorbidities during hospitalization, etc.]

- Establish Longer Glidepath to Two-sided Risk. CMS' proposed one year of upside-only risk for all hospitals is insufficient given the infrastructure investment required and risk versus reward equation. Indeed, the agency's other APMs have provided much longer glidepaths to two-sided risk. For example, in the Medicare Shared Savings Program, organizations inexperienced with performance-based risk can access upside-only risk for the first five years of participation. **Considering CMS is proposing to oversample from markets with low previous exposure to bundles, we recommend extending the upside-only glidepath to a minimum of two years. Additionally, safety-net hospitals, rural hospitals and special designation hospitals should receive upside only risk for the duration of the model.** [Insert data/examples on why this change would be helpful in terms of what actions you would need to take to be successful under two-sided risk that will take longer than the proposed one year for upside-only risk.]

- Revise the Low-volume Threshold. CMS proposes a low-volume threshold of 31 cases. This would be measured across all five-episode categories and all three baseline years. In addition, those not meeting the threshold would not be excluded from TEAM, they would simply have access to slightly lower risk metrics. A threshold of 31 cases across five different clinical episode categories across three years is extremely low and ignores principles of statistical significance. It would unnecessarily expose low-volume hospitals to, for example, outlier cases and volatility. **As such, we urge CMS to increase the low-volume threshold to ensure statistical significance, establish separate thresholds within each clinical episode category, and fully exclude organizations not meeting those thresholds from participation.** At a bare minimum, the threshold should be increased to 40 cases within an individual episode category, like the BPCI Advanced model. [Insert data/examples on why this change would be helpful in terms of how you have a low volume of the TEAM clinical episodes, and the proposal would subject you to aberrant swings in cost that are inherent with small sample sizes.]

The changes we recommend above would help facilitate our and other hospitals' success in providing quality care to Medicare beneficiaries, achieving savings for the Medicare program and having an opportunity for reward that is commensurate with the risk they are assuming. We appreciate your consideration of these comments.

Sincerely,