PREMIER TRANSFORMING HEALTHCARE TOGETHER®

June 6, 2024

Ms. Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1808-P

Submitted electronically to: http://www.regulations.gov

Re: 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 [Docket Number: CMS-1808-P]

Dear Administrator Brooks-LaSure:

Premier Inc. appreciates the opportunity to submit comments to the Centers for Medicare & Medicaid Services (CMS) on the proposed Transforming Episode Accountability Model (TEAM). Under its proposal, CMS will require selected acute care hospitals to participate in a five-year mandatory episodic payment model starting in CY 2026. Premier believes that voluntary models with the appropriate incentives are ideal as they allow providers to select participation based on their mission, abilities and market realities.

However, if CMS chooses to move forward with the mandatory episodic models, ***Premier strongly urges CMS to consider the following key design principles****:*

- ***Provide opportunities for upside financial gains, as well as gradual risk options***. CMS should design alternative payment models (APMs) that allow for meaningful opportunities to take on two-sided risk. For example, when designing a mandatory model, CMS must ensure that there are opportunities to reward participants for their performance under the model and that the model is not simply a payment cut. As discussed in greater detail below, ***Premier is concerned that as designed the TEAM does not offer meaningful rewards for high performing participants***. Under the proposal, all hospitals would be subject to a 3 percent discount, with no opportunity to reduce that discount based on quality and efficiency. As we have noted previously, the goal of APMs should be to fundamentally change care delivery and improve population health, rather than seeking opportunities to leverage market dynamics to reduce costs. To that end, CMS should incorporate meaningful opportunities for both upside and downside risk in models. ***Premier recommends that CMS modify the model to allow high quality participants to "earn back" or reduce the discount applied under the model based on their quality performance.***

  Additionally, mandatory models should also offer opportunities for providers to gradually assume financial risk to ensure all providers have an opportunity to succeed. This allows providers who may have limited experience in APMs to gain experience in the model before incurring significant financial risk. Providers who are prepared for significant risk could accelerate to a track with higher risk (and higher reward) if they so choose. ***Premier appreciates CMS' proposal that all participants would have the opportunity to participate under an upside-only track for the first performance year. However, as discussed in greater detail below, Premier recommends that CMS extend that policy an additional year for all participants and allow certain safety net and rural hospitals to remain in upside only for the entirety of the model.*** This approach would allow participants to change workflows to align with the model, utilize

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performance data from CMS to identify areas for transformation and receive additional education from CMS on model parameters and meeting objectives.

- ***Establish appropriate provider exclusion criteria that recognize the challenges that rural and low-volume providers face with mandatory participation***. Many rural and low-volume providers cannot absorb the additional costs and potential payment cuts that may result from mandatory payment models. Additionally, providers who have a low volume of procedures can face significant variability in performance and large losses due to only a handful of patients. As a result, ***Premier recommends several modifications to the model as detailed below to ensure that the model includes appropriate flexibilities that protect rural and low-volume providers and help protect access in these communities.***

- ***Provide sufficient information and data in advance of model test starts***. We appreciate that CMS has undertaken rulemaking well in advance of the proposed start of the model in 2026. It is essential that CMS provides participants with sufficient time from when policies are finalized until the launch of the model. To that end, ***Premier urges CMS to finalize policies and provide additional guidance, including participant selection and available waivers, at least one year prior to the launch of the model – therefore by January 1, 2025.*** As discussed in more detail below, we also recommend that CMS extend the opportunity for upside financial risk for an additional year to ensure participants have enough time to implement system changes necessary to participate under the model prior to taking on downside risk.

- ***Provide options for participation***. Premier recognizes that CMS is interested in pursuing a mandatory model to ensure broad participation and to minimize selection bias. However, ***Premier strongly encourages CMS to provide flexibilities and options for those participants who are mandated to participate***. For example, CMS should allow participants to select from a menu of available episodes, as this will allow participants to select those episodes of care that best meet the needs of their patient population and align with their facilities' experiences and clinical focus. As discussed in greater detail below, we also recommend that if CMS adopts additional episodes in the future that it makes their inclusion optional.

- ***Provide opportunity for voluntary participation***. CMS should create an opportunity for providers not in a mandatory region to opt-in to the mandatory model to maintain momentum in value-based care and continue a patient-centric focus.

- ***Engage with stakeholders early on the design of mandatory models.*** We appreciate CMS ongoing engagement with stakeholders on the design of the mandatory model, including through a request for information (RFI) last summer. ***Premier encourages CMS to continue to engage with the provider community on this model after its launch to address any operational challenges and to ensure providers have meaningful opportunities to advance delivery system transformation***.

We discuss these and other recommendations in greater detail below.

I. BACKGROUND ON PREMIER INC.

Premier is a leading healthcare improvement company and national supply chain leader, uniting an alliance of 4,350 hospitals and approximately 300,000 continuum of care providers to transform healthcare. With integrated data and analytics, collaboratives, supply chain solutions, consulting and other services, Premier enables better care and outcomes at a lower cost. Premier's sophisticated technology systems contain robust

data gleaned from nearly half of U.S. hospital discharges, 2.7 billion hospital outpatient and clinic encounters and 177 million physician office visits. Premier is a data-driven organization with a 360-degree view of the supply chain, working with more than 1,460 manufacturers to source the highest quality and most cost-effective products and services. Premier's work is closely aligned with healthcare providers, who drive the product and service contracting decisions using a data driven approach to remove biases in product sourcing and contracting and assure access to the highest quality products. In addition, Premier operates the nation's largest population health collaborative, having worked with more than 200 accountable care organizations (ACOs).

A Malcolm Baldrige National Quality Award recipient, Premier plays a critical role in the rapidly evolving healthcare industry, collaborating with healthcare providers, manufacturers, distributors, government and other entities to co-develop long-term innovations that reinvent and improve the way care is delivered to patients nationwide. Headquartered in Charlotte, North Carolina, Premier is passionate about transforming American healthcare.

II. MODEL PERFORMANCE PERIOD AND RISK TRACKS

Model duration. CMS proposes a 5-year model performance period, defined as January 1, 2026 through December 31, 2030. The start of the model aligns with the end of the Bundled Payment for Care Improvement (BPCI) Advanced model, which ends on December 31, 2025. CMS notes that it considered a shorter (3 years) and longer (5 years) model. However, CMS felt that a 3-year model would not provide adequate time for hospitals to invest in transformation and achieve savings for Medicare. Additionally, CMS opted to not pursue a 10-year model, similar to several other recently announced Innovation Center models, as it believes five years should be sufficient time to evaluate the model, given its mandatory nature. CMS seeks comment on if one-year is sufficient time for hospitals to prepare for participation.

Participant Selection. CMS notes that it considered making the model voluntary, but it does not believe doing so would lead to meaningful evaluation findings since CMS has previously tested voluntary episode-based payment models. CMS notes that it also considered allowing hospitals that had previously participated or are participating in a Medicare episode-based payment model to voluntarily opt into TEAM to allow these entities to maintain participation and momentum in value-based care. However, CMS is concerned that allowing for opt-in may limit the ability of the model to achieve Medicare savings and may compromise the rigor of the model evaluation by limiting the size of the comparison group.

Citing the challenges of including multiple providers in a model, CMS is proposing to limit the model to acute care hospitals paid under the IPPS. By limiting the model to one type of provide, CMS notes it avoids having to establish precedence rules for assigning beneficiaries and it makes it easier for a participant to identify beneficiaries that may be included in the model. CMS also notes it believes hospitals are likely to have access to the resources that will allow them to coordinate care through an episode and that they are more likely than other providers to have "an adequate volume of episodes to justify an investment in episode management."

Stratification. CMS proposes to identify model participants by first selecting geographic areas, and then requiring all hospitals (except for those specifically excluded) in the geographic area to participate. Geographic areas, as defined on the basis of core-based statistical areas (CBSAs), would be identified and selected using stratified random sampling to improve the statistical power of subsequent evaluations. CMS proposes to exclude CBSAs located in Maryland (in whole or in part) and those where hospitals generated no episodes in any of the five episode categories between January 1, 2022 and June 30, 2023.

CMS proposes to stratify CBSAs into groups based on average historical episode spending, the number of hospitals, the number of safety net hospitals and the CBSA's exposure to prior CMS bundled payment

models. Under this proposal, CMS would oversample CBSAs with a higher number of safety net hospitals and who have hospitals with limited experience with prior CMS' bundled payment models. CMS estimates that will select approximately 25 percent of eligible CBSAs for participation in TEAM through this method.

TEAM Participation Tracks. CMS propose three risk tracks, each with differing financial risk and quality performance adjustments. Under the proposal, all participants would have a one-year glide path to two-sided risk. During Performance Year (PY) 1, all TEAM participants would have the option of participating in one of two tracks: Track 1 (up-side only financial risk) or Track 3 (two-sided financial risk, subject to 20 percent stop-gain/stop-loss limits and a quality adjustment percentage of up to 10 percent). In subsequent performance years (PYs 2-5), participants would be assigned to either Track 2 or Track 3 depending on eligibility. Under Track 2, participants would still be subject to two-sided financial risk, but would have lower stop-gain/stop-loss limits of 10 percent and subject to quality adjustment of up to 10 percent for positive reconciliation amounts and up to 15 percent for negative reconciliation amounts.

CMS proposes to limit Track 2 to:

- *Safety net hospitals* (as discussed in more detail below)
- *Rural hospitals*
- *Medicare dependent hospitals (MDHs)*
- *Sole community hospitals (SCHs)*
- *Essential access community hospitals (EACHs)*

CMS notes that it believes it proposal would provide these hospitals with the "opportunity to deliver value-based care and would avoid the financial pressures of a two-sided financial risk model that could make their participation in TEAM untenable." It also believes that requiring these hospitals to participate in downside risk for PY 2 and subsequent years would help drive care improvement and establish care efficiencies that could lead to better outcomes on cost and quality. However, CMS does seek comment on allowing these hospitals to remain in Track 1 (upside-only financial risk) for the duration of the model.

Recommendations

We appreciate that CMS is offering all participants the opportunity to participate in upside-only financial risk for PY1. With mandatory models, in particular, it is essential that CMS offers providers the opportunity to gradually assume financial risk to ensure all providers have an opportunity for success under the model. However, as noted above, ***Premier urges CMS to extend Track 1 for an additional year to support practice transformation and ensure all providers can participate in the mandatory model***. This approach would allow participants to change workflows to align with the model, utilize performance data from CMS to identify areas for transformation and receive additional education from CMS on model parameters and meeting objectives. Additionally, it would allow CMS to work through any operational challenges to help minimize any changes once participants are subjected to two-sided risk. If CMS is concerned about its ability to evaluate the models impact on Medicare savings (since the opportunity for two-sided risk would be shortened to PYs 3-5), it could consider extending the model an additional year (up to six years).

Additionally, ***Premier strongly urges CMS to reevaluate its proposal to require safety net and rural hospitals to take on two-sided risk.*** The goal of models in rural or underserved communities should be to improve access and sustainability of care, not to achieve savings to the Medicare program. Many rural and safety net providers have not historically participated in value-based care models because they often operate under tight financial margins and lack the resources to take on risk or invest in the infrastructure necessary to successfully participate in these programs***. If CMS is interested in targeting inclusion of rural and safety net hospitals, we strongly urge CMS to allow these participants the option to remain in upside only (Track 1) for the duration of the model***. Pushing these providers to take on two-sided risk, even with the guardrails proposed under Track 2, could further jeopardize access to care in these communities.

We also encourage CMS to provide up-front investment opportunities for rural and safety net providers, similar to flexibilities offered under the MSSP's Advanced Investment Payment policy. Many rural and safety net providers may lack the financial resources to invest in the care management and analytics infrastructures needed to succeed under the model. Ideally, the upfront investment should not be recouped from participants. At a minimum, CMS should hold these hospitals harmless if they are unable to achieve sufficient savings during the model performance period.

As discussed in greater detail below, ***it is also essential that CMS establish appropriate exclusion criteria for low-volume hospitals***. To that end, we also encourage CMS to either exclude low-volume hospitals from participation or allow these facilities to remain in Track 1 for the duration of the model.

Finally, ***CMS should create an opportunity for providers to opt-in to the mandatory model to maintain momentum in value-based care and continue a patient-centric focus***. Many providers have invested heavily in participation in episodic payments over the last decade and should be given an opportunity to continue those efforts. With the concentrated focus on health equity, allowing voluntary participants in a new mandatory model has the potential to extend beneficiary reach and access to high-quality care, as well as provide additional opportunities for CMS and providers to work together to improve cost, utilization and patient care broadly.

III. EPISODE DESIGN

Episode selection. CMS proposes to test five surgical episode categories in TEAM:

1. Coronary Artery Bypass Grafting (CABG);
2. Lower Extremity Joint Replacement (LEJR);
3. Surgical Hip and Femur Fracture Treatment (SHFFT);
4. Spinal Fusion; and
5. Major Bowel Procedure

Episode categories would be identified by Medicare Severity-Diagnosis Related Group (MS-DRG) for inpatient admissions or by Healthcare Common Procedure Coding System (HCPCS) codes for hospital outpatient procedures.

CMS notes that it is proposing to test surgical episodes because they are typically "time-limited with well-defined triggers, have clinically similar patient populations with common care pathways, and have sufficient spending or quality variability, particularly in the post-acute period, to offer participants the opportunity for improvement." However, CMS notes that it intends to include additional episode categories in future years and seeks input on additional episodes for inclusion, including the potential adoption of medical service bundles.

Episode length. CMS proposes to define TEAM episodes as consisting of all Part A and Part B services (with limited exceptions), beginning with an inpatient admission ("anchor hospitalization") or outpatient procedure ("anchor procedure"), and ending 30 days after discharge or after the anchor procedure. This is a change from both the Bundled Payment for Care Improvement (BPCI) Advanced and Comprehensive Care for Joint Replacement (CJR) models, which include 90-day episodes. CMS notes that it believes an episode lasting longer than 30 days "poses a greater risk for the hospital because of variability due to medical events outside the intended scope of the model." Its analysis of the BPCI Advanced model found that patients needed care for chronic conditions and other non-anchor MS-DRG-related conditions more often in the days 31 to 90 following a hospital discharge. CMS finally notes that "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," which it believes ACOs are better equipped to address. Finally, CMS notes that the majority of episode spending occurs in the first 30 days following discharge or the anchor procedure.

Exclusions. CMS proposes to use similar exclusion criteria as under the BPCI Advanced program to identify items or services that may be clinically unrelated to the episode. For example, CMS would exclude admissions and readmissions for specific categories of diagnoses (e.g., oncology, trauma medical admission, organ transplant), new technology add-on payments or outpatient pass-through payments, or other low-volume, high-cost drugs.

Episode cancellation. CMS proposes to cancel an episode if a beneficiary no longer meets criteria for inclusion, dies during the admission or participation or if the participating hospital is subject to an extreme and uncontrollable circumstance.

Premier's Recommendations

The goal of episodic payment models should be centered around the management of acute medical events or procedures that present opportunities for improving quality of patient outcomes and addressing variations in cost. This stands in contrast to total cost of care models, which are centered around preventive care and are better suited to addressing chronic conditions over longer periods of time. To that end, ***Premier recommends that CMS differentiate episodes of care based on the condition and procedures, needs of the patient and which entity is best suited to manage care of the patient.***

Premier supports CMS' proposal to focus on surgical episodes of care that have defined and well-established care practices or medical protocols. As CMS notes in the rule, these types of procedures or conditions typically will require care for a set-period of time, which will be managed by a specialist in coordination with other providers. The types of care furnished under these procedures or conditions are also typically well-defined, lending themself to be included in an episode of care.

CMS notes that it is considering adopting additional episodes into the model as part of future rulemaking. ***Premier urges CMS to not expand the model at this time, as it will introduce additional burden onto hospitals at a time they are already trying to adapt to the episodes mandated under this model.*** If CMS wishes to include additional episodes, Premier recommends that it makes those episodes voluntary for participating hospitals. Additionally, CMS should generally consider avoiding any chronic condition or medical episodes that are typically managed by primary care physicians or other specialists long-term and allow those to be managed through accountable care relationships.

Episode design should be based on the clinical protocols for the acute condition or procedure. To date, CMS has typically designed episodes around an acute care hospitalization or outpatient procedure (or a "trigger" event) and includes nearly all care furnished during the hospitalization and for 90 days post-discharge with minimal exclusions. This can create challenges for participants who are oftentimes held accountable for additional care that is unrelated to the episode, such as hospitalizations for a new condition or drug costs for treatment of unrelated health issues.

As noted above, CMS is proposing a shorter 30-day episode under the model. ***Premier is concerned that this approach may severely limit the ability of participants to improve both the quality and efficiency of care furnished during the episode***. While CMS is correct in noting that most episode costs under a 90-day episode occur during the admission or procedure and in the first 30 days, most of these costs are incurred during the hospital stay or procedure. Given hospitals are paid a MS-DRG payment – which is already an episodic payment – participants would be left with minimal opportunities to improve care coordination and

reduce Medicare spending post-discharge. The challenge is even more pronounced when looking at certain surgical episodes, such as cardiac procedures or spinal fusion. Under a 30-day CABG, nearly 87 percent of the target price would be accounted for in the MS-DRG payment, leaving participants with minimal opportunity to improve care coordination post-discharge and reduce Medicare spending. Under a 30-day spinal fusion episode, approximately 82 percent of spending occurs during the hospital admission or procedure. This will not only limit the success of model participants but will also reduce the opportunities for CMS to realize Medicare savings under the model. As a result, at a minimum, ***Premier recommends that CMS make both the CABG and spinal fusion episodes optional for model participants.***

Episode design should <u>not</u> be one-size-fits all but instead be tailored to the specific condition or procedure and the needs of the patient. To that end, ***Premier strongly recommends that CMS work with stakeholders, including clinicians, to model and design future episodes of care around defined acute conditions or procedures.*** As part of this, CMS should explore modifying the point at which an episode is triggered and broaden episodes to include pre-operative care or office visits related to the procedure, with a focus on improving care coordination prior to the procedure or hospital stay. Some episodes of care are planned and start prior to a hospital admission or outpatient procedure. In doing this, CMS should prioritize episodes of care that provide meaningful opportunities for participants to engage in care re-design efforts. To improve stability of episode pricing methodologies and ensure participants have meaningful opportunities to participate, CMS should select episodes that are high volume and have variability in costs.

Additionally, many of the challenges associated with a longer episode could be addressed if CMS were to revisit how it identifies which costs are included in the episode of care. The current "exclusion lists," which are used to identify which items or services are not included in the episode, are limited in scope and often leave many unrelated items and services as part of the episode. For example, some BPCI Advanced participants are being held accountable for items and services unrelated to the initial episode of care, such as a joint replacement on Day 80 of an episode triggered by a urinary tract infection. ***CMS should revisit the development of its exclusion list for episodes to ensure participants are only held accountable for care that is truly relevant and clinically appropriate to the episode of care.*** As part of this, CMS should expand its exclusion list policy to exclude patients with a cancer diagnosis, not just cancer readmissions. Additionally, CMS should exclude high-cost drugs and procedures that are unrelated to the episode (e.g., benign tumor treatments and infusion treatments).

Finally, Premier also recommends that CMS align its episode cancellation policy with the policy under the CJR model**,** which cancels an episode if a death occurs during the episode, rather than just during the anchor admission or procedure. Since the proposed model is procedural based, patients may have more complex conditions unrelated to the surgery, especially as the model looks to include more safety net providers and address health inequity. The recommendation to exclude any death during the episode aligns with the current CJR procedural based model, for reasons that there may be patients that expire post-surgery for unrelated conditions to the surgery itself.

IV. QUALITY MEASURES AND REPORTING

CMS notes that it is proposing quality measures for TEAM that focus on care coordination, patient safety and patient reported outcomes (PROs) and that, where possible, it sought to align measures with those already used in ongoing programs to minimize participant burden. CMS proposes three initial measures for TEAM:

1. Hybrid Hospital-Wide All-Cause Readmission Measure with Claims and Electronic Health Record Data (CMS Measure Inventory [CMIT] ID #356)
2. CMS Patient Safety and Adverse Events Composite (CMS PSI 90) (CMIT ID #135)
3. Hospital-Level Total Hip and/or Total Knee Arthroplasty (THA/TKA) Patient-Reported Outcome-Based Performance Measure (PRO-PM) (CMIT ID #1618)

The first two measures would be applicable to all episodes, while the third measure (THA/TKA PRO-PM) would only be applicable to LEJR episodes.

CMS proposes that participants would use existing Hospital IQR program processes to report data and that performance would be publicly reported with a one-year lag (e.g., PY 1 performance would be reported in 2027). As noted below, CMS will adjust reconciliation amounts based on participants' quality performance, beginning in PY 1.

CMS also seeks comment on additional measures for future adoption, including three measures that are currently proposed for adoption in the Hospital Inpatient Quality Reporting (IQR) Program:

1. Hospital Harm – Falls with Injury electronic clinical quality measure (eCQM)
2. Hospital Harm - Postoperative Respiratory Failure eCQM
3. 30-day Risk-Standardized Death Rate among Surgical Inpatients with Complications (Failure-to-Rescue), a claims-based measure

If adopted, these measures would replace the CMS PSI 90 measure beginning in 2027.

Premier's Recommendations

Premier appreciates CMS proposing measures that are already in use under other programs and which would not require participants to report new measures. Reporting quality metrics requires resources and time that participants must absorb in addition to the discounts applied under the model. Use of existing measures and reporting processes can significantly reduce burden and resource costs for participants.

However, Premier is concerned that the proposed measures do not directly measure performance under the model. For measures to be meaningful, those selected must be focused on what the model is trying to accomplish and limited to the model's patient population to ensure participants have meaningful opportunities to improve quality and are held accountable under the model for care that is relevant to their care improvement efforts. The proposed measures utilize hospital-wide metrics. For example, the PSI-90 measure includes adverse events that are not generally linked to the proposed episodes. This has been a similar challenge under past episodic models, like the CJR model. This approach has greatly frustrated CJR participants who feel like that given the breadth of hospital-wide measures, such as the HCAHPS measure, they have limited opportunities to drive improvement under the model, but yet they are held financially accountable for performance on the measure. As a result, even if patients under TEAM had zero readmissions or adverse events, this would have minimal impact on the hospital-wide measures due to the relatively small volume of episodes.

Additionally, the proposed hybrid readmissions measure is currently in its first mandatory reporting period for the hospital IQR programs. Many hospitals have reported challenges with extracting the required data from their electronic health records.

Another challenge with the proposed measures is they are a measure of inpatient performance, whereas the model includes both inpatient and outpatient episodes. For procedures that can be furnished in either the inpatient or outpatient setting, typically the patients who continue to receive care in the inpatient setting tend to be higher risk and with higher prevalences of complications, which can negatively impact performance on measures. A similar challenge has occurred in the CJR model. Over the last few years, we have seen a significant shift in the volume of joint replacement procedures performed in outpatient settings. While CMS modified the CJR model to allow for outpatient procedures to trigger episodes, it did not update the quality measures included in the model. As a result, CJR participants are held accountable for complication rates for elective joint replacements that are conducted in the inpatient setting, but not outpatient. Patients who continue to receive elective joint replacements in the inpatient tend to be higher risk, which has negatively impacted performance on the complications quality measure. Additionally, the shift to outpatient has also resulted in significantly lower inpatient volume, which can create volatility in quality measurement. ***To that end, Premier urges CMS to develop measures that are applicable to the episodes included under the model, including both inpatient and outpatient settings***. As part of this, CMS could consider alternatives, such as registry-based data, which are available for all proposed clinical episodes, except major bowel. CMS could adopt a similar approach to BPCI Advanced, allowing participants to select registry-based measures rather than claims-based measures.

Additionally, CMS has expressed interest in creating quality alignment across all programs, including the Innovation Center, by utilizing a core set of measures as part of its recently announced Universal Foundation initiative. Measures most often included in the core set are primary care centric and may not be appropriate for episodic or specialty care models. As a result, Premier cautions CMS in its evaluation of measures for inclusion under an episodic model to ensure whatever measures are selected are appropriate and relevant to the model.

CMS notes that it is interested in developing additional patient-reported outcome measures for other episodes under the model. While Premier is supportive of PROMs and acknowledges that PROMs can be the impetus for initiating conversations between patients and providers and improving shared-decision making, a number of challenges exist to the current construct. ***As a result, Premier encourages CMS to consider the following principles when designing PROMs for future episodic payment models:***

- ***Ensure timing of survey and who administers the survey aligns with the practice of care and does not create undue burden on episodic participants***. For example, under the CJR model, the point at which the post-operative survey is currently conducted is well after the procedure (anywhere from 275 to 425 day after the procedure.) At this point, the patient has long left the hospital and is likely being followed by an orthopedic practice. The longer the beneficiary waits to complete the post-operative survey, the more opportunity exists for bias to be introduced into the patient's response. Events that may have happened outside the program's control may also now influence the patients' responses. Additionally, as some patients may maintain multiple residences based on the seasons (e.g., "snowbirds"), some facilities may be challenged to collect post-operative surveys multiple months after a procedure or admission for patients who may no longer be living in the area. Finally, once the patient leaves the hospital, any ongoing follow-up is likely to occur through the specialists' practice. As a result, it may be more appropriate for the specialists to field the survey. CMS should explore modifying data collection to be done through a specialist practice rather than assigning the responsibility to the hospital.

- ***Partner with patient advocacy groups to test patient and family-centered care and patient experience questions.*** 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.

Finally, CMS is considering adoption of three new measures for TEAM that are also being proposed for adoption into the Hospital IQR Program. This includes two new electronic clinical quality measures (eCQMs), which are being added to the Hospital IQR Program as measures that hospitals can self-select to meet eCQM reporting requirements. ***Premier cautions CMS from adopting these new measures until which time hospitals have had an opportunity to report and receive feedback under the Hospital IQR Program.*** While the measures are proposed for adoption into the Hospital IQR Program for the 2026 reporting period, it is important to note that the Hospital IQR Program is a pay-for-reporting program, which means hospitals will not be evaluated for their performance on these measures. Typically, CMS adopts measures into the Hospital IQR Program prior to adoption into its pay-for-performance quality programs, which provides hospitals with time to receive feedback on their performance and implement any necessary quality improvement efforts. Adoption into the TEAM will immediately make these measures pay-for-performance metrics, as participants under TEAM are held accountable for their performance.

Additionally, providers have faced a number of challenges with eCQM reporting. Feedback to hospitals about their performances on eCQMs is infrequent and seldom helpful as a basis for performance improvement. While Premier is supportive of ongoing efforts by CMS to advance digital quality measurement, we caution CMS from adopting these measures into a pay-for-performance programs until which time it is able to address the eCQM reporting challenges. This include difficulties extracting data from "production-ready" eCQM products delivered by developers and insufficient time to complete testing, validation, staff education and rollout of eCQMs before their reporting is required. Costs to hospitals also remain a substantial obstacle to eCQM adoption.

Finally, the three measures under consideration are not specific to the episodes under the TEAM model. ***As a result, Premier cautions CMS from adopting the three measures into TEAM until which time hospitals have had time to report the measures for several years under the Hospital IQR Program.***

V. PRICING AND PAYMENT METHODOLOGY

CMS will use experience from CJR and BPCI Advanced to inform the calculation of episode target prices under TEAM, noting its goal of a "target price methodology that blends the most successful elements of each of these model iterations, striking a balance of predictability and accuracy."

Baseline Period for Benchmarks. CMS proposes to use a three-year rolling baseline of data, trended forward to the performance year, to calculate target prices for each MS-DRG/HCPCS episode type and region. As a result, target prices would be re-based each year. For example, for PY1, CMS would use baseline data for episodes that started between January 1, 2022 and December 31, 2024. CMS would then roll the baseline forward by one-year so that by PY5 the baseline would be based on spending for episodes that started between January 1, 2026 and December 31, 2028, or the first three-years of the model.

Within each three-year baseline period, CMS proposes to trend the first two baseline years (baseline year [BY]1 and BY2) forward to most recent year of the baseline period, or BY3. This adjustment would capture the impact of inflation and any other changes in episode spending resulting from changes in Medicare payment policies or other factors in the baseline period. CMS would apply more weight to more recent baseline years when calculating the target price: spending in BY3 would be weighted at 50 percent, spending BY2 would be weighted at 33 percent and spending in BY1 would be weighted at 17 percent.

Regional Target Prices. CMS proposes to set target prices for each MSDRG/HCPCS episode type and region based on 100 percent regional data for all TEAM participants prior to each PY. The approach is similar to the methodology used under the CJR model for PYs 4-8.

CMS proposes to group episodes from the baseline period by applicable MS-DRG for episode types that include only inpatient hospitalizations, and by applicable MS-DRG or HCPCS code for episode types that include both inpatient hospitalizations and outpatient procedures. For episode types that include both inpatient hospitalizations (identified by MS-DRGs) and outpatient procedures (identified by HCPCS codes), HCPCS codes are combined for purposes of target pricing with the applicable MS-DRG representing an inpatient hospitalization without Major Complications and Comorbidities, as CMS expects those beneficiaries to have similar clinical characteristics and costs.

CMS proposes to use average standardized spending for each MS-DRG/HCPCS episode type in each region as the benchmark price for that MS-DRG/HCPCS episode type for that specific region, resulting in 216 MS-DRG/HCPCS episode type/region-level benchmark prices. CMS proposes that TEAM participants would be provided the regional prices as episode targets, rather than hospital-specific or a blend of regional/hospital-specific prices.

High-Cost Outlier. CMS proposes to cap both baseline episode spending and performance year episode spending at the 99th percentile of spending at the MS-DRG/HCPCS episode type and region level. This is similar to the policy that is in place under the CJR three-year extension.

Prospective Trend Factor and Discount. CMS proposes to apply a prospective trend factor and a discount factor (3 percent) to benchmark prices (as well as a prospective normalization factor, as discussed in more detail below) to calculate preliminary target prices.

The prospective trend factor would represent expected changes in overall spending patterns between the most recent calendar year of the baseline period and the performance year, based on observed changes in overall spending patterns between the earliest calendar year of the baseline period and the most recent year of the baseline period. CMS proposes to calculate the prospective trend as the difference between the average regional MS-DRG/HCPCS episode type expenditures between BY1 and BY3. This approach is similar to the policy applied under the CJR extension, with the exception that CMS would be performing the calculation prospectively and performance year expenditures would not be considered. CMS believes this approach may improve the predictability of target prices.

The discount factor, which is similar to the discount applied under the CJR model and to the surgical episodes under BPCI Advanced, would represent Medicare's portion of potential savings from the episode. CMS notes that it considered no discount factor for safety net hospitals, given the proportion of underserved beneficiaries they care for and that many safety net hospitals may be new to participating in bundled payments. CMS also considered varying the discount based on baseline spending, so that episodes with minimal variability may have lower discounts as it may indicate fewer opportunities for savings in the episode. CMS seeks comment on these alternatives.

Risk Adjustment and Normalization. CMS proposes to risk adjust episode-level target prices at reconciliation by beneficiary age, the beneficiary's Hierarchical Condition Count (HCC) and social risk. CMS proposes to use a modified version of the risk adjustment methodology used under the CJR model.

Under the proposal, CMS would calculate risk adjustment multipliers prospectively for each MS-DRG/HCPCS episode type level based on baseline data, and hold those multipliers fixed for the performance year. This differs from the CJR model, which calculates on national set of risk adjusters across all MS-DRGs for a given episode category. Additionally, CMS notes that it considered setting risk adjustment at the regional level for each of MS-DRG/HCPCS episode type level, but opted not to propose this policy out of concern that the low volume of episodes for certain MS-DRG/HCPCS episode types could create inaccuracies or unreliability in the risk adjustment multipliers.

For beneficiary age, CMS proposes to use the same age brackets used in CJR: less than 65 years, 65-75 years, 75-85 years, and 85 years or more, based on the beneficiary's age on the first day of the episode as determined through Medicare enrollment data. This is similar to the methodology used in the CJR model extension.

CMS also proposes to use an HCC count risk adjustment variable (known as the TEAM HCC count). Under this proposal, CMS would conduct a 90-day lookback for each beneficiary, beginning with the day prior to the anchor hospital or anchor procedure. CMS would use Medicare FFS claims from the 90-day lookback period to determine which HCC flags the beneficiary is assigned and create a count using those flags. This methodology is consistent with the BPCI Advanced model.

Finally, CMS proposes to use a variable to account for social risk composed of three elements:

(1) fully dually eligible for Medicare/Medicaid,
(2) position on the distribution of the beneficiary's geographic residence on the distribution of Area Deprivation Index (ADI) values (>the 80th percentile for national ADI, and the 8th decile for state ADI), and
(3) whether or not the beneficiary qualifies for the Part D Low-Income Subsidy (LIS).

Under this policy, a beneficiary would be assigned a value of "yes=1" on this single, binary social risk variable if one or more of these three indicators of social risk applied to the beneficiary.

To ensure that risk adjustment does not inflate target prices overall, CMS proposes to calculate a prospective normalization factor based on the data used to calculate the risk adjustment multipliers. The prospective normalization factor would be applied, in addition to the prospective trend factor and discount factor described previously, to the benchmark price to calculate the preliminary target price for each MS-DRG/HCPCS episode type and region. CMS proposes that the prospective normalization factor would be subject to a limited adjustment at reconciliation based on TEAM participants' observed performance period case mix, such that the final normalization factor would not exceed +/- 5 percent of the prospective normalization factor.

Premier's Recommendations

While we appreciate that CMS acknowledges the ratchet effect created by using benchmarking methodologies that are dependent on historical spending, we do not agree with CMS' assertion that a three-year rolling baseline addresses these issues. Even with a rolling average, the benchmarking approach still relies on historical spending which will be untenable in the long term. This will create a "race to the bottom," especially for episodes like joint replacements which have been included in episodic models for more than a decade at this point. To mitigate the ratchet effect, ***Premier encourages CMS to work with stakeholders to test***

innovative approaches to incorporate administratively set benchmarks into the benchmarking methodology.

Premier supports CMS' proposal to set benchmarks based on regional spending. For both the BPCI Classic and BPCI Advanced models, CMS based the target prices primarily on an episode initiator's historical performance with a discount applied to account for Medicare savings. As bundles have matured this is no longer a sustainable method of deriving targets, as it does not recognize efficiencies gained under prior models and may limit a participant's ability to succeed overtime, creating a "race to the bottom." Regional pricing, as seen in the CJR model alleviates some concern, while accounting for regional differences in care referral patterns. Furthermore, a regional pricing methodology encourages even the most efficient providers to continue to refine care coordination across the continuum to remain efficient as compared to peers in the region. However, ***Premier strongly urges CMS to assess the sustainability of benchmarking in regions where there has been high CJR penetration.*** Given the CJR model has been in operation for more than eight years at this point, these regions have already created notable efficiencies which may make it challenging for participants to achieve additional cost savings. If CMS continues to discount benchmarks, this could ultimately create access issues in these regions. As a result, we urge CMS to provide additional information on what benchmarks would be in these regions and work with stakeholders to evaluate the sustainability of continuing to discount these benchmarks year-over-year.

As noted above, CMS proposes to set one target price for each episode type that includes both inpatient hospitalizations and outpatient procedures. CMS has used a similar approach in the CJR model since PY6, at which point CMS began including outpatient joint replacement procedures. Under the CJR model, CMS distinguishes its target prices based on if a procedure is elective versus fracture and if a patient had major complications or comorbidities (MCC) or non-MCCs. Setting one target price for inpatient and outpatient procedures has not appropriately accounted for the costs of providing care to patients in an inpatient setting (who tend to be sicker and more complex) versus outpatient. For example, CJR participants are currently coming in below target for fractures but are facing significant losses for elective procedures. Elective procedures make up about 89 percent of CJR episodes, nearly 80 percent of which are administered in an outpatient setting.

Without more exact risk adjustment approaches, setting one target price for each episode group introduces inaccuracies into the target price methodologies that could create market distortions. ***Premier recommends that CMS revise its methodology and set target prices at the MS-DRG and HCPCS levels.*** There should be sufficient volume at the regional level to set more specific and accurate target prices than relying on a blended mix from both the outpatient procedures and inpatient procedures.

Premier recommends revising the high-outlier policy to cap both baseline and performance year spending at the 5th and 95th percentile to reduce variability with outlier cases.

Premier supports CMS' proposal to implement a prospective trend factor. One of the challenges with the current bundled payment models has been the significant fluctuations between initial target price and the final target price at reconciliation. Participants need predictable, achievable target prices that allow them to identify the desired goal under an episodic arrangement.

As discussed in greater detail below, ***Premier urges CMS to vary the discount factor applied under the model based on quality of performance.*** This will ensure that the model is not simply a payment cut and that participants have meaningful opportunities to take on both upside and downside risk under the model.

***Premier supports CMS' proposal to set risk adjustment based on age, HCC count and social risk. However, we recommend the following modifications to the proposal to further strengthen the accuracy of risk adjustment*:**

- ***Premier urges CMS to set risk adjustment at the regional level for each of the episode types***, which would better account for variations nationwide. As noted above, CMS did not propose this option because it was concerned around episode volume. We would encourage CMS to set risk adjustment at the regional level when there is sufficient volume for a certain episode type. For those regions and episode types where there is not sufficient volume, CMS could still use a national coefficient.
- ***Premier urges CMS to extend the lookback period for evaluating HCC count for purposes of risk adjustment from 90-days to one year, which would align with the CJR model.*** Using a 90-day look back period will underestimate the care needed for a patient. We also urge CMS to account for both HCC weights and counts in the risk adjustment, as well as HCCs captured during the episode, as is done in BPIC Advanced.
- ***Premier urges CMS to include additional patient-level clinical risk factors,*** such as if a procedure is elective or emergent and if a patient lived in a nursing home prior to the episode. For example, there is a meaningful clinical difference between if a surgical episode is planned or due to an emergency as that can drive patient complexity and the need for more intensive care patterns, which in turn increases costs. Additionally, patients who previously lived in a nursing home and will return to a nursing home after discharge can substantially drive-up spending during the episode and post-episode period. This care pattern reflects appropriate care delivery for known clinical risks, which are outside the control for model participants. Omitting this data from the risk adjustment model would penalize hospitals that care for the sickest patients, potentially leading to unintentional consequences that harm patient access, quality of care and equity.

Finally, ***Premier urges CMS to cap the normalization factor at the average gain for a region due to risk adjustment.*** For example, under the CJR model, we have seen participants see an increase of nearly 7 percent in their target prices, due to risk adjustment, be completely wiped out by a normalization factor of more than -16 percent. The purpose of the normalization factor is to ensure risk adjustment does not inflate target prices. However, in the example noted above, the normalization factor had more than twice the impact of the risk adjustment itself. Finally, CMS notes that it will adjust the prospective normalization factor at reconciliation. We urge CMS to not adjust the normalization factor and maintain its prospective nature. As noted above, one of the main challenges that participants have faced under both CJR and BPCI Advanced is large swings in their target price from performance period to reconciliation, which makes it difficult for participants to plan and succeed under the model. ***Premier appreciates efforts by CMS to address these concerns by limiting retrospective adjustments elsewhere under the model***. We encourage CMS to maintain a similar policy and not adjust the normalization factor at reconciliation.

VI. RECONCILIATION

CMS proposes to conduct an annual reconciliation calculation that would compare performance year spending against target prices for those episodes. CMS proposes to conduct the reconciliation six months after the end of the performance year. Under the policy, CMS would compare each participant's performance year spending (after adjusting for outliers) to its reconciliation target prices. The reconciliation amount represents the difference between the reconciliation target price and performance year spending for each MS-DRG/HCPCS episode type, prior to adjustments for quality, stop-gain/stop-loss limits and post-episode spending, which are discussed in more detail below.

***Composite Quality Score*.** CMS proposes to adjust a participant's reconciliation amount by its Composite Quality Score (CQS). As noted above, CMS is proposing to use three quality measures under the model that are currently collected through existing Medicare hospital quality reporting programs. Similar to BPCI Advanced, CMS proposes to calculate scaled quality measure scores by comparing a participant's raw quality measure score on each measure against a national cohort of hospitals, which would include both TEAM participants and hospitals not participating in TEAM in the CQS baseline period (CY 2025). For each measure, hospitals would receive a score of 0 to 100 based on their percentile performance compared to the national cohort. Prior to calculating the CQS, CMS would volume weight the quality measures based on the volume of episodes for a participant, which would give more weight to quality measures that apply to more episode categories.

Under this proposal, the CQS percentage adjustment would be a function of the model participant's track:

- *Track 1* (upside-only): CQS Adjustment could adjust positive reconciliation amount by as much as -10 percent based on performance (i.e., participants would receive lower positive reconciliation amount if have lower quality performance)
- *Track 2*: CQS Adjustment could adjust positive reconciliation amount by as much as -10 percent or negative reconciliation by as much as +15 percent based on performance (i.e., would owe less back to Medicare based on higher quality performance)
- *Track 3*: CQS Adjustment could adjust positive reconciliation amount by as much as -10 percent or negative reconciliation by as much as +10 percent based on performance

CMS notes that it considered applying its CQS methodology to adjust the discount factor, similar to how the policy is applied under the CJR Model. However, CMS believes the proposed approach "creates a greater incentive to improve quality measure performance because a TEAM participant must achieve a CQS of 100 in order to receive the maximum quality-adjusted reconciliation amount."

Low-Volume Threshold. CMS proposes to apply a low-volume threshold policy at reconciliation. Under the policy, if a TEAM participant did not meet the proposed low volume threshold of at least 31 total episodes across all episodes in the baseline period for PY1, CMS would still reconcile their episodes, but the TEAM participant would be subject to the Track 1 stop-loss and stop-gain limits for PY1. If a TEAM participant did not meet the proposed low volume threshold of at least 31 total episodes in the applicable baseline periods for PYs 2-5, they would be subject to the Track 2 stop-loss and stop-gain limits for PY 2-5. CMS notes that it considered removing participants under the model if they did not meet the minimum volume threshold. However, it opted not to propose this policy because of concerns that it would "restrict the number of hospitals eligible to participate in TEAM and limit beneficiary access to the benefits of value-based, coordinated care."

Limitations on reconciliation amounts. As noted above, CMS proposes to phase in risk under the model:

- Under Track 1, participants would not be subject to downside risk in PY1, but would be subject to a stop-gain limit of 10 percent.
- Under Track 2, participants would be subject to downside and upside risk with symmetric stop-gain and stop-loss limits of 10 percent for PYs 2-5. S
- Under Track 3, participants would be subject to both upside and downside risk, with symmetric stop-gain and stop-loss limits of 20 percent for all performance years. CMS notes Track 3 would be designed for TEAM participants with prior experience in value-based care or those who are prepared to accept greater financial risk in the first year of TEAM

Post-Episode Spending. To mitigate any potential incentives for hospitals to defer necessary care to the period after the episode, CMS proposes to calculate total Part A and Part B spending in the 30-day period following the completion of each episode, whether or not the spending is related to the defined episode. CMS proposes that starting in PY1 for Track 3 participants, and PY2 for Track 2 participants, if the participant's

average post-episode spending exceeds a defined threshold (three standard deviations from the regional average 30-day post-episode spending), the amount above the threshold would be subtracted from the reconciliation amount or added to the repayment amount for that performance year. The amount above the threshold would not be subject to the stop-loss limits.

Premier's Recommendations

Premier supports CMS' proposal to conduct reconciliation six months after the end of the performance year. Delayed results and reconciliations have a negative impact on participants as they may not have clarity on which of their cost reduction initiatives are driving the most value and if they will receive positive reconciliation to continue to enhance and reinvest in bundled payment programs.

As noted above, ***Premier is concerned that the model as designed does not offer meaningful opportunities for participants to take on two-sided risk.*** CMS' proposal to apply the CQS at reconciliation will only serve to mitigate negative reconciliation for high quality entities. CMS notes that it believes its proposal will incentivize hospitals to be top performers as the only way they would be eligible to receive their full positive reconciliation amount is if they score 100. Since the CQS is calculated comparing hospitals to their peers, it is unrealistic to expect that all top performers will score 100 based on their performance. As a result, CMS' proposal to adjust quality only serves as yet another payment cut to participating providers. ***Premier strongly advises CMS to revise its policy to allow high-quality and efficient participants to "earn back" or reduce their discount under the model based on their quality performance.*** Doing so would allow providers to take on meaningful risk***. Premier also encourages CMS to include opportunities for participants to earn points based on improvements in quality performance.*** CMS could utilize the same methodology that it has under the CJR model, which allows hospitals to earn improvement points for applicable quality measures if the hospital's performance increases from the prior year by at least 2 deciles on the performance percentile scale.

Premier is also concerned that the proposed low-volume threshold is not sufficient to protect low-volume hospitals from catastrophic losses. Providers who have a low volume of procedures can face significant variability in performance and large losses due to only a handful of patients. For example, under CJR, the low-volume threshold is set at fewer than 20 procedures across a three-year historical period. This threshold is exceptionally low and has resulted in CJR participants being included in the model who may not see more than 10 to 15 joint replacement procedures each year. Not only will this limit the participant's ability to fully engage and invest in the model, but the low volume can create significant variability in their performance. For example, one CJR participant that Premier works with never exceeded 15 episodes per performance period. The low volume combined with social determinants of the population they served resulted in significant financial losses due to the inability to create a normalized population distribution.

As a result, ***Premier recommends that CMS set the low-volume threshold as 40 episodes per episode category during the baseline period.*** This is similar to the methodology applied under the BPCI Advanced model. ***Hospitals that meet the low-volume threshold should either be excluded from the model or be subject to Track 1.***

Finally, Premier encourages CMS to explore calculating post-episode spending by comparing a participant's spending to the regional average for its peers rather than just the region as a whole. This would better capture any differences in spending that may be driven by hospital type and the types of patients that a facility serves. For example, a trauma hospital may have higher spending compared to its region because of the patient population that it serves. CMS could define a hospital's peer group by using the same peer group characteristics that it uses for the BPCI Advanced model.

VII. MODEL OVERLAP

Under prior models when there has been overlap in provider participation or beneficiary attribution, CMS has defined certain attribution or precedence policies to ensure that Medicare did not make duplicate payments and to ensure that the incentives created by participation in multiple models were not misaligned. However, these efforts have often resulted in confusing methodologies or misaligned incentives which were difficult to navigate, including challenges with identifying whether a beneficiary may be aligned or attributed.

In alignment with its Innovation Center Strategy Refresh, CMS continues to believe it is important to simultaneously allow beneficiaries to participate in broader population-based and other total cost of care models, as well as episode payment models that target a specific episode with a shorter duration, such as TEAM. As a result, CMS proposes that a beneficiary could be in an episode in TEAM and be attributed to a provider participating in a total cost of care or shared savings model or program. This proposal would allow any savings generated on an episode in TEAM and any contribution to savings in the total cost of care model to be retained by each respective participant. The episode spending in TEAM would be accounted for in the total cost of care model's total expenditures, but TEAM's reconciliation payment amount or repayment amount would not be included in the total cost of care model's total expenditures. CMS notes that it believes this policy will foster "a cooperative relationship between accountable care and TEAM participants where all parties have interest in providing coordinated, longitudinal care."

Finally, CMS acknowledges that some ACOs may prefer that their aligned beneficiaries not be included in TEAM, given that this would amount to ceding control over spending for these beneficiaries to an entity outside the ACO. CMS seeks comment on an alternative proposal whereby ACO-aligned beneficiaries would be prohibited from being in a TEAM episode. CMS also seeks comment (but does not propose) requiring TEAM participants to notify an ACO that one of their aligned beneficiaries has triggered a TEAM episode, including the timeframes for such notification and any available data that could inform more effective communications between TEAM participants, and participants in total cost of care models.

Premier's Recommendations

Premier supports CMS' proposal to allow for overlap between TEAM and total cost of care initiatives. We agree with CMS' assessment that allowing for patients to participate in both models presents unique opportunities for providers to collaborate on improving patient outcomes. Research has also found significant benefit to beneficiaries being affiliated to both ACOs and bundled payment initiatives, including being associated with better outcomes and lower readmissions and post-acute spending.[1]

Premier recommends that CMS allow providers already participating in voluntary APMs, such as ACOs, an opportunity to opt out of TEAM if they are actively managing the proposed episodes through a shadow bundle or other type of care intervention. This would ensure that TEAM does not duplicate the efforts that ACOs already have underway with hospital partners. CMS should work with stakeholders to identify a process for participants to identify these interventions – including the criteria for the types of interventions that would qualify – and to request an exclusion from the mandatory model.

Instead of developing beneficiary exclusions, ***Premier encourages CMS to maintain flexibility and instead create incentives and policies that support ACOs and episode initiators in developing partnerships that improve care coordination and patient outcomes.*** When the model incentives align, participating in multiple programs can provide more opportunities to coordinate care for beneficiaries.

[1] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8796940/

VIII. HEALTH EQUITY

In alignment with the Administration's goals, CMS proposes several policies focused on advancing health equity:

Safety Net Hospitals and Rural Hospitals. CMS proposes to use the CMMI Strategy Refresh definition of safety net hospital,[2] which defines a safety net hospital as:

- Exceeding 75th percentile of the proportion of Medicare beneficiaries considered dually eligible for Medicare and Medicaid across all IPPS acute care hospitals in the baseline period
- Exceeds the 75th percentile of the proportion of Medicare beneficiaries partially or fully eligible to receive Part D low-income subsidies across all PPS acute care hospitals in the baseline period

CMS notes that because TEAM participants are selected from CBSAs, by definition no rural hospitals would be explicitly included in the model. However, due to geographic reclassifications or rural referral center designations, some rural hospitals could be pulled into the model. CMS proposes to define rural hospitals for purposes of TEAM as an IPPS hospital that is located in a rural area as defined under §412.64; is located in a rural census tract defined under §412.103(a)(1); has reclassified as a rural hospital under §412.103; or is designated a rural referral center (RRC) under §412.96.

As noted and discussed in more detail above, CMS proposes that safety net and rural hospitals would be included in Track 2.

Beneficiary Social Risk Adjustment. As discussed in greater detail above, CMS is proposing a beneficiary social risk adjustment. CMS believes this adjustment may provide more resources to providers who care for underserved beneficiaries to offset the additional costs often attributed to social determinants of health.

Health Equity Plans and Reporting. CMS proposes that participants would be required to submit health equity plans to CMS in a form and manner and by the date(s) specified by CMS. Under this proposal, submission of a health equity plan would be voluntary in PY1, but would be mandatory in PY2 and subsequent years.

Demographic Data Reporting. CMS proposes that participants would be required to report demographic data on aligned beneficiaries. Under this proposal, reporting would be voluntary in PY1. However, beginning in PY2 and subsequent performance years, participants would be required to report demographic data in a form and manner and by a date specified by CMS. CMS proposes that the demographic data would also be required to conform to USCDI version 2 data standards, at a minimum.

Screening for Health-Related Social Needs. Beginning in PY1, CMS proposes that participants would be required to screen attributed beneficiaries for at least four health-related social needs (HRSN), such as but not limited to: food insecurity, housing instability, transportation needs and utilities difficulty. CMS also proposes that participants would need to report aggregated HRSN screening data and screened-positive data for each HRSN domain to CMS in a form and manner and by date(s) specified by CMS beginning in PY1 and for all following performance years. As part of this reporting, participants would also be required to report on policies and procedures for referring beneficiaries to community-based organizations, social service agencies or similar organizations that may support patients in accessing services to address unmet social needs.

[2] https://www.cms.gov/priorities/innovation/data-and-reports/2022/cmmi-strategy-refresh-imp-tech-report

CMS acknowledges that participants may already report some of this HRSN screening data through other CMS initiatives. For example, the Hospital IQR Program, which began mandatory reporting of two HRSN measures in CY 2024: the Screening for Social Drivers of Health measure and the Screen Positive Rate for Social Drivers of Health measure. CMS seeks comment on reporting processes that would streamline reporting of aggregated HRSN screening data for attributed beneficiaries, including potential use of the Hospital IQR Program measures.

Additional Considerations. CMS also seeks comment on providing upfront infrastructure payments to qualified safety net hospital participants to further support transformation of care delivery. Funds would be available to support certain expenses aimed at supporting beneficiaries with unmet health and social needs. CMS notes that payment could support Health Information Technology/Electronic Health Records (EHR) enhancements, to the extent these activities support population health analytics, care coordination, referrals to address HRSNs.

Premier's Recommendations

Reducing disparities in care and achieving health equity across communities requires a holistic approach to care, shifting the incentives in our health system from sickness-based to wellness-based. When providers are responsible for the cost and quality of care for their patients, such as through APMs, and have flexibility to address SDOH, providers will be proactive in addressing inequity and disparities. However, addressing the underlying social and economic inequities as well as systemic barriers and biases that drive disparities in care requires (1) data collection and monitoring of key outcomes and health equity measures; and (2) shifting the payment system to account for a more comprehensive set of services that address disparities.

However, one of the major challenges to addressing disparities in care is the lack of standardized sociodemographic data at the patient-level. Health systems are currently capturing SDOH data, but the information is not easily translatable for CMS purposes. For example, despite an available framework for mapping the more than 900 race ethnicity codes provided by the Centers for Disease Control and Prevention (CDC) to the Office of Management and Budget (OMB), race and ethnicity codes captured in the EHR cannot be consistently mapped. This is a result of lack of use of standard taxonomies - in part by the EHRs and in part by the providers to allow the category selections to align with how their populations would like to report information. Similarly, there are an abundance of tools to screen for SDOH with underlying definitions for certain social risk factors (e.g., food insecurity) varying significantly even when the same tool is used by different providers.

Premier continues to urge CMS to focus on improving data collection and standardization, which is vital to providers' success in driving towards health equity as it will foster the development and sharing of best practices within and among clinical settings, health systems and delivery system designs. The Agency for Healthcare Research and Quality (AHRQ) has found that one of the biggest barriers most health systems face in improving quality and reducing disparities within their own walls is systematically identifying the populations they serve, addressing the needs of these populations and monitoring improvements over time.[3] AHRQ further found that the principal challenges in obtaining race, ethnicity and language data for use in quality improvement assessments include a lack of standardization and understanding of why the data are being collected.

To help foster better data collection and standardization, CMS should:

[3] https://www.ahrq.gov/research/findings/final-reports/iomracereport/index.html

- ***Invest in educating both patients and providers about the importance of collecting SDOH information, the evidence for how it affects care and existing privacy requirements under HIPAA that safeguards information patients share with their providers.***

- ***Adopt incentives, such as quality program bonuses, to help incentivize standardized data collection*.** For example, CMS should consider developing a health equity adjustment to its quality program under TEAM. The bonus points should be based on the percentage of SDOH and/or demographic data that model participants report on their aligned beneficiaries. Over time, CMS could evolve this adjustment to address other challenges with SDOH data collection, with the goal of eventually setting the adjustment based on patient-level SDOH data. For example, CMS took a similar approach under the OCM model for metastatic status reporting, which was eventually incorporated into the target price.

- ***Consider advancing standards that clearly indicate the dates and times associated with data collection***, as certain sociodemographic factors (e.g., homelessness) are subject to change. In particular, Premier encourages CMS to use existing tools such as the United States Core Data for Interoperability (USCDI), Z-codes, HL7 and Fast Healthcare Interoperability Resources (FHIR) standards. This coordinated approach requires significant input from providers across the continuum, vendors, payers, and suppliers.

- ***Evaluate the standards that hospitals and other entities already have in place to advance health equity.*** This creates opportunities for CMS to build on and create synergies where possible on existing efforts as CMS and other federal partners work towards a national standard.

Recognizing it will be difficult for CMS to assess health equity outcomes until race, ethnicity and SDOH information is standardized, Premier encourages CMS to consider incorporating structural measures that address health equity, such as collection of SDOH information and engagement with community-based organizations.

Premier supports CMS' proposal to risk adjust based on social risk factors. Use of proxies such as dual status, area deprivation index at the beneficiary level, rural geographies or percentage of charitable care at the participant level is a good start until data collection is standardized. However, CMS should continue to advance standardization of SDOH data to further improve these methodologies. We also encourage CMS to explore ways to modify the target price to better account for historical underutilization. CMS has modified payments under Innovation Center models, such as ACO REACH, to better account for historical underutilization of services by underserved patients. However, under ACO REACH CMS offsets those increases by reducing benchmarks for lower risk patients. Premier strongly urges CMS to ensure any modifications it makes to target prices to account for underutilization is done as additional payments and not offset through reductions elsewhere in the model. Reducing target prices for other beneficiaries introduces new inaccuracies into the payment methodology and potentially introduces new inequities.

Premier encourages CMS to explore other ways to adopt episode-related payments to support enhanced services. For example, under the Oncology Care Model (OCM), participants received a monthly fee for delivering enhanced services. This allowed participants to create triage clinics, hydration stations and hire financial counselors. Premier encourages CMS to consider adopting a similar enhanced payment for participants which would allow them to provide innovative wrap-around services aimed at addressing SDOH and advancing health equity. In designing that payment, Premier encourages CMS to establish an automatic payment to participants based on attributed beneficiaries, rather than doing a claims-based payment. Under OCM, CMS had included a claims-based payment which had created several operational challenges for OCM practices.

Finally, ***Premier encourages CMS to streamline its requirement for reporting health-related social needs data by allowing hospitals to fulfill this requirement through the reporting they are already doing for the Hospital IQR Program***. As CMS notes, hospitals are already required to report the two screening measures as part of the quality reporting program. Requiring hospitals to report this data again through TEAM is duplicative of these efforts and creates undue burden on participants.

IX. FINANCIAL ARRANGEMENTS

CMS asserts that it is necessary to provide participants with flexibilities that could support their performance in the model and allow for greater support for the needs of beneficiaries, including the ability to engage with other providers and suppliers and engage in gainsharing arrangements. CMS proposes several policies to help facilitate downstream financial arrangements. If the proposed arrangements are finalized, CMS expects to make a determination that the anti-kickback statute safe harbor for CMS-sponsored model arrangements is available to protect certain remuneration with eligible providers and suppliers.

CMS proposes that the following types of providers and suppliers that are Medicare-enrolled and eligible to participate in Medicare or entities that are participating in a Medicare ACO initiative may be TEAM collaborators:

- Skilled Nursing Facility (SNF)
- Home Health Agency
- Long-Term Care Hospital
- Inpatient Rehabilitation Facility
- Physician
- Nonphysician practitioner
- Therapist in a private practice
- Comprehensive Outpatient Rehabilitation Facility
- Provider or supplier of outpatient therapy services.
- Physician Group Practice (PGP)
- Hospital
- Critical Access Hospital (CAH)
- Non-physician provider group practice (NPPGP)
- Therapy group practice (TGP)
- Medicare ACO

Premier's Recommendations

In 2020, the HHS Office of Inspector General (OIG), in coordination with CMS, finalized several significant policies to modernize the Anti-Kickback Statute and rules around beneficiary inducement to better align with the movement to value-based care. Specifically, the OIG established and modified several safe harbors for compensation arrangements that meet certain value-based criteria. These policies, along with changes to the regulations governing the Physician Self-Referral Law ("Stark Law"), were intended to reduce significant regulatory barriers that have impeded providers as they look to provide high-value care to their patients. ***Premier urges CMS to evaluate if the policies proposed for TEAM align with the value-based care Stark Law exceptions and AKS Safe Harbors that CMS and OIG finalized, respectively, in 2020.*** Additionally, we continue to urge CMS and OIG to provide greater clarity and educate providers on the types of arrangements and flexibilities that are allowed under these exceptions and safe harbors. We are concerned that a lack of clarity around these requirements have left many providers uncertain about whether arrangements are protected and therefore less likely to utilize the flexibilities given the risk of non-compliance

with Stark Law or AKS, which can result in civil monetary penalties, criminal charges or exclusion from federal health programs.

We also encourage CMS to expand the types of entities that are allowed to participate as Team Collaborators to include entities such as drug or device manufacturers. Value-based contracts through these types of entities are critical to the movement towards value and can be useful in addressing rising healthcare costs.

Under the current legal infrastructure and constraints within both Anti-Kickback Statute and Stark Law, most value-based contracts are structured as evidence-based care discounts. Modernization of these barriers is necessary to permit value-based contracts for drugs and devices to be implemented that are structured as product/service guarantees or risk sharing arrangements. For example, the following are types of value-based arrangements that are currently *not* permissible under the existing legal infrastructure but could be beneficial for patients and participants under the model:

Scenario 1 - A medical device manufacturer and payer enter into a value-based contract. The manufacturer will reimburse all costs associated with re-hospitalization if the device fails.

- This arrangement would not be permissible as the warranty safe harbor under Anti-Kickback Statute only covers the cost of replacing the device. The payment of costs associated with re-hospitalization would be considered remuneration.

Scenario 2 - A manufacturer and payer enter into a value-based contract. The manufacturer will discount the cost of therapy by 40 percent if a patient relapses within a five-year time frame.

- This arrangement would not be permissible as the discount safe harbor requires that the payer claim the benefit within a two-year time frame. It is also unclear if the discount safe harbor can be extended to payers as a “buyer” of the product or service.

Scenario 3 - A medical device manufacturer and provider enter into a value-based contract. The manufacturer will reimburse the cost of the device if the device fails.

- This arrangement would not be permissible as while the warranty safe harbor permits the manufacturer to reimburse the value of the device if it fails, the OIG may see this as an inducement for the provider to use a certain device over others. This is an example where a value-based contract would be permissible for a manufacturer-payer relationship, but not for a manufacturer-provider relationship.

***To truly move the needle and expand the utilization of value-based contracts, it is critical that CMS and the OIG remove the exclusion on certain entities from participating in value-based arrangement and patient engagement safe harbors*.**

X. WAIVERS OF MEDICARE PROGRAM REQUIREMENTS

CMS proposes to use its authority to waive certain Medicare program rules for providers and suppliers furnishing services to TEAM beneficiaries.

Telehealth. Similar to both the BPCI Advanced and CJR models, CMS is proposing to waive under the model two requirements governing the provision of telehealth services:

- *Geographic site requirements* of section 1834(m)(4)(C)(i)(I) through (III) of the Act that limit telehealth payment to services furnished within specific types of geographic areas or in an entity participating in a federal telemedicine demonstration project approved as of December 31, 2000,
- *Originating site requirements* of section 1834(m)(4)(C)(ii)(I)–(VIII) of the Act that specify the particular sites at which the eligible telehealth individual must be located at the time the service is furnished via a telecommunications system.

Waiving these requirements will allow all beneficiaries, including those in urban areas to receive telehealth services, as well as allow beneficiaries to receive telehealth services in their home or place of residence.

Like under the BPCI Advanced and CJR model, CMS proposes to create a specific set of nine HCPCS G-codes to describe the E/M services furnished to TEAM beneficiaries in their homes via telehealth, with corresponding new payment rates that would be published in the CY 2026 Medicare Physician Fee Schedule. With respect to beneficiaries receiving telehealth services in their home or place of residence, CMS emphasizes the current law requirement that such visits cannot substitute for in-person home health visits per section 1895(e)(1)(A) of the Act.

3-Day SNF Rule. CMS propose to waive requirements that a beneficiary have a 3-day hospital stay in order to qualify for coverage of a subsequent SNF care (i.e., "SNF 3-day rule"). Under this proposal, participants would be required to discharge TEAM beneficiaries to a SNF with a quality rate of three stars or higher as indicated on Medicare's Nursing Home Compare. Participating hospitals could also discharge a beneficiary to a swing bed in an acute-care hospital or critical access hospital if that is the beneficiary's preference. (The Medicare Shared Savings Program offers a similar flexibility for participating ACOs.) CMS also proposes that participating hospitals would be required to provide beneficiaries with a discharge planning notice outlining their potential financial liability. Participating hospitals would be financially liable in circumstances where the TEAM participant does not provide the beneficiary with proper notice, or otherwise violates the terms of the waiver.

Premier's Recommendations

Premier supports CMS' proposal to include waivers around telehealth and the SNF 3-Day Rule. We urge CMS to make both waivers available for both inpatient and outpatient procedures, similar to how they are applied under the CJR and BPCI Advanced models.

We also encourage CMS to establish a standard set of waivers across all APMs to streamline requirements across models. As part of this policy, CMS could still vary which waivers are offered under each model based on the design and goals of the model. However, establishing a standard set of waivers would reduce administrative burden on participants who may be engaged in multiple APMs and increase the likelihood of participants utilizing waivers.

XI. ADDDITIONAL REQUIREMENTS

Referral to Primary Care Services. CMS proposes that participating hospitals would be required to include a referral to a supplier of primary care services as part of hospital discharge planning on or prior to discharge from an anchor hospitalization or anchor procedure. CMS believes this requirement would connect beneficiaries with ongoing care beyond the episode. CMS also notes that it believes many hospitals are already doing this as a standard of care for discharge planning, so anticipate the requirement would create minimal burden on hospitals.

Premier's Recommendations

While we generally agree that most hospitals are already making referrals as part of the standard of care for discharge planning, ***Premier cautions CMS from requiring hospitals located in Health Professional Shortage Areas (HPSA) to comply with this requirement***. As noted above, CMS is proposing to target safety net and rural hospitals as part of its participant selection methodology. Many of these facilities may be located in communities that have a shortage of primary care clinicians, which may make it difficult for the facilities to comply with this requirement for reasons outside their control. As a result, we recommend exempting these facilities from this requirement.

XII. DATA SHARING

CMS proposes to make certain beneficiary-identifiable claims data for episodes under the model through two formats – summary and raw – both for the baseline period and on an ongoing monthly basis during a hospital's participation in the model.

CMS proposes that a participant who wishes to receive beneficiary-identifiable claims data must submit a formal request for data on an annual basis in a manner of a form and by a date specified by CMS, indicating if they want to receive summary or raw beneficiary-identifiable data, or both, and sign a TEAM data sharing agreement. Data would be delivered through a data portal for model participants in a "flat" or binary format. CMS notes that it will exclude information that is subject to the regulations governing the confidentiality of substance use disorder patient records (42 CFR part 2) from the data shared with a TEAM participant.

CMS also proposes to share regional aggregate data on the total expenditures during an anchor hospitalization or anchor procedure and the 30-day post-discharge period for all Medicare FFS beneficiaries who would have initiated an episode during the baseline period and performance years. This data would be provided at the regional level.

Premier's Recommendations

Premier supports CMS' efforts to make data available in the format that works best for their organization. We also urge CMS to make more data available at the regional level, in addition to data at the individual participant level. This data is critical for participants to understand their performance given the financial methodology is largely set at the regional level. We also urge CMS to provide participants with data at least a year in advance of the model start. It is critical for participants to understand historical performance, identify opportunities for improvement and monitor the effects of implemented change over time. There are multiple challenges with analyzing claims data, ranging from varying time periods, timeliness of data availability, accuracy of data and inability to replicate methodologies or validate outcomes. Providing enough data to allow participants to evaluate a patient's care is of critical importance as we look to create efficient care across the continuum.

In addition to the claims that make up an episode, supplemental data is also beneficial to participants in understanding other opportunities for improvement. For example, providing additional data such as SDOH data, integrating with hospital electronic health records (EHRs) to collect real-time information and providing information as it relates to other providers in the region associated with episode-specific care could serve to identify high-quality partners and high-risk beneficiaries. For example, Premier encourages CMS to work with the stakeholder community to identify additional ways to get participants real-time or more timely access to data, which would allow for them to identify transitions of care earlier and opportunities to further improve care coordination across the continuum.

XIII. DECARBONIZATION AND RESILIENCE INITIATIVE

CMS proposes a voluntary Decarbonization and Resilience Initiative within TEAM to assist hospitals in addressing the threats to the nation's health and its healthcare system presented by climate change and the effects of hospital carbon emissions on health outcomes, healthcare costs and quality of care. Under the initiative, CMS would assist TEAM participants in measuring their GHG emissions, reporting these metrics, and sharing benchmark data on GHG emissions through Individualized Feedback Reports.

The voluntary initiative would have two elements:

(1) technical assistance for all interested TEAM participants
(2) voluntary reporting option to capture information related to Scope 1 and Scope 2 emissions as defined by the Greenhouse Gas Protocol (GHGP) framework, with the potential to add Scope 3 in future years

CMS notes that the surgical episodes under TEAM represent opportunities for hospitals to become more energy efficient, pointing to studies showing that although operating rooms represent a relatively small proportion of a hospitals' physical footprint, they typically consume significantly more energy per square foot, produce more waste, and account for larger share of the hospital's supply costs.

The GHGP framework referenced by CMS includes three "scope levels:"

- *Scope 1: Direct emissions.* Direct GHG emissions from sources that are owned or controlled by an organization or company. For health care, Scope 1 captures healthcare operations such as direct facilities emissions, anesthetic gases, and GHG emissions from leased or owned vehicles.
- *Scope 2: Indirect emissions from purchased energy.* GHG emissions from the generation of purchased electricity consumed by the organization or company. For healthcare facilities, Scope 2 includes purchased or acquired electricity, and steam, heat, or cooling consumed by the reporting organization or company.
- *Scope 3: Other indirect GHG emissions*. Scope 3 allows for the treatment of all other indirect emissions. Scope 3 incorporates upstream and downstream emissions in the supply chain. For healthcare, Scope 3 may include purchased pharmaceuticals and chemicals, medical devices and supplies, food, water, waste, employee and patient transportation, and additional emissions outside of Scopes 1 and 2.

Technical Assistance. Under this part of the initiative CMS would provide three types of support to interested TEAM participants:

- Offer guidance on best practices and methods for developing approaches to enhance organizational sustainability and resilience, including identifying opportunities to reduce GHG emissions. CMS notes that particular attention will be placed on building efficiency and sustainable transportation and that it would help identify potential non-Medicare financial strategies to support this work (e.g., tax credits, grant programs)
- Offer guidance on transitioning to care delivery methods that result in lower GHG emissions and are clinically equivalent to or better than previous care delivery methods, especially as relates to inhaled anesthetic gasses
- Identify relevant measures and tools to measure emissions and associated measurement activities

Voluntary Reporting. CMS proposes that TEAM participants could elect to report metrics and questions related to emissions to CMS on an annual basis following each performance year. TEAM participants that elect to report on all the initiative metrics and questions to CMS, in the form and manner required by CMS, would

be eligible for benefits such as receiving individualized feedback reports and public recognition, as well as potentially achieving operational savings.

CMS proposes four areas for reporting, each with their own metrics: (1) Organizational Questions; (2) Building Energy Metrics; (3) Anesthetic Gas Metrics; and (4) Transportation Metrics. TEAM participants opting into the initiative would be required to answer questions under each reporting area.

CMS proposes that participants who elect to participate in the Decarbonization and Resilience Initiative would report information to CMS annually no later than 120 days after the end of each performance period, in a form and manner to be specified by CMS. Under the proposal, participants that report all the metrics would receive individualized feedback reports and be eligible to receive public recognition for their commitment to decarbonization.

CMS also seeks input on ways to provide technical assistance to participants to address Scope 3 and Metered-dose Inhalers (MDI) emissions. CMS also seeks input on future incentives for participating in the initiative, noting that while it is not currently proposing bonus payments or payment adjustments under the initiative, it may consider doing so in the future.

Premier's Recommendations

Premier supports HHS' and CMS' focus and efforts in tackling climate change and reducing greenhouse gas (GHG) emissions. ***Premier has been, and remains, committed to doing our part in improving the environment and will continue to work toward advancing environmentally sound and climate-related best practices within our business and in our communities*.**

In response to climate change, many healthcare organizations, including Premier members, are accounting for the impact of climate change on the health of the communities they serve. Guidelines issued by organizations such as the Greenhouse Gas Protocol and the Taskforce on Climate-Related Financial Disclosures (TCFD) provide a roadmap. In addition, Premier, alongside many of our members, have voluntarily signed the HHS Climate Pledge committing to reduce our GHG emissions by 50 percent by 2030 and achieve net zero emissions by 2050.

While many larger health systems have committed to reducing their GHG emissions, the reality is that many health systems and smaller hospitals wish to do their part but are struggling which where to start and how. As such, ***Premier supports CMS including a voluntary mechanism for TEAM participants to engage in these activities with support and guidance from CMS***. However, Premier recommends the following to ensure that TEAM participants can take advantage of CMS' offer:

- CMS should ensure that any required reporting leverages the least burdensome approach for hospitals. In order for hospitals to participate, the program should ensure that reporting requirements are streamlined, easy to understand, and automated to the extent possible to reduce administrative burden.
- CMS should offer at least one year of technical assistance to hospitals prior to requiring reporting. As currently designed, hospitals would be required to submit reports to receive technical assistance from CMS. Given that many hospitals are struggling with where and how to start accounting for their impact on GHG emissions or may not have the resources in place to focus energy on these efforts, Premier recommends that CMS offer an initial one-year period of technical assistance prior to requiring reporting. This will allow hospitals an opportunity to be educated on what would be required, how to structure their programs, what kind of expertise they will need, the time commitment involved etc. prior to initiating reporting.
- CMS should permit all hospitals, regardless of whether they are part of the mandatory TEAM, to participate in the voluntary decarbonization and resiliency initiative. To truly move the needle on

decarbonization efforts in healthcare, it is important that all hospitals throughout the country be given the same opportunity to access technical assistance and CMS resources to achieve the nation's goals.

In addition to the decarbonization and resilience initiative, Premier believes the Administration can help create incentives to drive greener choices for the safety and health of patients, workers, and the environment by:

- Giving healthcare providers a seat at the table in setting emissions goals and other climate-related targets. It is critical that, once climate-related targets are identified, healthcare entities are given a reasonable runway to implement such targets.
- Recognizing that a one-size-fits-all approach may not work. Flexibility is key as GHG reduction approaches leveraged in other industries may not apply in healthcare due to the complexities in its unique needs and operations, including the non-profit status of many healthcare entities.
- Ensuring the availability of resources to assist healthcare entities in assessing their GHG emissions, goal setting, and reducing their emissions. Appropriate resources are a critical factor for success in this space, especially given the financial constraints healthcare entities currently face.
- Considering incentives for healthcare providers to purchase greener medical supplies and pharmaceuticals, similar to the payment adjustment that CMS finalized in 2023 for domestically manufactured N95 masks.
- Creating incentives for manufacturers of critical medical supplies and pharmaceuticals to manufacture products using more environmentally sustainable processes and materials.

XIV. CONCLUSION

In closing, Premier appreciates the opportunity to submit comments on the proposed mandatory episodic payment model, TEAM. We look forward to working with CMS to further refine the model and work towards successful implementation. If you have any questions regarding our comments or need more information, please contact Melissa Medeiros, Senior Director of Policy, at melissa_medeiros@premierinc.com or (202) 879-4107.

Sincerely,

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Premier Inc.