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Advancing Health in America

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June 10, 2024

The Honorable Mehmet Oz, M.D.
Administrator
Centers for Medicare & Medicaid Services
Hubert H. Humphrey Building
200 Independence Avenue, S.W., Room 445-G
Washington, DC 20201

Submitted Electronically

RE: CMS-1833-P, Medicare 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 2026 Rates; Requirements for Quality Programs; and Other Policy Changes, (Vol. 90, No. 82), April 30, 2025.

Dear Administrator Oz,

On behalf of our nearly 5,000 member hospitals, health systems and other health care organizations, our clinician partners — including more than 270,000 affiliated physicians, 2 million nurses and other caregivers — and the 43,000 health care leaders who belong to our professional membership groups, the American Hospital Association (AHA) appreciates the opportunity to provide comment on the Centers for Medicare & Medicaid Services' (CMS) proposed changes to the Transforming Episode Accountability Model (TEAM). We are submitting separate comments on the agency's proposed changes to the inpatient and long-term care hospital prospective payment systems (PPSs).

TEAM is a new, mandatory, episode-based payment model scheduled to begin on Jan. 1, 2026. The five-year program will require acute care hospitals in selected geographic areas to participate in five surgical episodes, including coronary artery bypass graft (CABG), lower extremity joint replacement (LEJR), major bowel procedure, surgical hip/femur fracture treatment (SHFFT) and spinal fusion. TEAM will hold acute care hospitals accountable for the quality and cost of all services provided during select surgical episodes, from the date of inpatient admission or outpatient procedure through 30 days post-discharge. Similar to other bundled payment models, TEAM participants will reconcile performance year spending against a target price to determine if a hospital is eligible for a reconciliation payment or repayment.

Hospitals and health systems are eager for opportunities to participate in value-based payment arrangements and to drive innovation in the Medicare program. As such, the AHA and its members support innovative payment models that improve quality and lower costs**. However, we continue to be concerned that TEAM does not meet these desired goals and may, in fact, hamper access to care by overburdening providers who do not have the infrastructure or population to be successful in this model, the way it is currently designed.** Indeed, a majority of our original concerns about the model persist or have even been heightened by this rule. For example, TEAM has a very similar design to models such as Bundled Payments for Care Improvement (BPCI), BPCI Advanced (BPCI-A), and Comprehensive Care for Joint Replacement, none of which have either generated significant net savings or met statutory criteria for expansion, and yet this rule does not change the aspects of TEAM that could result in the same disappointing outcomes. In addition, in four out of the five TEAM episodes, over 71% of costs are incurred during the anchor hospitalization or outpatient procedure, for which reimbursement is already paid on a bundled basis, leaving few opportunities for savings by participants. Furthermore, for procedures such as spinal fusion and LEJR, over 40% of anchor costs are tied to supplies, equipment and implantable devices. We have advocated for exemptions of medical devices and equipment from tariffs, but should they go into effect, hospitals' and health systems' ability to impact these costs will decrease even further.[1,2]

Our primary request continues to be that CMS make TEAM voluntary, as most recently highlighted in our response to the administration's deregulation request for information. Mandatory participation is inappropriate given that many of the selected organizations are neither of an adequate size nor in a financial position to support the investments necessary to transition to mandatory bundled payment models. Requiring hospitals to take on large, diverse bundles would require more risk than many can manage, threatening their ability to maintain access to quality care in their communities.

In addition, we urge the agency to make several additional modifications to model design features. For example, we recommend that CMS:

- Establish a low-volume threshold of 200 cases per individual episode category. Hospitals that do not meet this threshold should be excluded from participation in the episode. Hospitals that do not meet thresholds for any episode category should not be required to participate in TEAM. The low-volume threshold policy should be finalized as soon as possible for planning purposes.
- Provide track 2 eligibility for current Medicare-dependent Hospitals (MDHs) for the duration of the model.

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[1] https://www.aha.org/lettercomment/2025-05-16-aha-responds-commerce-department-investigation-critical-minerals
[2] https://www.aha.org/system/files/media/file/2025/02/AHA-Urges-Administration-to-Grant-Exceptions-for-Tariffs-for-Medications-and-Medical-Supplies.pdf

- Make participation voluntary for new hospitals and Indian Health Service (IHS) hospitals.
- Release specifications for the Community Deprivation Index (CDI) to inform stakeholder comments.
- Expand the hierarchical condition categories (HCC) lookback to include the anchor hospitalization or procedure and ensure that the lookback period is at least one year.
- Add additional variables to the model's risk adjustment methodology, including fracture status, frailty, severity of illness (i.e., HCCs and major complications or comorbidities (MCCs) or complications or comorbidities (CCs)), inpatient versus outpatient procedure, and emergent versus scheduled procedure.
- Remove primary care referral requirements.
- Add waivers to rules such as the inpatient rehabilitation facility (IRF) "60% Rule" and "three-hour rule."
- Leverage maximum abilities to waive fraud and abuse laws to enable participating hospitals to form the financial relationships necessary to succeed in the TEAM model
- Provide data to participants no later than 60 days before the performance period.

The changes we recommend would help facilitate hospitals' success in providing quality care to Medicare beneficiaries, achieving savings for the Medicare program, and rewarding hospitals commensurate with the risk they are assuming. If CMS does not make participation voluntary and modify the design features, TEAM will simply be a hospital payment cut that fails to spur innovation to advance quality and access to care for beneficiaries.

Our detailed comments are attached. Please contact me if you have questions, or feel free to have a member of your team contact Jennifer Holloman, AHA's director of policy, at jholloman@aha.org.

Sincerely,

/s/

Ashley Thompson
Senior Vice President
Public Policy Analysis and Development

Cc: Abe Sutton
Director, Center for Medicare and Medicaid Innovation

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MANDATORY PARTICIPATION

First, we urge CMS to make participation voluntary for the model as a whole and to allow hospitals to select individual episode categories for participation.

The last administration, despite stakeholder concerns, finalized mandatory participation for TEAM and selected 188 core-based statistical areas (CBSAs) for the model. Currently, all inpatient prospective payment system (IPPS) hospitals in those selected markets will be required to participate. While the agency did provide a voluntary pathway for previous participants from CJR and BPCI-A models to opt in to participate (10 in total opted in), the agency did not extend this voluntary option for the model as a whole.

CBSAs were selected for mandatory participation based on certain criteria — areas with higher numbers of safety net hospitals and hospitals that have never participated in bundled payment models were intentionally oversampled. This methodology was counterintuitive because it ignored the very real barriers that many hospitals face in transitioning to value-based payment models, as well as the flawed model design features that led many to opt out of alternative payment models to begin with.

As such, we continue to have significant concerns with CMS requiring participation in TEAM. Hospitals should have the opportunity to determine whether models like this — or particular clinical episodes within the model — make sense for their communities. This is particularly true because, as our analysis shows below, hospitals that are forced to participate stand to lose a staggering 500% more than those that are voluntarily participating, even with maximum quality and stop loss/stop gain adjustments (see Table 1).

Table 1. Mandatory vs. Voluntary Participant Episode Performance Across TEAM Episode Categories

	Number of Hospitals	Number of Episodes	Avg. Episode Spending	Avg. Target Price	Difference Between Target and Spending	Difference Between Target and Spending with Max. Quality Adjustment	Difference Between Target and Spending with Max. Quality and Stop Loss/Gain
Mandatory*	702	593,969	$29,705	$29,090	-$615	-$506	-$444
Voluntary**	10	16,245	$30,443	$30,272	-$172	-$81	-$72

* Mandatory hospitals include 702 of the 741 hospitals in selected CBSAs, which have volumes for the five surgical bundles in the three baseline years.

**Voluntary hospitals include 10 hospitals that historically participated in BPCI-A and CJR and notified CMS of their intent to participate in TEAM.

In addition, hospitals that are projected to have the highest spending may face greater barriers to addressing costs due to the characteristics of their patient populations. When the AHA broke participating hospitals into quintiles based on the difference between their regional target price and their payments per episode across all clinical episode categories (see Table 2), we found that hospitals in the highest spending quintiles included those serving a disproportionate share of dual-eligible (DE) or low-income subsidy (LIS) patients. They also had higher proportions of patients entering through the emergency department (ED). These trends were consistent even when looking at certain individual clinical episode categories. As such, the very organizations that CMS oversampled for inclusion in the model are the ones that would be hardest hit financially within the model. These organizations also are those that are less able to make infrastructure investments or absorb financial losses due to existing financial challenges. Organizations that are not able to absorb losses may be forced to cut services or shut their doors, resulting in significant access challenges. The impact on certain communities would be devastating, as there simply may not be provider capacity to support patients who could no longer be served by the hospital.

Table 2. Distribution of Hospital Characteristics for All TEAM Episodes by Quintile

	Number of Hospitals	Average Number of TEAM Episodes per hospital	Average Spending Per Episode	Average Target Price	Percent Difference Between Target and Spending	Percent of Episodes with Patients Admitted for Anchor Stay through ED or Trauma	Percent of DE Patients	Percent of LIS Patients
Highest Spending Quintile	142	453	$35,779	$32,175	-11%	32.1%	15.8%	17.1%
2nd Quintile	142	1,032	$31,871	$30,285	-5%	25.6%	12.5%	13.5%
3rd Quintile	143	1,226	$29,401	$28,841	-2%	19.7%	9.8%	10.7%
4th Quintile	142	959	$27,148	$27,530	1%	19.2%	9.0%	9.9%
Lowest Spending Quintile	143	614	$26,345	$27,968	6%	20.7%	9.8%	10.8%
Total	712	857	$29,724	$29,121	-2%	22.4%	10.9%	11.9%

The fact remains that many hospitals are neither adequately sized nor financially positioned to support the investments necessary to transition to mandatory bundled payment models. Taking on large, diverse bundles would require more risk than many can manage, threatening their ability to maintain access to quality care in their communities. **We continue to strongly urge CMS to make TEAM participation voluntary.**

In addition to voluntary participation for the model as a whole, we reiterate that hospitals also should have the flexibility to choose the individual episode categories in which they participate. It is vitally important for participants to have the ability to select individual clinical episodes, as opposed to the current all-or-nothing approach.

PARTICIPATION DEFERMENT FOR NEW HOSPITALS

CMS proposed a deferment period for certain new hospitals. Specifically, any new hospital established in a TEAM CBSA or any hospital that begins to meet the TEAM participant definition after Dec. 31, 2024, would be eligible for a one-year deferment from participation. These hospitals would be required to participate in TEAM starting on Jan. 1 of the subsequent performance year (PY) after the one-year period expires.

We appreciate that CMS is attempting to address the difficulties that a new hospital would face in entering an alternative payment model (APM) in the first year of existence, however, a one-year deferment is simply inadequate. New hospitals face an overwhelming number of challenges in their first year and beyond, including recruiting and training new staff, developing electronic health record workflows, ramping up billing and claims systems, engaging community members and patients, and developing reporting infrastructure. Their patient volumes and revenues often see large fluctuations. Considering TEAM is a five-year model, there is simply not an adequate runway for these new hospitals to not only stand up operations but also assume downside risk in a new APM. To do so at such an early stage poses unwarranted burdens, unnecessary risk and serves as a disincentive for hospitals to open in those areas despite access needs. **Unless and until CMS makes TEAM voluntary so that hospitals can determine if and when there is an appropriate time to participate, we recommend that CMS exclude new hospitals (after Dec. 31, 2024) from the model.**

MEDICARE-DEPENDENT HOSPITALS

CMS finalized last year that MDHs will be eligible for track 2 of the model, which provides them with modest additional protections from losses. However, the MDH program is currently scheduled to expire on Sept. 30, 2025. As such, CMS proposed that MDHs would remain eligible for track 2 participation as long as the MDH program is active at the time the participation track selections are due to CMS.

Given the reasons that hospitals qualify for MDH status to begin with, we recommend that all hospitals designated as MDHs as of Sept. 30, 2025, remain eligible for track 2 for the duration of the model, regardless of the status of the MDH program as a whole. If the MDH program is extended, then hospitals designated as MDHs before the expiration of the MDH program also should be eligible for track 2 for the duration of the model. The ability of hospitals to know upfront that they will be eligible for track 2 for the duration of the model would arm them with the certainty that

they will qualify for lower risk thresholds and therefore allow them the flexibility for additional investments in the model. Indeed, the MDH program was established in 1987 to support small hospitals where Medicare patients make up a significant percentage of inpatient days or discharges. It was also designed to support the network of providers that serve rural Americans, which is financially fragile and more dependent on Medicare revenue due to the high percentage of Medicare beneficiaries who live in rural areas. Rural residents also, on average, tend to be older, have lower incomes and higher rates of chronic illness than their urban counterparts. To require these hospitals to assume the higher, 20% stop-loss limit of track 3 would pose more risk than they can bear. Ultimately, this would translate to reduced access when those organizations must either cut services or close their doors.

It is also worth noting that the overall volume of MDHs in the model is relatively small. As such, the impact of providing track 2 eligibility up front would also be minimal. Specifically, CMS estimates that of the 741 hospitals that were selected for TEAM, only 25 have an MDH designation.

PARTICIPATION TRACKS

CMS previously finalized three participation tracks for TEAM, with an optional one-year glidepath to two-sided risk (safety-net hospitals have a three-year glidepath). Details of the three tracks are below.

Table 3: TEAM Risk Tracks

Track	Eligible Hospitals	PYs	Type of risk	Stop-Gain	Stop-Loss	Composite Quality Score (CQS) Adj.
Track 1 "Glidepath"	• All	PY1 Only	Upside Only	10%	N/A	10%
	• Safety-net hospitals	PY1-PY3	Upside Only	10%	N/A	10%
Track 2	• Safety-net • Rural • Medicare-dependent • Sole community • Essential access community	PY2-PY5	Two-sided	5%	5%	10% for positive adjustments 15% for negative adjustments
Track 3	• All others outside Track 1 and Track 2	PY1-PY5	Two-sided	20%	20%	10%

However, the agency did not previously finalize the form, manner and deadlines for participants to select tracks, and also did not propose a process in this rule. **Therefore, we ask CMS to issue details soon on how to do so.**

Additionally, while not proposed, we continue to urge CMS to provide a more gradual glide path to downside risk. While we appreciate that the agency extended track 1 eligibility for safety net hospitals through PY 3, other rural and special designation hospitals face similar challenges in migrating to downside risk. As such, track 1 should also be extended for rural and special designation hospitals through PY 3.

INDIAN HEALTH SERVICE HOSPITALS

IHS hospitals are included in TEAM. However, these hospitals are not paid under the outpatient PPS, and two of the TEAM episode categories (LEJR and spinal fusion) include outpatient episodes. **Given that for 40% of TEAM episode types, IHS hospitals are not paid in a manner that fits with CMS' target price methodology, IHS hospitals should be exempt from the model.** It is unclear how CMS would calculate its targets, let alone reconciliation payments, under the model. Even if information was issued in the final rule, that does not provide adequate planning time for these hospitals.

ALIGNMENT OF HYBRID HOSPITAL-WIDE READMISSION MEASURE TO HOSPITAL IQR PROGRAM

CMS proposes to change the performance period for the hybrid hospital-wide readmission (HWR) measure for PY 1. In the CY 2025 outpatient PPS final rule, CMS delayed mandatory reporting of the HWR measure for the Hospital Inpatient Quality Reporting (IQR) program. Specifically, mandatory reporting of the HWR measure in the Hospital IQR program will begin with the period of July 1, 2025, through June 30, 2026. This would impact TEAM PY 1 as the TEAM HWR performance period for PY 1 was July 1, 2023, through June 30, 2024. CMS proposes to use July 1, 2025, to June 30, 2026, as the TEAM PY 1 performance period for the HWR measure.

While we appreciate the effort to align performance measure timelines and processes with the IQR to minimize reporting burden, we remain concerned that this measure is not well-aligned with the structure of the payment model.

First, CMS has proposed multiple changes to the hybrid hospital-wide readmission measure. Several of these proposed changes intend to make the measure more feasible to report, such as lowering the data completeness thresholds linking variables and core clinical data variables to 70%. Yet, it is unclear whether these modified reporting thresholds also would apply to those hospitals in the TEAM model. We urge CMS to clarify that any changes to the hybrid readmission measure reporting requirements in the IQR would also apply to TEAM.

Second, while the hybrid readmission measure is pay-for-reporting in the IQR, it would be pay-for-performance in TEAM *immediately*, even though the measure is only scheduled to be required of IQR-participating for the first time in 2026. It is important to note that while we agree the changes CMS has proposed likely would improve the feasibility of the measure, hospitals that participated in the voluntary reporting process for this measure encountered significant challenges that raise questions about the measure's readiness for the IQR program, let alone the TEAM model. Hospitals have not received enough information from CMS on the accuracy of the vital signs, labs and linking variables that they submitted to the agency. These data are essential because the measure relies on a matching process between data hospitals submit from their EHRs with Medicare claims data. Furthermore, based on the information received from CMS, it appears some patients may have been included or excluded from the measure calculation inappropriately. As such, the methodology requires additional fine-tuning before it is integrated into TEAM.

Lastly, with the updated measure performance timeline and 6-month claims runout, hospitals will not know how they performed on the measure until they are already in downside risk. We have consistently advocated for a gradual glide path to downside risk, in part to ensure that participants can analyze baseline data and determine appropriate interventions to improve performance before taking on a financial risk.

INFORMATION TRANSFER PATIENT REPORTED OUTCOME-BASED PERFORMANCE MEASURE

CMS proposes to add the Information Transfer Patient Reported Outcome-based Performance Measure (PRO-PM) to the quality measure set. CMS proposes to include this measure starting in PY 3 (2028).

The measure reports the average score of a patient's ratings on a three-domain, nine-item post-operative survey regarding the clarity of clinical information given before, during, and after an outpatient surgery or procedure.

The AHA opposed the adoption of this measure for the Hospital Outpatient Quality Reporting Program (OQR) when CMS proposed it last year and does not support its adoption for TEAM. Certainly, hospitals and health systems deeply value the patient perspective on their care and use data from patient experience and Patient-Reported Outcome Performance Measures (PRO-PM) across their efforts to make care safer and higher quality. PRO-PMs are a newer measure type that carries the important potential to capture whether patients are regaining function and activities that matter in their daily lives. At the same time, such measures also require patients to provide a significant amount of information — often, the same information multiple times. Furthermore, we are concerned that the survey administration timeframe for this measure overlaps too closely with the total hip arthroplasty/total knee arthroplasty (THA/TKA) PRO-PM that CMS has already adopted for TEAM. This creates the

potential for confusion among patients about what aspect of their care they are being asked to assess.

In last year's outpatient PPS proposed rule, CMS argued that the administration timeline of the information transfer PRO-PM proposed in this rule "mitigates overlap" with the PRO-PM for THA/TKA. The information transfer PRO-PM survey would be administered between two and seven days post-procedure, whereas the survey for PRO-PM for THA/TKA is administered up to 90 days before the procedure and 300-425 days following. Indeed, the surveys would not be administered during the exact same time; however, we do not believe this "mitigates" overlap at all, as the same patient could still receive multiple surveys within days of a surgical procedure.

In addition to the logistical challenges, this particular measure suffers from conceptual disadvantages. CMS' purported purpose with the measure is to evaluate the clarity of clinical information provided to patients. We agree that a patient's understanding of information presented to them certainly relies partly upon the completeness and articulation of the information provided by the facility. However, there are other factors, including the health literacy of patients and caregivers who may complete the survey on the patient's behalf, that would influence the patient's evaluation. In other words, this measure does not evaluate the quality of information provided to the patient, but rather the patient's ability to comprehend it. Yet, the study that CMS cited in support of the measure based its conclusions on documentation review rather than patient responses.

Lastly, the subjective nature of the response categories (very, somewhat, and not) may pose challenges for providers to use to improve how well they communicate information to patients. The survey does not provide details on how the information could be clarified or what information was missing. In fact, hospitals already work closely with their Patient and Family Advisory Councils to meaningfully improve their patient-facing communications materials. We question whether this measure would provide useful insights into this process. For these reasons, the AHA urges CMS not to add this measure to TEAM.

APPROACH FOR WHEN TEAM PARTICIPANT HAS NO QUALITY MEASURE PERFORMANCE DATA

In the FY 2025 inpatient PPS final rule, CMS did not address how quality measures would be adjusted in instances where no quality measure performance data are available. For example, for new hospitals or for hospitals that are not voluntarily reporting the Hospital Harm-Falls with Injury or Hospital Harm-Postoperative Respiratory Failure measures, the agency did not address how quality scores would be adjusted.

In this rule, CMS proposes to assign a neutral quality score for participants who have no or incomplete data for specific quality measures. Specifically, participants would be

assigned a scaled quality measure score of 50 for those measures, which is the midpoint on the Composite Quality Score scale of 0-100.

We are concerned that in providing a score of 50 for hospitals without quality measure performance data, CMS may unfairly penalize hospitals for reasons unrelated to quality performance. A hospital may simply be reporting other eCQMs and may have elected not to report Falls with Injury or Postoperative Respiratory Failure. Applying an artificial score for quality measures defeats the purpose of value-based payment models, which is to incentivize participants based on their performance on standardized quality measures.

This is another reason why we urge CMS to make this model voluntary. Hospitals should not be forced into a model that judges quality based on voluntary measures they are not even required to report on.

ACCOUNTING FOR FUTURE CHANGES TO MS-DRGS AND HCPCS

In the FY 2025 inpatient PPS final rule, CMS acknowledged that changes to Medicare-severity Diagnosis-related Groups (MS-DRGs) and Healthcare Common Procedure Coding System (HCPCS) may impact episode pricing. Specifically, the agency received comments regarding modifications to the spinal fusion episode category, including the deletion of MS-DRGs 453-455 and the addition of eight new MS-DRGs, and how these modifications would be addressed in TEAM. The agency indicated it would issue subsequent rulemaking to address this issue.

As such, CMS proposes a three-step approach to account for MS-DRG or HCPCS changes by remapping and adjusting episode types during the baseline period to estimate performance year costs.

In general, we support the proposed mapping and adjustment methodology. We appreciate CMS' thoughtful approach to ensure future coding changes are accounted for in the model.

BENEFICIARY ECONOMIC RISK ADJUSTMENT

Last year, CMS finalized a risk adjustment factor to account for multiple beneficiary markers of non-medical risk. This was a binary measure if beneficiaries met any one of three categories to include:

- DE status.
- Residing in a census block group that exceeded the threshold for Area Deprivation Index (ADI) (80th percentile nationally or 8th decile for the state).
- Eligibility for Part D LIS.

In this rule, CMS proposes to modify the deprivation index methodology from the ADI to the community deprivation index (CDI). The CDI would be a factor-weighted composite measure of 18 variables from the Census Bureau and is being constructed as part of the Accountable Care Organization Realizing Equity, Access, and Community Health (ACO REACH) model. The agency proposes to maintain the use of percentile rankings relative to the nation and the 80th percentile threshold for the measure. With the proposed transition to the CDI, the agency also proposes to only use national-level CDI rankings as opposed to national and state-level rankings, as would have been the case with the ADI.

We appreciate that the agency is attempting to refine the methodology to account for non-medical drivers of risk. However, given that the CDI is still being vetted in the ACO REACH model, specifications for its calculation have not been widely released or reviewed. **We urge CMS to release a detailed methodology on how to calculate the CDI to inform stakeholder comments.**

HCC IN RISK ADJUSTMENT

CMS previously proposed but did not finalize the look-back period for the HCCs used in the TEAM risk adjustment calculation. In this rule, it proposes a 180-day look-back period for each beneficiary beginning the day prior to the anchor hospitalization or anchor procedure. **This proposed HCC look-back period is insufficient in that it does not include the anchor hospitalization and is too short to account for the breadth of chronic conditions supported by physician documentation that a patient may have.**

We conducted an R-squared analysis using the TEAM risk-adjustment variables to determine whether models with or without the anchor hospitalization in the HCC look-back period explained a greater degree of variation. R-squared analysis assesses the "goodness of fit" of a regression model, or how well variation in a regression is explained by independent variables. Our analysis shows that including the anchor hospitalization in the look back explains more variation through higher R-squared values (see Table 3 below) than excluding it. This conclusion applies across all episode categories.

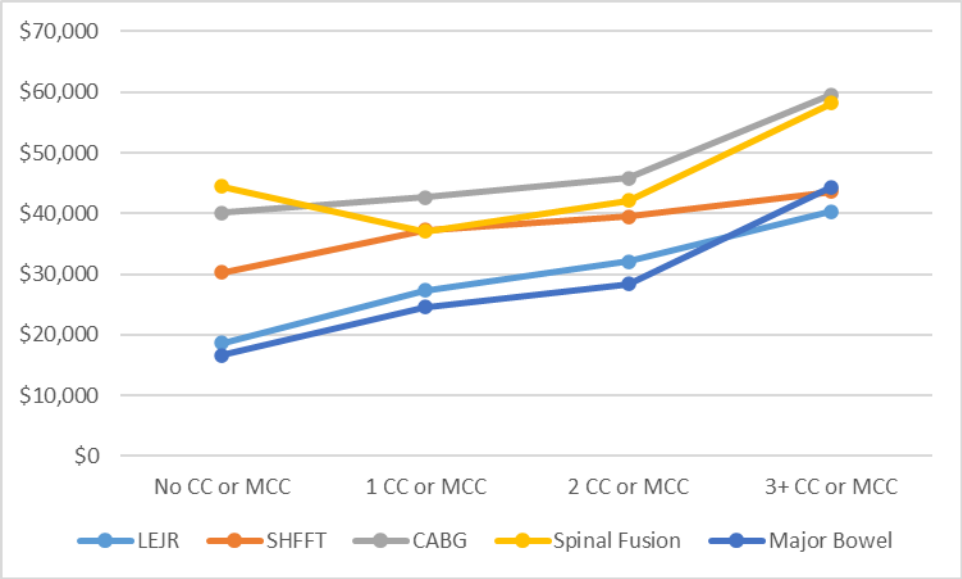
Table 4. R-squared Values for HCC Look-back Period, Excluding versus Including Anchor

Episode Group	180-day Look Back Excluding Anchor Admission/Procedure	180-day Look Back Including Anchor Admission/Procedure
Lower Extremity Joint Replacement	0.6251	0.6290
Surgical Hip and Femur Fracture Treatment	0.1728	0.1845

Coronary Artery Bypass Grafting	0.5377	0.5697
Spinal Fusion	0.7248	0.7344
Major Bowel Procs	0.6539	0.6757

Furthermore, we found that for each of the five clinical episode categories, spending increases almost linearly with the number of beneficiary CC and MCC flags (MCC) (see Figure 1). It is therefore imperative to the creation of a fair and accurate model that the risk-adjustment methodology appropriately captures the patient's history of chronic conditions.

Figure 1. TEAM Clinical Episode Category Spending by Number of Beneficiary CCs and MCCs



As such, we urge CMS to include the anchor hospitalization or procedure in the HCC look-back period. In addition, to be consistent with its other models, such as BPCI-A, we urge the agency to implement a longer look-back period of 12 months.

Additionally, we do support CMS' proposal to use HCC version 28 for beneficiary risk adjustment.

LOW-VOLUME THRESHOLDS

In the FY 2025 inpatient PPS proposed rule, CMS proposed that participants with fewer than 31 episodes across all episode categories be included in the model and subject to track 2 beginning in PY 2. However, based on stakeholder comments that this was an

insufficient threshold, it did not finalize the policy and instead indicated it would propose a new policy in future rulemaking.

In this rule, however, CMS proposes to have no low-volume policy for PY 1, given that it is upside only; the agency seeks feedback on the policy for outyears. **We recommend that CMS implement a low-volume policy of 200 cases for *each* episode category as soon as possible. Hospitals that do not meet an individual threshold should not be required to participate in the model for that episode category.** We recommend individual thresholds because a single threshold across all categories would inappropriately mask any disproportionately low volume from an individual episode category. For example, if the low-volume threshold were 200 across all episodes, a hospital hypothetically could have 196 CABG episodes and only one LEJR, one SHFFT, one major bowel, and one spinal fusion episode. Forcing hospitals with such a small number of episodes in a category to participate in the model is inappropriate.

Our analysis of the thresholds identified in the proposed rule (11, 21, 41, 61 and 91) showed that a 91-case threshold for each episode category still results in significant variation in terms of weighted average net payment reconciliation amounts (NPRA). Indeed, hospitals with less than 91 cases had projected repayments nearly three times as high as all hospitals for two of the five-episode categories (see Table 4). The gap was even greater for track 2 hospitals, where, across all episodes, projected repayments for hospitals with less than 91 cases were twice as high as all hospitals. **As such, rounding up to a 200-case threshold per episode category is appropriate.**

Table 5: Hospital Weighted Mean NPRA Before CQS and Stop-loss/gain Adjustments by Number of Cases and Track

	LEJR	CABG	Major Bowel	Spinal Fusion	Total
All TEAM Hospitals	-$520	-$778	-$466	-$922	-$603
All TEAM Hospitals with Less Than 91 Cases	-$1,830	-$2,142	-$901	-$1,137	-$1,241
All TEAM Track 2 Hospitals	-$559	-$1,045	-$576	-$931	-$633
All TEAM Track 2 Hospitals with Less Than 91 Cases	-$2,013	-$2,925	-$1,146	-$1,842	-$1,434

In addition, as mentioned, hospitals with volumes below the low-volume thresholds should not be required to participate in TEAM for that episode category. Ultimately, alternative payment models should provide a level playing field to ensure that participants have a fair chance of earning savings. This goal would not be met by forcing hospitals without sufficient volume for a particular episode to participate. By definition, these hospitals' costs are highly subject to outliers. As such, performance is largely outside of their control because even one case that is significantly more

clinically complex can skew costs. We also note that the low-volume threshold should apply to all hospitals, not a certain subset or type. A hospital that does not generate sufficient volume would experience the same issues in bundled payment models regardless of its geography or status. **And although PY 1 is upside only, for planning purposes, hospitals must be aware of key elements of the model before starting.** We have consistently advocated for transparency of model design features and against changing model design features mid-way through models. **Therefore, CMS should finalize the low-volume policies as soon as possible.**

Finally, CMS discusses the option of lowering the maximum stop-loss for hospitals below the low-volume threshold, rather than excluding them. While this would be a step in the right direction, it does not go far enough. Again, the point of these models is to provide a fair playing field for participants to administer interventions to improve quality and reduce costs. Hospitals without adequate volume have no way of determining which interventions have a statistically significant impact on quality or costs and which do not.

OTHER RISK ADJUSTMENT VARIABLES

While not addressed in the proposed rule, we continue to urge CMS to expand the risk adjustment variables included in its methodology. For example, as outlined in our prior TEAM comments, risk adjustments and target prices must account for clinical complexity within episode categories, including, but not limited to, inpatient versus outpatient episode initiators, fracture versus non-fracture status, frailty, and emergent versus elective procedures.[3]

ALIGNING DATE RANGE IN THE BASELINE AND PERFORMANCE YEARS AND TIMING OF RECONCILIATION

In the FY 2025 inpatient PPS final rule, CMS finalized that TEAM preliminary target prices would be based on a three-year rolling baseline period with episodes attributed based on the episode start date. However, final target prices would be based on the date of discharge for the anchor hospitalization or procedure.

To better align these methodologies, the agency proposes to use the same date — the date of discharge. **We agree that the timing should be aligned and support this proposal.**

REFERRAL TO PRIMARY CARE

[3] https://www.aha.org/system/files/media/file/2024/06/aha-comments-on-cms-proposed-transforming-episode-accountability-model-team-letter-6-10-24.pdf

In the FY 2025 inpatient PPS final rule, CMS finalized that TEAM participants will be required to include a referral to a supplier of primary care services as part of hospital discharge planning. Referrals will need to be made prior to discharge and in accordance with beneficiary choice requirements. In this rule, CMS requested feedback on this requirement.

While many hospitals already provide such referrals, we urge CMS not to require this action. This requirement fails to account for many factors, such as hospitals located in provider shortage areas. Further, we oppose the option discussed in the proposed rule for CMS to require hospitals to refer patients specifically to a primary care provider (PCP) they have visited in the past two years, as shown in the claims. Such a requirement would impose a significant administrative burden on participants — this information is not available to hospitals at discharge, and we question how they would obtain it. Also, given the lag in claims data, there may be more recent changes to a patient's primary care provider that would not be captured if a patient moved or changed providers.

WAIVERS OF MEDICARE PROGRAM RULES — SKILLED NURSING FACILITY THREE-DAY RULE

TEAM includes a waiver of the three-day skilled nursing facility (SNF) rule to allow participants to refer beneficiaries to qualified SNFs without meeting the requirement for a three-day inpatient hospital stay. The waiver previously excluded referrals to swing beds, but CMS now proposes to allow such referrals under the waiver. **We support this proposal and agree that it would help ensure beneficiaries have access to this care, particularly for beneficiaries in rural and underserved areas.**

In addition, CMS clarifies that the requirement that SNF care provided under this waiver must be at a facility with at least a three-star rating applies only if the provider furnishing SNF services is eligible for the CMS five-star quality rating system. **However, we continue to have concerns with this requirement given the limited availability of three-star-rated facilities in certain markets.** Specifically, we are concerned that the structure of CMS' waiver would lead to two separate and unequal tiers of care: a more flexible, patient-centered level for patients in markets with an adequate supply of three-star SNFs and a more restrictive, regulation-driven level of care for patients in markets with an inadequate supply of three-star SNFs.

We also have concerns about the star rating methodology itself. For example, the biggest part of a SNF's star rating is the facility inspections conducted by CMS or, most likely, state surveyors. While surveys are an important activity for assuring compliance with regulations, there is significant state-to-state and surveyor-to-surveyor variation in how survey standards and guidance are applied. As a result, the findings from surveys can be highly subjective. Although CMS has attempted to account for the variation in survey practices by creating a distribution of star ratings on inspection data based on the relative performance of facilities within a state, we have concerns about the extent

to which this adequately addresses the problem. Since CMS proposes to hold participating hospitals financially accountable for the quality and costs of the entire episode of care, the decision to admit a patient to a setting of care should be at the discretion of the patient's physician working together with the beneficiary and the participating hospital.

OTHER WAIVERS

While not addressed in the proposed rule, we continue to urge the agency to provide additional waiver flexibilities for participants. The waiver of certain Medicare program regulations is essential so that hospitals and health systems may coordinate care and ensure that it is provided in the right place at the right time. We urge CMS to provide hospital participants with additional and maximum flexibility to identify and place beneficiaries in the clinical setting that best serves their short- and long-term recovery goals. These waivers include:

- Hospital Discharge Planning Requirements**.** The AHA strongly urges CMS to waive hospital discharge planning requirements that prohibit hospitals from specifying or otherwise limiting the information provided on post-hospital services. Such regulations inhibit the efficient coordination of care. When a patient elects to receive a bundle of services from a provider, that patient also elects to receive a carefully prescribed course of treatment that can span multiple provider settings. CMS will hold participating hospitals financially accountable for quality and costs for the entire episode of care. The agency also must provide them with the flexibility to direct patients to the most clinically appropriate, high-quality next setting of care.

- IRF "60% Rule**."** We urge CMS to waive the IRF 60% Rule that requires that at least 60% of an IRF's patients have one of 13 clinical conditions. Hospital participants have no incentive to over-utilize or inappropriately direct patients to IRFs. In contrast, they may find good clinical rationale for IRF stays for some patients, such as allowing beneficiaries to return to their communities more quickly. Further, since CMS will hold participating hospitals financially accountable for the quality and costs of the entire episode of care, the agency should provide them with the flexibility to direct patients to the most clinically appropriate next setting of care.

- IRF "Three-hour Rule**."** Medicare has a long-standing requirement that IRF patients require and receive at least three hours of therapy a day, the "preponderance" of which must be provided one-on-one. We urge CMS to waive the "preponderance" requirement under TEAM. Medicare has stated that, for IRFs, the "standard of care is individualized (i.e., one-on-one) therapy." However, each mode of therapy is carefully selected by the therapist based on the individual needs of the patient, and hospital participants have every incentive to work with IRFs to obtain the best possible treatment for their patients. And for

many patients, such as those for whom medical improvement, restoration of functional independence and the achievement of patient education goals are advanced through the social interaction and motivation gained through the group dynamic, where concurrent or group therapy are often preferred treatment methods. Allowing more flexibility on the type of therapy an IRF provides would serve as a valuable tool for participants to increase quality and reduce unnecessary costs.

- Fraud and Abuse Waivers**.** While this issue was not addressed in the FY 2026 IPPS proposed rule, the AHA continues to urge the secretary to use the full scope of the combined authority granted by Congress under Section 1115A(d)(1) of the Affordable Care Act to issue waivers of the potentially applicable fraud and abuse laws to enable participating hospitals to freely form the financial relationships necessary to succeed in the TEAM model. Specifically, to the extent these arrangements are not already captured within the value-based care and CMS-sponsored payment model exceptions and safe harbors, the secretary should waive the Physician Self-Referral Law, the Anti-Kickback Statute, and the Beneficiary Inducement Civil Monetary Penalty Law (fraud and abuse laws) with respect to financial arrangements formed by hospitals to facilitate TEAM. The secretary ultimately recognized the necessity of these waivers to the success of the Comprehensive Care for Joint Replacement, issuing them in conjunction with the rule finalizing that program. We urge the Secretary to facilitate the same for the TEAM model. These waivers are consistent with the Department of Health and Human Service's (HHS's) efforts to broaden the use of value-based payment models and essential to enable hospitals to form financial arrangements with other providers collaborating in the model and ensure that those providers (whose outcomes would in part be the responsibility of the hospitals) have a real stake in achieving the model's goals.

  Under TEAM, hospitals would bear responsibility for the financial and quality outcomes of other providers who provide care to Medicare beneficiaries during qualifying episodes. In the FY 2025 IPPS final rule, CMS notes that participating hospitals may rely on financial arrangements with those providers, which CMS refers to as "TEAM collaborators," to share the program's potential risks and rewards. Indeed, our members report that such financial arrangements are not just desirable but in fact are an essential component of successful participation in the TEAM model. Despite this recognition, the FY 2025 IPPS final rule did not provide fraud and abuse waivers for TEAM.

  Although AHA takes the position that the value-based exceptions to the fraud and abuse laws and the CMS-sponsored model arrangement safe harbor to the Anti-Kickback Statute should cover many scenarios, it is critical that HHS fully mitigate the risk for hospitals, whose participation in this program would be mandatory. They should not have to spend hundreds of hours or thousands of dollars in hopes of stringing together components from the existing exceptions

and safe harbors or developing inefficient workarounds to meet the demands of this new program and avoid running afoul of the fraud and abuse laws. Hospitals must have explicit protections in place and adequate time to form the necessary financial arrangements. As the administration is aware, these experimental payment models depend on these protections to maximize their benefit for Medicare and its beneficiaries.

TIMELINESS OF DATA

Model participants should have timely access to data about their patient populations. Historically, the lack of transparent, real-time data has created confusion on trigger events, eligibility for episodes and program participation. **While not addressed in the proposed rule, we urge the agency to make beneficiary claims data, aggregate regional data and historical baseline data available to participants at least 60 days prior to the start of the relevant performance period.**

Moreover, a number of hospitals participating in historical models have indicated that the target prices for these programs have often changed during the performance period, sometimes significantly and inexplicably. To further stabilize the target prices for model participants, we urge CMS only to update its underlying assumptions related to the target price annually.