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Submitted via email to: www.regulations.gov

Dr. Elizabeth Fowler, PhD., J.D.
Deputy Administrator and Director
Center for Medicare and Medicaid Innovation
Centers for Medicare and Medicaid Services
7500 Security Boulevard Baltimore, MD 21244

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

Dear Dr. Fowler,

Vizient, Inc. appreciates the opportunity to respond to the Centers for Medicare and Medicaid Services (CMS) Request for Information regarding the design of a future episode-based payment model (hereinafter the "RFI").[1] Vizient thanks CMS, particularly the Center for Medicare and Medicaid Innovation (CMMI), for its efforts to learn from experiences with existing models and noting that any mandatory model would be implemented via notice and comment rulemaking, with ample time for public comment. While Vizient is not commenting on all questions posed in the RFI, we emphasize the importance of considering providers' perspectives, especially considering the time providers would need to prepare for any new model.

Background

Vizient, Inc. provides solutions and services that improve the delivery of high-value care by aligning cost, quality, and market performance for more than 60% of the nation's acute care providers, which includes 97% of the nation's academic medical centers, and more than 20% of ambulatory providers. Vizient provides expertise, analytics, and advisory services, as well as a contract portfolio that represents more than $130 billion in annual purchasing volume, to improve patient outcomes and lower costs. Headquartered in Irving, Texas, Vizient has offices throughout the United States.

Recommendations

Vizient appreciates the willingness of CMS to consider stakeholder feedback regarding a future episode-based payment model. As noted in the RFI, CMS anticipates this model, aimed to advance health equity, would require participation by certain entities and be implemented no earlier than 2026. Consistent with prior feedback, Vizient urges CMS to refrain from using the

[1] https://www.govinfo.gov/content/pkg/FR-2023-07-18/pdf/2023-15169.pdf

Area Deprivation Index (ADI) in models and we recommend using the publicly available, patent pending Vizient Vulnerability Index™ as an alternative approach. In addition, we urge CMS to refrain from imposing a future mandatory payment model, as such models have been disruptive and burdensome to providers, among other concerns. Vizient offers feedback should CMS continue to pursue a mandatory model.

Care Delivery and Incentive Structure Alignment

How can CMS structure episodes of care to increase specialty and primary care integration and improve patient experience and clinical outcomes?
Vizient suggests CMS consider multiple mechanisms for improving the integration between specialty and primary care. For example, Vizient believes it will be critically important that CMS provide the participating episode-based providers with details on the patient's attributed primary care provider, if in a CMS Accountable Care Organization (ACO) model. Alternatively, if not in a CMS ACO model, CMS would need to provide information on who the attributed primary care provider would be based on a plurality of evaluation and management (E&M) services. In addition, details such as the frequency of primary care visits throughout the baseline period will provide insight into the patient's overall care profile. Vizient also encourages CMS to consider process metrics or bonus payments to support continuity of care, as the patient receives care from the primary care provider at the end of the episode period. Similarly, we suggest CMS consider metrics or bonus payments for referring historically unmanaged patients to a primary care provider for future management.

How can CMS support providers who may be required to participate in this episode-based payment model?
As noted above, Vizient does not believe the agency should proceed in developing a mandatory episode-based payment model. Should the agency continue to do so, to support providers who may be required to participate in such a model, Vizient suggests CMS offer a glidepath into risk with downside protection, similar to what was historically offered in the Medicare Shared Savings Program (MSSP). Considering the ongoing financial struggles providers continue to endure and the mandatory nature of the model, Vizient believes it will be important for CMS to consider these options, especially during early model years. Also, should CMS decide to have physician groups participate in this model, either in lieu of or in addition to hospitals, downside risk protection should consider the existing revenue streams of those practices and the ability to repay CMS.

For population-based entities currently engaging specialists in episodic care management, what are the key factors driving improvements in cost, quality, and outcomes?
The ability to provide meaningful incentives and actionable data remain critical in driving improvement in cost, quality, and outcomes. Any new episode-based program must continue to allow waivers to Stark and Anti-Kickback Statute (AKS) laws so participating providers can effectively engage specialists and share in any achievable savings.

Clinical Episodes

Should CMS test new clinical episode categories?
Vizient suggests CMS should limit which categories may be tested by focusing on clinical episodes that have both significant annual volume and a significant impact on a patient's total cost of care. This will ensure a sizeable population with an opportunity for repeatable processes and standards, the ability to smooth actuarial risk, and a population whose overall management will yield meaningful savings. Further, CMS should not consider testing clinical episodes with extremely low annual volume. Even when grouped together with other clinical episodes in the same service line, these areas are more difficult to consistently manage, and period-to-period performance often shows significant variability.

Should CMS consider alternatives to a 30-day episode length?
Vizient appreciates the agency's efforts to consider a shorter-term episode length and we believe a 30-day episode length may help reduce duplication between the episode-payment model and ACOs. However, given post-acute care opportunities would be limited due to the episode length, Vizient notes this would likely limit the potential new clinical episode categories that CMS could test. Also, we recommend CMS work with providers to consider potential exclusions as such a model is being developed.

Which clinical episodes are most appropriate for collaboration between episode-based model participants and ACOs?
Based on the agency's goal of limiting duplication and clearly delineating provider responsibility, Vizient believes the most appropriate clinical episodes for an episode-based payment model are surgical in nature and/or clearly tied to a particular specialist. As CMS is aware, generally, the medical-based clinical episodes offered involve many providers and include patients with multiple chronic conditions. Given there is not a singular specialist managing these cases, many of these conditions may be managed by an ACO and the patient's primary care provider. For example, ACOs could be responsible for all medical conditions and could transition to a specific specialty provider only when surgery or specialized care is required.

Outside of surgical episodes only, another potential option may be to revisit the idea of disease-based bundles that focus on overall management of specific conditions and incorporate surgical appropriateness. The historical bundled payment models aimed to promote efficiency and quality within a specific episode, but they did not address whether surgery was the appropriate treatment. Although any new model must be careful not to limit care, improving competencies around surgical appropriateness and patient optimization may be beneficial. As CMS identifies potential clinical episodes, we encourage the agency to work with providers for additional feedback and refinements in advance of any proposed rulemaking.

For which clinical episodes are ACOs better positioned than episode-based payment model participants to efficiently manage care?

Vizient believes ACOs are better positioned than episode-based payment models to effectively manage care for non-specialty specific medical episodes (such as those included in the BPCI-Advanced Medical and Critical Care clinical episode service line group).

Health Equity

What risk adjustments should be made to financial benchmarks to account for higher costs of traditionally underserved populations and safety net hospitals?
As CMS is likely aware, in the FY 2024 IPPS proposed rule, CMS issued a request for information regarding safety net hospitals and indicated it would consider stakeholder feedback in future rulemaking and other actions in this area. Since the definition of safety net hospitals can vary and may change soon, additional clarity regarding this term is needed before we can respond to this question. In addition, Vizient notes that as CMS considers risk adjustment for underserved populations, the agency should ensure that disparities are not masked as a result. Vizient welcomes the opportunity to share feedback with CMS in the future as more detail is shared. We also encourage CMS to collaborate with external experts (e.g., technical expert panels) regarding risk adjustment.

Should episode-based payment models employ special adjustments or flexibilities for disproportionate share hospitals, providers serving a greater proportion of dually eligible beneficiaries, and/or providers in regions identified with a high ADI, SVI, or SDI?
Vizient encourages CMS to use the Vizient Vulnerability Index, which was specifically designed for health equity purposes, flexes geographically, and is publicly available for purposes of identifying more vulnerable regions. The below table highlights the benefits of the VVI over other indices CMS notes in the RFI. In addition, Vizient suggests CMS consider exemptions for financially distressed providers.

	Area Deprivation Index	Social Vulnerability Index	AHRQ Socioeconomic Status Index	Vizient Vulnerability Index
Data granularity	× County × Zip Code × Census Tract ✓ Block Group	✓ County ● Zip Code possible ✓ Census Tract ● Block Group possible	× County × Zip Code × Census Tract ✓ Block Group	✓ County ✓ Zip Code ✓ Census Tract ✓ Block Group
Timeliness	Updated in 2015, 2019, and 2020	Updated every two years	Updated in 2015 and 2019	Updated annually
Social Determinants of Health Domains	✓ Income & Wealth ✓ Employment ✓ Education ✓ Housing × Health Systems ✓ Transportation ✓ Social Environment × Physical Environment × Public Safety	✓ Income & Wealth ✓ Employment ✓ Education ✓ Housing × Health Systems ✓ Transportation ✓ Social Environment × Physical Environment × Public Safety	✓ Income & Wealth ✓ Employment ✓ Education ✓ Housing × Health Systems × Transportation × Social Environment × Physical Environment × Public Safety	✓ Income & Wealth ✓ Employment ✓ Education ✓ Housing ✓ Health Systems ✓ Transportation ✓ Social Environment ✓ Physical Environment ✓ Public Safety

Health Care Focus	✓ Life Expectancy / Mortality × Chronic Disease Prevalence ✓ Readmissions × ED utilization × Maternal Health	× Life Expectancy / Mortality × Chronic Disease Prevalence × Readmissions × ED utilization × Maternal Health	✓ Life Expectancy / Mortality × Chronic Disease Prevalence ✓ Readmissions × ED utilization × Maternal Health	✓ Life Expectancy / Mortality ✓ Chronic Disease Prevalence ✓ Readmissions ✓ ED utilization ✓ Maternal Health
Measurement Focus	17 components 2 components account for almost all of the variation (income and housing) Intended to predict mortality, but only a moderate fit to life expectancy (r^2 0.40)	14 components in 4 domains, 2 components account for almost all of the variation (income and education) Intended for disaster management planning; poor fit to life expectancy (r^2 0.20)	7 components No serious issues with partial correlations Intended to describe economic factors related to health care access; poor fit to life expectancy (r^2 = 0.30)	43 components in 9 domains. All are significant in different locations Intended to describe differences in life expectancy (r^2 0.75)
Geospatial Adjustments	Single index algorithm for the whole country	Single index algorithm for the whole country	Single index algorithm for the whole country	Index adapts to local relevance of each domain as it correlates with life expectancy

What other factors could be considered for providers who serve underserved beneficiaries or beneficiaries who experience social risk factors? Can measure stratification among patient subgroups and composite health equity measures improve how CMS identifies and quantifies potential disparities in care and outcomes?
Other factors that could be stratified include more granular race and ethnicity data, sexual orientation and gender identity (SOGI), neighborhood vulnerability using the Vizient Vulnerability Index, and language. Such stratification could help ensure providers are adequately resourced. For example, additional support to facilitate access to language services based on stratified data could be a helpful intervention that can be more quickly implemented.

Vizient also encourages CMS to clarify the scope of beneficiaries (e.g., Medicare only) in which the agency is considering quantifying potential disparities in care and outcomes for purposes of identifying providers serving beneficiaries experiencing social risk factors versus the model more broadly.

Aside from claims data, what data sources would be valuable for evaluation and tracking of health equity?
Vizient believes use of the VVI paired with clinical outcomes and electronic health record data would be valuable for evaluation and tracking of health equity. Also, Vizient encourages CMS to give providers a choice regarding data or metrics shared publicly to help inform beneficiaries of provider performance. Also, to the extent many providers elect to use alternative data or metrics, CMS should consider sharing such data publicly to help inform beneficiaries of provider performance.

Quality Measures and Multi-Payer Alignment

Which quality measures, currently used in established models or quality reporting programs, would be most valuable for use across care settings?
Vizient notes that historically, many organizations have struggled with the Advanced Care Planning metric within the episode-based payment models because the variability of clinical episode selection impacts the ability of the participating providers to address this metric in the right setting. Removal of this metric from the future episode-based payment model would also eliminate duplication of metrics across model types.

What PRO measures should CMS consider including in this next episode-based payment model?
Patient reported outcome (PRO) measures are still not highly standardized across organizations or payers, but they remain a critical measurement function in the context of value-based care. As was learned in the early years of the Comprehensive Joint Replacement (CJR) model, it is important to consider the burden of these collection efforts and ensure the PRO tools selected are simple and easy to administer. Vizient notes that these workstreams are not well-embedded in most organizations, so we encourage CMS to provide incentives for episode-specific PRO collection and ample guidance and implementation time.

The CAHPS® for the Merit-based Incentive Payment System (MIPS) includes questions to assess the degree to which shared decision-making has been implemented in the outpatient setting. How can CMS most effectively measure these activities in the hospital setting?
Vizient notes that utilizing CAHPS as a quality component for episode-based payment models can be challenging. For example, if an episode-based payment model is limited to specific service lines, the CAHPS scores that measure overall hospital quality do not always directly tie to the service line that is being managed. Any quality measures that are not directly applicable to the specific episodes can often be beyond the provider's (e.g., the surgeon) control.

What supports can this new model provide for decreasing burden of data collection?
Vizient suggests CMS consider multiple avenues for quality reporting to allow organizations that are already fulfilling quality reporting requirements to leverage existing efforts and minimize additional burden and duplication. A combination of leveraging existing registries/reporting, utilizing relevant claims-based metrics, and introducing PROs is one approach that may simplify the reporting process while also including other quality measures (e.g., voluntarily reported PROs).

Are there opportunities to reduce provider burden across episodes through multi-payer alignment of quality measures and social risk adjustment?
Vizient encourages CMS to work with providers and other payers, including through already established groups, to support standardized measure sets for specific service lines and populations, as this would ease burden associated with different payment models.

Also, Vizient notes our concern regarding social risk adjustment, as the agency should ensure such risk adjustment does not mask disparities. Further, tools such as the ADI should not be used for risk adjustment purposes given its numerous limitations, as noted in prior comments.

Payment Methodology and Structure

Vizient suggests that CMS further explore, particularly with provider input, incorporating a value-based purchasing (VBP) approach (as CMS further details in the RFI). While Vizient appreciates this concept is shared in the RFI for feedback, there are numerous details that must be clarified before we can opine on this approach. For example, many organizations engage in sharing arrangements with other providers through these episode-based payment models and depend on the reconciliation lump sum payments for making those distributions. The timing of applying any VBP-type adjustments will impact the ability of health systems to engage effectively with their participating providers. CMS must consider the impact this will have on both cash flow and financial viability. As one way to effectively manage episodes is to financially incentivize physician partners, any change to the reconciliation process should add simplicity and expediency to this collaboration.

How should CMS balance participants' desire to receive reconciliation results as close as possible to the performance period, while also allowing for sufficient claims runout to finalize the results and minimize the administrative burden of multiple reconciliations?
Engaging providers can be challenging when reconciliation results lag real-time data by months or in some cases, years. Vizient anticipates that reducing the episode-length to 30 days may certainly help this data review process to occur more quickly, but there are other considerations. For example, having more than one true-up may overcomplicate results and program administration.

Also, CMS has historically provided monthly data feeds and then a quarterly, semi-annual, or annual reconciliation. One of the challenges with the monthly data feeds is that although organizations have insight into claims, they do not have any insight into changes to their target prices. This makes projecting results, even directionally, extremely challenging. To support transparency and predictability for organizations attempting to measure performance in real-time, Vizient suggests CMS consider provider updates to target prices on a more regular cadence to provide insight into national trends and performance period patient case mix changes when compared to the baseline.

How should risk adjustment be factored into payment for episode-based payment models?
Vizient encourages CMS to refine their risk adjustment approach for these payment models, as Vizient understands that many organizations feel that the historical risk adjustment methodology does not adequately account for the acuity of their patient populations. Also, it is important CMS maintain alignment with other Medicare programs (e.g., MSSP and Medicare Advantage).

Regarding changes in coding patterns, Vizient suggests CMS monitor changes in coding patterns during the early years of a new mandatory episode-based payment model prior to implementing any coding intensity prohibitions. Should such prohibitions be put in place, Vizient suggests they not be applied retroactively.

How could CMS incorporate other non-claims-based variables, such as from electronic health records or nonmedical determinants of health, to improve risk adjustment, care coordination, quality measurement, and/or address health equity?
Vizient encourages CMS to incorporate the Vizient Vulnerability Index, which is free and publicly available, among its efforts to address health equity. For example, the Vizient Vulnerability Index could replace the ADI in various policies CMS has already implemented and in future policies that would rely on an area-based social needs index.

Model Overlap

Vizient appreciates that CMS aims to resolve previous model overlap, especially as CMS works to achieve its stated goal of having all Medicare FFS beneficiaries in an ACO model by 2030. Vizient suggests CMS use this time as a testing ground for how various models can work together more collaboratively.

For example, participants in a mandatory episode-based payment model could have precedence for the 30-day episode timeframe for which they are responsible should there be overlap, and these costs could be effectively removed from the ACO to avoid duplication of savings payouts. Given that context, CMS could also provide additional incentives to both ACO participants and episode-based payment model participants when savings are achieved in both areas.

Regarding incentives and model overlap, Vizient suggests they be provided based on results and transitional processes that get established between primary care and specialists. Incentives can be an effective tool, especially in early years, to ensure model participants are working together and establishing new processes for communication. However, for incentives to be achievable, CMS must provide data to all parties that highlights performance in both models. Also, Vizient suggests CMS share the following information with participating providers in episode-based models: information regarding the patient's primary care provider and how many E&M visits the patient has had during the baseline timeframe. This information will assist the provider when transitioning the patient from/to the primary care provider.

Vizient also suggests CMS continue to simplify and refine quality requirements for overlapping programs, include complementary (not duplicative) measures, and ensure the timeframe for episodic management is limited and focused on specialty-driven conditions to ensure clear delineation of responsibilities. We recommend CMS work with providers to further consider measurement as potentially overlapping models are considered.

Conclusion

Vizient thanks CMS for the opportunity to share feedback in response to the RFI. Vizient continues to suggest CMS refrain from implementing a mandatory model. Should CMS continue to develop such a model, we recommend the agency utilize the Vizient Vulnerability Index in health equity-related policies versus the ADI, which does not provide the same level of granularity as the VVI and does not effectively account for geographic variation. Vizient also recommends the agency consistently gain provider feedback, including after the RFI

comments are received and before proposed rulemaking, to ensure such a model would be sustainable and meaningful.

Vizient membership includes a wide variety of hospitals ranging from independent, community-based hospitals to large, integrated health care systems that serve acute and non-acute care needs. Additionally, many are specialized, including academic medical centers and pediatric facilities. Individually, our members are integral partners in their local communities, and many are ranked among the nation's top health care providers. In closing, on behalf of Vizient, I would like to thank the CMS for providing the opportunity to comment on the RFI. Please feel free to contact me or Jenna Stern at jenna.stern@vizientinc.com, if you have any questions or if Vizient may provide any assistance as you consider these issues.

Respectfully submitted,

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