

Submitted via regulations.gov

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August 17, 2023

Re: Request for Information: Episode-Based Payment Model [CMS-5540-NC]

Dear Administrator Brooks-LaSure,

We appreciate this opportunity to provide comments and recommendations on the request for information (RFI) on the episode-based payment model, hence forth known as the Request. We thank the Centers for Medicare and Medicaid Services (CMS or the Agency) and the Center for Medicare and Medicaid Innovation (CMMI) for their continued focus on specialists in support of achieving its 2030 goal of having all Medicare beneficiaries and the vast majority of Medicaid beneficiaries to have access to comprehensive, coordinated, equitable care models. We further examine in our comments CMS' overall strategy for achieving its goals for improving the health outcomes, equity, and affordability of care for all of its beneficiaries. Our comments reflect our research and broader evidence on specialty-based payment models, and our comments were prepared with the support of staff from the Robert J. Margolis, MD Center for Health Policy at Duke University ("Duke-Margolis" or "the Center") and Dell Medical School at the University of Texas at Austin (UT Dell). Further, this letter draws on discussions with the individuals and groups listed in the Appendix, but the specific comments reflect the perspectives of the authors.

Executive Summary

The important questions CMMI asks in this Request demonstrate CMS' continued commitment to short-term episode payments as part of its overall payment reform strategy to enable all Medicare beneficiaries to have access to well-coordinated, high-quality, longitudinal care by 2030. CMS has noted that its accountable care programs – including the Shared Savings Program (SSP) and the ACO REACH program, which hold primary care providers and health systems accountable for total costs and population outcomes of care – will continue to be the foundation of this payment reform strategy. Consequently, ***as CMMI appropriately identifies, future episodic models must be complementary to, or nested within, these core "whole-person" payment reform approaches.***

Evidence suggests that short-term episode payment models are well-suited for relatively standard and common acute medical events and procedures, especially when nested within such whole-person care models. ***However, while CMS can build momentum towards its 2030 accountable care goals and specialty strategy through a mandatory short-term specialty episode program, making more comprehensive progress requires timely complementary action to improve supports for specialists engaged in managing longitudinal and chronic care as well as acute episodes and procedures.***

Specifically, CMS and CMMI must take steps to support longitudinal specialty care management of serious chronic and complex conditions in partnership with primary care physicians, which would be in addition to short-term specialty episode models and whole-person specialty care models for specific population like chronic kidney disease.

CMS can most meaningfully demonstrate progress on specialty care by 2026, in line with the proposed launch of the BPCI-A successor, by simultaneously strengthening and aligning the model infrastructure needed to support short-term specialty episodes and other specialty payment reforms. Aligning these efforts will provide a much clearer path for specialists and primary care providers to work towards achieving the goal of high-quality, well-coordinated whole-person care – including high-quality and well-integrated specialty care.

Our main evidence-based conclusions and recommendations are:

- The proposed short-term episode program for standard and common acute medical events and procedures (encompassing the initial DRG payment + 30-day episode) can address exacerbations during hospitalizations, which are major drivers of complications and costs. Mandatory models can further encourage meaningful and widespread care transformation changes, especially compared to a voluntary model where there is pressure to select those conditions, exacerbations, or procedures where an organization will already succeed under.
- However, short-term episodes by themselves are an incomplete strategy: reforms must support longitudinal specialty care reforms to prevent avoidable hospitalizations and procedures, achieve greater outcome improvements, and lead to cost savings. Payment reforms need to account for the diversity of specialty practice as well as be complementary or nested within broader whole-person payment models.
- There are specific steps that CMS can take now to strengthen the data and infrastructure to support the proposed short-term episode payment models and lay a foundation for more substantial specialty payment modes, such as through expanded use and development of better specialty performance measures, better data sharing and feedback (such as through challenge.gov initiatives and common data elements), early incentives for primary care-specialty collaboration nested within whole-person payment reforms (such as through care coordination payments and partial to full per member payments), and implementation of Patient Reported Outcome Measures.
- Physician-group-led and hospital-led Accountable Care Organizations (ACOs) face different incentives and challenges in implementing longitudinal specialty payment models, which may require differential strategies for implementing specialty-focused payment models. CMS should seek comments on how specialty models may be implemented in a mandatory or voluntary manner for these different types of ACOs.

These efforts can not only strengthen episode-specific interventions, but specialty care as a whole, ensuring it can support accountable care interventions throughout the patient journey. To progress

towards CMS' 2030 accountable care goals, it is imperative that immediate steps are taken to streamline a transition to a mandatory short-term program and further build out a strategy to promote the advancement of longitudinal specialty care models.

Introduction

We thank CMS for the agency's increasing strategic focus on coordinating its payment reform and other policies around its 2030 goal of having all Medicare beneficiaries and the vast majority of Medicaid beneficiaries to have access to coordinated, high-quality, equitable care. Providing a more complete pathway for integrating specialty care into this strategy should be an urgent priority for the agency. Specialists comprise most of the physician workforce and oversee the vast majority of health care spending, leveraging increasing technological capabilities and evidence-based insights across the patient journey, particularly for those at risk for complications from serious and complex health problems.

To date, Medicare payment reforms for specialists have largely focused on episode-based payments for major acute medical events and major procedures (particularly elective procedures), an important and costly part of specialty care. We support CMS in their continued focus on such episodes, especially in attempting to address some of the insights and evidence gained from the voluntary Bundled Payments for Care Improvement (BPCI) and Bundled Payments for Care Improvement Advanced (BPCI-A) initiatives. However, a strategy to support effective management of serious disease complications and of advanced diagnostic tests and procedures, while critical, represents only one component of how specialty care can support better care journeys, outcomes, and affordability for patients. In our research, we have identified three major types of specialty care, only one of which is primarily focused on short-term episodes:

- **Episodic specialty** care, managed by specialized teams who care for patients to achieve key outcome goals over a limited time period, including many surgical and procedure-oriented specialties and hospitalist care, which requires excellent, efficient patient-centered technical care and smooth handoffs before and after;
- **Whole-person specialty care** provided by specialty teams who lead and fully coordinate all care for specific populations, such as nephrologists for Chronic Kidney Disease and End Stage Renal Disease and oncologists for the initial treatment of certain serious cancers; and
- **Longitudinal and chronic specialty care**, where specialty providers focus significant time and effort on collaborating with primary care providers and others to avoid costly complications and progression to acute episodes, in such common areas of care for Medicare beneficiaries as orthopedic, cardiovascular, and gastrointestinal care.

CMS can build some momentum towards achieving its 2030 accountable care goals by developing and implementing a transition to a mandatory short-term episode program for major acute medical events and procedures, but a comprehensive specialty care strategy also requires timely action to improve supports for specialists engaged in managing longitudinal and chronic care. Many leading specialty care providers are building care teams, improving data infrastructure to support earlier and more efficient diagnosis of serious conditions, and helping more patients avoid the episodic procedures that make up BPCI-A and similar acute episode programs altogether. The lack of available payment reforms to support this kind of engagement increases the burden and coordination challenges facing ACOs and such specialty groups in transforming care. It can also indirectly encourage hospital-based ACOs to focus on increasing the volume of high-margin elective procedures and other specialty services, rather than

investing in primary-specialty care coordination to avoid them. Supporting longitudinal specialty-focused payment models *complements* CMS' existing strategy around ACOs strategy and short-term episode reforms.

In this comment letter, we describe a more comprehensive strategy for specialty care that complements the current CMMI strategy for advancing primary care and whole-person, coordinated care. We then provide additional details on short-term steps that support short-term episode-focused models, such as a BPCI-A "successor," in ways that also advance longitudinal and other specialty care transformations. While CMMI has noted a [long-term interest](#) in expanding its specialty care strategy to support specialty care transformation beyond acute episodes, achieving Medicare's 2030 goals requires initial steps *starting now*.

A Missing Piece in Achieving CMS Strategic Goals for Whole-Person Care is Longitudinal Specialty-Focused Payment Reforms

As noted above, more meaningful specialist engagement requires tandem efforts to support specialists who primarily deliver specialized short-term episodic care as well as those who can provide longitudinal and chronic care. Several leading specialty care providers are implementing advanced care reforms, such as those at [UT Dell](#) and [Project Sonar](#), such as building care teams, coordinating with primary care (either to assure smooth handoffs or for longitudinal care), and expanding data infrastructure to support care improvements. In fact, action in just three areas could address a large share of the health needs of Medicare beneficiaries and of Medicare spending, and provide tremendous opportunities for cost and quality improvements by engaging specialists earlier in the care journey. Example actions in these three areas include:

- ***Musculoskeletal Care***: Collaborating with primary care providers to assess osteoarthritis and other musculoskeletal conditions, supporting functional outcome tracking and shared decision-making, providing services to meet people's social needs, expanding access through remote monitoring, and facilitating appropriate treatment including effective physical therapy, behavioral health, nutrition support, and effective major procedures all supported by evidence-based practices;
- ***Cardiovascular Care***: Supporting assessment and longitudinal risk factor management of more complex cardiovascular patients (including those requiring more intensive medical management to prevent or reverse cardiovascular disease progression), providing surveillance and modification of risk factors in complex patients to prevent or slow disease progression and complications, avoiding complications (such as heart failure exacerbations and strokes), and improving functional status, quality of life, and time spent at home for patients with advanced cardiovascular conditions; and
- ***Gastrointestinal Care***: Preventing exacerbations and avoiding associated complication costs for Inflammatory Bowel Disease through more integrated tracking and management in collaboration with primary care providers.

However, specialists lack longitudinal payment models that can support them in carrying out these care reforms.

To advance these types of specialty care reforms, Duke-Margolis released [a paper](#) in November 2022, including authors from UT Dell, describing how complementary specialty care reforms could augment

short-term episode payments and reforms for accountability for whole-person care, and recommending the creation of Specialty Condition Models. These condition and episode models would be nested within an ACO or similar whole-person care model to support engaging specialty care in accountable care strategies (Figure 1). Alternative payments linked to condition management, combined with management of acute event and procedure episodes within conditions, would support not only efficient short-term episode care but also preventive and coordination services designed to avoid costly complications. Such payment models could be phased in over time and could include flexibility in the amount and financial risk involved to facilitate different primary and specialty care arrangements.

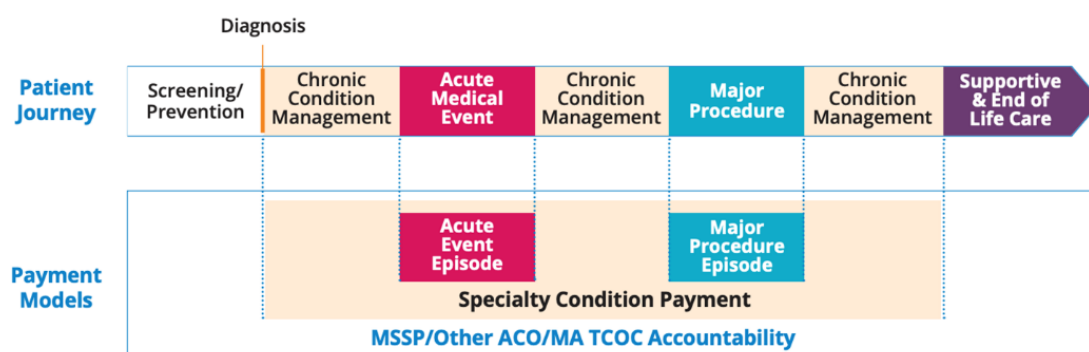


Figure 1: Nested Structure of Specialty Payment Models

Short Episode (“DRG+30 Days”) Payments

Short-term episodes will and should remain a key part of any specialty payment reform strategy. The Bundled Payments for Care Improvement (BPCI) Programs have driven some incremental improvements in cost, coordination, and integration during several short-term episodes. For example, Medicare’s Bundled Payment for Care Improvement – Advanced (BPCI-A) Model [was estimated to reduce payments](#) by \$743 per episode over its first two years, largely due to lower spending on post-acute care services. Joint replacement bundles have perhaps shown the most evidence of success; [a 2020 evidence review](#) of bundled payments found that joint replacement studies accounted for the majority of studies showing spending reduction.

Given this evidence, the CMS proposal for mandatory, 30-day + DRG episodes is the right strategic path forward for relatively standard and common acute medical events and procedures. Such episodes would accelerate trends toward coordinating hospital and physician services, post-acute care, and pre- and post-episode care coordination. The motivation for these types of short-term bundles is because substantial costs occur around the hospitalization (with significant variability in those costs), such that the short-term bundled payments can encourage specialists to work with hospital capabilities to drive greater value.

One of the challenges in current episode-based payment models is that they have been voluntary. As such, the main providers who participate are those who are likely to succeed, which contributed to the lack of substantial savings to Medicare and limited participation. A mandatory model will encourage providers of acute specialty services to make meaningful care transformation changes, increasing the chance of savings and quality improvement versus a voluntary model.

However, short-term episode payment models likely work less well for more complicated health conditions and interventions in high-risk complex patients, where health needs extend beyond 30 days. Further short-term episode payment models do not provide incentives for reducing the rate of the triggering intervention or hospital admission, and the quality measures focus on short-term impacts (e.g., readmissions) versus implementation of high-performance systems of care. As such, ***CMS should expect at best modest and incremental changes from any new short-term episode-based initiative.*** CMS could increase the impact of these specific reforms by identifying sets of related acute episode bundles – for example, in different areas of specialty surgery – that could be linked to meaningful measures of systems quality, safety, and efficiency. The American College of Surgeons has developed such quality systems-based measures in some areas of care, including [bariatric surgery](#) and [geriatric surgery](#).

Building Infrastructure to Support Both the Currently Proposed Episodic Models and Additional Specialty Care Reforms

To complement this path forward on acute episodes and show meaningful progress on supporting all types of specialty care by 2026, CMS should simultaneously develop aligned initial supports and infrastructure.

For example, one of CMS' upcoming specialty priorities is increasing data transparency to support ACOs through “shadow bundles” to disseminate performance information to drive primary care and specialty collaboration, including referrals. These efforts can serve multiple purposes: highlight the opportunity for savings and quality improvement, show how a range of models work, identify how providers would perform under various models, and illustrate opportunities for improvement. CMS' current data infrastructure generally supports the implementation of shadow bundles for acute episodes of care based on BPCI-A. This step is important—referral patterns can and should improve to ensure patients are receiving high-value episodic care. At the same time, CMS can also begin to provide information and tools to help providers accountable for total costs of care to collaborate with specialty providers to improve longitudinal care.

This section describes a variety of actions that can support both the current and needed future specialty care reforms.

Identify Innovations in Specialty Care Measurement and Expand Feedback on Longitudinal Specialty Measures: Several specialty payment reform innovations are occurring under Medicare Advantage, commercial, and Medicaid plans, and [our research finds](#) that there is substantial interest among these plans and some professional societies in developing new approaches to specialty reforms. As part of those reforms, plans are measuring and providing feedback to providers on a variety of specialty- and condition-based measures. There are opportunities for CMS to learn from these innovations and provide similar feedback based on care provided under Traditional Medicare, such as by improving longitudinal care involving specialty providers; supporting high-value referrals and collaborations that span the patient journey; and providing evidence-based, effective alternatives that lead to significant reductions in short-term episode utilization. Example areas for feedback to support such primary-specialty care coordination for prevalent conditions include:

- Cardiology: CV hospitalization rates per capita in ACO patients, rates of cardiac catheterization resulting in a therapeutic intervention; heart failure and atrial fibrillation utilization and hospitalization rates;
- Musculoskeletal: orthopedic procedure and imaging rates per capita, likelihood of non-surgical treatment (e.g., physiotherapy program) after orthopedic referral, spending and outcome episodes for beneficiaries referred to orthopedists for degenerative joint disease; and
- Gastrointestinal: Hospital and emergency department use, surgical procedure rate for IBD patients.

CMS should rapidly solicit comments on where these types of metrics can be part of its near-term strategy to provide “shadow bundle” information. CMS could also support a Challenge.Gov initiative to identify specific, feasible proposals for metrics and supporting data sharing. Winning proposals would identify open-source data sharing opportunities and metrics that could be incorporated into CMS shadow bundles. The initial production and availability of such acute and chronic shadow-bundle information would advance CMS’ strategic goals of comprehensive, whole-person care in Traditional Medicare and Medicare Advantage.

Improve Collection and Automated Reporting of Critical Patient Data: There is a further need for progress toward automated reporting of critical patient data at the point of care. For example, in collaboration with clinical and stakeholder input, CMS could identify the top 25 data elements needed to augment current claims data to refine and develop more meaningful measures about major specialty-related conditions. Example data might include heart failure stage, patient reported outcomes used to track back pain and joint pain, and others that are widely accepted by specialists and patients as clinically relevant for assessing risk and disease course in key specialty-related conditions. These efforts could be integrated into current initiatives of the Office of the National Coordinator for Health Information Technology to apply United States Core Data for Interoperability (USCDI) use cases with Bulk Fast Healthcare Interoperability Resources standards to capture relevant clinical data from EHRs in the near term. Such critical clinical data, which are clearly needed by primary and specialty care providers for effective longitudinal patient management, would go beyond current short-term measures (like readmissions) and are necessary to develop and implement nested longitudinal alternative payment models for major specialty conditions.

Enable the Selection and Implementation of Patient Generated Health Data including Patient Reported Outcome Measures (PROMs): There is also a critical need for supporting implementation of the latest available set of PROMs as tools to refocus attention from improving life expectancy and limiting morbidity toward improving health from the patient’s perspective. For instance, PROMs in musculoskeletal care aim to monitor and improve understanding of patient comfort (e.g., symptom intensity, levels of symptoms of depression and anxiety) and capability (e.g., magnitude of activity limitations and participation restrictions) while also improving understanding of the benefits and harms of tests and treatments. PROMs enable a virtuous and self-reinforcing cycle for improvement at the individual level (e.g., clinical decision support, shared decision making) and aggregate level (e.g., care pathway design, treatment efficacy, benchmarking and quality improvement, and performance measurement). Supportive measures including implementation guidance and infrastructure support should be promoted to enable the continuous process of collection, analysis, visualization and feedback to improve health outcomes for patients and populations. While PROMs offer a powerful range of functions, they are only as effective as their integration, adoption, and application in real-world settings.

Begin Building Nested Alternative Payment Models for Primary-Specialty Collaboration Within CMMI ACO Programs and MSSP: Progressively better “shadow bundle” feedback and point of care data will provide an initial infrastructure for longitudinal specialty APMs. As we and others have described in previous work, the intent is to enable primary and specialty providers to sustain longitudinal specialty care models that improve longitudinal outcomes. By being nested within a total cost of care models, there are incentives to focus on prevention and care management to prevent hospitalizations and costly procedures.

CMS could describe a pathway now that would begin with initial efforts to focus on care coordination payments for specialty groups that partner with primary care providers in such specialties as cardiovascular, orthopedic, and gastrointestinal care. These would be similar to the care coordination payments to primary care and behavioral health providers included in the new Making Care Primary model. However, for primary care providers and specialists with the capabilities and supports to implement more fundamental reforms in longitudinal specialty care, more advanced partial- and full-subcapitation models should be available. These payments would be risk-adjusted, per-member per-month, with gainsharing or two-sided risk sharing, replacing some or all payments for relevant specialty care that are currently FFS-based or based on short-term episodes. Relevant performance measures for these nested APMs would build on the metrics and data laid out above.

These longitudinal care models will require further development over time, but they are critical to the success of CMS’ 2030 vision for comprehensive, whole-person care that includes effective longitudinal specialty management. If CMS starts now, much of the infrastructure regarding these models could be in a state by 2026 where both short-term episode and longitudinal pathways could be launched.

Acknowledge and Account for Differences in ACO Types: Physician-led and hospital-led ACOs have different characteristics and different approaches to care transformation. For example, physician-led ACOs have achieved both Medicare savings and beneficiary care improvements in limited-risk arrangements. However, much of this impact has come through continuing advances in delivering advanced, coordinated primary care; such ACOs often have difficulty developing aligned contracts and well-supported collaborations with specialty groups. Hospital-led ACOs typically have affiliated or employed specialists, but often compensate them based on the volume and intensity of major diagnostic and therapeutic procedures, including surgeries. As ours and others’ research has found, current and proposed CMS payment rules – including the potential adoption of mandatory short-term-episode bundled payments for major procedures and admissions – may lead to modest reductions in spending within the short-term episode. But in models with limited shared risk, most revenues for the hospital-based ACOs remain linked to procedures and admissions. Although they include some “whole-person” risk, they do not support and sustain more integrated primary-specialty care relationships that substantially prevent future procedures and hospital admissions.

For these reasons, CMS should solicit comments on whether differential strategies should be implemented to best advance whole-person, coordinated primary-specialty care in each type of ACO. This could be undertaken along with the gradual transition from current DRG payments to mandatory “DRG+30 day” episodes for certain major procedures and medical complications typically associated with hospital admission. In particular, CMS could propose *optional* payment templates and model contracts for care coordination payments and gain- and loss-sharing with specialists in physician-led ACOs; such optional reforms could build on advancements in data sharing and performance

measurement described above to help physician-led ACOs and collaborating specialists adopt more sustainable payment reforms for innovative longitudinal care models.

In addition, for hospital-led ACOs (through the high-revenue surrogate category) in less than full-risk models, CMS could propose an incremental, gradual transition to partial longitudinal specialty- and condition-based payments in specialties with substantial opportunities for longitudinal care coordination and patient management. In contrast to relying only on short-term episode payment reforms for such ACOs, these models would provide more upfront resources for care coordination and increase the financial gains to the ACO for reducing elective procedures and admissions through better longitudinal care models. Since both the person- and episode-level payments go to the same clinical organizations, this payment shift will support internal financial alignment and clinical integration for longitudinal specialty care in these organizations.

Conclusion

The Center appreciates CMS for making this opportunity available to provide feedback on a future episode-based payment model. Our evidence-based recommendations aim to leverage feasible, immediate steps that CMS can undertake now to implement a mandatory short-term episode program and strengthen the data and infrastructure necessary to support future reforms that account for the different incentive and payment structures of physician-group-led and hospital-led ACOs. It is critical for CMS and CMMI to act now to provide a clearer path in establishing coordinated, well-integrated specialty care that aligns with goals of achieving high-quality, whole-person accountable care by 2030. The Duke-Margolis team welcomes any questions to provide further information on the content addressed herein. Please contact Mark Japinga (mark.japinga@duke.edu). These comments are those of the authors at Duke-Margolis and the individuals acknowledged below. They are not reflective of the view of Duke University leadership, staff, or other affiliated individuals or organizations.

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About the Duke-Margolis Center

Established with a founding gift through the Robert and Lisa Margolis Family Foundation, the Duke-Margolis Center brings together capabilities that generate and analyze evidence across the spectrum of policy to practice, supporting the triple aim of health care—improving the experience of care, the health of populations and reducing per-capita cost of care. The Duke-Margolis Center’s activities reflect its broad multidisciplinary capabilities, fueled by Duke University’s entrepreneurial culture. It is a university-wide program with staff and offices in both Durham, North Carolina, and Washington, DC, and collaborates with experts on health care policy and practice from across the country and around the world.

The mission of the Duke-Margolis Center is to improve health and the value of health care through practical, innovative, and evidence-based policy solutions. The Center’s work includes identifying effective delivery and payment reform approaches that support the transition to value-based care and collaborating with expert stakeholders to identify pathways to increase the value of biomedical innovation to patients – both through better health outcomes and lower overall health care spending. A key focus area of Duke-Margolis’s work is to accelerate the adoption of accountable care reforms that support whole person, comprehensive care through rigorous policy analysis, consensus building through stakeholder convenings, and evidence generation.

About The University of Texas at Austin, Dell Medical School

The University of Texas at Austin is one of the largest public universities in the United States and is the largest institution of The University of Texas System. Since being founded in 1883, it now has over 24,000 faculty and 51,000 students with more than 12,000 degrees awarded annually in over 170 fields of study. As a leading provider of education and research, the university drives progress and is known as a center of knowledge and creativity. The university’s core purpose is to transform lives for the benefit of society, and its mission is to achieve excellence in the interrelated areas of undergraduate education, graduate education, research, and public service.

Dell Medical School at The University of Texas at Austin and UT Health Austin were opened in 2017 with a vision to create a vital, inclusive health ecosystem and educate physician leaders who will innovate and bring change to the health care system. The mission of the school is to revolutionize how people get and stay healthy by evolving new models of person-centered multidisciplinary care that reward value, and by advancing innovation from discovery to outcomes. The mission of the clinical enterprise is to teach, deliver, and evaluate integrated models of value-based care that continuously improve patient outcomes relative to cost. In collaboration with the Duke Margolis Center, these institutions are geared toward a collective vision of improving health and the value of health care through practical, innovative, and evidence-based policy solutions.

Appendix

Duke-Margolis would like to thank the following organizations for discussion and input at a July 31 meeting to discuss this Request:

- American Gastroenterological Association
- American College of Cardiology
- Rubicon Founders
- Accountable for Health