June 10, 2024

Chiquita Brooks-LaSure
Centers for Medicare & Medicaid Services,
Department of Health and Human Services,
Attention: CMS-1808-P, Mail Stop C4–26–05,
7500 Security Boulevard, Baltimore, MD 21244–1850

Dear Administrator Brooks-LaSure:

On behalf of the American College of Physicians (ACP), I am pleased to share our comments on the proposed 42 CFR Parts 412, 413, 431, 482, 485, 495, and 512; 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. ACP is the largest medical specialty organization and the second-largest physician group in the United States. Members of ACP include 161,000 internal medicine physicians, related subspecialists, and medical students. Internal medicine physicians apply scientific knowledge and clinical expertise to the diagnosis, treatment, and compassionate care of adults across the spectrum from health to complex illness.

Our comments on the proposed rule focus on the Transforming Episode Accountability Model (TEAM), distribution of recently created GME slots, and changes to payments related to Social Determinants ("Drivers") of Health (SDOH).

Transforming Episode Accountability Model (TEAM)
Financial Accountability and Incentives

TEAM is a new mandatory model proposed by the CMS Innovation Center that would assign responsibility for a patient's care to select hospitals that perform specific procedures for patients with traditional Medicare. Under this model, the hospital would be responsible for the cost and quality of a patient's care from the initiation of surgery through the first 30 days after the patient leaves the hospital. Additionally, hospitals would need to set up accountable care relationships with primary care services to support optimal and long-term health outcomes for the patient's care. If the costs for an entire patient episode are lower than an expected episode price, then hospitals may earn a financial reward for achieving these savings. After considering this information, ACP is concerned that there is a lack of clarity about how primary care physicians will be reimbursed fairly for their services if a patient's optimal and long-term health outcomes are largely due to that individual physician's efforts and care.

ACP is concerned about the possibility that when a facility receives bundled payments for services or procedures, it could create an incentive for them to concentrate on achieving cost-

savings as opposed to focusing on innovation that will bolster quality and reduce unnecessary spending on care. The TEAM creates a similar incentive where a hospital can partner with a primary care physician and sanction lower-cost, lower-quality services against the recommendation of a patient's primary care physician. **ACP urges CMS to strengthen the TEAM's emphasis on the delivery of high-quality care to avoid facilitating a course for obtaining cost-savings at the expense of care delivery. Similarly, ACP urges CMS to improve the TEAM design to include a clear method for rewarding primary care physicians that support optimal, long-term health outcomes by entitling them to a share of any rewards accorded for obtaining cost-savings after completing a patient's episode of care.**

Additionally, the TEAM covers major surgeries that fall within the 90-day global period. ACP questions how the primary care physician will be compensated for follow-up care provided to the patient during this 90-day global period. **ACP strongly recommends that there be clear direction and policy describing how primary care physicians will be compensated within the TEAM**.

Care Coordination and Quality

The TEAM model aims to promote comprehensive care coordination and improve quality during a specific episode of care. By establishing accountable care relationships through coordination from surgery to the patient's discharge period, the model could enhance patient outcomes and reduce costs. Coordinating care among various physicians with smooth transitions, time for collaboration, and maintaining high-quality standards within a 30-day period after the hospital stay may present concerns regarding implementation. Logistical difficulties such as having seamless communication channels and interoperable health IT systems may increase administrative burden, especially when considering organizations have varying levels of technological adoption and differing protocols and procedures. The variability in patient needs may also impact the amount of care and physician follow-ups needed post-surgery.

To support the successful management of transitions between inpatient and post-acute care, ACP urges CMS to provide physicians with additional support and resources. This could be in the form of technological tools like electronic health records (EHRs) with interoperability features that can facilitate a streamlined exchange of health information to enhance the continuity of care. An established care coordination infrastructure could also ensure physicians and other members of a patient's care team can align their efforts and reduce readmissions. When addressing the complexities of patient transitions and improving quality, having the appropriate tools and infrastructure can have a significant impact.

The TEAM assesses performance on three quality measures: hospital readmission, patient safety, and patient-reported outcomes. **Given that patient outcomes and quality of care are influenced by factors such as socioeconomic status, education, and access to resources, ACP urges CMS to incorporate mechanisms that account for differences in patient complexity and SDOH when evaluating performance.** Without adjustments for these variables, hospitals and

physicians may be unfairly penalized for serving more complex and underserved populations. Adjusting for these factors can help ensure a more accurate and fair assessment of quality and supports the model's goals of promoting health equity.

Adequate resources, time, and support systems will be crucial to the success of the TEAM model. Addressing these issues in advance will help the model reach its full potential to improve patient outcomes and strengthen accountable care relationships. ACP welcomes the opportunity to further inform these matters.

Impacts on Patient Access

Episode-based payment models can inadvertently incentivize physicians or organizations to avoid high-risk or complex patients to minimize financial risk. This could result in exacerbated health disparities, especially in more vulnerable or underserved populations who already face challenges in accessing quality care. To mitigate these risks, **ACP urges CMS to incorporate safeguards within the TEAM to ensure patient-centered care remains a priority.** These could include adjusting the payment model to account for patient complexity and risk level or enhanced monitoring and reporting of SDOH into quality reporting. It is crucial to consider these challenges to ensure that certain patient populations aren't excluded and that the model's measures are effective for achieving the intended outcomes.

Graduate Medical Education (GME)

In the Consolidated Appropriations Act of 2023, Congress authorized the creation of 200 GME slots for FY 2026. The act maintained that at least 100 of these positions will be distributed to psychiatry or psychiatry subspecialty residency training programs and that hospitals falling under certain categories (e.g., located in rural areas, serve areas designated as Health Professional Shortage Areas) will be provided a minimum amount of the residency positions. While we appreciate Congress' intent to increase the number of available residency positions to meet the nation's future health care needs, ACP believes there has been a failure to emphasize the pressing need to increase the number of primary care physicians in the future workforce. According to a report published by the Association of American Medical Colleges (AAMC) in March 2024, it is projected that there will be a supply shortfall of 20,200 to 40,400 primary care physicians by 2036. The AAMC report further projected that there will be a supply shortfall of 10,100 to 19,900 surgeons and 19,500 physicians in other specialties (e.g., psychiatry) by 2036. The forecasted insufficiency of primary care physicians in the future health care workforce makes this a pressing concern for public health agencies to take immediate action to prioritize educating and training the next generation of primary care physicians and providing sufficient resources to training centers to competently supervise and instruct these scarce professionals. **Therefore, ACP recommends that primary care be prioritized in the distribution of the remaining 100 GME slots.**

Social Determinants ('Drivers') of Health

SDOH have become increasingly important as major drivers of health in recent years, and ACP is pleased that CMS is taking steps to formally recognize this by adjusting payment for care delivery for patients afflicted by inadequate housing and housing instability. These adjustments will help support sustainable care delivery by providing the necessary resources to deliver consistent care and design treatment plans that can be implemented both effectively and successfully. While current progress is encouraging, **ACP strongly urges CMS to implement similar adjustments for SDOH in the Hierarchical Condition Category (HCC) risk-adjustment model and is interested in learning more about CMS' plans.** As was previously mentioned, SDOH are now recognized as major drivers of health and an appreciable portion of a patient's outcome can derive from risk factors such as inadequate housing and housing instability. Further, health care resources are appreciably more employed when treating patients afflicted by social conditions, which requires proper reimbursement for delivering consistently appropriate levels of care. Implementing payment adjustments in the HCC risk-adjustment model for SDOH will foster necessary support for delivering consistent levels of care and help mitigate the challenges that social risk factors pose to creating effective treatment plans for patients.

Thank you for the opportunity to provide feedback on CMS' proposed policy. We look forward to continuing to work with CMS to implement policies that support and improve the practice of medicine. Please contact Brian Outland, PhD, Director of Regulatory Affairs for the American College of Physicians, at boutland@acponline.org or (202) 261-4544 with comments or questions about the content of this letter.

Sincerely,

Leslie F. Algase, MD, FACP
Chair, Medical Practice and Quality Committee
American College of Physicians