AMA
AMERICAN MEDICAL ASSOCIATION

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The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
Hubert H. Humphrey Building, Room 445–G
200 Independence Avenue, SW
Washington, DC 20201

Re: File Code CMS–1808–P: Transforming Episode Accountability Model; Proposed Rule

Dear Administrator Brooks-LaSure:

On behalf of the physician and medical student members of the American Medical Association (AMA), I appreciate the opportunity to provide comments to the Centers for Medicare & Medicaid Services (CMS) on the proposed Transforming Episode Accountability Model (TEAM) that was included in the Notice of Proposed Rule Making (Proposed Rule) for the Hospital Inpatient Prospective Payment System, published in the *Federal Register* on May 2, 2024 (89 Fed. Reg. 36381). In summary, our comments and recommendations are:

- **CMS should not finalize the TEAM program as proposed because it could harm patients and exacerbate inequities in access to care while failing to support improvements in care delivery.**
- **CMS should only implement payment models that are designed by physicians or designed in close collaboration with physicians.**
- **CMS should not mandate participation of hospitals or physician practices in TEAM or any other new episode-based payment program.**
- **CMS should continue the many successful physician-led episode projects that are currently operating under the Bundled Payments for Care Improvement–Advanced (BPCI-A) program beyond the end of 2025.**
- **CMS should not create special payment codes or lower payment amounts for telehealth services for participants in TEAM or other payment models. The telehealth visit codes developed by the Current Procedural Terminology (CPT®) Editorial Panel should be available for use by all physicians.**
- **CMS should assist all hospitals to reduce emissions and improve energy efficiency, not just those located in communities selected for the TEAM program.**

Additional details on our comments and recommendations are provided below.

I. CMS Should Not Finalize TEAM as Proposed Because It Could Harm Patients and Exacerbate Inequities in Access to Care While Failing to Support Improvements in Care Delivery

The AMA supports efforts by CMS to make appropriately structured alternative payment models (APMs) available, including bundled and episode payment models. However, the goal of a payment model should be to improve care for Medicare patients, not simply to reduce Medicare spending. We were surprised and disappointed that the TEAM program appears to have been designed primarily to force reductions in Medicare spending, rather than to improve patient care. There are serious flaws in the design of the proposed TEAM program that could result in harm to Medicare beneficiaries and exacerbate inequities in access to care, while failing to support improvements in care delivery.

For the reasons described below, **the AMA opposes finalizing and implementing the TEAM program using the structure that CMS has proposed.**

Potential Reduction in Access to Surgery for Complex and High-Need Patients

The proposed TEAM program would penalize a hospital if it had above-average spending on post-acute care, readmissions, and other services during surgical episodes. While CMS intends that this would force hospitals to reduce average episode spending on the types of patients hospitals currently treat, a hospital could also reduce its average spending by avoiding patients who have higher-than-average needs for post-acute care services, higher-than-average risk of post-surgical complications, or higher risk of hospital readmissions for unrelated problems (e.g., due to limited access to primary care or other factors).

Moreover, hospitals, physicians, and post-acute care providers are unlikely to be able or willing to make truly significant improvements in the way they deliver care for a demonstration program that may only last for five years. The short lifespan of the proposed TEAM program, combined with the significant downside risk it requires, will create unfortunate financial incentives for hospitals (1) to reduce the number of services for higher-need patients below the level they require to achieve good outcomes, and (2) to simply avoid performing these surgeries on higher-need patients altogether.

The risk adjustment methodology proposed for TEAM would be unlikely to prevent this kind of "cherry-picking" and "lemon dropping." For example, the risk adjustment methodology does not include a measure of a patient's functional status, even though the primary mechanism for generating savings is reducing post-acute care utilization. Patients with lower functional status will likely require more expensive forms of post-acute care; this means that if one hospital treats more patients with low functional status than another hospital, the first hospital will be more likely to be penalized financially. In the Proposed Rule, CMS admits that it has data that could be used to adjust for functional status, but it is not proposing to use functional status because it believes this would make the payment calculations "challenging to understand" for participants. We believe that physicians and hospitals who deliver surgical care are quite capable of understanding a well-designed risk adjustment model that uses functional status as a variable.

In addition, the risk adjustment methodology is based on the number of different health problems the patient has rather than the nature and severity of those conditions or their relevance to surgical outcomes. It includes a count of the number of Hierarchical Condition Categories (HCCs) in which the patient has health problems, instead of a score based on summing the relative HCC weights the way other CMS risk adjustment methodologies do. CMS presents no evidence that the number of HCCs is the best or even an adequate way of adjusting surgical episode spending for differences in patient risk or needs. Although the

HCC score is not an ideal method of risk adjustment for specific procedures, it provides more information than the number of HCCs. For example, using the count of HCCs instead of the HCC score means that hospitals will have an incentive to favor treating patients who have multiple mild chronic conditions or conditions that have little impact on post-acute care use and to avoid patients with one or two conditions severe enough to increase the risk of poor surgical outcomes.

The proposed risk adjustment model also fails to adjust for differences in the Medicare Advantage penetration in participating communities. In communities with high levels of Medicare Advantage enrollment, the hospitals will have fewer patient episodes in the TEAM program, making it more difficult for them to make the investments needed to deliver care in different ways. Moreover, if healthier beneficiaries are more likely to enroll in Medicare Advantage plans, then the Original Medicare beneficiaries in the TEAM program will be less healthy and more likely to experience complications from surgery or to require additional services after discharge. Failure to adjust for this will make it more likely that the hospitals in communities with high levels of Medicare Advantage penetration will receive penalties under the TEAM program.

To properly calibrate a risk adjustment model that is designed to adjust payment amounts, one must know how much it actually costs to deliver needed services for the different categories of patients. CMS has done nothing to ensure that any of the payment amounts in the TEAM program would be adequate to cover the costs of delivering the services that patients need to achieve good outcomes. It plans to merely take the amounts it is currently spending during the defined episodes, and then apply a trend factor and an arbitrary discount. Current spending on episodes is likely too high for some patients but too low for others, yet the CMS methodology assumes that spending for every patient should be at least three percent lower than it is today. As a result, the episode payments will also be lower than necessary for some patients, and this will discourage hospitals from treating these patients or result in the patients receiving fewer services than they should. This could create or exacerbate inequities in access and outcomes for disadvantaged patients.

Requiring that a hospital participate in the TEAM program does not mean that the hospital is required to provide surgeries to the same types of patients it would otherwise have served. A large proportion of the surgeries included in TEAM are elective surgeries, so a hospital could either discourage higher-risk and higher-need patients from receiving elective surgeries or encourage them to go to a hospital located in a non-participating region of the country to receive the surgery.

The most recent evaluation of the Comprehensive Care for Joint Replacement (CJR) program stated:

"For the highest volume and least complex episode group, elective lower extremity joint replacements without major complications or comorbidities, the CJR patient population was relatively less complex in the intervention period than in the baseline period. Relative changes in complexity occurred in each performance year. A reduction in complexity could help mandatory CJR hospitals meet payment and quality targets and thus receive reconciliation payments." (*CMS Comprehensive Care for Joint Replacement Model: Performance Year 5 Evaluation Report, p. 46.)*

Forcing higher-need patients to go to non-participating communities to receive surgery will not only create added burden on the patients, but also will reduce spending for TEAM participants and increase spending at non-TEAM hospitals, thereby artificially increasing the amount of savings attributed to the TEAM program.

AMA Recommendation: To prevent harming higher-need patients, any new episode-based payment program should use a risk adjustment formula or risk stratification structure that considers all of the patient-level and regional factors that could have a significant impact on surgical outcomes and post-acute care usage. Surgeons who perform the kinds of procedures included in TEAM have developed and routinely utilize far more sophisticated risk adjustment methodologies than CMS is proposing to use for the TEAM program, so CMS should utilize those methodologies rather than trying to create its own. In addition, before establishing target prices for episodes and the parameters for a risk adjustment model, CMS should conduct a study to determine the actual costs of delivering high-quality care to patients with higher and lower needs for each type of episode.

Potential Reduction in Access to Surgery for Low-Income and Rural Beneficiaries

It is extremely problematic for CMS to mandate participation of small rural and safety net hospitals in a program requiring significant downside risk when there is evidence that these kinds of hospitals have been disproportionately penalized in other CMS pay-for-performance and risk-based payment programs. Although the proposed stop-loss percentage would be lower for these hospitals, CMS has provided no evidence that losses up to this amount would be feasible for rural and safety-net hospitals, particularly those that are currently losing money overall. As a result, the TEAM program could cause rural and safety net hospitals to stop offering some or all of these types of surgery, and in some cases, the hospitals could be forced to close entirely due to either the financial penalties from TEAM or the inability to offer a sufficient number of services.

AMA Recommendation: Rural and safety net hospitals should be permitted to voluntarily opt out of participation in any new episode-based payment program.

Failure to Protect Beneficiaries from Undertreatment

CMS proposes to use only three quality measures in the TEAM program–the rate of all-cause hospital readmissions following discharge for all hospital admissions, the rate of patient safety and adverse events that occur during all inpatient hospital stays, and patient-reported outcomes following hip or knee replacement. The third measure only applies to patients receiving elective hip and knee replacements, not to the other surgeries included in the TEAM program. The first two measures are calculated for all hospital inpatients, not just for the inpatient surgeries included in TEAM, so it is possible that the patients receiving the surgeries included in TEAM could receive significantly lower quality care without reducing the overall average performance on the measures sufficiently to impact the reconciliation payment significantly. The first two measures also only apply to inpatient care, so there would be no assessment of quality for outpatient procedures other than elective hip and knee replacements.

Under TEAM, hospitals would be at financial risk for episode spending, but the primary way to reduce spending is by reducing utilization of post-acute care services, not by reducing spending during the hospitalization itself. Since most hospitals do not deliver post-acute care services themselves, their ability to redesign the way those services are delivered is limited. As a result, TEAM would create a strong financial incentive for hospitals to use fewer and lower-cost post-acute care services than would be necessary in order to achieve the best results in terms of the patient's recovery.

CMS is proposing to use fewer episode-specific quality measures in TEAM than in either BPCI-A or CJR. The Fifth Evaluation Report for BPCI-Advanced found that patients with hospital-initiated episodes were significantly less likely to report improvement after surgical episodes than comparison patients, and that dually eligible patients were less likely to report favorable changes than non-dually eligible patients.

Patients with hospital-initiated episodes were also less likely to report favorable care experiences than those receiving care in non-participating hospitals (*CMS BPCI Advanced Evaluation–Fifth Evaluation Report*, pp. 107-110). Using even fewer quality measures could lead to even worse outcomes.

Moreover, there would be no actual penalty for a hospital that delivers low-quality care under the TEAM program unless the hospital also reduces spending sufficiently to qualify for a reconciliation payment. If it did reduce spending enough to qualify for a reconciliation payment, it would still receive at least 90 percent of that amount regardless of how poorly it scores on quality.

The hospital's quality score under the TEAM program would be determined by comparing its performance on the measures to the national average of hospitals in 2025. Since two of the measures are hospital-wide measures, a hospital's performance on the measures will depend as much or more on how its readmission rate and patient safety performance compares to other hospitals for patients who are <u>not</u> eligible for TEAM than for the patients in TEAM episodes.

Moreover, the proposed quality score in TEAM does not assess whether a hospital's performance has changed, it merely compares each year's performance to the national average. As a result, a hospital's performance on the quality measures could decrease under the TEAM program, but the hospital might receive no penalty or only a small penalty as long as its lower performance was higher than the average of other hospitals nationally.

As noted earlier, the payment methodology in TEAM does nothing to ensure that the target prices for the episodes are adequate to cover the costs of providing sufficient services to higher-need patients, so hospitals could be financially penalized if they provide all of those services. In contrast, the quality component of the methodology would result in little or no penalty if a hospital reduces costs by not providing some of those services.

Congress required that CMS Innovation Center models either improve quality without increasing spending or reduce spending without harming quality. The proposed methodology for TEAM fails to comply with this requirement.

AMA Recommendation: Any new episode-based payment program should only include episodes for which there are a sufficient number of episode-specific measures to protect patients from undertreatment.

<u>Failure to Support Delivery of High-Value Services That Would Improve Outcomes</u>

When Congress created the Center for Medicare and Medicaid Innovation (CMMI) in 2010, it explicitly required that CMMI test a model only if it determined "that there is evidence that the model addresses a defined population for which there are deficits in care leading to poor clinical outcomes or potentially avoidable expenditures" (42 U.S.C. 1315a(b)(2)(A)). Although CMMI was also required to focus on models expected to reduce Medicare spending, it is not sufficient under the law to design a payment model with the sole or primary purpose of reducing spending. Moreover, the statute explicitly states that preference must be given to models that "improve the coordination, quality, and efficiency of services" delivered to patients.

The TEAM proposal is not a true episode payment program that is designed to improve the coordination and quality of services. It is instead a pay-for-performance program based on total Medicare spending during a hospital admission and the 30 days following discharge. This means that, in most cases,

hospitals, physicians, and post-acute care providers participating in TEAM cannot be paid directly for any services other than those for which they could be paid outside of TEAM, and they will be paid the same amount for those services as providers that are not in TEAM. As a result, in most cases, if a physician, hospital, or post-acute care provider delivers a service for which there is currently no Medicare payment, or for which the Medicare payment is less than the cost of delivering the service, they will incur a loss. For example, surgeons have indicated that providing some patients with exercise and rehabilitation services prior to surgery can improve surgical outcomes for those patients, and that providing intensive home-based rehabilitation for some patients can achieve better outcomes at a lower cost than standard post-acute rehabilitation services, but there are currently no payments to support these services.

A hospital that is participating in TEAM might be able to receive a reconciliation payment if it reduces average episode spending below the target prices established by CMS, but this payment will not arrive until at least 8-20 months after any new services are delivered, and there is no assurance that the reconciliation payment would cover the cost of the new services. Moreover, if a physician practice or a post-acute care provider delivers the new service that resulted in lower episode spending, it could only receive a portion of the reconciliation payment if the hospital had agreed to share the payment with them, and the share it receives could be less than the cost of delivering the service. This risk of losing money from delivering new and innovative services will discourage physicians and other providers from delivering such services as part of TEAM, and this will reduce the likelihood that savings will be achieved and that outcomes will be improved.

CMS only proposes two services for which TEAM participants will be able to be paid in different ways than non-TEAM participants:

- Skilled Nursing Facility (SNF) care. The payments for SNF care would not change, but SNFs could be paid even if the beneficiary had an inpatient stay of less than three days. However, this does nothing to permit higher payments for fewer days of more intensive SNF care that could lead to better outcomes at a lower cost for Medicare while paying the SNF provider enough to cover their cost of delivering services.

- Telehealth services. CMS would waive the geographic and originating site requirements that traditionally limited providing telehealth services to patients in their homes, although these restrictions have been temporarily removed and may be permanently extended by Congress. However, rather than simply extending the current waivers for telehealth, CMS is proposing to create a problematic new payment structure for telehealth; this is discussed in more detail below.

AMA Recommendation: Any new episode-based payment program should pay participating physician practices, hospitals, and post-acute care providers amounts that are sufficient to cover the costs of the services they believe will improve outcomes for patients while maintaining or reducing average Medicare spending during episodes.

Potential Reduction in Access to Outpatient Surgery for Beneficiaries

Because the proposed TEAM program is designed around hospitals, it only includes procedures performed on an inpatient or outpatient basis in hospitals, and it does not include the same procedures if they are performed in an ambulatory surgery center (ASC). If a surgeon and patient agree that a hip or knee replacement surgery should be performed in an ASC rather than a hospital outpatient department,

the procedure would not be included in TEAM. If spending is lower for performing the procedure in the ASC, the savings would all go to CMS, and none would be shared with the surgeon, ASC, or hospital.

As more and more of the lowest-risk patients receive their surgeries in ASCs, procedures that are still performed in hospitals will disproportionately consist of higher-risk cases. Since spending on those cases will be higher, the hospital could be penalized compared to a facility where all procedures are performed in the hospital. In addition to the other problems with the risk adjustment model for TEAM described earlier, there is no adjustment for the differences across communities in terms of the access to ASCs. This could discourage physicians from performing appropriate surgeries in ASCs rather than hospitals, which in turn could make it more difficult for Medicare beneficiaries to (1) obtain surgery in an ASC and/or (2) obtain surgery in a timely fashion. This could also result in higher overall spending for CMS.

There is evidence that this is likely to happen. Prior to 2021, only inpatient hip and knee replacement surgeries were eligible as episodes in CJR, even though Medicare began to pay for the surgeries on an outpatient basis in 2018. The evaluation reports for CJR found that hospitals participating in CJR did a smaller proportion of these surgeries on an outpatient basis than non-participating hospitals, and that this difference was due solely to participation in the CJR program. The evaluations also concluded that the savings due to CJR were overestimated by looking only at changes in spending on inpatient episodes.

In 2021, CMS expanded the CJR model to include hip and knee surgeries performed in hospital outpatient departments, but the surgeries performed in an ASC are excluded from CJR. The most recent CJR evaluation included only the first nine months of 2021, so the impact of including procedures in hospital outpatient departments and excluding ASC procedures has not been fully evaluated yet. However, the evaluation report notes that CJR model incentives may motivate shifts in care to ASCs for certain beneficiaries, which could impact the case mix of beneficiaries receiving inpatient procedures included in CJR. They are continuing to monitor the effects of the change in policy (*CMS Comprehensive Care for Joint Replacement Model: Performance Year 5 Evaluation Report*, p. 5).

AMA Recommendation: Any new episode-based payment program should allow procedures performed in ASCs to be eligible for episode payments as well as procedures performed in hospital outpatient departments.

Failure to Use Evidence from Current APMs in Defining the Payment Methodology

CMS has proposed an approach to defining episodes, calculating target prices, etc. for the payment methodology in TEAM that is completely different than it has used in past episode payment programs. As shown in the table in Appendix 2, CMS has used some elements from CJR, some from BPCI-A, and some from neither. In many cases, there is very little justification for why a particular component of the methodology has been defined in a particular way or why it differs from the approaches used in BPCI-A and CJR. CMS claims that some choices were made because it wanted to "create a pricing methodology that all TEAM participants, regardless of experience or resource, can understand." It appears likely, however, that the true rationale was to create a methodology that is more financially favorable for CMS.

For example, CMS has proposed that episodes in TEAM would last for 30 days following discharge from the hospital, whereas both BPCI-A and CJR use a 90-day window after discharge. CMS provides no analysis as to the types or proportion of savings in BPCI-A and CJR that have been achieved in the 30 days after discharge versus the next 60 days. Since most patients will need some type of post-acute care after surgery, the shorter the time period in which savings can be achieved, the more difficult it will be to reduce spending without harming patients. Consequently, this change could increase the likelihood that

hospitals will be unfairly penalized under the TEAM program and result in some patients receiving inadequate post-acute care because of the pressure to reduce spending.

The Proposed Rule provides little or no evidence supporting why the payment methodology proposed for TEAM would be preferable to the methodology used in BPCI-A. CMS changed the payment methodology in BPCI-A in 2023 but the most recent evaluation of BPCI-A was based on 2021 data, so there is no evidence that the methodologies currently used in BPCI-A are ineffective or that the approach CMS has proposed for TEAM would be better. If the same time gap continues in the future, evaluation results based on 2023 will likely not be available until 2026, when CMS proposes that TEAM would already have begun. Moreover, the differences in the methodology will make it difficult to compare results between TEAM, BPCI-A, and CJR. For example, the quality measures are different, which means that it will be impossible to compare the quality of care delivered under TEAM to the quality of care delivered for the same procedures in BPCI-A and CJR.

AMA Recommendation: Any new episode-based payment program should use a payment methodology designed using the lessons from the evaluations of BPCI-A and other CMMI demonstration programs.

II. CMS Should Only Implement Payment Models Designed by Physicians or in Close Collaboration with Physicians

We are extremely disappointed that CMS developed the TEAM program without adequately involving the physicians who would be delivering services to the patients included in the program in order to ensure that the program would improve the quality of care. As we stated in our August 16, 2023 response to the CMS Request for Information (RFI) regarding episode-based payment models, if CMS is truly committed to developing successful APMs that support meaningful improvements in care for patients, practicing physicians who deliver that kind of care must be involved in all stages of model development and implementation. CMS should also seek public input on APM payment amounts, risk requirements, quality measures, and other key elements long before they are formalized in proposed rulemaking. These steps were not taken with TEAM, and the result is the long list of problems described above.

In addition, in contrast to the BPCI-A program, which allows physicians as well as hospitals to take accountability for managing surgical episodes, the proposed TEAM program would only allow hospitals to be participants. Physicians could be "downstream participants" in TEAM, but they cannot be the primary managers of the episode payments even if they can and want to. Yet there is clear evidence that physician-led programs achieve better results than hospital-led episodes. As shown in Appendix 1, the biggest savings in BPCI-A have come from the episodes managed by physician groups, not from the hospital-led episodes, so the savings that would be achieved the way CMS has defined the TEAM program will likely be significantly less than what would be possible if physicians were included or playing a lead role. Moreover, while the Fifth Evaluation Report for BPCI-Advanced found that patients with hospital-initiated surgical episodes were significantly less likely to report improvement than comparison patients, patients with surgical episodes initiated by physician groups were more likely to report favorable changes in functional status (*CMS BPCI Advanced Evaluation–Fifth Evaluation Report*, pp. 107 and 111).

The exclusion of physician-managed episodes appears to be due to CMS' desire to force all hospitals in a region to participate and to require them to take on high levels of financial risk. While CMS seems to believe that this will achieve greater savings, far more net Medicare savings annually have been achieved from the hip and knee replacement episodes in the voluntary BPCI-A program that allows physicians to

manage episodes than CMS has achieved in the mandatory CJR program that is restricted to hospitals (see Appendix 1).

For any new payment program to successfully achieve savings for Medicare without harming beneficiaries, the program must:

- be designed to place physicians at the center of decision-making about care delivery;
- give physicians adequate resources and flexibility to deliver services that can achieve good outcomes for all types of patients;
- avoid placing physicians directly or indirectly at risk for outcomes or costs they cannot control; and
- be designed to ensure that savings come from reductions in truly avoidable services, not simply from reducing the amount of payment for services or shifting risk for spending to hospitals or physicians.

The TEAM program fails to do these things.

Better payment models have already been developed by physicians that are explicitly designed to achieve savings for the Medicare program by improving care for patients. This includes not only payment models designed to improve care for surgeries and other procedures, but also payment models designed to help avoid the need for hospital admissions and expensive treatments. More than a dozen payment models developed by physicians were recommended for testing or implementation by the Physician-Focused Payment Model Technical Advisory Committee. However, CMS has failed to implement any of these payment models.

AMA Recommendation: We urge that CMS implement the payment models that have already been developed by physicians rather than CMS attempting to select clinical episodes and develop new payment models itself. If CMS believes that a new episode-based payment program for surgery is needed, it should work with physicians to develop a physician-led program that is designed to improve care for beneficiaries who need surgical care as well as achieve savings for the Medicare program.

In addition, participants in past CMS alternative payment model demonstrations have consistently stated that the lengths of the demonstrations have been too short, and the evaluations of several programs have confirmed that many of the types of care delivery changes needed for success could not be fully implemented before the end of the demonstration. Other recently announced CMMI demonstration projects have much longer lifespans than the five-year period proposed for the TEAM program. For example, the Transforming Maternal Health program has a seven-year implementation period, and the Making Care Primary program is scheduled to last for 10 years. The BPCI-A program was extended to last a total of seven years, and the CJR program was extended to eight years.

The short lifespan of the proposed TEAM program is particularly surprising given that CMS has stated a goal of having all Medicare beneficiaries in a "care relationship with accountability for quality and total cost of care by 2030," yet CMS is proposing to terminate the TEAM program at the end of that year. Moreover, based on the evaluations of other CMMI models, it seems highly unlikely that meaningful evaluation results for TEAM would be available in time to make a decision about extending the program before 2030.

AMA Recommendation: Any new episode-based payment program should be operated for at least eight years, rather than the five-year period proposed for TEAM, unless evaluation results clearly indicate that the program should be terminated earlier.

III. CMS Should Not Mandate Participation of Hospitals or Physician Practices in TEAM or Any Other New Episode-Based Payment Program

There is no shortage of physicians who want to be part of well-designed payment models that will enable them to deliver better care. The reason many physicians have not participated in CMMI APMs to date is not because the physicians are unwilling to accept different methods of payment, but because the payment models have not provided the support the physicians need to improve the delivery of care to their patients and/or the APMs require the physicians to accept unmanageable levels of risk.

Moreover, not every physician or physician practice has adequate time and resources to make significant changes in care delivery and to respond to frequent changes in CMS requirements, particularly during the initial years of implementation of a new payment model as it is still being refined. This is particularly true for small, independent, rural, and safety-net physician practices, and it is also true for the small rural hospitals and safety-net hospitals that CMS proposes to require participating in TEAM.

If a payment program is designed with adequate support for improvements in care delivery and manageable levels of financial risk and accountability, there will be no need to mandate participation. By actively involving practicing physicians in the design of APMs, barriers to participation can be identified and overcome. In contrast, mandating participation in payment programs with high levels of financial risk, inadequate risk adjustment, and burdensome measurement and accountability requirements could force some small physician practices or hospitals to close, reduce access to care for already underserved patient populations, and increase inequities in health outcomes.

There is clear evidence that voluntary payment models can achieve greater savings than mandatory payment models. As shown in Appendix 1, CMS has achieved far more net savings annually from hip and knee replacement episodes in the voluntary BPCI-A program than it has in the CJR program.

AMA Recommendation: The AMA strongly opposes creation of a mandatory payment program for surgical episodes or other types of episodes. We will only support new episode-based payment programs based on voluntary participation by physicians and hospitals.

In its announcement of the TEAM program, CMS stated that it is intended to "improve the patient experience from surgery through recovery by supporting the coordination and transition of care between providers and promoting a successful recovery." Yet if CMS truly believes that the program would be beneficial in this way, it is inappropriate to preclude the majority of hospitals in the country from participating, thereby denying these benefits to the majority of Medicare beneficiaries.

The maximum benefit from well-designed alternative payment models will be achieved by allowing voluntary participation by any physicians and hospitals that wish to participate. That is the approach that has been successfully used in the BPCI-A program.

AMA Recommendation: Any new episode-based payment program should permit voluntary participation by any physicians who wish to participate and should not be restricted to specific geographic areas.

IV. CMS Should Continue Operating the Bundled Payments for Care Improvement–Advanced (BPCI-A) Program Beyond the End of 2025

Although the Notice of Proposed Rulemaking does not say this explicitly, it appears CMS intends to terminate the current BPCI-A demonstration program entirely at the end of 2025, and replace it with TEAM, which would start in 2026. This is problematic for several reasons:

- BPCI-A allows physician groups as well as hospitals to participate, but TEAM only allows hospitals to be participants. As a result, creation of TEAM and termination of BPCI-A would mean that the approximately 90 physician groups currently participating in BPCI-A would be terminated from bundled payment models after 2025. The patients they treat would lose the benefits of the better approaches to care these physician groups have been able to deliver by participating in the BPCI-A program, and the Medicare program would no longer receive the savings they have been able to generate through participation in the program.

- The proposed TEAM program is far narrower than BPCI-A in terms of the types of conditions and procedures for which episode payments would be made. The current BPCI-A episode payment demonstration includes 30 different types of clinical conditions and procedures, half of which are for medical hospitalizations, and half of which are for surgical or invasive procedures. TEAM would not include any of the medical admissions, and it would only include five of the 15 types of procedures that are included in BPCI-A. Although the Proposed Rule states that the goal of TEAM is to "improve the patient experience…by supporting the coordination and transition of care between providers and promoting a successful recovery that can reduce avoidable hospital readmissions and emergency department use," TEAM would do nothing to improve care coordination and transitions for patients who are hospitalized for medical problems or for patients receiving other types of procedures.

- Many hospitals and physician groups that are participating in BPCI-A would be unable to participate in the proposed TEAM program because of its geographic restrictions. Hospitals that have been participating in lower joint replacement episodes in BPCI-A will only be included in TEAM if they are in regions that happen to be selected in a new randomized process, regardless of whether the hospital has been successful in BPCI-A. This is problematic for the planned evaluation of TEAM for two reasons. First, many hospitals and physician practices that have been participating in BPCI-A for joint replacement and the other TEAM episodes have already been reducing spending below the levels achieved in other regions. If the hospitals and physician practices that are dropped from BPCI-A are included in the "control" group of regions for TEAM, and if their spending on surgical episodes increases because they can no longer receive the additional payments and regulatory waivers under BPCI-A, this could make it appear that the TEAM participants are more effective in reducing spending than they actually are.

The most recent evaluation results for BPCI-A indicate that the program saved money for the Medicare program. Excluding physician groups from the TEAM program and terminating the BPCI-A program would not only eliminate the savings being achieved in the BPCI-A program, it could reduce the willingness of physician groups to make the investments in care delivery changes needed to achieve savings in BPCI-A in 2024 and 2025, since they will know they will be unable to benefit from those investments after 2025. If this diminishes the savings in BPCI-A, the final evaluation could then appear to reinforce CMMI's decision to terminate the program.

CMS states that it may expand the TEAM program to other types of hospital episodes, but this would presumably not occur until after the BPCI-A program ends. This could mean that hospitals participating in BPCI-A for those same episodes could be forced to abandon efforts to improve care in those episodes when BPCI-A ends and then restart those efforts again if and when TEAM expands to include them. If the TEAM program ends in five years as proposed, hospitals would have at most two-three years to implement any additional episodes that are added.

AMA Recommendation: CMS should continue the BPCI-A program at least until after the results of the changes made in the past two years can be evaluated. An informed decision can be made then as to whether to continue or expand BPCI-A for those episodes and whether to include them in any new episode-based payment program.

V. CMS Should Not Create Special Payment Codes or Lower Payment Amounts for Telehealth Services for Participants in TEAM or Other Alternative Payment Models

CMS has proposed creating nine new G-codes for evaluation and management (E/M) services provided to beneficiaries in their home via telehealth. The new payment codes would only be used by TEAM participants. CMS says it does "not believe that the kinds of E/M services furnished to patients outside of health care settings via real-time, interactive communication technology are accurately described by any existing E/M codes." Yet it defines eight of the G-codes using the same definitions of services used for eight existing office visit E/M CPT codes (99202-99205 and 99212-92215). (The ninth G-code is defined based on a CPT code (99201) that no longer exists.) Moreover, CMS proposes to assign the exact same work and professional liability insurance relative values to each of the new G-codes as are assigned to the parallel existing CPT codes, and it proposes to update these amounts each year to match the amounts for the CPT codes.

It appears that the sole purpose of creating the new codes is to enable CMS to assign a practice expense amount of zero to each of the G-codes rather than the amount that is currently used for the parallel CPT codes. The proposed rule assigns a zero practice expense value for level 1-3 visits for new patients and level 2-3 visits for established patients because CMS believes that auxiliary medical staff would not need to be available in the home for those visits, and so (according to CMS) there would be no need to pay for any practice expenses. As for the higher-level codes, although CMS says it "believes it would be rare for a practitioner to conduct as complex a service as a level 4 or 5 E/M home visit via telehealth…without licensed clinical staff support in the home," it also proposes to assign a zero practice expense value to these telehealth visits because CMS "would expect to observe level 4 and 5 E/M visits to be reported on the same claim with the same date of service as a home visit or during a period of authorized home health care," and (according to CMS) payments for these home services would pay for the staff costs and there would be no other practice expenses associated with telehealth services. Moreover, if the level 4 or 5 E/M visit was not accompanied by such a home visit, CMS proposes to "require the physician to document that auxiliary licensed clinical staff were available on site in the patient's home during the visit and if they were not, to document the reason that such a high-level visit would not require such personnel."

The CPT Editorial Panel has already developed new CPT codes for these types of telehealth visits, so it is unnecessary for CMS to define new G-codes for the same services and it is counterproductive to define and price these G-codes differently than the CPT codes. CMS is wrong to assert that there are no practice expenses associated with telehealth services other than the presence of auxiliary medical staff in the home, and it is inappropriate for CMS to attempt to define when physicians should and should not have staff present in a patient's home, since only the patient's physician can determine what each patient needs.

AMA Recommendation: The telehealth visit codes developed by the CPT Editorial Panel, along with their corresponding relative values and payment rates, should be available for use by all physicians, rather than creating special codes and payment amounts solely for TEAM participants.

VI. CMS Should Assist All Hospitals to Reduce Emissions and Improve Energy Efficiency, Not Just Those Located in Communities Selected for the TEAM Program

CMS has proposed an initiative in which hospitals participating in the TEAM program would voluntarily collect and submit data to CMS on greenhouse gas emissions, and CMS would provide technical assistance to the hospitals in transitioning to lower-emission approaches to care delivery. The AMA supports efforts by CMS to promote decarbonization efforts, and we support rapid implementation and incentivization of clean energy solutions and significant investments in climate resilience. AMA believes climate change is a public health crisis that is already threatening the health and well-being of Americans. Due to the scale of the problem, we believe this new initiative should include all hospitals in all parts of the country, not just hospitals in the small subset of the country chosen for the TEAM program. In addition to helping mitigate the current and future health harms from climate change, reducing emissions from hospitals across the country will have the co-benefit of reducing local air pollution, as hospitals can contribute to emissions of criteria air pollutants like particulate matter (soot) and ozone (smog) as well as other cancer-causing pollution.

In addition, while improved data collection and accounting for emissions is necessary to provide efficient, targeted solutions for decarbonization efforts, there are also significant potential costs of collecting emissions data and transitioning to lower-emission approaches. Therefore, we urge CMS to provide financial assistance to help hospitals take these steps, particularly the rural and safety-net hospitals that would likely have greater difficulty allocating resources to this effort. As CMS notes in the proposed rule, "reductions in operating costs and spending due to energy efficiency and more efficient provision of care …directly contribute to savings for CMS." Consequently, we believe it would be appropriate for CMS to pay for all or part of the costs of activities undertaken by hospitals that lead to reduced emissions.

We do not support modifying the quality scores for hospitals or physicians in an episode-based payment program based on whether they report information on greenhouse gas emissions or undertake activities designed to reduce emissions. As noted earlier, the quality measurement system proposed for TEAM is already inadequate to protect patients in the face of significant downside risk. Adding bonuses or modifications related to greenhouse gas emissions would further weaken the program's ability to protect patients from receiving inadequate care.

AMA Recommendation: CMS should encourage and support decarbonization initiatives at all hospitals, not just those participating in TEAM or other alternative payment models.

Thank you for the opportunity to provide input on this proposal. If you have any questions, please contact Margaret Garikes, Vice President of Federal Affairs, at margaret.garikes@ama-assn.org.

Sincerely,

James L. Madara, MD

Attachments

APPENDIX 1

Savings in Hip and Knee Replacement Episodes in the BPCI-A and CJR Programs

Program	Entity	Year	Number of Episodes	Gross Savings Per Episode	Net Savings to Medicare
CJR	Mandatory Hospitals	2019[1]	48,807	$1,194	$13.7M
BPCI-A	Hospitals	2019[2]	20,707	$1,162	$33.2M
BPCI-A	Physician Groups	2019[3]	50,136	$1,373	$134.8M
CJR	Mandatory Hospitals	2020[4]	34,277	$1,092	($61.4M)
BPCI-A	Hospitals	2020[5]	9,367	$766	$3.6 M
BPCI-A	Physician Groups	2020[6]	30,297	$2,135	$59.6M
CJR	Mandatory Hospitals	2021[7]	18,556	$973	($34.0M)
BPCI-A	Hospitals	2021[8]	*	*	$26.76M
BPCI-A	Physician Groups	2021[9]	*	*	$36.56M

[1] *CMS CJR Model Performance Year 5 Evaluation Report*, Exhibits D-1 and E-1
[2] *CMS BPCI Advanced Evaluation – Third Evaluation Report*, Exhibits E.13 and H.8
[3] *CMS BPCI Advanced Evaluation – Third Evaluation Report*, Exhibits E.29 and H.10
[4] *CMS CJR Model Performance Year 5 Evaluation Report*, Exhibits D-1 and E-1
[5] *CMS BPCI Advanced Evaluation – Fourth Evaluation Report*, Exhibits F.13 and J.5
[6] *CMS BPCI Advanced Evaluation – Fourth Evaluation Report*, Exhibits F.31 and J.9
[7] *CMS CJR Model Performance Year 5 Evaluation Report*, Exhibits D-1 and E-1
[8] *CMS BPCI Advanced Evaluation – Fifth Evaluation Report*, Exhibit N.8
[9] *CMS BPCI Advanced Evaluation – Fifth Evaluation Report*, Exhibits N.10
* The Fifth Evaluation Report does not include these data on individual procedures, only orthopedics in aggregate.

APPENDIX 2

Differences in the Structure and Payment Methodologies in BPCI-A, CJR, and TEAM

Component	BPCI-A	CJR	TEAM
Participants	• IPPS hospitals • Physician Group Practices	• IPPS hospitals except rural hospitals	• All IPPS hospitals
Participation	• Voluntary nationwide	• Mandatory in 34 metropolitan areas • (Voluntary in 33 metropolitan areas until 2021)	• Mandatory in ~100 metropolitan areas • Mandatory in ~ 135 micropolitan areas
Episodes	• Hip or Knee Replacement (LEJR) • Surgical Hip and Femur Fracture Treatment (SHFFT) • Spinal Fusion • Coronary Artery Bypass Graft (CABG • Major Bowel Procedures • 25 Other Episodes	• Hip or Knee Replacement (LEJR) • Hip Replacement for Fracture	• Hip or Knee Replacement (LEJR) • Ankle Replacement (TAA) • Surgical Hip and Femur Fracture Treatment (SHFFT) • Spinal Fusion • Coronary Artery Bypass Graft (CABG) • Major Bowel Procedures
Facility Where Surgery is Performed	Hospital Inpatient or Outpatient (not ASC)	Hospital Inpatient or Outpatient (not ASC)	Hospital Inpatient or Outpatient (not ASC)
Episode Length	90 days post-discharge	90 days post-discharge	30 days post-discharge
Services/Costs Included	All Part A & Part B with certain exclusions	All Part A & Part B with certain exclusions	All Part A & Part B with BPCI-A exclusions and prorated portion of acute and post-acute care payments for services lasting longer than 30 days
Baseline Period	4 Years	1 Year (originally 3 years)	3 Years
Low Volume Exclusion	<41 episodes for a clinical category during 4-year baseline period	<20 LEJR episodes in 3 years prior to Year 1	<31 episodes in total for all types of episodes

Component	BPCI-A	CJR	TEAM
Benchmark Group for Target Prices	Hospitals in peer group	Hospitals in region (initially hospital specific)	Hospitals in region (not hospital specific)
Peer Group Adjustment	• Major Teaching Hospital • Urban/Rural • Safety-Net Hospital • Geography • Bed Size	• None	• None
Adjustment to Benchmark for Spending Trend	• Prospective trend factor for preliminary target price based on regression model of past quarterly trend • Retrospective trend adjustment for each peer group, limited to ±5%	• Retrospective trend adjustment based on 1-year change between baseline and performance period, with no limit on size of adjustment	• Prospective trend factor based on 2-year change during baseline period • No retrospective adjustment
Adjustment to Target Price for FFS Updates in Performance Year	• Adjusted for payment updates in performance year	• No explicit adjustment for payment updates, but retrospective trend adjustment captures this	• No adjustment for payment updates in performance year
CMS Discount	• 3% of 90-day episode spending for surgical episodes • 2% of episode spending for medical episodes	• 3% of 90-day episode spending if quality is unacceptable • 1.5% for good quality • 0% for excellent quality	• 3% of 30-day episode spending for all episodes
Risk Adjustment Factors	• Age • Disability • Dual Eligibility status • HCC score • # of HCCs • Recent resource use • Long-term institution resident • Dementia	• Age • Dual Eligibility status • # of HCCs (not HCC score)	• Age • High vs. Low Social Risk (based on low income status and neighborhood distress • # of HCCs (not HCC score)

Component	BPCI-A	CJR	TEAM
	• Episode-specific factors • COVID-19 rate		
Adjustment for Average Risk Score Changes	• No adjustment	• Normalization to national average, with no cap	• Normalization to national average by up to ±5%
Share of Spending Above or Below Target Price	• 100% of spending difference up to stop loss or stop gain amount	• 100% of spending difference up to stop loss or stop gain amount	• 100% of spending difference up to stop loss or stop gain amount
Penalty for High Post-Episode Spending	• 100% of spending beyond 99.5% confidence interval around average	• 100% of spending beyond 3 standard deviations above average	• 100% of spending beyond 3 standard deviations above average
Maximum Downside Risk (Stop Loss)	• 20% of episode price	• 20% of episode price	• 20% of episode price in years 2-5 (0% in first year) for large hospitals • 10% of episode price for rural and safety net hospitals (0% in first year)
Maximum Bonus (Stop Gain)	• 20% of episode price	• 20% of episode price	• 20% of episode price for large hospitals (10% in first year) • 10% of episode price for rural and safety net hospitals
Quality Measures (for episodes in TEAM)	• Readmission Rate for All Hospital Inpatients • Patient Safety Indicators Composite for All Hospital Inpatients • Complication Rate Following Hip or Knee Replacement • Advance Care Plan • Cardiac Rehabilitation Referral	• Complication Rate Following Hip or Knee Replacement • Hospital CAHPS Survey	• Readmission Rate for All Hospital Inpatients • Patient Safety Indicators Composite for All Hospital Inpatients • Patient-Reported Outcomes Following Elective Hip or Knee Replacement

Component	BPCI-A	CJR	TEAM
	• Society of Thoracic Surgeons CABG Composite Score • 30-Day Mortality Rate for CABG • Substance Use Screening and Intervention • Care Transition Measure • Patient-Centered Surgical Risk Assessment and Communication		
Payment Adjustment for Quality	• Bonus based on savings is reduced by up to 10% based on quality score • Penalty based on exceeding target price is reduced up to 10% based on quality score	• CMS discount is adjusted between 0% and 3% based on quality score, which affects amount of savings	• Bonus based on savings is reduced by up to 10% based on quality score • Penalty based on exceeding target price is reduced up to 10% based on quality score for large hospitals • Penalty based on exceeding target price is reduced up to 15% for rural and safety net hospitals