June 10, 2024

The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244-1850

Dear Administrator Brooks-LaSure:

On behalf of AMGA, we appreciate the opportunity to comment on the Transforming Episode Accountability Model (TEAM) included in the Centers for Medicare & Medicaid Services (CMS) “Medicare and Medicaid Programs and the Children’s Health Insurance Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Policy Changes and Fiscal Year 2025 Rates; Quality Programs Requirements; and Other Policy Changes Proposed Rule” [CMS-1808-P].

Founded in 1950, AMGA is a trade association leading the transformation of health care in America. Representing multispecialty medical groups and integrated systems of care, we advocate, educate, innovate, and empower our members to deliver the next level of high-performance health. AMGA is the national voice promoting awareness of our members’ recognized excellence in the delivery of coordinated, high-quality, high-value care. Over 177,000 physicians practice in our member organizations, delivering care to more than one in three Americans. Our members are also leaders in value-based care delivery, focusing on improving patient outcomes while driving down overall healthcare costs.

AMGA strongly supports CMS’ effort to transition the Medicare population to value-based care by 2030. Value-based care will result in better outcomes for Medicare beneficiaries and long-term savings to the Medicare program. However, as currently constructed, we do not believe that TEAM will aid in this transformation. The inflation and labor shortages that have plagued providers since the pandemic remain, and many hospitals are not in a financial position where they can make the investments necessary to participate in a model not of their choosing. Accordingly, we cannot support TEAM as a mandatory model. However, we have identified multiple areas where we believe the model can be improved to allow hospitals to generate savings and sustainably transition to value.

AMGA is pleased to offer comments on TEAM for your consideration. Specifically, we are providing comments on the following:

- Post-Acute Care: AMGA is concerned that the workforce shortages plaguing the post-
acute care sector and the recently finalized minimum staffing requirements will increase episode costs for TEAM participants.

- **Ability to Generate Savings**: AMGA believes the proposed discount factor and target price weighting that favors more recent years will make it difficult for providers to achieve positive reconciliation under the model.

- **Telehealth Policy**: AMGA applauds CMS’ proposal to provide telehealth waivers to TEAM participants.

- **Gainsharing**: CMS should clarify whether gainsharing agreements between TEAM participants and collaborators can be based solely on a participant’s performance on episodes where the collaborator provided care.

- **Supporting Rural and Safety Net Hospitals**: While AMGA supports efforts to expand the benefits of value-based care to all populations, the proposed model does not properly account for the barriers that safety net and rural providers face in transitioning to value-based care.

### Post-Acute Care

**Comment**: Given the devastating impact that workforce shortages will continue to have on the post-acute sector, and the unknown effect of the recently finalized minimum staffing standards, AMGA is concerned TEAM participants will struggle to discharge patients to quality post-acute care providers and accordingly, struggle to generate savings under the model.

Outside of a few exclusions, TEAM participants would be responsible for all Part A & B spending for 30 days following an anchor hospitalization or procedure. As a result, hospitals unable to build up a quality post-acute care network may struggle under the model. AMGA is concerned that, due to the current state of the post-acute care sector, many hospitals will be unable to maintain such a network through no fault of their own.

The post-acute care sector is currently plagued by workforce shortages that affect hospitals’ ability to quickly discharge patients to post-acute care. A 2022 survey\(^1\) of nursing homes from the American Health Care Association/National Center for Assisted Living found that, in response to these shortages, 61% of respondents were limiting admissions and 73 respondents were concerned that they would need to close their facility. These shortages are structural and will be extremely difficult to mitigate given the country’s aging population. The National Center for Health Workforce Analysis projects that demand for direct care workers will grow by 45 percent in 2035\(^2\). While AMGA agrees wholeheartedly with the intentions of the recently finalized minimum staffing standards for long-term care facilities,\(^3\) this rule, which does not address the structural issues leading to staffing shortages but rather requires hospitals to increase staffing despite these shortages, will exacerbate rather than solve this problem. While not directly related to TEAM, the importance of timely discharge is a longstanding AMGA concern. As noted in recent comments on Medicare Advantage, the prior authorization process often delays patients’ discharge from a facility to post-acute care settings. TEAM may result in further complications.

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\(^1\) [AHCA/NCAL Survey: Nursing Homes Still Facing Staffing & Economic Crisis, June 6, 2022.](https://www.ahca.org/about-the-industry/stateissues/long-term-services-and-support-demand-projections-2020-2035/

\(^2\) [HRSA Long-Term Services and Support: Demand Projections, 2020-2035, November 2022.](https://www.hrsa.gov/about/demand-projections.html)

\(^3\) 89 FR 40876
If hospitals cannot promptly discharge patients to post-acute care providers, they will struggle to generate savings under TEAM. AMGA finds it likely that hospitals will struggle with this through no fault of their own, which contributes to our skepticism that they will be able to succeed in TEAM.

**Ability to Generate Savings**

**Comment:** The use of a 3% discount factor on episode types that may have already achieved efficiencies under past episode-based models will make it difficult for providers to beat their target prices. If providers are able to generate savings, AMGA is concerned the weighing methodology for baseline years will make it difficult for providers to keep these savings in future years.

CMS is proposing to apply a 3% discount factor to TEAM target prices to capture Medicare’s portion of reduced expenditures. AMGA recognizes that CMS must generate savings for the Medicare program through TEAM. However, this discount factor does not account for the fact that many of the procedures covered by TEAM have already been included in past episode-based models such as the Comprehensive Care for Joint Replacement (CJR) model and the Bundled Payments for Care Improvement Advanced (BPCI Advanced) model. Given the inclusion of these procedures in past payment models, provider likely already have achieved efficiencies in care for these procedures. For example, CMS states that CJR “resulted in roughly a 4% reduction in lower extremity joint replacement (LEJR) spending for participants over the course of the model.” While it is possible that further reductions in spending would be achievable, baseline prices would be set using data partially including CJR participants, so expecting similar reductions is unrealistic.

In addition, heavier weighting of more recent years when calculating target prices means any savings hospitals do generate will quickly be reflected in their targets, making sustained success under the model difficult. AMGA understands that accountable care necessitates winners and losers, however, as proposed, TEAM is structured such that it will be extremely difficult for hospitals to win.

**Telehealth**

**Comment:** AMGA applauds CMS for proposing to waive the geographic site requirements and originating site requirements for TEAM participants, and for acknowledging that these waivers are essential to maximizing quality of care and efficiency. We urge CMS to finalize this aspect of TEAM.

Since the COVID-19 Public Health Emergency (PHE), telehealth has become a critical component of the healthcare system. In addition to allowing patients more flexibility and ownership over their care, telehealth increases access for rural patients, those with transportation or mobility issues, and for immunocompromised patients who are at heightened risk for exposure to COVID-19 and other illnesses. The flexibility and patient engagement facilitated by telehealth are critical components of value-based care, and will certainly lead to better outcomes and improve chances for cost savings for TEAM episodes. In fact, if CMS did not propose this waiver and Congress does not renew these flexibilities for all hospitals, the targets under the first three performance years of TEAM would be unfair, as providers would have had access to telehealth
flexibilities during the baseline period for these performance years.

**Gainsharing**

**Comment:** AMGA seeks clarification on whether gainsharing agreements between TEAM participants and collaborators could be tied to the specific episodes that collaborators contributed to. The ability to tie gainsharing to specific episodes is essential, as failure to do so would risk punishing collaborators for episodes they have no control over.

Under TEAM, hospitals may enter into sharing agreements with other providers that contribute to TEAM episodes, such as post-acute care facilities and physician groups. Enabling hospitals to share savings with other providers will increase collaboration and allow hospitals to better control their model performance. However, TEAM collaborators will not impact a hospital’s performance on every episode. If providers are not able to tie their gainsharing agreements solely to episodes they contribute to, these agreements will punish or reward providers for episodes they do not control, defeating the purpose of accountable care. While CMS states that the methodology of these gainsharing arrangements may account for the amount of TEAM activities provided by a TEAM collaborator relative to other collaborators, it is not clear whether the methodology may tie gainsharing to the specific episodes under control of the collaborator. CMS should clarify this, and, if this sort of agreement is not allowed, should rectify this before finalizing TEAM.

**Supporting Rural and Safety Net Providers**

**Comment:** AMGA fully endorses CMS’ vision of bringing the benefits of value-based care to all Medicare beneficiaries, including those served by safety net hospitals, which have historically participated less in episode-based payment models. The patients served by these hospitals stand to benefit immensely from value-based care. Rural populations face higher rates of a number of chronic diseases, including diabetes and heart disease, which value-based system of care that emphasizes preventative care and care coordination could better manage. However, a phased approach is necessary to transition these providers to value-based payment systems. **CMS should consider a smoother path to risk for safety net providers than as proposed in the TEAM model.**

As proposed, TEAM would expose safety net and rural hospitals to 10% downside risk after only one year of participation in the model. AMGA is skeptical these hospitals would be able to absorb this level of loss on the episodes included in TEAM, which accounted for more than 11% of inpatient PPS payments in FY 2023, without impacting other programs run by the hospital. AMGA also is skeptical that one year of no downside risk will give these hospitals enough experience with value-based care to avoid these losses, especially against a regional benchmark, which includes hospitals that have past episode-based model experience. A recent report found that more than 700 rural hospitals are at risk of closing. Rural providers are often the sole

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5 AHA, FAH Request Comment Period Extension for Proposed Mandatory Bundled Payment Model. May 17, 2024.
6 Center for Healthcare Quality and Payment Reform. Rural Hospitals at Risk of Closing. April 2024.
source of care for their communities. By rushing these financially vulnerable hospitals into risk, CMS may negatively impact risks hurting the populations that it intends to help.

One reason that safety net hospitals have participated less in past episode-based payment models is that these hospitals lack the economies of scale that allow hospitals to make the significant upfront financial and staff time investments needed to understand the model and to be comfortable taking on risk. Participation in TEAM will require hospitals without past model experience to make significant changes to how they handle covered procedures. Sharing agreements must be made with TEAM collaborators, which requires negotiations and legal work. Finance departments must project performance under the model, which will be difficult given the difference between prospective target prices and those used at reconciliation. Clinicians would have to change their care practices and systems would need to be overhauled. These efforts, which are not accounted for in the model, create significant opportunity costs for less resourced providers, who must pull staff away from other projects.

AMGA firmly believes that a transition to value will optimize health outcomes while providing long term savings to Medicare—but it is also what makes transitioning to value-based care so difficult, especially for less resourced providers. To ensure that safety net populations are able to reap the benefits of value, we must provide a smooth on ramp to risk for the providers that serve them.

We thank you for your consideration of our comments. Should you have questions, please do not hesitate to contact AMGA’s Darryl M. Drevna, senior director of regulatory affairs, at 703.838.0033 ext. 339 or at drevna@amga.org.

Sincerely,

Jerry Penso, M.D., M.B.A.
President and Chief Executive Officer, AMGA