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June 10, 2024

Ms. Chiquita Brooks-LaSure, Administrator  
Centers for Medicare & Medicaid Services  
U.S. Department of Health and Human Services  
ATTN: CMS-1808-P  
P.O. Box 8013 Baltimore, MD 21244-1850

Submitted electronically via [www.regulations.gov](http://www.regulations.gov)

**Subject: CMS-1808-P Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals Policy Changes and Fiscal Year 2025 Rates; Quality Programs Requirements; and Other Policy Changes**

Dear Administrator Brooks-LaSure,

On behalf of the American Association of Neurological Surgeons (AANS) and the Congress of Neurological Surgeons (CNS), representing more than 4,000 neurosurgeons in the United States, we appreciate the opportunity to comment on the provisions of the above-referenced notice of proposed rulemaking.

**SPINAL FUSION MS-DRG CHANGES**

The AANS and the CNS note that CMS has proposed to change the spinal fusion Medicare Severity-Diagnosis Related Groups (MS-DRGs) to better account for what CMS has concluded is the biggest driver of cost differentials: whether the case is single or multiple levels. While we appreciate and share the agency's desire to reflect the hospital facility costs as accurately as possible, we need more information about the potential impact of the new DRG designations and an opportunity to study the changes further. We request that additional insight and rationale be provided for the MS-DRGs that CMS proposes to change. We also would like to understand why the agency did not incorporate six MS-DRGs into the analysis. Finally, we would like to learn why CMS excluded several MS-DRGs from any proposed changes at all, instead opting to maintain the current structure.

Furthermore, the AANS and the CNS recommend that CMS not conduct this significant restructuring in the midst of also considering a spinal fusion episode accountability model (discussed below in the section related to TEAM). Doing so will cause confusion and make tracking claims across previous and future years more difficult. **We urge the agency to allow more time, provide more details on the impact and seek additional stakeholder input before making changes in the Spinal Fusion MS-DRGs** and to consider our detailed comments below regarding the TEAM program.

**TRANSFORMING EPISODE ACCOUNTABILITY MODEL (TEAM)**

**BACKGROUND**

CMS proposes a new mandatory episode-based payment model, referred to as the Transforming Episode Accountability Model (TEAM), which aims to test whether episode-based payments for five procedures — including spinal fusion — would reduce Medicare expenditures while preserving or enhancing the quality of care. Under the model, which CMS proposes to test for five years beginning in

January 2026, acute care hospitals that initiate episodes in select geographic regions would be required to participate and would be accountable for ensuring that Medicare beneficiaries receive high-value care during and after these surgical procedures. According to CMS, TEAM incorporates and builds on what it deems are the most promising model features from other CMS Innovation Center (CMMI) episode-based payment models, such as the Bundled Payments for Care Initiative Advanced (BPCI-A) Model and the Comprehensive Care for Joint Replacement (CJR) Model.

Hospitals required to participate in TEAM would be selected based on a stratified random sampling of geographic regions from across the country that would account for average historical episode spending, the number of hospitals and safety net hospitals in the region, and the region's exposure to prior CMMI bundled payment models. Critical Access Hospitals and very low-volume hospitals would be excluded.

Episodes related to the five targeted procedures would begin with a hospital inpatient stay, identified using specific MS-DRGs associated with the anchor hospitalization, or a hospital outpatient procedure, identified through specific Healthcare Common Procedure Coding System (HCPCS) codes. Surgeries performed in Ambulatory Surgery Centers (ASCs) would not trigger an episode included under this proposed model. Each episode would end 30 days after the patient leaves the hospital.

Hospitals selected for TEAM would continue to bill Medicare fee-for-service (FFS) but would be subject to target spending amounts for all services delivered in the hospital and during the 30-day episode. Target prices would be based on all non-excluded Medicare Parts A and B items and services included in an episode. They would be risk-adjusted based on beneficiary-level factors. CMS proposes to use three years of baseline episode spending to calculate benchmark target price at the level of MS-DRG/HCPCS episode type and regions. To mitigate the ratchet effect, CMS would roll this 3-year baseline period forward every year and trend all episode spending to the most recent year of the baseline period to reflect the impact of inflation and any changes in episode spending due to evolving patterns of care. CMS also proposes to apply a 3% discount factor to the benchmark price, designed to serve as Medicare's portion of savings from the episode.

Performance in the model would be assessed by comparing the hospitals' actual Medicare FFS spending for the episode to the target price, as well as through an assessment of performance on three quality measures focused on hospital readmission, patient safety, and patient-reported outcomes. CMMI proposes to conduct an annual reconciliation of each TEAM participant's actual episode payments against the target price(s) six months after the end of each performance year. Hospitals could earn a reconciliation (i.e., bonus) payment from CMS, subject to a quality performance adjustment if the total Medicare costs for the episode are below the target price. Conversely, hospitals could owe CMS a repayment amount, subject to a quality performance adjustment, if the total Medicare costs for the episode are above the target price. These amounts would be subject to a stop/loss gain limit of 20% of the episode price.

TEAM would offer three participation tracks: Track 1 would have no downside risk and lower levels of reward for the first year; Track 2 would be associated with lower levels of risk and reward for certain hospitals, such as safety net hospitals, for years 2 through 5; and Track 3 would be associated with higher levels of risk and reward for years 1 through 5.

Although CMS proposes that only hospitals may serve as TEAM "participants" who bear sole financial risk under the model, it recognizes that hospitals may want to engage in financial arrangements with certain providers — including physicians — who contribute to performance in the model but are not the risk-bearing entity and not the direct recipient of any reconciliation or repayment amounts. As such, CMS proposes that physicians and physician groups could participate as "TEAM collaborators" at the discretion of hospital participants.

Additionally, clinicians who enter into financial arrangements with a participating hospital in Tracks 2 and 3 of TEAM could qualify as a Qualifying Participant (QP) in an Advanced Alternative Payment Model (APM) under the Quality Payment Program (QPP). Those clinicians would be exempt from the Merit-

based Incentive Payment System (MIPS) and eligible for a higher annual conversion factor update under the Medicare Physician Fee Schedule compared to non-QPs.

## CONCERNS REGARDING TEAM

### *Mandatory Participation*

Overall, the AANS and the CNS recognize that Medicare beneficiaries undergoing a surgical procedure either in the hospital or as an outpatient may experience fragmented care that can lead to complications in recovery, avoidable hospitalizations, and other high costs. As such, we support efforts to improve care transitions and to incentivize care coordination and higher-value care across the inpatient and post-acute care settings.

At the same time, **the AANS and the CNS strongly oppose compulsory participation in alternative payment and delivery models. CMS must maintain voluntary participation models that allow hospitals and surgeons to tailor bundled and other innovative payment reforms to their specific patient populations, practice settings, administrative capabilities and resources.** We recognize that mandatory models can address participation challenges inherent to voluntary models, such as participant attrition or selection bias. Still, they also ignore the very real barriers that some providers face in terms of building the resources and infrastructure needed to succeed in these models. These providers face real challenges, such as staff shortages, lack of access to interoperable health information technology systems and robust data analytics, insufficient or otherwise non-representative patient volumes and a lack of negotiating power in their community, all of which make it more difficult to provide higher value, coordinated care. What providers need most is more flexibility, better support and guidance, and stronger incentives — not a restrictive mandate that could drive participant hospitals to skimp on clinically necessary care and to avoid higher-risk patients in order to meet price and quality targets.

The AANS and the CNS are especially concerned that CMS is proposing a mandatory approach based on the CJR and BPCI-A models since those models are still ongoing and have not yielded significant net savings to date. For example, a CMS-funded evaluation of the CJR in its fifth year found that mandatory CJR hospitals generated an estimated \$23.4 million in losses (versus savings) to Medicare during the first five performance years.<sup>1</sup> Another study found that between 2013 and 2019, BPCI-A was associated with a \$279.2 million net increase in Medicare spending.<sup>2</sup> We also remind CMS that it has achieved far more net savings annually from hip and knee replacement episodes in the voluntary BPCI-A program than it has in the mandatory CJR program, which throws into question CMS' belief that mandatory payment models will achieve greater savings than voluntary models.

Evaluations of models to date have also shown that they tend to favor more well-resourced providers. One study found that voluntary participants in BPCI-A were more often large, for-profit, urban teaching hospitals and system members compared to non-participants and had higher operating margins and lower proportions of dually enrolled beneficiaries. That same study found that among participants, almost 15% dropped out of inpatient bundles entirely, and nearly 45% dropped out of at least one bundle. These hospitals were more often smaller and located in areas with a lower supply of skilled nursing and inpatient rehabilitation facilities.<sup>3</sup>

We are also concerned that mandatory participation in TEAM would undermine progress made to date by individual providers outside of the model. Required participation of select providers could exclude those who have historically participated in BPCI-A and CJR and done well, leaving them with no option once the two models end. Mandatory participation in a hospital-led model also will leave physician group practices, who served as episode initiators under BPCI-A, with no option if they wish to continue

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<sup>1</sup> <https://www.cms.gov/priorities/innovation/data-and-reports/2023/cjr-py5-annual-report>

<sup>2</sup> <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC9597389/>

<sup>3</sup> <https://jamanetwork.com/journals/jama/fullarticle/2738537?resultClick=1>

participating in a bundled payment model. Additionally, mandatory models could force certain hospitals and health systems that have already adopted their own innovative ways to provide high-value care to alter their care processes in ways that might reverse progress made in terms of patient outcomes and efficiencies.

Finally, we have concerns about model overlap. Hospitals could be chosen to participate in TEAM and be held accountable for patients regardless of whether they participate and are also responsible for those patients under other total cost of care or shared savings models (e.g., ACOs). We are concerned that this could result in a situation where hospitals face numerous overlapping financial incentives, which could create confusion and place substantial administrative burdens on hospitals and the clinicians and staff employed by those institutions. It also raises questions about whether savings and improvements in quality will be attributed to the correct initiative.

**Ultimately, if an alternative payment or delivery model is appropriately contemplated — with the active involvement of physicians in the design, implementation and evaluation of the model — then physicians will willingly participate, negating the need for mandatory participation.**

### ***Limited Role of the Physician***

The AANS and the CNS are disappointed that CMS did not directly consult physicians who are directly impacted by this model, including our spine surgeon members. **It is critical that CMS directly engage relevant practicing physicians in model development and implementation, including defining appropriate participation parameters, episode triggers, quality measures, and risk adjustments, as well as methods for assessing model success over time.** When CMS fails to engage front-line physicians, it raises questions about whether the agency is genuinely interested in higher-quality care or whether its sole goal is cost reduction. We ask CMS to maintain as a guiding principle that hospitals do not propose and perform surgical procedures; surgeons do.

**We are equally concerned that CMS fails to provide physicians with any autonomy under TEAM and fails to recognize the leading role that physicians play in an episode.** Surgical patients look to their surgeon and not the hospital where they had the operation as the ultimate authority on their perioperative care. Simply put, the buck stops with the surgeon. Yet under TEAM, only hospitals may be considered “participants,” and CMS proposes to leave it to the hospital’s discretion to engage with or form a financial arrangement with “TEAM collaborators,” such as physicians. This differs from the BPCI-A, which allows physician group practices, as well as hospitals, to take on leading roles through clearly defined partnership policies. We are concerned that the TEAM approach could result in perverse incentives that encourage hospitals to make care decisions that are not in the best interest of the patient — especially since this model would include elective and non-elective cases.

Further, hospital administrators with no clinical experience could be empowered by this model to alter hospital operations to optimize their facility’s short-term performance metrics at the expense of quality and cost after the measurement period. This increases the risk of cherry picking, lemon dropping, and other forms of favorable selection that risk-adjustment methodologies may not capture. In other situations, hospitals might cut necessary post-acute spending, which can impact patient outcomes and longer-term costs. Involving relevant clinicians who are directly accountable for the patient’s care would minimize these risks.

A 2024 analysis by the Congressional Budget Office<sup>4</sup> found that ACOs led by independent physicians generated substantially larger Medicare savings than hospital-led ACOs. The report noted that independent physician-led ACOs have clear financial incentives to reduce hospital care to lower spending, unlike hospital-led ACOs, which earn more revenue when patients are admitted. Hospitals also have less direct control over what services patients receive.

**In light of these concerns and findings, CMS must adopt policies under TEAM that:**

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<sup>4</sup> <https://www.cbo.gov/publication/60213>

- **Require hospitals to integrate clinically relevant specialties into TEAM leadership and governance roles to ensure the provision of appropriate care and to ensure that savings are a result of improved efficiencies, and not simply favorable selection or gaming at the expense of the patient.**
- **Require hospitals to pass on a proportional portion of the shared savings generated under this model to the surgeons who are responsible for the treatment of patients triggering the episodes. Distribution of such savings should not be simply at the hospital's discretion. This better aligns with financial incentives.**
- **Ensure that physicians have adequate resources and flexibility under the model to deliver services that result in good outcomes for all types of patients and to ensure that physicians are not directly or indirectly at risk for outcomes or costs they cannot control.** Unfortunately, under some of the most widespread models implemented to date, such as Shared Savings Program ACOs, physicians do not have a leading role. As a result, they have little control over decisions related to clinical appropriateness, patient selection, referrals, and performance measurement.

As noted earlier, it is also essential to provide physicians with autonomy and authority under TEAM to ensure that when BPCI-A ends in 2025, physician groups who have served as episode initiators will continue to have an opportunity to play a leading role in CMMI's next iteration of bundled payments.

### ***Implementation Timeline***

**The AANS and the CNS believe that CMS' implementation timeline for TEAM is too aggressive and that it is irresponsible to propose a mandatory model based on incomplete evaluation data of predecessor models.** Although BPCI-A and CJR have informed the development of TEAM, CMS notes that the BPCI-A and CJR models have experienced significant changes in more recent years, including changes in participation volume, and that assessing the results of these models based on their current methodologies requires additional evaluation data, which will not be available until after each model has concluded. CJR is set to conclude at the end of 2024, and BPCI-A is set to conclude at the end of 2025, yet CMS proposes to initiate TEAM shortly after that on Jan. 1, 2026. **The AANS and the CNS believe that a 2026 implementation date is premature since the models on which TEAM is based have not yet ended, have not yet been thoroughly evaluated for their effectiveness and have not yet demonstrated positive results.**

**The AANS and the CNS are also concerned that CMMI's proposed TEAM implementation timeline fails to account for CMS' concurrent proposal to update the MS-DRGs for spinal fusion for FY 2025.** Under TEAM, CMS proposes to include a spinal fusion episode category for beneficiaries undergoing inpatient and outpatient spinal fusion. CMS proposes to define the spinal fusion episode category as any cervical, thoracic, or lumbar spinal fusion procedure paid through the IPPS under specific MS-DRGs and through the OPSS under specific HCPCS codes.<sup>5</sup> Hospital claims for the following MS-DRGs would trigger the TEAM inpatient spinal fusion episodes:

- MS-DRG 453 (*Combined Anterior and Posterior Spinal Fusion with MCC*)
- MS-DRG 454 (*Combined Anterior and Posterior Spinal Fusion with CC*)
- MS-DRG 455 (*Combined Anterior and Posterior Spinal Fusion without CC/MCC*)
- MS-DRG 459 (*Spinal Fusion Except Cervical with MCC*)
- MS-DRG 460 (*Spinal Fusion Except Cervical without MCC*)
- MS-DRG 471 (*Cervical Spinal Fusion with MCC*)
- MS-DRG 472 (*Cervical Spinal Fusion with CC*)
- MS-DRG 473 (*Cervical Spinal Fusion without CC/MCC*)

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<sup>5</sup> Using HCPCS codes 22551, 22554, 22612, 22630, or 22633.

However, in the section of the FY 2025 IPPS proposed rule titled “Changes to Medicare Severity Diagnosis-Related Group (MS-DRG) Classifications and Relative Weights,” which is separate from the TEAM proposal and impacts hospital payments more generally, CMS proposes to delete MS-DRGs 453, 454 and 455 and to create eight new MS-DRGs for FY 2025. Specifically, CMS proposes to:

- Create the following new MS-DRGs:
  - MS-DRG 426 (Multiple Level Combined Anterior and Posterior Spinal Fusion Except Cervical with MCC)
  - MS-DRG 427 (Multiple Level Combined Anterior and Posterior Spinal Fusion Except Cervical with CC)
  - MS-DRG 428 (Multiple Level Combined Anterior and Posterior Spinal Fusion Except Cervical without CC/MCC)
- In their place, CMS proposes creating the following new MS-DRGs:
  - MS-DRG 402 (Single Level Combined Anterior and Posterior Spinal Fusion Except Cervical)
  - MS-DRG 429 (Combined Anterior and Posterior Cervical Spinal Fusion with MCC)
  - MS-DRG 430 (Combined Anterior and Posterior Cervical Spinal Fusion without MCC)
- Given the impact the changes have on MS-DRGs 456, 457, and 458, CMS proposes the following new MS-DRGs:
  - MS-DRG 447 (Multiple Level Spinal Fusion Except Cervical with MCC)
  - MS-DRG 448 (Multiple Level Spinal Fusion Except Cervical without MCC)
- Finally, CMS proposes to review the following MS-DRG titles as follows:
  - MS-DRG 459 (*Single Level Spinal Fusion Except Cervical with MCC*)
  - MS-DRG 460 (*Single Level Spinal Fusion Except Cervical without MCC*)

In the original publication of the FY 2025 IPPS proposed rule, CMS failed to cross-reference its proposed changes to the spinal fusion MS-DRGs in the TEAM discussion. However, in a subsequent correction notice published in the *Federal Register* on May 31, CMS acknowledged this inadvertent omission and its intention to use the updated MS-DRGs, if finalized, to define the spinal fusion episode category for TEAM. Specifically, CMS states that if the updated MS-DRGs are finalized for FY 2025, it would include the eight new MS-DRGs in TEAM rather than MS-DRGs 453, 454 and 455, as initially proposed.

While the AANS and the CNS appreciate this correction, we are concerned that it fails to account for other aspects of the TEAM proposal that would be impacted by these MS-DRG changes, which would occur prior to the start date of the model. As illustrated in the table below, CMS proposes to use three years of baseline data to calculate target price benchmarks under TEAM. The orange cells below indicate years in which hospitals would be billing the new spinal fusion inpatient MS-DRGs but assessed against benchmarking baseline data based on certain MS-DRGs that are no longer billable. We are concerned this will result in inaccurate performance calculations, as well as confusion during the first three performance years of TEAM.

Performance Year	Performance Year Dates	Baseline Period for Benchmarking <sup>6</sup>	Implicated TEAM MS-DRGs if FY 2025 IPPS Finalized?
1	CY 2026	CY 2022 (17%) CY 2023 (33%)	CY 2022: MS-DRG 453-455, 459-460, or 471-473

<sup>6</sup> CMS proposes to weight episode spending from baseline year 1 at 17%, baseline year 2 at 33%, and baseline year 3 at 50%.



Performance Year	Performance Year Dates	Baseline Period for Benchmarking <sup>6</sup>	Implicated TEAM MS-DRGs if FY 2025 IPPS Finalized?
		CY 2024 (50%) <sup>7</sup>	CY 2023: MS-DRG 453-455, 459-460, or 471-473 CY 2024: MS-DRG 453-455, 459-460, or 471-473
2	CY 2027	CY 2023 (17%) CY 2024 (33%) <sup>6</sup> CY 2025 (50%)	CY 2023: MS-DRG 453-455, 459-460, or 471-473 CY 2024: MS-DRG 453-455, 459-460, or 471-473 <b>CY 2025:</b> MS-DRG 402, 426-430, 447-448, Revised 459-460, or 471-473
3	CY 2028	CY 2024 (17%) <sup>6</sup> CY 2025 (33%) CY 2026 (50%)	CY 2024: MS-DRG 453-455, 459-460, or 471-473 <b>CY 2025:</b> MS-DRG 402, 426-430, 447-448, Revised 459-460, or 471-473 <b>CY 2026:</b> MS-DRG 402, 426-430, 447-448, Revised 459-460, or 471-473
4	CY 2029	CY 2025 (17%) CY 2026 (33%) CY 2027 (50%)	<b>CY 2025:</b> MS-DRG 402, 426-430, 447-448, Revised 459-460, or 471-473 <b>CY 2026:</b> MS-DRG 402, 426-430, 447-448, Revised 459-460, or 471-473 <b>CY 2027:</b> MS-DRG 402, 426-430, 447-448, Revised 459-460, or 471-473
5	CY 2030	CY 2026 (17%) CY 2027 (33%) CY 2028 (50%)	<b>CY 2026:</b> MS-DRG 402, 426-430, 447-448, Revised 459-460, or 471-473 <b>CY 2027:</b> MS-DRG 402, 426-430, 447-448, Revised 459-460, or 471-473 <b>CY 2028:</b> MS-DRG 402, 426-430, 447-448, Revised 459-460, or 471-473

**We strongly recommend that CMS delay the implementation of TEAM to allow for a thorough and complete evaluation of current bundled payment models and to ensure that proposed changes to the spinal fusion MS-DRG (if finalized) do not interfere with TEAM financial performance assessments. If CMS is unwilling to delay the implementation date of the model in its entirety,**

<sup>7</sup> CY 2024 data would include historic spinal fusion MS-DRGs data, as well as the shift to the new MS-DRGs beginning on October 1, 2024.

**then we request that it at least delay the rollout of the spinal fusion episodes under TEAM until at least 2029, when the new spinal fusion MS-DRGs will be reflected fully in both performance year and baseline assessments.** In contrast to a program such as CJR, which has well-established cost baseline data, the benchmarking for spinal fusion under TEAM would be impacted by significant changes to the MS-DRGs.

### ***Inadequate Adjustments to Target Prices***

CMS discusses how the BPCI-A relies on a more complex methodology to risk-adjust target prices that account for numerous factors, including patient and provider characteristics, but that participants found it challenging to interpret. As such, CMS proposes to rely on a modified version of the simpler CJR methodology for TEAM, which accounts for fewer factors. For example, the proposed methodology does not account for a patient's functional or disability status, which is one of the strongest predictors of length of post-operative stay and the need for post-acute care. This contradicts CMS' stated goal of generating savings through the reduction of post-acute care services and its acknowledgment of evidence suggesting that risk adjustment models may be improved when taking into account patient functional status. CMS goes on to note that there are existing data sets that capture patient functional status but that it is not proposing to use them since it would make it challenging for TEAM participants to understand payment calculations.

**While we appreciate that CMS is trying to keep things simple and digestible, the AANS and the CNS urge CMS to adopt a risk adjustment methodology that is as robust as possible and accounts for as many patient and provider-level factors that could impact surgical outcomes and post-acute care usage as possible. CMS should adopt risk adjustment methodologies that are specific to each procedure category and episode, that account for hospital characteristics, and that rely on standardized patient assessment data or other functional status data.** If CMS fails to adopt an adequate risk adjustment methodology, it will increase the chance of hospitals engaging in practices to avoid patients at higher risk for post-operative complications, hospital readmissions for unrelated issues and higher-than-average post-acute care service needs. Risk adjustment must consider whether an operation is scheduled/elective vs. non-scheduled/urgent, as that alone can dramatically alter the expected cost, and it is easily observable.

CMS also proposes to employ the "TEAM Hierarchical Condition Category (HCC) Count" methodology to adjust target prices. Similar to the CJR model, the proposed TEAM HCC count is a categorical risk adjustment variable derived by counting the total number of HCC categories that apply to the beneficiary during a 90-day lookback period from the date of surgery. **While HCC is not ideal for all procedures, the AANS and CNS recommend that CMS at least adjust this methodology to account for the severity or weight of certain HCC conditions instead of the count of conditions alone.** For example, CMS should consider the relative impact on the perioperative period of some cardiovascular/pulmonary codes versus more chronic diseases that might be impactful longitudinally but do not have as much effect in an acute intervention setting. If CMS misuses HCCs in the risk adjustment process, it replicates many of the challenges that apply to HCC risk adjustment in Medicare Advantage, where patients may appear to be sicker at hospitals that better capture a high count of HCCs, but caring for these patients may not actually be more resource-intensive.

The AANS and the CNS are also concerned that the current model does not account for elective versus emergent surgeries. Patients who come to the emergency department for a workup of neurological symptoms may be found to have a spinal condition requiring a fusion or have known spine pathology with new rapidly progressive or concerning symptoms that require surgery on that same admission, which might be earlier than initially planned on a scheduled basis. **The AANS and the CNS believe that CMS should exclude from TEAM spinal fusion MS-DRGs that are used for admissions with non-scheduled/non-elective surgeries since the hospital has little ability to control costs and outcomes ahead of time. If CMS declines to exclude these cases, they should be sub-grouped or risk-adjusted at a minimum.**



The AANS and the CNS are also concerned about the 3% discount factor, which arbitrarily assumes that all spending across all surgical procedure episodes included in this model should be at least 3% lower than it is today. Discount factors fail to account for the fact that successful value-based care delivery requires heavy investments in infrastructure and process re-design. The TEAM payment methodology also does not account for whether target prices adequately cover the cost of providing services to specific patients, including higher-risk patients. As a result, participants could be penalized for appropriate but more costly specialized care.

**If CMS is genuinely concerned about overall value and not simply cost savings, it should reconsider the use of a discount factor — especially if it finalizes a mandatory model (which we oppose). We believe the 3% discount factor is arbitrary, out of step with the inflationary trend (if intended to be compounding) and unsustainable. It is also inappropriate for CMS to take the first dollar of savings from the very entities that will require additional resources to invest in delivery reform and succeed under this model. If CMS insists on applying a discount factor, it should at least delay adoption so that it does not apply in the initial years of the program when participants need those resources the most. It is also critical that CMS make distinct determinations based on each episode type or even specific MS-DRGs to minimize risk selection and patient access issues. Before establishing discount factors, target prices, and risk adjustment methodologies, CMS should thoroughly evaluate the actual costs of delivering high-quality care to patients with higher and lower needs for each type of episode. We also encourage CMS to explore linking the discount factor to variability in episode spending during the baseline. For example, as CMS notes in the rule, an episode with minimal variability in baseline spending might have a lower discount percentage due to fewer opportunities for savings, as opposed to episodes with greater spending variability.**

### **Quality Measures**

The AANS and the CNS are extremely disappointed by CMS' proposal to use only three measures to evaluate quality under TEAM, two of which are not even episode-specific:

- For all TEAM episodes:
  - Hybrid Hospital-Wide All-Cause Readmission Measure, which evaluates the rate of all-cause hospital readmissions following discharge for all hospital admissions; and
  - CMS Patient Safety and Adverse Events Composite (CMS PSI 90), which evaluates the rate of patient safety and adverse events that occur during all inpatient hospital stays.
- For LEJR episodes:
  - Hospital-Level Total Hip and/or Total Knee Arthroplasty (THA/TKA) Patient-Reported Outcome-Based Performance Measure (PRO-PM)

While we appreciate that CMS tried to focus on measures that are already reported by hospitals under other CMS quality programs in order to minimize administrative burden, **we firmly believe that episode-based payment models must rely on episode-specific quality measures for each episode in order to ensure accurate assessments of value and to guard against under- and inappropriate treatment.**

The readmission measure and PSI 90 measure are problematic for numerous reasons. Most importantly, they provide little meaningful insight into the quality of care provided to spinal fusion patients since they are not procedure-specific. Additionally, scores on these measures would be based on the hospital's performance in other CMS programs (i.e., the Hospital Inpatient Quality Reporting Program and the Hospital-Acquired Condition Program). As a result, these measures would capture all hospital inpatients and not just those specific to the episode being analyzed under TEAM. This could dilute quality concerns related to particular episodes. For example, these measures could result in a situation where a TEAM participant might still receive a relatively high quality performance score despite high readmission rates among its spinal fusion patients.

Additionally, in order to convert a hospital's raw performance score from these other programs into a scaled score that could be used for TEAM, CMS proposes to compare the raw score to the distribution of raw score percentiles among the national cohort of hospitals, which would consist of both TEAM participants and hospitals not participating in TEAM. It is inappropriate to compare the quality of care provided under this model to care provided outside of the model for purposes of accountability. Finally, since these two measures only apply to inpatient care, they would not capture the quality of TEAM episodes that include outpatient procedures. Again, we appreciate CMS' effort to minimize the burden and duplication of reporting. **Still, adopting these two measures for all TEAM episodes is imprudent and will inevitably result in unfair, inaccurate and unmeaningful quality assessments specific to TEAM participants.**

**If CMS hopes to raise the bar on quality through this model, the agency must work with the specialties directly impacted by TEAM episodes to identify more focused quality measures, including patient-reported and other outcome measures collected by specialty society clinical data registries, that are relevant to each specific episode included under the model.** CMS is taking a step backward by proposing to use fewer episode-specific quality measures in TEAM than in either BPCI-A or CJR. CMS made progress in recent years under BPCI-A by incorporating "alternate" episode-specific measures, which were developed by specialty societies and could be submitted through specialty-society clinical data registries. These measures are more relevant to each episode, rely on more informative clinical data versus claims data, provide participants with greater choice and flexibility, reduce administrative burden since many providers already use these registries for quality reporting and result in actionable and meaningful feedback. CMS should adopt similar measures under TEAM.

In recent years and across its quality programs, CMS has made an effort to prioritize patient-reported outcomes measures and to incorporate alternative data sources to address the limitation of claims data. In its recently announced "Quality Pathway,"<sup>8</sup> CMMI recognized the limitations of administrative claims data and noted it would look to other data sources to assess model impact, identify effective interventions, and share information among model participants. CMMI also stated its desire to elevate patient-centered quality goals in the design and evaluation of alternative payment models, including through the evaluation of patient-reported outcomes. Importantly, CMMI acknowledged that its first decade of models focused more on decreased spending and avoidable utilization but that its next decade will shift the balance to quality and promoting patient-centered goals. **We strongly urge CMS to make good on its stated goals by adopting a more diverse and meaningful set of quality measures for use under this model.** The agency's failure to do so again raises questions as to whether this initiative aims to improve the quality of care for Medicare beneficiaries or if its sole goal is to reduce spending for the program.

**In selecting more focused measures, it is also critical that CMS better align the manner it evaluates quality and cost under TEAM, which has been a challenge for CMS on other value-based programs.** As noted above, the model needs more episode-specific quality measures to ensure that reductions in cost will not compromise quality. However, there is also a misalignment between the performance periods used to assess cost and quality. Under the current proposal, a TEAM participant's Composite Quality Scores (CQS) would determine reconciliation payment adjustments. However, the CQS baseline period would be calendar year 2025 for the duration of TEAM, as opposed to a contemporaneous CQS baseline period or a rolling baseline period, which CMS contemplated but felt would be too complex and challenging for participants to implement quality improvement efforts. At the same time, CMS proposes to use three years of baseline episode spending, rebased and shifted up annually, to calculate benchmark prices. As a result, CMS quality and cost assessments would be on different schedules.

**Furthermore, the AANS and the CNS believe that quality benchmarks should be based on the most current data available and updated annually to reflect that data. We also question why CMS cannot adopt a contemporaneous or rolling CQS baseline period for TEAM when it uses that methodology under the MIPS.** Under MIPS, CMS relies on historic benchmarks based on performance data from two years prior to the performance year. When historic data are not available, CMS relies on performance year data to calculate benchmarks. In either scenario, benchmarks are updated annually.

Finally, we are concerned that the quality component of the methodology would result in little or no penalty if a hospital reduces costs by not providing appropriate services. Under CMS' proposal, there would be no actual penalty for a hospital that delivers low-quality care under TEAM unless the hospital also reduces spending sufficiently to qualify for a reconciliation payment. If a hospital reduces spending enough to be eligible for a reconciliation payment, it would still receive at least 90% of that amount regardless of how poorly it scores on quality. **TEAM participants should not be eligible for reconciliation payments for an episode category if the quality of care on episode-specific measures decreases during the performance period compared to the hospital's performance during the baseline period. At the same time, CMS should reward quality improvement independent of cost performance.** For example, hospitals should receive a bonus if they demonstrate enhanced quality performance, even if they keep costs consistent.

### ***Episode Length***

CMS proposes that all episodes under this model would end 30 days after discharge from the anchor hospitalization or anchor procedure. CMS believes that 30 days would cover time periods marked by significant post-acute care needs, potential complications of surgery, and short-term, intense management of chronic conditions that may be destabilized by the surgery. Although CJR and BPCI-A both utilize a 90-day post-discharge episode duration, CMS notes that an episode duration 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.

Neurosurgeons often see their spine fusion patients at 30 days, three months, and nine months (and sometimes even six months) if all is going well. It is also quite common for surgeons to do a one-year follow-up.

The AANS and the CNS do not believe it is appropriate for CMS to adopt a universal 30-day episode length across TEAM episodes since each episode has unique patient populations and distinct patterns of post-operative care. For the spinal fusion episodes specifically, it is impossible to meaningfully analyze the quality of a spine fusion operation so soon after surgery, particularly if the aim of measuring quality is to determine if the operation achieved the surgeon's or patient's stated goals for undergoing the operation. In fact, quality measures already used in CMS programs demonstrate, with clinical evidence, that a longer window is necessary. For example, measure [#471: Functional Status After Lumbar Surgery](#), which is part of MIPS, evaluates functional status at one year (9 to 15 months) following surgery for fusion patients. **The AANS and CNS urge CMS to consider a longer episode window for spinal fusions — ideally 90 days.**

We also remind CMS that if the length of the episode is measured starting with a hospital discharge, total episode lengths could vary since inpatient stay durations could vary. While it is rare to have an extended post-operative stay after a spine fusion, when it does happen, longer inpatient stays are typically associated with higher post-acute-care costs. **We request that CMS adopt policies to ensure that there is not a potential compounding penalty to hospitals for patients who have a more extended inpatient stay.**

### ***Alignment for the Quality Payment Program***

CMS seeks to align the design of TEAM with the Advanced APM criteria in the QPP. Eligible participating TEAM clinicians may be assessed for QP determinations under the QPP if in one of the risk-based tracks of TEAM. CMS proposes that each TEAM participant (i.e., hospital) would be required to

submit information about the eligible clinicians who enter into financial arrangements or otherwise participate in TEAM activities. This would satisfy CMS' criteria for an Affiliated Practitioner List, which CMS would use to make determinations regarding which clinicians should receive QP status under the QPP.

**The AANS and the CNS appreciate that this would expand opportunities for specialists to qualify for the APM track of the QPP and receive an exemption from MIPS. However, we recommend that CMS include clearer language to guarantee QP status for any clinician who contributes to the quality and cost goals of the TEAM participant and otherwise meets the definition of a QP.** We are concerned about a situation where a hospital participant only includes its employed surgeons on a pathway to QP status but does not want to give competing private groups or non-hospital employed surgeons — who may operate and have a financial arrangement with the hospital — the same advantage. Having transparency and clarity over the qualification requirements will help to minimize these circumstances.

### **CONCLUSION**

The AANS and the CNS appreciate the opportunity to provide feedback on provisions in the FY 2025 Medicare IPPS proposed rule and look forward to working with CMS to find reasonable solutions to our policy concerns. If you have any questions or need additional information, please feel free to contact us.

Sincerely,



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