July 27, 2023

Centers for Medicare and Medicaid Services
US Department of Health and Human Services
Attention: CMS-2023-0010

Comments related to “Request for Information; Episode-based Payment Model [CMS-5540-NC]"

Dear CMS Officials,

We are pleased to submit these comments in response to the Request for Information; Episode-based Payment Model [CMS-5540-NC]. We are health policy and medical scholars specializing in issues related to healthcare payment policy. We have extensively researched episode-based payment policies and offer our comments and suggestions in response to this request. The views expressed in these comments do not necessarily reflect those of our institutions or employers.

Comment 1: Mandatory participation is essential for episode-based payment to meet CMS’s objectives.

Voluntary participation in CMS’s episode-based payment models – including Bundled Payments for Care Improvement, Bundled Payments for Care Improvement Advanced, and the Oncology Care Model – have failed to realize financial net savings (inclusive of financial bonuses) for CMS.

A major contributing factor is that CMS, in an effort to encourage participation in these voluntary models, has made participation rules that are too generous for providers. This has led to strategic provider participation and payouts of bonuses that have exceeded the generally small reductions in gross spending observed under these programs.\(^1\),\(^2\),\(^3\)

When CMS has tightened program rules to limit bonus payments in voluntary models, participation has cratered. For example, starting from Model Year 4 of BPCI-A, participants had to choose entire service lines of clinically related bundles (e.g. cardiac care) and could no longer strategically choose individual, unrelated bundles (e.g. acute myocardial infarction, joint replacement). CMS also modified target prices in Model Year 4 to more accurately reflect

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spending patterns. Both changes were expected to limit bonus payments.\(^4\) Before these policy changes in Model Year 3, 833 unique hospitals participated in one or more bundles; in Model Year 4 following these changes, only 107 participated.

Episode-based payment must be mandatory in order to reduce gaming – particularly in the form of selective participation – and achieve savings for the Medicare program through provider-driven reductions in avoidable utilization.

**Comment 2:** Hospitals should be the focus of episode-based payment. Physician groups and conveners do not require a formal role.

Mandatory participation in bundled payment is not tenable for physician groups because many groups do not care for the inpatient cases included in the models. Voluntary participation is a bad idea. Therefore physician groups should not be included. Hospitals should be free to contract with consultants to support operational changes (e.g., care management services) but no formal role is necessary for conveners. Conveners have facilitated strategic provider participation\(^5\) – a risk that would be minimized under mandatory participation.

**Comment 3:** Selection of clinical episodes should be driven by sufficient sample size and levels and variation in the use of institutional postacute care.

Reducing the use of institutional postacute care is the only consistent mechanism through which episode payment programs have reduced spending.\(^6,7,8,9\) It is logical that clinical episodes with greater levels of and variation in post-acute care spending would be the focus on future episode payment programs. Unwarranted variation in postacute care for surgery also argues that surgical episodes should be prioritized.\(^10\) Included episodes can be pooled within hospitals to increase sample size and facilitate profiling.

**Comment 4:** The payment methodology and structure must be reformed for CMS to achieve savings.

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\(^{5}\) Berlin NL, Peterson TA, Chopra Z, Gulseren B, Ryan AM. Hospital participation decisions in Medicare bundled payment program were influenced by third-party conveners. *Health Affairs.* 2021;40(8):1286-1293. doi:10.1377/hlthaff.2020.01766


Mandatory participation alone is not sufficient to secure savings for CMS. Other payment model and model features need to be calibrated appropriately. Our research has identified several reforms that could improve the episode-based payment methodology:

**Setting target prices:** In BPCI and BPCI-A, episode targets were in essence a hospital–bundle-specific prediction about what episode spending would have been had the entity not participated in the program (which was then discounted by a specific factor). Our research has found that these predictions have been poor, leading to inaccurate targets and excess payments to participants. We also found that targets can be improved by using Bayesian estimation methods.\(^\text{11}\) Similar estimation methods have been used in other CMS programs (like the HRRP) and have been further refined.\(^\text{12}\)

In an effort to harmonize targets and reduce regional variation, CMS has proposed or adopted targets in a variety of alternative payment models – including CJR\(^\text{13}\) and the Medicare Shared Savings Program\(^\text{14}\) – that blend providers’ historical spending with regional spending averages. However, these blended benchmarks do not fully capture the variation in costs associated with treating medically complex patients across hospitals within the same region.\(^\text{15}\) As a result, certain hospitals will be unfairly penalized, while others will be unfairly rewarded under regional benchmarks.\(^\text{16}\) One solution would be to forego regional benchmarks in place of peer benchmarks, which could be based on a combination hospital size, teaching status, share of Medicaid patients, population density, and other factors which may better capture unobserved patient risk. This approach may also alleviate concerns about disparities in bonuses and penalties (see below). Another solution is for CMS to specify a very slow adjustment period – approximately 10 years – over which targets shift from institution-specific to peer or region-specific targets. This would give participants more runway to adjust practices in response to targets.

**Establishing the discount rate:** CMS has used a 3% discount rate for most bundles in BPCI and BPCI-A. Our research indicates that this has been too low for CMS to generate savings. Simulation evidence from our team found that, if Model Year 4 of BPCI-A had been mandatory, CMS would have realized net losses of $1.153 billion with a discount rate of 3%. However, CMS would have realized net gains of $262 million with a discount rate of 5%.

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\(^{11}\) Cher BAY, Gulseren B, Ryan AM. Improving target price calculations in Medicare bundled payment programs. *Health Services Research*. 2021;56(4):635-642. doi:https://doi.org/10.1111/1475-6773.13675


\(^{13}\) Comprehensive Care for Joint Replacement Model | CMS Innovation Center. innovation.cms.gov.

https://innovation.cms.gov/innovation-models/cjr


**Modifying the shared savings and shared loss rate:** In BPCI-A, participants keep 100% of shared gains and are responsible for 100% of shared losses up to the stop-loss or stop-gain thresholds of 20% of baseline spending. CMS should consider reducing the shared gain rate, which would decrease the incentive payments back to hospitals. Simulation evidence from our team found that, if Model Year 4 of BPCI-A had been mandatory and used a discount rate of 3%, CMS would have realized net gains of $578 million with a shared gain rate of 50% and a shared loss rate of 100%.

**Comment 5: Stratifying or adjustment of targets based on the population of treated patients can address equity.**

Payment reforms have the potential to exacerbate disparities if participants caring for patients with lower socioeconomic status or people from marginalized communities are more likely to be penalized or less likely to receive bonus payments. In the context of episode-based payment, however, some research suggests that, after risk adjustment, measures of social risk are not strongly associated with hospital performance. In addition, evidence from BPCI-A (which sets spending benchmarks based on each hospital’s historical spending, rather than shared spending benchmarks across hospitals regionally or nationally) indicates that hospitals with a higher share of Medicaid patients are more likely to receive bonus payments. Nonetheless, disparities in bonuses and penalties remain possible, especially when benchmarks are set regionally across hospitals (i.e. regionally or nationally). Evidence from the Hospital Readmissions Reduction Program and the Hospital-Acquired Condition Reduction Program shows that payment disparities can be minimized by stratifying targets on the basis of hospital characteristics, such as the proportion of patients dually enrolled in Medicare and Medicaid. Alternatively, statistical adjustment could be used to adjust targets simultaneously using multiple factors, like size, teaching status, region, and the share of Medicaid patients.

**Comment 6. Quality measures should focus on patient access and experience.**

BPCI-A adjusts reconciliation payments to participants on the basis of several quality measures, including all-cause 30-day readmissions and advance care planning. The program also incorporates registry-based measures for certain bundles. While the logic for adjusting bonuses and penalties for quality performance is compelling, BPCI-A’s current approach is exceedingly weak. The quality measures are not clinically meaningful for many episodes; reducing readmissions is already incentivized within the HRRP; registry-based quality measures are administratively burdensome; and small sample sizes for many hospital-bundle pairs render

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18 Shashikumar SA et al., *supra* note 2
performance evaluation unreliable. Perhaps most importantly, current measures are not sufficiently focused on the most likely quality shortcoming from BPCI-A: denial of clinically warranted and beneficial post-acute care.

Instead of the current measures, CMS should re-orient quality measurement in BPCI-A to capture potential stinting in post-acute care where patients face the greatest likelihood of suboptimal care. Information for these measures could be captured through a combination of patient surveys (a slightly expanded HCAHPS) and existing post-acute care assessments completed by clinicians in home health (the Minimum Data Set), skilled nursing facilities (the Outcome Assessment Information Set [(OASIS)], and inpatient institutional rehabilitation facilities (the Patient Assessment Instrument)).

Comment 7. The growth of Medicare Advantage introduces new challenges for alternative payment in Traditional Medicare.

Over half of Medicare beneficiaries are now enrolled in Medicare Advantage plans. This has several important implications for alternative payment in Traditional Medicare, including episode-based payment. First, the sample size of Traditional Medicare beneficiaries is decreasing across hospitals, which decreases program impact and makes provider-level profiling more challenging. Second, research favorable selection into Medicare Advantage may undermine risk adjustment in episode-payment programs: for the same level of measured risk, beneficiaries who shift into Medicare Advantage have lower spending in Traditional Medicare. This implies adverse selection among beneficiaries who stay in Traditional Medicare. Particularly in areas with high Medicare Advantage penetration, beneficiaries in Traditional Medicare will likely have higher severity than is reflected by risk adjustment. This will challenge the calculation of target spending prices and thus bonus payments, particularly if CMS adopts regional targets. Finally, hospitals are increasingly initiating Medicare Advantage plans and integrating with existing plans. If episode payment and other alternative payment strategies in Traditional Medicare squeeze hospitals too hard, it may accelerate these market shifts.

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Thank you for considering these comments and recommendations.

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