August 16, 2023

Chiquita Brooks LaSure
Administrator, Centers for Medicare & Medicaid Services
Department of Health and Human Services
Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201

Submitted via https://www.regulations.gov/commenton/CMS-2023-0127-0001

Re: Design of a Future Episode-Based Payment Model Request for Information CMS–5540–NC

Dear Administrator Brooks LaSure:

America's Physician Groups (APG) appreciates the opportunity to respond to the Centers for Medicare & Medicaid Services' (CMS) Request for Information (RFI) on Designing a Future Episode-Based Payment Model. We welcome the agency's openness to stakeholder input and its ongoing commitment to improving health care for all Americans.

Below, APG will first provide (I) a brief description of our organization, followed by (II) a summary of CMS's request for input, (III) a summary of APG's recommendations, and (IV) our fuller comments and recommendations. Together they reflect the voice of our membership and our commitment to working with the agency to ensure that all Americans have consistently accessible, high-quality, person-centered health care; that health care be equitable; and that the health care system more fully embrace value-based care models in which providers are accountable for both the costs and quality of care.

I. About America's Physician Groups

APG is a national association representing more than 360 physician groups that are committed to the transition to value, and that engage in the full spectrum of alternative payment models and Medicare Advantage (MA). APG members collectively employ or contract with approximately 195,000 physicians (as well as many nurse practitioners, physician assistants, and other clinicians), and care for roughly 90 million patients, including roughly 30 percent of all Medicare beneficiaries who are enrolled in MA.

Our motto, “Taking Responsibility for America’s Health,” underscores our members’ preference for being in risk-based, accountable, and responsible relationships with all payers, including MA health plans, rather than being paid by plans on a fee-for-service basis. Delegation of risk from payers to providers creates the optimal incentives for our groups to provide integrated, coordinated care; make investments in innovations in care delivery; advance health equity; and manage our populations of patients in more constructive ways than if our members were merely compensated for the units of service that they provide.

II. CMS Request for Information

In its recent RFI (CMS–5540–NC), CMS reiterated two goals: First, the Innovation Center’s vision as announced in the 2021 Strategic Refresh for a health care system that achieves equitable outcomes through high-quality, affordable, person-centered care;[1] and second, the CMS goal of having 100 percent of Medicare fee-for-service (FFS) beneficiaries and the vast majority of Medicaid beneficiaries in accountable care relationships by 2030. Given these goals, CMS acknowledges that additional opportunities for accountable care relationships with specialists are essential.

CMS sees episode-based payment models as one approach to support accountable care and to create avenues for specialists to participate in value-based care initiatives. The Innovation Center plans to use lessons learned from experience with earlier episode-based payment models, such as the Bundled Payments for Care Improvement (BPCI), Bundled Payments for Care Improvement Advanced (BPCI Advanced), and the Comprehensive Care for Joint Replacement (CJR) models. Drawing on these lessons, CMS plans to design and implement a new episode-based payment model focused on accountability for quality and cost, health equity, and specialty integration. This RFI does not seek feedback on models that address particular conditions over a longer period of time, such as the Enhancing Oncology Model and the Kidney Care Choices Model.

Specifically, CMS requests input on a broad set of questions related to care delivery and incentive structure alignment and six foundational components:

- Clinical Episodes
- Participants
- Health Equity
- Quality Measures, Interoperability, and Multi-Payer Alignment
- Payment Methodology and Structure
- Model Overlap

In addition to maintaining or improving quality of care and reducing Medicare spending (two requirements articulated in the Innovation Center statute), CMS intends to test an episode-based payment model with the following goals:

- Improving care transitions for the beneficiary; and

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[1] CMS White Paper on CMS Innovation Center's Strategy: Driving Health System Transformation—A Strategy for the CMS Innovation Center's Second Decade (https://innovation.cms.gov/strategic-direction-whitepaper).

- Increasing engagement of specialists within value-based, accountable care.

CMS acknowledges that for these goals to be realized, there must be a change in how episode-based payment models coexist with population-based Medicare Accountable Care Organizations (ACOs). CMS's view is that, in theory, ACOs and episode-based payment models should be complementary, as ACOs are well situated to prevent unnecessary care, while episode-based payment model participants focus on controlling the cost of acute, high-cost episodes. However, these value-based care approaches have not consistently been complementary and, in some cases, have complicated health care operations.

CMS anticipates this model would require participation by certain entities, such as Medicare providers or suppliers or both located in certain geographic regions, to ensure that a broad and representative group of beneficiaries and participants are included. Further, requiring participation would also help to overcome voluntary model challenges such as clinical episode selection bias and participant attrition. Therefore, any such model would be implemented via **notice-and-comment rulemaking**, with ample opportunity for public input. CMS expects this episode-based payment model to be implemented no earlier than 2026, ensuring participants have sufficient time to prepare for the model.

III. Summary of APG's Recommendations

A. Recommendations Related to Clinical Episodes

- **APG recommends that CMS limit episodes in a new episode-based payment model primarily or exclusively to single-specialty surgical episodes.**
- **APG recommends that participation be voluntary if CMS includes any medical episodes in a new episode-based payment model.**
- **APG recommends that CMS exercise caution as the agency deliberates shortening the episode window from 90 days to 30 days, and that it should propose in notice-and-comment rulemaking episode lengths tailored to the features of specific episodes.**

B. Recommendations Related to Participants

- **APG recommends that CMS tailor the types of participants eligible for a new episode-based payment model to the specific episodes that will be included in the model and obtain stakeholder feedback on this mapping through notice-and-comment rulemaking.**
- **APG recommends that CMS obtain stakeholder input through notice-and-comment rulemaking on allowing ACOs to serve as conveners for a new episode-based payment model.**
- **APG recommends that CMS reflect the outcome of the Qualifying APM Participant (QP) change proposed in the 2024 Medicare Physician Fee Schedule proposed rule and potential extension of the Advanced APM bonus payment in the design proposed for a new episode-based payment model.**

C. Recommendations Related to Health Equity

- **APG recommends that CMS consider adopting an updated version of the Area Deprivation Index (ADI) or other refinements, such as blending multiple indices, to capture data more accurately on social needs of underserved populations across all geographic regions.**

D. Recommendations Related to Quality Measures, Interoperability, and Multi-Payer Alignment

- **APG recommends that CMS obtain stakeholder feedback through notice-and-comment rulemaking on a full list of proposed quality measures for a new episode-based payment model.**
- **APG recommends that CMS minimize the total number of quality measures used in a new episode-based payment model to avoid undue clinician burden, and that the agency seek to use the same or similar high-value measures across episodes, such as the Days at Home and Unplanned Readmissions that can be measured through claims.**

E. Recommendations Related to Payment Methodology and Structure

- **APG recommends that CMS provide more timely payment reconciliation in a new episode-based payment model than existed in prior models – for example, a 6-month provisional and 8-month final payment reconciliation timeline.**
- **APG recommends that CMS include in the eventual proposed rule detailed proposals, and analysis of the anticipated impact, on the ways in which the agency will capture data on – and account for expected differences in resource use of – patients according to their full demographic and social-determinants-of-health-related characteristics.**
- **APG recommends that CMS include in the eventual proposed rule detailed proposals, and analysis of the anticipated impact, on the ways in which the agency will develop and validate episode-specific risk adjustment models that account for condition severity/stage and patient co-morbidities.**

F. Recommendations Related to Model Overlap

- **APG recommends that CMS, when implementing a new episode-based payment model or any other type of model, ensure that the choice between double counting or reducing payments not disadvantage ACOs that have accepted responsibility for the quality and total costs of care (TCoC) of the patients they serve.**
- **APG recommends that CMS consider models that allow providers groups to gain experience with risk over time and design such transitional models accordingly.**
- **APG recommends that CMS lay out a detailed roadmap explaining how the agency envisions participants in a new episode-based payment model advancing to greater levels of risk, including eventually to ACOs and other models that accept responsibility**

for the quality and TCoC for all the patients they serve.

- **APG recommends that CMS carve out beneficiaries assigned or aligned to ACOs from potential assignment to episode-based models and to apply this carveout to the clinicians participating in ACOs as well.**
- **APG recommends that CMS allow interested ACOs to voluntarily choose on a case-by-case basis to nest episode-based approaches similar to other optional beneficiary enhancements.**
- **APG recommends that CMS provide high-quality, detailed data about participants in the episode-based payment model in a timely manner to ACOs.**

IV. APG's Detailed Comments and Recommendations

APG welcomes CMS's RFI seeking stakeholder input on a new episode-based payment model. We appreciate the Innovation Center's efforts to balance competing goals of the model, such as seeking new measures of quality and health equity while avoiding increased reporting burden for providers. APG members are especially grateful that CMS plans to develop the new model through notice-and-comment rulemaking. We look forward to reviewing and providing feedback on CMS's detailed proposal for a new episode-based payment model. Below, APG offers some suggestions for finetuning CMS's plans for the new model to better achieve these goals.

A. Clinical Episodes

The CJR and BPCI Advanced models test condition-specific **medical or surgical episodes**, or both, which are initiated by either an inpatient hospitalization or a hospital outpatient procedure and include items and services provided over the following 90-day period.[2] CMS' BPCI Advanced evaluation found that reductions in episode payments were more substantial for surgical episodes compared to medical episodes.[3]

CMS maximizes the items and services included in a clinical episode to align with a total cost-of-care (TCoC) approach and ensure that providers have accountability for all related aspects of care. Participants are generally accountable for the anchor event, along with post-acute care (PAC), hospital readmissions, physician, laboratory, and durable medical equipment costs.[4] Participants have expressed concern that they have limited influence over some included items and services.

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[2] CMS defines medical episodes are those requiring medical management of an acute exacerbation of a condition whereas surgical episodes are those requiring a procedural intervention.

[3] In the BPCI Advanced: Fourth Annual Report (https://innovation.cms.gov/data-and-reports/2023/bpci-adv-ar4), the reduction in per-episode payments was larger for surgical clinical episodes than medical clinical episodes (−$796 or −3.1 percent for medical clinical episodes vs. −$1,800 or −5.8 percent for surgical clinical episodes).

[4] Items and services typically included in a clinical episode include inpatient/outpatient hospital services, post-acute care services, laboratory services, durable medical equipment, Medicare Part B drugs, physician services, and mental health services. Items and services typically excluded from a clinical episode include certain readmissions (for example, transplant or cancer), blood clotting factors, new technology addon payments, and transitional pass-through payments.

The **90-day episode** length has demonstrated success in reducing post-acute care spending, but the extended duration of overlap between episode-based payment models and ACO initiatives may contribute to inefficiencies. CMS posits that reducing episode duration to 30 days could both sustain the spending reductions and mitigate some of the current challenges. Specifically, a **30-day episode** would position the specialist as the principal provider near the anchor event with a handoff back to the primary care provider for longitudinal care management.

CMS anticipates that the next episode-based payment model would test a set of clinical episodes that is broader than CJR, but narrower than BPCI Advanced, with shorter episode lengths.

APG agrees with evaluation findings that surgical episodes are more likely to result in decreased spending. There are more opportunities for coordination between surgical and post-surgical care providers, including physical therapy and post-acute care rehabilitation in many cases. Among surgical episodes, orthopedic and cardiovascular are especially promising in terms of opportunities to achieve greater efficiencies.

With respect to medical episodes, APG recommends that CMS consider the availability of alternate, high-value pathways of treatment that offer opportunities for better quality and efficiency when determining which episodes to include in a new model. An example of this includes orthopedic conditions that can benefit from earlier medical intervention, including employing physical therapy before surgical procedures or other more invasive treatments.

APG members' experience with various types of medical episodes suggests that many chronic conditions and acute exacerbations of chronic conditions are not well-suited to incorporation in episode-based payment approaches. The clinical heterogeneity of the populations affected by these conditions calls for unique, person-centered care plans, and attempts to pursue efficiencies, while inherently laudable, may inadvertently jeopardize quality outcomes for patients. Particular conditions that CMS should not include in a new episode-based model include opioid use disorder, other substance use disorders, and complex conditions like sepsis.

APG members note that many medical conditions and even some surgical episodes that may be under consideration for inclusion in a new episode-based payment model, such a cardiovascular medical conditions and treatment of sepsis, are best managed in an ACO responsible for TCoC and quality for a whole patient. ACOs are best positioned to care for patients' comorbidities according to longitudinal, person-centered care plans.

If CMS opts to make participation in the new episode-based model mandatory, we urge the agency to opt for a limited set of primarily or exclusively surgical episodes. Medical episodes would be particularly challenging if they required participation of multiple providers.

- **APG recommends that CMS limit episodes in a new episode-based payment model primarily or exclusively to single-specialty surgical episodes.**
- **APG recommends that participation be voluntary if CMS includes any medical episodes in a new episode-based payment model.**

Finally, APG urges caution as CMS deliberates shortening the episode window from 90 days to 30 days. We appreciate CMS's goal of transitioning care from specialists back to primary care providers

in a timely manner. However, the appropriate episode length will be highly dependent on the specific procedures and conditions selected for the model, clinical and demographic characteristics of individual patients, prevailing local practice patterns, and other features. We look forward to reviewing and providing feedback on the proposed episode length for each episode that CMS includes in notice-and-comment rulemaking.

- **APG recommends that CMS exercise caution as the agency deliberates shortening the episode window from 90 days to 30 days, and that it should propose in notice-and-comment rulemaking episode lengths tailored to the features of specific episodes.**

B. Participants

Participant eligibility differed between BPCI Advanced and CJR, and other entities have also expressed interest in being participants in future episode-based payment models.

The BPCI Advanced model has convener and non-convener participants. A convener bears and apportions financial risk and facilitates coordination among one or more "downstream episode initiators." In contrast, a non-convener participant bears financial risk only for itself and does not have any downstream episode initiators. Non-convener participants and downstream episode initiators must be either an acute care hospital or physician group practices.

Convener participants have generally been the dominant participant type in BPCI Advanced. Conveners provide support such as analytics, care navigators, and administrative assistance to their downstream episode initiators, who otherwise may not have joined the model. However, this arrangement has been challenging for some hospitals and physician group practices participating as downstream episode initiators as they were removed from decision-making, including when to exit the model. Furthermore, convener participants are required to have financial guarantees that can impose significant upfront financial investment for participation.

The participant structure of the CJR model is more straightforward than BPCI Advanced. **Acute care hospitals** in select metropolitan statistical areas are the only participants to trigger an episode and be held accountable for cost and quality performance. When CJR was implemented in 2016, we believed that the best policy approach was to assign financial accountability to large entities, such as hospitals, that care for a higher volume of Medicare beneficiaries. However, we recognized the importance of smaller entities, such as **physician group practices**, and allowed gainsharing arrangements and other flexibilities to support collaboration with participating CJR hospitals.

Aside from hospitals and physician group practices, other providers have signaled interest in managing or initiating clinical episodes. Expanding provider or participant eligibility may increase model scope, but also adds operational complexity and reduces the likelihood of a seamless care experience for the beneficiary. For this reason, CMS attributes episodes to a single entity, regardless of the number of providers involved. Precedence rules generally dictate to which entity an episode of care is attributed, but these rules are often difficult for participants to follow. Data feeds inform entities of episode attribution when multiple providers have interacted with the beneficiary, but participants still express challenges with identifying their potential episodes due to a lack of real-time data.

As described below in the Model Overlap section, APG recommends that CMS consider mandatory

episode-based payment models only for limited application. One option is for CMS to identify the medical conditions and procedures that have the highest correlation with hospital readmissions and then identify the medical specialties that provide services for these medical conditions and procedures. These specialists could then be mandated to participate in episode-based payment models. Alternatively, these specialists could be given the choice of either participating in mandatory episode-based payment models or joining ACOs or other models as participating providers in which they are responsible for quality and TCoC.

APG members note that the types of organizations that should participate in a new episode-based payment model depends on the episodes under consideration. We urge CMS to avoid designing an episode-based payment model so that all model characteristics would apply for all possible participants. Many characteristics of episode-based payment models should differ for hospital-based specialists, interventional specialists, chronic care specialists, and others. APG anticipates that, to the extent that CMS proposes to include different types of episodes in a new episode-based payment model, there ideally should be flexibility to include a variety of participants, including conveners. If CMS opts to include conveners in the new model, the agency should get stakeholder input through notice-and-comment rulemaking on allowing ACOs to serve as conveners.

APG notes that there are two key policies currently under consideration that will have a significant impact on specialist physicians' desire to participate in a new episode-based payment model. First, in the 2024 Medicare Physician Fee Schedule proposed rule, CMS is proposing to switch Qualifying APM Participant (QP) designation to the individual clinical level. Second, Congress is deliberating extending the Advanced APM bonus payment. APG encourages CMS to reflect the outcome of these two policy decisions in the design proposed for a new episode-based payment model.

- **APG recommends that CMS tailor the types of participants eligible for a new episode-based payment model to the specific episodes that will be included in the model and obtain stakeholder feedback through notice-and-comment rulemaking on this mapping of types of participants to episodes.**
- **APG recommends that CMS obtain stakeholder input through notice-and-comment rulemaking on allowing ACOs to serve as conveners for a new episode-based payment model.**
- **APG recommends that CMS reflect the outcome of the Qualifying APM Participant (QP) change proposed in the 2024 Medicare Physician Fee Schedule proposed rule and potential extension of the Advanced APM bonus payment in the design proposed for a new episode-based payment model.**

C. Health Equity

Advancing health equity is a pillar of the Biden Administration and is included in the CMS 2022 Strategic Plan and the Innovation Center's 2021 Strategy Refresh.[5] BPCI Advanced and CJR were designed prior to this more intentional focus on equity, but both models allow safety-net hospital participation and incorporate risk adjustment for dually eligible beneficiaries. CMS recognizes that there

[5] Executive Order (E.O.) 13985 (https://www.whitehouse.gov/briefing-room/presidential-actions/2021/01/20/executive-order-advancing-racial-equity-and-support-for-underserved-communities-through-the-federal-government/), CMS Innovation Center Strategic Direction (https://innovation.cms.gov/strategic-direction), and CMS Strategic Plan (https://www.cms.gov/CMS-strategic-plan).

is room for improvement and intends to advance health equity through the design, implementation, and evaluation of this next episode-based payment model.

The Innovation Center is committed to prioritizing the unique needs of providers who care for a large proportion of underserved populations. This includes flexibilities that providers may need to be successful in future models. Furthermore, to help address the increased social needs of underserved populations, future episode-based payment models will need to consider the use of area-level indicators, such as the social deprivation index (SDI), the social vulnerability index (SVI), and the area deprivation index (ADI).[6] These indicators would not only help address the increased social needs of beneficiaries but would also help determine if additional risk adjustment variables would increase future models' reach to underserved groups.

APG applauds CMS for the agency's commitment to advancing health equity for all beneficiaries. We recognize that requiring mandatory participation in a new episode-based payment model could alleviate concerns about participants cherry picking patients that have affected previous voluntary models. As described in the Model Overlap section below, APG recommends that CMS carve out ACO beneficiaries and clinicians from potential assignment to episode-based models and allow ACOs to voluntarily choose on a case-by-case basis to nest episode-based approaches similar to other optional beneficiary enhancements. As ACOs are at risk for the quality of care of all of their patients and are subject to health equity adjustments to quality measures, they already take responsibility for improving health equity. In addition, REACH ACOs must submit specific Health Equity Plans for CMS approval.

APG supports the use of area level indicators to identify and help address the increased social needs of underserved populations. We are grateful the CMS continues to evaluate various area level indicators to determine the best available options. As we have noted in a prior comment letter and discussions with CMS staff, we are concerned that the while the ADI has several advantages, the current version does not accurately depict levels of deprivation in areas within their states and regions, in large part because it overstates the contribution of home values[7]. As an example, the Tenderloin district of San Francisco has a high overall ADI, despite the growing presence of luxury housing in the area, so that use of the ADI to "label" the neighborhood as socioeconomically disadvantaged will paradoxically capture high-income populations in the calculation.[8]

APG understands that the custodian of the ADI, the Center for Health Disparities Research at the University of Wisconsin School of Medicine and Public Health, is exploring options to refine and update the ADI to address local housing-cost concerns. We encourage CMS to consider adopting an updated version of the ADI or other refinements, such as blending multiple indices, to capture data more accurately on social needs of underserved populations across all geographic regions. We look forward to reviewing the details about CMS's proposal for use of area level indicators to identify and help address the increased social needs of underserved populations in a new episode-based payment model.

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[6] Refer to Table 2.1 in the Landscape of Area-Level Deprivation Measures and Other Approaches to Account for Social Risk and Social Determinants of Health in Health Care Payments document (https://aspe.hhs.gov/sites/default/files/documents/ce8cdc5da7d1b92314eab263a06efd03/Area-Level-SDOH-Indices-Report.pdf) for descriptions of ADI, SDI, and SVI.

[7] Hannan E et al, The Neighborhood Atlas Area Deprivation Index For Measuring Socioeconomic Status: An Overemphasis On Home Value. Health Affairs, vol. 42, no. 5, https://doi.org/10.1377/hlthaff.2022.0140.

[8] APG Response to CMS on Make Your Voice Heard: Promoting Efficiency and Equity Within CMS Programs. November 4, 2022. https://www.apg.org/news/apg-response-to-cms-on-make-your-voice-heard-promoting-efficiency-and-equity-within-cms-programs/

- **APG recommends that CMS consider adopting an updated version of the Area Deprivation Index (ADI) or other refinements, such as blending multiple indices, to capture data more accurately on social needs of underserved populations across all geographic regions.**

D. Quality Measures, Interoperability, and Multi-Payer Alignment

Current and prior models have used a combination of claims data, participant-reported or registry-based quality measures, and patient-reported outcome (PRO) measures, to incentivize improvement and assess model and participant performance. To reduce provider burden, the Innovation Center is focused on including multi-payer alignment approaches where feasible.

The CJR model and surgical episodes managed by physician group practices in the BPCI Advanced model significantly decreased readmissions, although neither model showed improvement in patient experience or reductions in emergency department use.

CMS has adopted a National Quality Strategy, including an effort to move toward digital quality measurement, and recently announced plans to employ a "Universal Foundation" of quality measures to create greater consistency in primary care quality reporting.[9] As an extension of that aim, and with a particular focus on specialty care, the Innovation Center is considering how to increase the use of model-specific measures and adopt a more person-centered quality strategy, including greater use of PRO measures.

APG observes that the Innovation Center requests stakeholder input on increasing the use of model-specific quality measures and reducing provider reporting burden – two goals that conflict with one another. APG encourages CMS to seek to use the same or similar high-value measures across episodes, such as the Days at Home and Unplanned Readmissions, and minimize the number of measures used overall. The appropriateness of specific quality measures will depend on the specific measures that CMS plans to include in a new episode-based payment model. We look forward to reviewing and providing feedback on the quality measures that CMS proposes to match with each episode that will be included in the new model.

- **APG recommends that CMS obtain stakeholder feedback through notice-and-comment rulemaking on a full list of proposed quality measures for a new episode-based payment model.**
- **APG recommends that CMS minimize the total number of quality measures used in a new episode-based payment model to avoid undue clinician burden, and that the agency seek to use the same or similar high-value measures across episodes, such as the Days at Home and Unplanned Readmissions that can be measured through claims.**

E. Payment Methodology and Structure

Although there are notable differences between the CJR and BPCI Advanced payment methodologies, the models are built on a similar underlying payment structure wherein participants receive preliminary target prices prior to the performance period; are paid through the traditional

[9] CMS Digital Quality Measurement Strategic Roadmap, March 2022, and Jacobs, D.B., Schreiber, M., Seshamani, M., Tsai, D., Fowler, E., & Fleisher, L.A. (2023). Aligning Quality Measures across CMS—The Universal Foundation. New England Journal of Medicine, 388 (9), 776–779. DOI: 10.1056/NEJMp2215539.

Medicare **fee-for-service (FFS) payment** systems during a performance period; and are subject to a **retrospective payment reconciliation** calculation after the performance period. This reconciliation calculation compares the participant's FFS spending to an adjusted target price, with the participant either earning a reconciliation payment or owing a repayment to Medicare. The retrospective reconciliation process avoids the need for changes to Medicare FFS claims-processing systems and for participants to pay downstream providers who deliver services during the episode, as is done with prospective model payments. However, both models have been subject to challenges with regard to various aspects of the payment methodology, including reconciliation timing, target price methodology, and risk adjustment.

The CJR and BPCI Advanced models initially used a **prospective trend methodology** to project future episode spending to construct target prices. However, early reconciliation results from both models, combined with nationwide spending data, suggested that the prospective trend had not accurately captured national changes in spending patterns during the model performance period, resulting in reconciliation payments that were higher than needed to incentivize care coordination. To reflect performance period episode costs more accurately and to help minimize the risk that the models increased spending, CMS incorporated a retrospective trend into the target price methodology for both models, allowing for a target price adjustment at reconciliation. However, a number of BPCI Advanced participants found the retrospective trend untenable, given the unpredictability and resulting challenge of gauging their performance in the model. The retrospective trend for most episodes was lower than the prospective trend had been in previous years, resulting in a downward adjustment to target prices at reconciliation and leading many participants to withdraw from the model.

Risk adjustment in Innovation Center episode-based models is largely based on CMS claims and enrollment data. However, beneficiary characteristics from other sources, such as electronic health records or non-medical determinants of health, are not accounted for by the use of claims and enrollment data. CMS is considering ways to incorporate non-claims-based variables, if collected uniformly and documented consistently, to improve risk adjustment and address health equity. Interested parties have also recommended the inclusion of trigger event diagnosis codes to better capture beneficiary acuity. However, CMS is concerned that risk adjusting based on variables that occur contemporaneous to the episode could incentivize increased coding intensity.

In light of the CJR and BPCI Advanced payment methodology challenges, CMS is considering changes to the new model’s payment approach, such as incorporating elements of **value-based purchasing**. Under a value-based purchasing framework, participants are assessed on certain measures and their future Medicare FFS payments are adjusted up or down based on their performance. For instance, the Hospital Value Based Purchasing (VBP) program withholds 2% of the base operating MS–DRG payments of participating hospitals, and then redistributes those funds to hospitals in a future year via a payment adjustment based on their Total Performance Score across four domains (Clinical Outcomes, Person and Community Engagement, Safety, and Efficiency and Cost Reduction). Similarly, in the traditional Merit-based Incentive Payment System (MIPS), clinicians submit data on four domains (Quality, Promoting Interoperability, Improvement Activities, and Cost), and the MIPS final score determines a payment adjustment to future Medicare Part B claims. To avoid duplicating the existing value-based purchasing initiatives, CMS is considering blending the traditional payment approach by setting a target price but paying the reconciliation payment (or recouping the repayment amount) in future years as a multiplier or add-on to future claims, rather than as a lump sum at the time of the reconciliation calculation. CMS anticipates that incorporating value-based purchasing design components could help to resolve concerns with pricing predictability and remove the operational

burdens of the reconciliation process.

APG members experienced with current and past episode-based payment models note that reconciliation timelines have proven challenging. Initial reconciliation timelines of six, nine, or 12 months reflect a problematic delay in feedback on performance. Final reconciliation timelines of 18 to 20 months present a significant problem. These timelines often cross performance and contract years and force participants to make choices blindly about ongoing participation and contracts with downstream providers. We encourage CMS to strive for a 6-month provisional and 8-month final payment reconciliation timeline.

- **APG recommends that CMS provide more timely payment reconciliation in a new episode-based payment model than existed in prior models – for example, a 6-month provisional and 8-month final payment reconciliation timeline.**

APG recognizes that v28 of the CMS Hierarchical Classification of Costs (CMS-HCC) risk adjustment model will probably play a role in risk adjustment for a new episode-based payment model. Aligning risk adjustment approaches across models and CMS programs makes sense as a goal. However, CMS-HCC is designed to account for risk in total spending per person across a population. Both medical and surgical episodes are narrower in terms of time frame and included services, so CMS-HCC is not designed for application at the episode level, and this limitation must be recognized.

Given the lack of detailed, episode-specific risk adjustment models, CMS may be tempted to employ the demographic factors included in CMS-HCC model to risk-adjust episodes. However, given that these factors are inadequate for capturing essential social determinants of health (SDOH) and other patient characteristics, AGP urges CMS to include in the eventual proposed rule detailed proposals and analysis of the anticipated impact of the ways in which CMS will capture data on, and account for, expected differences in resource use.

Furthermore, expected resource use within medical and surgical episodes is largely driven by the severity of patients' conditions and co-morbidities. Yet too often the administrative and claims data that are available to all participants and CMS lack the detail necessary to populate an appropriate episode-specific risk adjustment model. Collecting more detailed data from electronic medical records could be promising, but doing so will require plans to standardize and collect these data and design and validate risk adjustment models for each episode to which they will be applied. The timelines for the development, validation, and final approval of such models for each episode presumably would differ, but many potential episodes would not have final risk adjustment models in time for a January 1, 2026 start.

- **APG recommends that CMS include in the eventual proposed rule detailed proposals, and analysis of the anticipated impact, on the ways in which the agency will capture data on – and account for expected differences in resource use of –patients according to their full demographic and social-determinants-of-health-care-related characteristics.**
- **APG recommends that CMS include in the eventual proposed rule detailed proposals, and analysis of the anticipated impact, on the ways in which the agency will develop and validate episode-specific risk adjustment models that account for condition severity/stage and patient co-morbidities.**

F. Model Overlap

While CMS continues to learn from tested policies, none have consistently encouraged overlap or promoted meaningful collaboration among primary care and specialty care providers. Overlap policies were intended to avoid **duplicative incentive payments** or give precedence to a single accountable entity. In some cases, these policies resulted in confusing methodologies or misaligned incentives that were difficult for providers to navigate. Providers have also cited confusion with identifying to which model(s) a beneficiary may be aligned or attributed.

In earlier episode-based payment models, such as CJR (when applicable) and BPCI, CMS addressed overlap by implementing a complex calculation and recouping a portion of the **pricing discount** for providers participating in certain ACO initiatives. The **recoupment** was intended to prevent duplicate incentive payments for the same beneficiary's care. Yet some participants perceived the recoupment as a financial penalty, discouraging providers from participating in both initiatives. To avoid complexity, the CJR and BPCI Advanced models exclude overlap for beneficiaries aligned or assigned to certain ACOs, and these beneficiaries will not initiate a clinical episode.

Although this exclusionary approach creates a clean demarcation of who is accountable for a beneficiary's care, it also limits the number of providers in accountable care relationships and becomes less tenable as CMS works towards the goal of increased accountability. Additionally, participants may be informed of beneficiary ACO alignment or assignment after the potential episode has been initiated and after the participant has expended resources for items or services not covered by Medicare on unattributed beneficiaries. This concern highlights the opportunity to incentivize coordinated care, expand care redesign efforts to more patients, and strengthen APM participation. Lastly, even passive avoidance of duplicate payments has its drawbacks, such as lack of incentive to coordinate care. For example, the CJR and BPCI Advanced models allow overlap with the Medicare Shared Savings Program (MSSP) without a financial recoupment. However, this does not encourage behavior change to ensure a smooth transition back to population-based providers.

Both episode-based payment models and ACOs have demonstrated successes in reducing **post-acute care** spending through reductions in skilled nursing facility length of stay or reduced institutional post-acute care use.[10,11] However, when the same beneficiary is included in both an ACO initiative and episode-based payment model, it may create confusion and inefficiencies. Providers in both models invest in care management and rely on the savings generated to support these functions. If those spending reductions are credited to only one of these entities, this may create a barrier for collaboration. Furthermore, if an episode of care is priced too high, this can negatively impact the ACO's financial performance and add to inefficiencies between episode-based payment models and ACOs.

Regardless of the issues identified, the evidence suggests that when the same beneficiaries are in episode-based payment models and ACOs, lower post-acute care spending and reduced readmissions result.[12] In light of such findings, CMS believes that overlap with episode-based payment models and

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[10] Comprehensive Care for Joint Replacement Model: Fourth Evaluation Report; BPCI Advanced: Fourth Annual Report (https://innovation.cms.gov/data-and-reports/2021/cjr-py4-annual-report).
[11] McWilliams, J.M., Gilstrap, L.G., Stevenson, D.G., Chernew, M.E., Huskamp, H.A., & Grabowski, D.C. (2017). Changes in Postacute Care in the Medicare Shared Savings Program.
JAMA internal medicine, 177(4), 518–526. doi:10.1001/jamainternmed.2016.9115.
[12] Navathe, A.S., Liao, J.M., Wang, E., Isidro, U., Zhu, J., Cousins, D.S., & Werner, R.M. (2021). Association of Patient Outcomes With Bundled Payments Among Hospitalized Patients Attributed to Accountable Care Organizations. JAMA health forum, 2(8), e212131. https://doi.org/10.1001/jamahealthforum.2021.2131.

ACOs should be supported through complementary policies. CMS wants to avoid precedence or exclusionary rules for entities who may be **required to participate** in the next episode-based payment model. This approach means that all of the participating entity's beneficiaries for a given clinical episode or service line group may be eligible to initiate an episode regardless of beneficiary ACO assignment/alignment. The result may help the participant create standard care pathways for all beneficiaries and make it easier for ACOs to know which beneficiaries may be initiating a clinical episode.

CMS also wants to encourage overlap between this next episode model and ACO initiatives to support coordination and ensure providers are not carved out of a beneficiary's continuum of care. This approach means that CMS must account for duplicate payments when there are shared beneficiaries. CMS is considering simple ways in which a target price can be factored into an ACO's benchmark or can be adjusted to account for shared beneficiaries so that providers in both models have financial incentives to drive efficiency and coordinate care.

As an APG member said, "driving true alignment is going to be the key" to appropriately incorporating a new episode-based payment model into the Innovation Center's portfolio of models and other Medicare and Medicaid programs, such as MSSP. APG appreciates CMS's desire to avoid pricing discounts or other means of reducing payments to ACOs. APG also understands the drive to avoid duplicative payments, given the Innovation Center's statutorily defined mission of seeking models that do not increase program spending. However, a choice between double counting or reducing payments to participants in at least one type of model is inherent in the approach of operating models with overlap. No degree of sophistication or complexity in model payment or other characteristics can escape this fact.

APG recognizes that the Innovation Center, since its inception more than a decade ago, has tested a portfolio of models across multiple domains, including ACOs, episode-based payment, primary care transformation, financial alignment of Medicare and Medicaid, new payment and service delivery models, and speeding the adoption of best practices.[13] Although all of these types of models have had an essential role to play in the transition from volume to value, and in achieving CMS's goal of having all Medicare and most Medicaid beneficiaries in accountable relationships by 2030, we note that not all of models will achieve optimal results.

For example, episode-based payment and primary care transformation models may be best viewed as necessary evolutionary steps along the path to the ultimate desired outcome of fully accountable care. Skipping these interim steps was not possible; indeed, participants needed these types of models to gain experience with value-based approaches to develop the skills necessary to begin to move away from traditional FFS. Yet the value of these types of models as a transitional step should not argue for their permanence or detract from the ultimate goal of fully accountable care.

As such, APG strongly urges that CMS – when implementing a new episode-based payment model or any other type of model – ensure that the choice between double counting or reducing payments not disadvantage ACOs that have accepted responsibility for the quality and TCoC of the patients that they serve. Any other choice is counter-productive to CMS's 2030 goal.

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[13] Jennifer Podulka and Yamini Narayan. Center for Medicare and Medicaid Innovation: Findings from Medicare Models To-Date. June 2021. https://www.healthmanagement.com/wp-content/uploads/HMA-AV-Issue-Brief-1-CMMI-findings.pdf

- **APG recommends that CMS, when implementing a new episode-based payment model or any other type of model, ensure that the choice between double counting or reducing payments not disadvantage ACOs that have accepted responsibility for the quality and TCoC of the patients that they serve.**

Furthermore, APG recognizes the need to maintain accessible "on ramps" for providers that have not yet begun the transition to accountable care.[14] However, we urge CMS to consider these transitional types of models that allow providers groups to gain experience with risk as a temporary interim step and design them accordingly. Following multiple years of episode-based payment models, there should be provider groups that are experienced enough to graduate to more sophisticated accountable care models. In fact, APG asks that in the proposed rule for a new episode-based payment model, CMS lay out a detailed roadmap explaining how the agency envisions that participants will advance on a pathway to greater levels of risk, including eventually to ACOs and other models and programs that accept responsibility for the quality and TCOC for all patients that they serve.

- **APG recommends that CMS consider models that allow providers groups to gain experience with risk over time and design such transitional models accordingly.**
- **APG recommends that CMS lay out a detailed roadmap explaining how the agency envisions participants in a new episode-based payment model advancing to greater levels of risk, including eventually to ACOs and other models and programs that accept responsibility for the quality and TCoC for all patients that they serve.**

Perhaps the most straightforward way to avoid inappropriate overlap between episode-based payment models and ACOs is to carve out beneficiaries assigned or aligned to ACOs from potential assignment to episode-based models and to apply this carve out the clinicians participating in ACOs as well. This carveout would be especially important in the case of a mandatory episode-based payment model. In this case, episode-based approaches could be offered on a voluntary basis for ACOs to nest within their models, much like the beneficiary enhancements and beneficiary engagement incentives that ACOs can opt for, such as care management home visits to prevent hospitalization and waiver of the Medicare homebound requirement for access to home health services. ACOs interested in incorporating episode-based options could then pursue downstream arrangements with participants for the conditions, procedures, and markets that make sense for their assigned or aligned patients.

The success of such an approach would hinge on the quality and timeliness of data about participants in the episode-based payment model that CMS makes available to ACOs so that these organizations can make informed decisions.

- **APG recommends that CMS carve out beneficiaries assigned or aligned to ACOs from potential assignment to episode-based models and to apply this carve out to the clinicians participating in ACOs as well.**
- **APG recommends that CMS allow interested ACOs to voluntarily choose on a case-by-case basis to nest episode-based approaches similar to other optional beneficiary enhancements.**

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[14] America's Physician Groups: CMS's "Making Care Primary" Model "Vital to Stimulating Spread of Value-Based Care" June 8, 2023 https://www.apg.org/news/americas-physician-groups-cmss-making-care-primary-model-vital-to-stimulating-spread-of-value-based-care/

- **APG recommends that CMS provide high-quality, detailed data about participants in the episode-based payment model in a timely manner to ACOs.**

V. Conclusion

APG appreciates and welcomes CMS's ongoing efforts to provide various models and programs to enable participants of different levels of experience to join the movement from volume to value in health care. We laud CMS's goal of achieving accountable care relationships for all Medicare beneficiaries and most Medicaid beneficiaries by 2030. APG looks forward to working with CMS as the agency develops detailed plans for a new episode-based payment model through notice-and-comment rulemaking.

Sincerely,

Susan Dentzer
President and CEO
America's Physician Groups
sdentzer@apg.org