

August 17, 2023

Chiquita Brooks-LaSure, Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
7500 Security Boulevard
Baltimore, MD 21244-1850

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

Submitted electronically via <http://www.regulations.gov>

Dear Administrator Brooks-LaSure,

Trinity Health appreciates the opportunity to comment on the episode-based payment model request for information. Our comments and recommendations reflect a strong interest in public policies that support better health, better care and lower costs to ensure affordable, high quality, and people-centered care for all.

Trinity Health is one of the largest not-for-profit, Catholic health care systems in the nation. It is a family of 123,000 colleagues and more than 26,000 physicians and clinicians caring for diverse communities across 26 states. Nationally recognized for care and experience, the Trinity Health system includes 88 hospitals, 135 continuing care locations, the second largest PACE program in the country, 136 urgent care locations and many other health and well-being services. Trinity Health has 15 medical groups with 1,324 primary care providers and 4,193 specialty care providers. Based in Livonia, Michigan, its annual operating revenue is \$21.5 billion with \$1.4 billion returned to its communities in the form of charity care and other community benefit programs. Trinity Health is committed to serving as a critical provider in our communities and coordinating care across settings and the care continuum, with 41% of our revenue coming from Medicare and 18% from Medicaid and uninsured patients.

Trinity Health is a strong proponent of value-based care delivery. We have 17 Clinically Integrated Networks (CINs) that are accountable for approximately 2 million lives across the country through alternative payment models. Our health care system participates in 14 markets with Medicare Shared Savings Program (MSSP) Accountable Care Organizations (ACOs), which includes 11 markets partnering in one national MSSP Enhanced Track ACO, Trinity Health Integrated Care. All of these markets participate in the “enhanced track”, which qualifies as an advanced alternative payment model (AAPM). Two of the 14 markets also participate in CPC+. In addition, we participated in the Bundled Payments for Care Improvement Advanced (BPCIA) initiative and the Comprehensive Care for Joint Replacement (CJR) program across 37 hospitals.

General Comments

The path to improving health outcomes and bending the cost curve is to encourage the movement of all alternative payment models (APMs), including Medicare Advantage, to provider systems in established ACOs that have proven their ability to manage total cost of care and outcomes, such as Trinity Health. Trinity Health strongly believes this is a better alternative to handing it over to commercial payers—public companies who maximize their profitability and restrict access to services by abusing utilization

management programs, such as prior authorization, change health plan coverage in the middle of a contract year, implement aggressive risk scoring and coverage denials.

Trinity Health urges CMS not to mandate a clinical episode model in markets or regions where there is already significant participation in voluntary value-based models or for providers who are ill-equipped or under-resourced to support implementation of this type of payment model. In addition, in markets with less value-based penetration, hospitals and medical professionals meaningfully engaged in total cost of care (TCOC) models by virtue of ACO participation should be given the opportunity to opt out of a mandatory model.

Trinity Health strongly recommends CMMI incorporate the following guidelines to identify the episodes or service lines that are best suited for use in a mandatory model:

- Include only episodes with a well-defined triggering event with costs of that event and subsequent services attributed to an accountable entity.
- Include only episodes conducive to accurate benchmark setting and common enough/of sufficient volume to justify including in a mandatory model.
- Include only episodes that have been found to generate savings without harming quality or improving quality without increasing spending.
- Focus on acute services, for example: total hip/knee arthroplasty, spinal fusion, stroke/transient ischemic attack, sepsis, where a beneficiary has a time-limited relationship with a provider to address a specific issue. The principal goal of the bundle should be to improve quality and address issues with quality, unexplained variations in cost, and efficiency.

Promoting Care Delivery and Incentive Alignment

Because of the prevalence and success of ACOs today and the many efforts and incentives in place to grow ACO participation to meet CMS' stated goals, any new models should "first do no harm" to ACOs. ACOs have accountability for total cost of care and outcomes across the continuum, and so any new care delivery and incentive models should be focused on populations and providers not aligned to or engaged with ACOs. The best way to promote integration of care delivery and incentives is to first preserve and grow ACO accountability for episodes of care, increasing specialty provider engagement and episode cost management within the ACO. Since ACOs are accountable for the total cost of care for Medicare beneficiaries, including expenditures related to episodes, they have the right incentive — aligned with CMS—to align within their ACO network the most efficient and high-quality specialists, acute and post-acute facilities and work with them to improve outcomes and affordability of care.

CMS can make changes to the existing ACO models to promote care delivery and incentive structure alignment. Today, Medicare ACOs have built in *disincentives* to include specialists in their ACO, as they are penalized by then being designated a "high revenue" ACO and are more likely to lose the 5% MACRA bonus afforded to Advanced APMs. For these reasons, ACOs are less likely to do the hard work of integrating specialists in their ACO. Rather than create new models to promote specialist engagement, CMS could create incentives (starting with removing disincentives) for ACOs to include specialists in their provider network. In addition, CMS can work with Congress to ensure legislation is passed that would reward specialists directly for participation in ACO models by extending the MACRA bonus for AAPMs. Primary care only ACOs may be able to more quickly drive savings, but sustained savings to support full delivery system transformation requires engagement of specialists and staff within acute and post-acute facilities. Engaging specialists in managing episodes of care would be new work for many ACOs, so incentives (or removal of disincentives) are necessary.

With ACOs incented to include and engage specialists, they would have the necessary alignment to opt out of episode-based payment models created by CMS or could use such a model to nest episodes within their ACO. For those ACOs wanting to use the model to holding specialists and facilities accountable for episodes of care, CMS would serve similarly to a third party administrator (TPA) where the ACO selects the episodes, providers, and price based on their specific opportunities within total cost of care, and CMS processes the payment. Making it easy for ACOs to take greater accountability for specialty and episodes of care will achieve CMS' goal of greater alignment and integration.

Even today, CMS can help ACOs identify high performing providers by providing cost and quality data on specialist providers beyond what an ACO has today (greater volume of data will provide more actuarial accuracy). CMS can also release provider participation data they have today to help ACOs identify what other entities the specialist is engaged with so ACOs can align and coordinate care within a community (and in an episode model, the episode initiator can do the same with their specialists on staff.)

For Medicare beneficiaries not yet attributed to an ACO but where the provider participates in an ACO, CMS can create a voluntary ACO alignment opportunity to that provider whereby, at the time of admission, the beneficiary can voluntarily align to that ACO and so receive the care coordination that ACO already has in place. Specifically, this would optimize the transition to and management of post-acute care where ACOs have established care coordination processes within a high performing network of providers.

In sum, CMS can take greater advantage of the benefits of the ACO to align care delivery and incentives through changes to existing ACO model design: 1) to remove disincentives for ACOs to include specialty providers in their ACO; 2) increase incentives for those specialists to coordinate care with the ACO; and 3) to align more beneficiaries to ACOs. Providing a greater risk option in MSSP also further incentivizes ACOs to engage and incentivize downstream providers to manage episodes of care through use of the ACO waivers.

To close the remaining gap, where there is no ACO to take accountability for the episode of care, CMS could create an episode management program for specialists similar to BPCI/A (with improvements suggested below). And for acute and post-acute facilities, CMS can build on value-based purchasing programs in place today such as the Hospital Readmissions Reduction Program (HRRP) to include additional incentives to discharge patients to the most appropriate next site of care. CMS will need to make it easy for all accountable providers to know at the point of admission which patients are part of an ACO by sharing that information (which CMS has today) at the point of admission, discharge and transfer. In addition, CMS can make this information available through query. Many ACOs individually and through NAACOS have called on CMS to modify the HIPAA Eligibility Transaction System (HETS) to allow access to all eligibility inquiries for ACO-assigned beneficiaries and to develop a proactive, real-time notification system for ACOs when beneficiary eligibility is requested. Doctor's offices, clinics, hospitals, surgery centers, and other providers ping HETS to check patients' Medicare eligibility at each encounter. If CMS, which operates HETS, allows access to the system's data, then Medicare providers would have real-time knowledge of beneficiaries' visits to medical providers, including hospital admissions, emergency department visits, and specialist encounters. CMS will also need to share with these providers the data they would need (similar to how CMS shares data with ACOs) to identify high performing acute and PAC providers.

Finally, CMS can support incentive alignment between settings by making changes to existing acute and post-acute value-based purchasing and payment models to reward hospital and post-acute providers when they reduce cost and improve clinical outcomes. For example, in both the ACO and bundles programs, we improved care and decreased cost by preparing beneficiaries for earlier transition to home, however CMS' SNF payment model creates a direct disincentive for SNF to work to support an earlier discharge.

Promoting person-centered care through addressing and integrating behavioral health and health-related social needs that supports patient independence in home and community settings

Poor access to behavioral health makes it hard to address behavioral and social care needs within a 30-day episode. CMS can promote integration of BH and social care through payment or other model incentives, many of which Trinity Health and others have recommended through prior comment opportunities:

- Direct payment for behavioral health screening and referral as part of the discharge plan to support patients with a successful discharge and transition care plan.
- Payment for screening and referral for health-related social needs as part of the discharge plan to support patients with a successful discharge and transition care plan.
- Pilot payment for removing the health-related social needs barriers through payment of utilities, workforce development, housing, transportation, etc.
- Expand direct payment for care coordination.
- Payment for evidence-based, self-paced online and distance learning such as the National Diabetes Prevention Program.
- Continued reimbursement for virtual delivery of Social Work, Psychology and Psychiatry services.
- Provide adequate reimbursement within an episode of care for providers to leverage a full array of health care workers, including community health workers, peer-to-peer support specialists, recovery coaches and case managers, and allow these professionals to practice according to their highest level of education, training, and licensure.
- Pay for home modifications, transportation, and digital devices to support earlier and more successful discharge to home (e.g., ramp, air conditioner window unit, transportation to not just medical appointments but also church, community centers, covering the cost of iPads or other devices to support remote monitoring).

Supporting Multi-payer alignment in episode-based and population-based models

Transparency of model design and data is the first step in multi-payer alignment. In the ACO programs, CMS sets the standard for payer data exchange, and provides transparent details on model development that has allowed private payers to replicate/align. Similarly, CMS should use and promote open source episode grouper and publish enough model detail for payers to replicate. CMS should also be transparent and share how they have modelled performance in various scenarios they run.

In addition, CMS should also make bundle model performance data easier to access for investigation and research to promote model replication by other payers. Additionally, CMS should make information about specialist providers' cost and quality performance transparent and accessible. This will create incentives for specialists and facilities to drive down costs and increase quality as they seek to either join an ACO or enter into performance-based agreements with ACOs as well as with Medicaid and commercial payers.

Payers are often reluctant to engage in multi-payer alignment efforts out of concern that conversations about payment model alignment could violate anti-trust statutes. To mitigate these concerns, CMS should:

- Invite state officials to facilitate alignment conversations and inquire whether state-action policies may be used to provide anti-trust protection or look to existing state sponsored initiatives to provide a framework for planning efforts.
- Be a neutral convener to facilitate conversations and ensure payment rates and other anti-trust issues are not discussed.
- Establish clear safe harbor exceptions specifically for multi-payer alignment efforts and provide clear guidance on acceptable coordination activities in this space.

Structural relationships between providers in population-based and specialty-based models that promote integration

Integration is most easily accomplished when both primary care and specialty care providers are employed by the same entity because payments can be aligned and reconciled, and incentives built, within the same internal payment system. In addition, a group of employed providers will be on the same electronic health record system which supports care integration and data sharing. Outside of employment, the best lever for integration is including the full array of providers within an ACO or Clinically Integrated Network where incentives and data are shared and aligned.

Promoting Health Information Technology and Interoperability

CMS should make it easy for entities to get notifications when a beneficiary seeks care from a Medicare provider during the episode. For example, if a patient is discharged from hospital A but then is admitted to hospital B emergently, hospital A should get notified so they can reach out to hospital B and coordinate care, particularly during the episode.

We recommend CMS consider requiring use of a certified EHR as part of participation. A certified EHR requirement could provide a pathway for standard exchange of necessary data for the entirety of that patient's care journey. Currently, the base CEHRT definition includes the capability/capacity to exchange electronic health information with and integrate such information from other sources. However, a certified EHR requirement may create a significant burden to providers and may be cost prohibitive; therefore, we recommend CMS provide financial incentives and ensure plenty of lead time should you decide to implement this in the future.

In addition, we urge CMS to offer incentives to post-acute providers to increase interoperability so they are more ready to receive data from and exchange with ambulatory and acute providers who benefitted from earlier incentives to adopt certified EHR technology and participate in HIEs.

Episode length and conditions that promote alignment and accountability to improve cost and care

The 90-day episodes in BPCI/A demonstrated success in reducing post-acute spending and readmissions, most of which occur in the first 30 days post discharge. We agree that reducing episode duration to 30 days could retain those spending reductions and mitigate some of the challenges in that model with integrating longitudinal care. When beneficiaries are attributed to an ACO that includes specialty care providers and facilities, these challenges are significantly reduced (see above), but where there is no ACO, a 30-day episode would position the specialist as the principal provider near the anchor event with a hand off back to the primary care provider for longitudinal care management that focuses on managing the underlying or contributing medical conditions.

The 30-day episode length is appropriate for the objectives to improve efficiency and reduce variation in cost and outcomes. Evidence of this was noted in our experience within the BPCI-A program, where readmissions occurring later in the episode (days 45 – 90) were typically unrelated to the reason for episode initiation.

Clinical conditions that lend themselves to specific acute clinical pathways where focused care progression and planning provide the ability to address and meet the needs of the beneficiary within the determined 30 day episode length are ideal for an episode-based payment model. This can be conducted either through targeted episodes and/or the exclusion of variables within the clinical episode that are not directly linked to episode initiation. Episodes that are focused on a specific relationship with a specialist provider to address a specific issue would best lend themselves to an episode-based model. We found this to be true in CJR, where we could target variations in practice, driving program goals of improved outcomes and lower costs.

In addition to the considerations noted above for appropriate episode-based episodes, clinical episodes should only be included if they are anticipated to have a population size where the provider can demonstrate true tests of change that provide meaningful opportunity. As noted in our learnings from BPCI/A, conditions that have a relatively small population size present a challenge of volatility in a risk-based model that does not lend itself well to the inclusion and overall objective of improved outcomes and cost reduction.

Chronic conditions lend themselves well to effective collaboration among providers in an ACO, so where a provider and beneficiary are part of an ACO, those conditions should be excluded. Where there is no ACO, there would be a benefit to holding specialists accountable for chronic conditions where they provide longitudinal care for that condition. Conversely, holding a hospital-based provider accountable for a chronic condition that is being managed by a community specialists would be more likely to disintegrate than integrate care. These conditions often involve many care partners and an extensive care plan that stretches beyond the 30-day snapshot that an episode payment model is designed to address.

For providers not participating in an ACO and beneficiaries not attributed to an ACO, our experience in BPCI/A informs our recommendation for a mandatory episode-based model:

- Include only episodes with a well-defined triggering event with costs of that event and subsequent services attributed to an accountable entity.
- Include only episodes conducive to accurate benchmark setting and common enough/of sufficient volume to justify including in a mandatory model.
- Include only episodes that have been found to generate savings without harming quality or improving quality without increasing spending.
- Focus on acute services, for example: total hip/knee arthroplasty, spinal fusion, stroke/transient ischemic attack, where a beneficiary has a time-limited relationship with a provider to address a specific issue. The principal goal of the bundle should be to improve quality and address issues with quality, unexplained variations in cost, and efficiency.
- Elements unrelated to the episode initiation should be excluded from the clinical episode evaluation. The participant should be rewarded, however, for implementing and achieving various elements of evidence-based care through transition, such as medication reconciliation and timely follow-up appointments.

Promoting Health Equity and Addressing Health Related Social Needs

Current benchmarking approaches generally fail to adequately account for equity in that they rely to some degree on historic spending and utilization as a proxy for appropriate levels of care. This is not a realistic expectation for individuals and communities that are underserved by the health care system and further entrenches historic inequities. We urge CMMI to continue leveraging a multi-faceted approach to advancing equity including equity plan requirements, benchmarking strategies that adjust for beneficiary and community level equity, risk adjustment methodologies tailored to providers working in underserved communities, demographic data collection, and quality measurement strategies that encourage the closing of health equity gaps. These efforts should be grounded on the establishment of reasonable expectations for the cost of providing efficient and high-quality care in a manner that adjusts for the historic underinvestment in some communities and demographic groups.

To advance health equity through model design, CMS can adjust benchmarks upward for episode initiators with higher proportion of beneficiaries dually eligible for Medicare and Medicaid and for those who are eligible for the Low Income Subsidy (LIS) or have zip codes associated with high social vulnerability as measures in the Social Vulnerability Index (SVI). There is plenty of evidence that black patients in particular have worse outcomes so race should be included. We also know that beneficiaries with severe and persistent mental health needs have poorer health outcomes and adjustment to quality and financial model elements should account for this with additional segmentation and financial adjustments similar to other social vulnerabilities.

In addition to financial adjustment upwards, CMS can limit downside risk for disproportionate share hospitals, providers serving a greater proportion of dually eligible beneficiaries, and/or providers in regions identified with a high ADI, SVI, or SDI, where these providers maintain or improve on their quality outcomes.

CMS should invest in strategies to improve more robust self-reporting of race and ethnicity data at point of service and acknowledge that Race and Ethnicity are separate data categories. We urge CMS to consider being the primary collector of this type of person-level data through the Medicare enrollment process or other targeted CMS data collection initiatives or partnerships and report this data publicly.

We recommend CMS provide each initiating provider participating in the model data from the Medicare beneficiary survey such as self-reported Race and Ethnicity, as well as frailty and living situation (especially where beneficiaries indicate they are living alone). Starting in CY2024, CMS can also include the social needs data that will be collected and provide that data on food insecurity, housing instability, transportation needs, utility difficulties, and interpersonal safety. In addition, CMS can provide incentives to promote greater EHR and Electronic Health Information Exchange adoption in communities where greater disparities exist.

Incorporating Quality Measures including Multi-payer Alignment on Quality

When CMS incorporates quality measures in new models or changes to existing models, the measures need to not only be clinically meaningful but should also be measures that are currently being used in established models or quality reporting programs. In addition, CMS should not rely on chart abstraction, which adds significant administrative burden, cannot be tracked internally on a regular basis to monitor performance, and is inconsistent with CMS' goals of relying on electronic measures. Examples of reasonable measures to consider for an episode-based payment model include:

- Depression screening, either upon admission or as part of the follow up plan.

- Advanced care planning, so that we understand patients' wishes for care at end of life and who of their loved ones they would like involved in those care decisions.
- Never events such as wrong-site surgery, unintended retention of a foreign object after surgery/procedure, and patient death or serious injury associated with a medication error (wrong drug, dose, patient, time, rate, preparation, or route).
- Return to hospital, as measured by readmission or ED visit during the episode.
- Return to primary care as measured by a follow up visit 7 days post discharge from acute or post-acute care (if transitioned to PAC), with additional payment if a TCM visit is documented.
- Medicare Spending per Beneficiary (MSPB) which spans the care continuum by including Medicare Part A and Part B claims for the time period 3 days prior through 30 days following an inpatient episode of care.

Patient Reported Outcome Measures (PROMs) are very promising for getting closer to the beneficiaries' experience of care and outcomes that matter to them. Because PROMs are still in development, including with commercial payers, CMS should take a step-wise approach that first establishes a PROM infrastructure with input from providers, then supports reporting and testing in a transparent process sharing data along the way, and then holds providers accountable for performance. Efforts to advance the use of PROMs should include looking at ways to improve the timeliness of collection and analysis of data and taking action to address issues raised.

To measure patient experience and care coordination, CMS needs to look outside of the existing Care Transition questions in the CAHPS survey. The historical trending is flat and this domain is the lowest among all HCAHPS domain. The suspected root cause is the patient interpretation of the question wording and recall bias. CMS should be more specific in asking patients about whether they were involved in the development of their treatment plan and post-discharge plan, whether their discharge instructions were clearly understood, and whether their family and caregivers were involved in decision making processes around their care. CMS should consider allowing larger sample sizes of patients to respond to the survey, rather than restricting based on the number of clinicians in a practice, to combat declining response rates. In addition, we recommend CMS partner with patient advocacy groups to develop or test patient family centered care patient experience questions.

To reduce data collection burden, CMS should first use measures that CMS and other payers can pull from common claims data. For clinical measures, CMS should align on use of electronic Clinical Quality Measures and fully eliminate registry reporting and manual chart abstractions. CMS can provide leadership with other payers who all currently have individual data submission processes.

Payment Methodology and Structure

To balance providing predictable, achievable target prices with the need to create a reasonable possibility of achieving net Medicare savings, CMS should look to the Next Generation ACO model where CMS combined guaranteed savings (a small discount to the benchmark) with a share of savings earned, giving providers the options to flex gross and net savings and allow entities to choose based on their own tolerance for risk. Similar to BPCI/A (as contrasted with ACO models), CMS can provide interim payments with true-ups, which is helpful to participants to see performance and be rewarded for that performance closer to the performance period. While this may be additional administrative work on the part of CMS, it is critical for provider engagement, to address the "FFS now, APM results...someday, if you're lucky" skepticism. [CMMI has also experimented with provisional reconciliation in the ACO REACH model and could similarly offer providers the option to receive advanced access to data and payment with the understanding that it is not final and subject to revision.](#)

On risk adjustment, while the current CMS-HCC model has its flaws, it has the benefit of being already applied in ACOs and other payment models and could be used here as well to risk-adjust the payment. Rather than try and divine what is clinical risk and what is not and apply “fixes” to each model, CMS should apply the risk adjustment program on a level playing field in all Medicare models, and work to improve the program as a whole.

CMS should make clinical modification to the risk adjustment program to more heavily value presence of dementia or other behavioral health diagnoses, and incorporate existing income and eligibility markers (e.g. dually enrolled in Medicaid or receiving LIS, as noted in the Health Equity section). To greater weigh disability and high needs, CMS could incorporate a tested measure of frailty, such as the adult frailty index developed by Joynt, Jha et al: [Segmenting high-cost Medicare patients into potentially actionable cohorts - ScienceDirect](#), which we use in our ACO risk stratification. In addition, CMS could weigh the presence of multiple social needs and multiple chronic conditions since the combined impact of multiple social and clinical conditions is greater than the sum of the individual impacts. Further, CMS could also look to experience with the inpatient hybrid measures for risk-adjusted readmission and mortality that combines EHR data with claims data. The EHR data incorporated into the hybrid measures would include Social Drivers of Health when screened by the provider.

Model Overlap

Many of our recommendations for model overlap align with those presented by the Medicare Payment and Access Commission (MedPAC) in their [June 2022 report to Congress](#).

As referenced earlier, CMS should first do no harm to providers willing to accept full accountability for the cost and quality of a beneficiary’s care. Under a hierarchical model arrangement, when a beneficiary is aligned to a provider or group responsible for managing the total cost of care in an ACO, that relationship would always take precedence. In our earlier comments, we identify many ways CMS can provide incentives (and remove disincentives) for the ACO to take accountability for episode cost and care. This will shift the conversation from “overlaps” where the ACO is penalized by payment against a target price that is higher than their historic or imputed benchmark cost, to a conversation about “alignment” where the ACO achieves cost and quality goals under one common care model and benefits from savings earned against that more appropriate target price. This is why it is so critical that target prices in the episode-based model not exceed the amount of episode spending implicitly included in an ACO’s benchmark. Otherwise, reductions in episode spending may result in bonus payments for episode providers but could still be higher than episode costs in an ACO’s benchmark— leading the ACO to owe shared losses to CMS despite the reduced spending.

CMS’ goals to grow ACOs and align specialists within ACO models conflicts with mandatory participation in episode-based models for ACOs and providers within their networks. However, ACOs may choose to opt-in to an episode-based payment model as above, where, for CMS and the ACO to achieve maximum net savings from the “overlap,” CMS will need to allow the ACO to set the target price for the attributed population based on their historical cost, which would allow CMS to reconcile savings during settlement without penalizing the ACO.

These recommendations align with MedPAC recommendations that CMS use discounted target prices in the episode-based payment model and include any episode bonus payment in the ACO’s annual spending tally; the ACO would realize shared savings payments based on the difference between the

undiscounted episode price implicitly included in the ACO's annual spending benchmark and the discounted episode target price in that model.

As helpfully summarized in the June 2022 MedPAC report on streamlining and harmonizing models (starting p. 15), "there is evidence that combining an episode-based payment model with a population-based accountable care model can have positive impacts. The authors (of a study reference in the report) speculate that the additive effect of the two models may result from ACOs' investments in improving ambulatory care complementing efforts by episode-based providers to reduce the cost of post-acute care." CMS should therefore design benchmarking methodologies across models that reduces friction from "overlap" by setting payment levels at a point where population-based model participants and bundled payment providers have a clear financial incentive to partner.

In sum, to encourage provider alignment and collaboration and drive maximum net savings, CMS should allow ACOs accountable for total cost of care and outcomes three options for engaging with specialists.

- **Option 1:** Exempt ACOs from mandatory models where they include specialists in their ACO (with incentives to do so, such as the MACRA AAPM bonus) and have clinical and financial distribution models they can demonstrate and share with CMS.
- **Option 2:** Give ACOs full flexibility and regulatory relief to negotiate collaborative care and payment arrangement. Current ACOs are already participating in enhanced and innovative risk sharing arrangements with their ACO participants and other healthcare providers and suppliers. The MSSP ACO waivers contemplated the need for more flexibility amongst ACOs and their participants to pursue innovative arrangements that encourage efficient service delivery that is reasonable related to the MSSP program. We believe the value-based arrangement safe harbors and exceptions finalized in 2020 supported additional regulatory flexibility in support of value-based systems of care and payment, which allow a value-based entity (such as a CIN or ACO) to share risk with physicians for managing the care of a target patient population. In addition, those same regulatory updates in 2020 included an AKS safe harbor for CMS-sponsored models (42 CFR 1001.952(ii)), that fosters the testing of innovations that improve quality and lower costs amongst providers under CMS-sponsored models such as the MSSP ACO program.
- **Option 3:** Allow ACOs to rely on the model designed by CMS, but only if CMS allows the ACO to select the provider(s), the episode type(s) and target price(s) so that ACOs are choosing the highest value providers and episode opportunity based on the ACO's imputed target based on their TCOC benchmark. CMS would effectively serve as the TPA for the ACO, managing model mechanics and making payments to providers under these selected terms. Those payments would then be reconciled in ACO settlement in a fully transparent and trackable manner.

This approach would allow ACOs the option to fully align specialists through contracting or outsource the model design and funds flow to CMS. ACOs would have an incentive to coordinate care as the TCOC risk bearing entity and duplicate shared savings issues would be avoided by virtue of all beneficiary spending being reconciled against the ACOs TCOC benchmark under both options. At the same time, this would encourage acute and post-acute entities to partner even more closely with ACOs who have TCOC accountability for a critical mass of their patients, driving overall community improvements in outcomes.

Waivers and benefit enhancements

In addition to our comments in payment overlap section (option 2), we offer the following recommendations for further flexibility:

- Allow the accountable entity to tailor the use of post-acute services to increase the proportion of patients that could efficiently be treated outside of an inpatient setting. For example, Home Health services are currently paid as an all or nothing benefit; a waiver in this case would allow providers participating in an APM to negotiate different rates for home care – such as smaller payments for shorter/more frequent home health visits – that better address patient needs. Allowing the accountable entity to set prices for post-acute providers in APM arrangements would add flexibility that fosters clinical decision making that is less affected by cost considerations.
- Allow the accountable entity to cover additional benefits (waive beneficiary inducement) that drive improved cost and outcomes such as home safety checks or home modifications – for example, prior to a surgery to foster a prompter return to home and recovery.
- Allow paramedics and community health workers to bill under part B when they are providing care to beneficiaries in an APM.

Conclusion

Trinity appreciates this opportunity to comment on episode-based payment model request for information. We welcome the opportunity to serve as a resource as CMMI continues to develop policy for mandatory bundles. Please feel free to contact Jen Nading with any questions at jennifer.nading@trinity-health.org

Sincerely,

/s/

Jennifer Nading
Director, Medicare and Medicaid Policy and Regulatory Affairs
Trinity Health