June 10, 2025

Mehmet C. Oz, MD
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1833-P
Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850

RE: 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

Dear Administrator Oz:

On behalf of the over 90,000 members of the American College of Surgeons (ACS), we appreciate the opportunity to submit comments to the Centers for Medicare & Medicaid Services' (CMS or the Agency) fiscal year (FY) 2026 Hospital Inpatient Prospective Payment Systems (IPPS) proposed rule published in the *Federal Register* on April 30, 2025.

The ACS is a scientific and educational association of surgeons founded in 1913 to improve the quality of care for the surgical patient by setting high standards for surgical education and practice. Since a large portion of surgical care is furnished in the inpatient hospital setting, the College has a vested interest in the IPPS and related hospital quality improvement efforts. With our more than 100-year history in developing policy recommendations to optimize the delivery of surgical services, lower costs, improve program integrity, and make the U.S. healthcare system more effective and accessible, we believe that we can offer insight into the Agency's proposed changes to the IPPS. Our comments below are presented in the order in which they appear in the rule.

INTRODUCTION

CMS continues to strive for an expansion of value-based care across the U.S. healthcare system which requires a significant shift in mindset and practice for all stakeholders who have worked under a fee-for-service (FFS) system. However, to achieve true value a new quality framework is required. What is needed is a framework with a meaningful relationship between cost and quality that puts greater emphasis on the care provided by a team, rather than individuals or single events.

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CHICAGO HEADQUARTERS
633 N. Saint Clair Street
Chicago, IL 60611-3295
T 312-202-5000
F 312-202-5001
E-mail: postmaster@facs.org

WASHINGTON OFFICE
20 F Street NW, Suite 1000
Washington, DC 20001
T 202-337-2701
F 202-337-4271
E-mail: ahp@facs.org

Rethinking the Unit of Analysis for Quality Measurement

From a patient's perspective, the care they receive is delivered by all practitioners they see (primary care physicians [PCPs], surgery, anesthesia, imaging, pathology, rehab, etc.) and the associated facilities all functioning together as a care team to deliver on patient goals. Instead of measuring the quality of care provided by the team, the current system separates the individual role players and relies on broad metrics at the facility level or overly specific measures at the physician level that fail to put care processes and outcomes into the larger context of team-based care. A system that only focuses on disconnected single measures collected around various role players, such as a surgeon or a facility, without regard to a specific patient cohort group (such as breast cancer or cholecystitis) will not directly measure value and distracts from driving team-based care and shared accountability. **The goal for measuring value is assigning shared accountability to the entire team of role players for an episode of care**.

Current Measures Lack Utility for Informing Patients

Because of the issues described above, such as the unit of analysis and focus on single metrics, Medicare's public reporting of quality measures is more aligned with payment and system accountability than with supporting patients in making individualized, informed choices about care they seek for a procedure. Despite decades where billions of dollars have been invested into the measure industry and hundreds of measures being reported, current quality measures do not help patients, or their referring physicians, find good care. This is extremely burdensome to the system because healthcare providers and facilities are required to expend valuable resources to report on quality measures that do not align with the care they provide, inform improvement cycles, or better inform patients.

Patients can access a wide range of general measures focused on singular events in a care journey, such as process measures for timely antibiotics or adverse events such as complications that led to readmissions. However, these measures reveal little about the services a clinical team performs, the types of risky patients they manage, the completeness of care for the patient's total care journey, and patient outcomes for a condition such as major digestive disease disorders or cancer care. Additionally, Care Compare does not distinguish between high-performing clinical teams. The measures are often designed for payment and accountability, not for nuanced clinical decision-making or personalized referral guidance. The data does not always allow a patient or PCP to construct a detailed image of the specific care experience or outcomes they will receive from a particular care team. The measures don't inform members of a care team about failure points or ways to improve and present a fragmented picture of quality. The public continues to rely on anecdotal information, and the care team games the system due to fatigue and apathy over resource-intensive requirements that do nothing to help them improve care.

Quality Framework for Surgery

CMS has made efforts to define the cost of surgical episodes of care—with one example being the introduction of the Transforming Episode Accountability Model (TEAM)—but has not had the same success in defining episode-based quality. Facility-level measurement is not granular enough to provide valuable feedback to clinicians and patients, while physician-level measures focus on very specific interventions or processes of individuals that do not always uniquely define the episode of care experienced by the patient. This measurement framework reflects a surgeon, a hospital, or both but does not align the metrics for the same conditions or procedures to better understand how the team works together. This makes understanding quality within an episode and the work of a care team inherently difficult to apply and interpret. Instead of trying to fit together physician- and facility-level measures that encompass different patient cohorts, differing procedures, and varied measure science, we recommend a solution that thinks of quality as a program.

ACS proposes to replace the current fragmented framework with a unified "quality program" framework that reflects real-world practice that is not constrained by the limitations of Medicare payment systems and has potential to streamline quality efforts with meaningful results. The quality program model is built based on concepts set forth by the Donabedian Model of Quality, which uses structure, process, and outcome as its fundamental building blocks. It is important to note that when applying quality metrics, no one component was intended to work alone; each part, structure, process and outcome must be interconnected for optimal success. **We**

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envision a program with a structural foundation, a set of processes, and accountable metrics, including metrics that focus on patient goal identification that aligns with episodes of care, drives meaningful outcomes, and can better inform patients and referring physicians. The ACS is available to partner with HHS and CMS to further develop episode-specific measures around patient goals, clinical outcomes, and verification of structures and resources. The ACS has extensive experience in developing and running quality programs with our various verification and accreditation programs including ACS Trauma, Bariatric Accreditation, and Geriatric Surgery Verification (GSV), to name a few. GSV has demonstrated decreased length of stay (LOS), decreased postoperative delirium, decreased readmission, decreased major complications, and improved patient satisfaction, leading to significant cost savings.[1] One example of how this has been implemented into the CMS Inpatient Quality Reporting Program (IQR) is the CMS Age Friendly Hospital measure, modeled after the ACS GSV program. The Age Friendly measure incentivizes hospitals to take an integrated approach to the care of older adults by implementing multiple data-driven modifications to the entire clinical care pathway from the emergency department to the operating room.

In conclusion, the underlying theme behind this mindset change is that modern healthcare is no longer a single clinician or even a single overarching facility as the sole role player. To deliver high-performing team-based care requires appreciation for system thinking. Working within a system involves building the structure and processes within the limits of the resources and using these limits to set the guardrails for care and for referrals. Value-based care relies on the ability to execute the processes to deliver on the optimal care pathway, AND, if the need arises, manage patients when rescue or transfer strategies are identified and needed. Lastly, how do we share this information with patients in a way that is useful? It is more than doing the routine steps; rather, it is the little details together that take care from good to great. A quality program that reflects the way patients receive care and incorporates incentives based on open transparency and payment-based rewards would offer greater value to physicians, their patients, and payers. Without the ability to measure quality in a manner that is meaningful to the patient, the American healthcare system will struggle to reduce waste, optimize cost, and maintain or improve quality.

HOSPITAL READMISSIONS REDUCTION PROGRAM (HRRP) UPDATES AND CHANGES

Proposal to Integrate Medicare Advantage (MA) Beneficiaries into the Cohorts of the Hospital Readmission Reduction Program Measure Set Beginning with the FY 2027 Program Year

CMS proposes to integrate MA beneficiaries into each of the program's measure's cohorts. Currently, the measure denominator for the HRRP measure set includes beneficiaries "Enrolled in Medicare FFS Part A and Part B for the first 12 months prior to the date of admission and enrolled in Part A during the index admission." CMS proposes to modify the measure cohort to "Enrolled in Medicare FFS and/or MA for the 12 months prior to the date of admission; and enrolled in FFS or MA during the index admission." CMS proposes to use claims and encounter data with admission dates beginning from July 1, 2023, through June 30, 2025, which is associated with the FY 2027 program year. CMS states that the addition of MA data to the measure doubles the cohort size and more accurately reflects the quality of care for both FFS and MA beneficiaries.

Numerous times throughout this proposed rule, CMS has stated its intent to move from FFS to a value-based system. However, to achieve value-based care, we must value the care delivered by all those who play a role in the care team as a whole—how well they come together to deliver on patient's goal. The ACS opposes the addition of MA beneficiaries in the HRRP's measure cohort. **Expanding these measures to include MA will continue to perpetuate measure concepts that aren't moving the needle in quality.** To achieve CMS' goals of value-based healthcare, the unit of analysis must become more patient-centric, focusing on the patient's episode of care. The traditional approach to facility-based quality metrics uses the facility or individual surgeon as the unit of analysis where specific events are measured regardless of the team, and in many

[1] Katlic MR, Wolf J, Demos SJ, Rosenthal RA. Making a Financial Case for the Geriatric Surgery Verification Program. *Ann Surg*. 2024;5(2):e439.

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instances regardless of the procedures. This does not help patients understand how a care team (including the facility) delivers on their personal episode of interest.

A system that only focuses on single measures within the FFS payment system can distract from driving team-based care and shared accountability. Today's care environment is extremely nuanced and complex. A high-performing care team must work within a system that has the right structures and processes to deliver on the optimal care pathway and manage patients when rescue strategies are identified and needed. In the modern care delivery model, the routine step coupled with the little details take care from good to great. The ACS has years of experience developing and implementing quality programs in our ACS verification and accreditation programs. These programs have demonstrated the ability to improve typical outcomes that complement metrics for payment programs, while also assessing the interconnectedness of a team in a service line. They assess a care team's capacity to identify problems, use clinical measures, formulate improvement plans, execute a work plan, and seek solutions, all as a learning health system.

We ask CMS to think about their existing quality programs and the information they offer from the patient perspective. When patients are preparing for a procedure and must select their care team or the facility in which they will receive their care, do the metrics offered by these programs seem informative enough for patients to make those important decisions? Or, does understanding that a facility/care team takes part in a quality program that can verify the care team has experience with high-risk patients and the resources to deliver optimal care to them, has implemented essential processes to handle routine as well as unexpected situations, follows evidence-based standards, prioritizes team-based care, avoids major complications, etc. seem more valuable to patients? While existing metrics may work for payment systems, they do not reflect the care model or a real view into the quality of care being provided by a team within a facility, which only results in burdensome reporting requirements that will not support patients and their referring physicians when making important decisions about their care. **We challenge CMS to consider how to leverage programs, such as the ACS verification and accreditation programs that have proven success in implementing systems, to support the Agency's goals to achieve higher value care for patients and better support care teams across Part A, Part B, and MA.**

HOSPITAL VALUE-BASED PURCHASING (VBP) PROGRAM

Proposed Measure Updates to the Hospital-Level Risk-Standardized Complication Rate (RSCR) Following Elective Primary Total Hip Arthroplasty (THA) and/or Total Knee Arthroplasty (TKA)

CMS proposes to update the Hospital-Level Risk-Standardized Complication Rate (RSCR) Following Elective Primary Total Hip Arthroplasty (THA) and/or Total Knee Arthroplasty (TKA) (COMP-HIP-KNEE) measure's inclusion criteria to include MA patients. The update to the measure would use index admission diagnoses and procedure codes from Medicare FFS claims and MA encounter data to determine cohort inclusion criteria complications outcomes, and present on admission (POA) comorbidities. This proposed update would be contingent on the adoption of the same update to the COMP-HIP-KNEE measure for use in the Hospital Inpatient Quality Reporting (IQR) Program beginning with the FY 2027 payment determination. CMS states that the addition of MA data would approximately double the cohort size, demonstrate measure reliability, and more accurately reflect the quality of care for both FFS and MA beneficiaries.

The ACS supports the addition of MA beneficiaries to this metric; while we did not support the expansion of measures for use in the MA more generally because they do not map to the episode, this measure is episode specific. This measure reflects the major complications that can arise following elective THA/TKAs and aligns with the goals of the episode. However, we recommend that in the future, when CMS aggregates and reports rates of complication, especially with intent to inform the public, they report the inverse complication rate. Instead of reporting the rate of complications experienced, we suggest reporting the rate without a major complication. This information should also be accompanied by the volume of associated procedures and the risk profile of patients who underwent the procedure within the hospital. This information offers patients a more complete view of care being offered within the hospital and distinguishing factors that can help them make more informed decisions are their care.

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Proposed Removal of the Health Equity Adjustment from the Hospital VBP Program

In the FY 2024 IPPS/Long-Term Care Hospital (LTCH) PPS final rule, CMS adopted a Health Equity Adjustment (HEA) that, beginning with the FY 2026 program year, rewards top performing hospitals that serve higher proportions of patients with dual eligibility status. In light of the Administration's priority to streamline regulations and reduce burdens on those participating in the Medicare program, CMS proposes to remove the HEA to simplify the Hospital VBP Program's scoring methodology. CMS considered altering the structure of the adjustment methodology to simplify it, but that process will require time to develop and test a new adjustment and, if pursued, would be addressed in future rulemaking.

CMS cites burden and overcomplication of scoring as a reason for removing the HEA. From the ACS' perspective, the problem of burden is more foundational to the existing quality framework and will not be solved by deleting specific measures or scoring adjustments, such as the HEA. The "burden problem" stems from the volume of disconnected measures that hospitals are required to report for payment programs that have little utility to care teams in defining surgical quality, informing referrals, or in identifying opportunities for improvement. This results in long lists of measures that require extensive resources to aggregate, report and ensure payment for services, without creating the quality linkages that show true performance and orchestration of complex surgical teams.

To design a framework that meaningfully measures quality and patient outcomes, patient cohorts must be defined, and analytics are required to speculate on risk-adjusted outcomes. Risk adjustments are never perfect, and the best practices rely on several adjustments to consider. There are numerous risk adjustment variables that must be considered such as chronic illnesses using tools such as Hierarchical Condition Categories (HCCs) or the Chronic Illness and Disability Payment System (CDPS); risk associated with the procedure's complexity measured using All Patient Refined Diagnosis Related Groups (APR-DRG) and four-tiered patient complexity; and social determinants that further define the heterogeneity of our healthcare system. These factors are all important, and to truly reflect patient risk and better understand potential complications, outcomes, and cost, all need to be considered. Proper risk adjustment and having mechanisms that can outline the prominent risk profiles of the patient cohort are important when trying to compare hospitals' performance and to inform patients of a hospital's readiness to care for high-risk patients. **As CMS explores alternatives to the HEA methodology, we recommend that CMS not remove the adjustment until it has developed an adequate alternative. When developing an alternative, we ask the Agency to consider the factors outlined in our comments and express our willingness to work with CMS in the development and design of future quality frameworks.**

TOWARD DIGITAL QUALITY MEASUREMENT IN THE CMS QUALITY PROGRAMS – REQUEST FOR INFORMATION (RFI)

CMS states their intent to transition to a fully digital quality measure (dQM) landscape; therefore, it is asking for feedback on its anticipated approach to the use of Health Level Seven (HL7) Fast Healthcare Interoperability Resources (FHIR) in electronic clinical quality measure (eCQM) reporting across CMS programs. CMS also describes its efforts to collaborate with other agencies such as the Assistant Secretary for Technology Policy (ASTP)/Office of the National Coordinator (ONC), the Centers for Disease Control (CDC), and others to support data standardization and alignment of requirements for the development and reporting of digital quality measures.

Approach to eCQM Reporting using FHIR in CMS Quality Programs

The ACS highlights the important progress that has been made through the implementation of various elements of the 21st Century Cures Act through the Cures Rules and other regulations in recent years. CMS' goals expressed in this RFI to leverage FHIR and standards to support quality measures will be beneficial to supporting the future of digital quality measurement. This shift is logical for measures that demonstrably improve patient outcomes or care quality. Automating the generation of such measures can free up clinical resources and improve data accuracy.

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However, there is a risk that moving to digital measures may simply make it easier to report on metrics that lack clinical, procedural, or patient-centered value—such as those that focus narrowly on provider or facility characteristics without reflecting meaningful aspects of surgical episodes or patient outcomes. If these measures are not critically evaluated for relevance, digitization could perpetuate the collection of low-value data rather than addressing the core issue: the need to retire or redesign measures that do not drive improvements in care. Instead of just digitizing existing measures, CMS should prioritize:

- Reviewing measures for clinical relevance and patient centricity;
- Retiring or revising those that do not meaningfully reflect quality or outcomes;
- Ensuring that new digital measures align with the realities of clinical practice and patient needs, including team-based, patient-centered care, and are not hampered by the limitations of specific payment systems.

If this is accomplished, ACS sees great potential in leveraging technology to support quality programs and quality improvement.

REQUIREMENTS FOR AND CHANGES TO THE HOSPITAL IQR PROGRAM

Proposed Modification to the Hospital-Level, Risk-Standardized Complication Rate Following Elective Primary Total Hip Arthroplasty (THA) and/or Total Knee Arthroplasty (TKA) (COMP-HIP-KNEE) Measure Beginning with the FY 2027 Payment Determination

The COMP-HIP-KNEE measure estimates a hospital-level, risk-standardized complication rate associated with elective primary THA and/or TKA procedures. CMS readopted the COMP-HIP-KNEE measure into the Hospital IQR program as part of FY 2023 rulemaking following substantive changes to the measure. In the FY 2024 IPPS rule, CMS readopted the measure into the Hospital VBP Program and finalized removal of the measure from the Hospital IQR Program beginning with FY 2030 payment determination. In this proposed rule, CMS proposes to expand the measure's inclusion criteria of the COMP-HIP-KNEE to include MA patients.

As stated in our comment in the Hospital VBP section of this letter, the ACS supports the addition of MA beneficiaries to this metric. This measure reflects the major complications that can arise following elective THA/TKAs and aligns with the goals of the episode of care. We ask that in the future, when CMS aggregates and reports rates of complication, especially with intent to inform the public, they report the inverse complication rate. Instead of reporting the rate of complications experienced, we suggest reporting the rate of surgeries without a major complication. This information should also be accompanied by the volume of associated procedures and the risk profile of patients who underwent the procedure within the hospital. This information offers patients a more complete view of care being offered within the hospital and distinguishing factors that can help them make more informed decisions are their care.

Proposed Removals in the Hospital IQR Program

Proposed Removal of the Hospital Commitment to Health Equity (HCHE) Measure Beginning with the CY 2024 Reporting Period/FY 2026 Payment Determination

CMS proposes to remove the HCHE measure beginning with the FY 2026 payment determination. CMS states that they believe the cost of reporting the measure may outweigh its benefit. They also explain that one of the Agency's priorities is to re-focus on measurable clinical outcomes and the removal of this structural measure would leave room in the program's measure set to focus on measurable outcomes.

The ACS believes that structural measures—alongside outcome and process measures—are essential to building an effective quality program and should be viewed as complementary components, as discussed in greater detail below. Therefore, the ACS respectfully disagrees with the Agency's assessment that removing structural measures would create space to focus solely on measurable outcomes and strongly urges CMS not to remove additional structural measures from the IQR and other quality programs.

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In recent years, it has become evident that outcome measurement alone without the drivers of structure and process, has led to unintended consequences, and have been the subject of "measure gaming," where hospitals and health systems demonstrate improvements on measures that are disconnected from true improvements in patient care.[2,3,4] The Donabedian Model of Quality, the foundation upon which quality measurement has been built, gave Structure, Process, and Outcome as its fundamental building blocks. No one component was ever intended to become the centerpiece of the model, as each part, structure, process and outcome are fundamentally interconnected in the orchestration of complex and competent care. **Rather than turning away from structure and process measures, the future of quality measurement must lean into these types of measures to avoid repeating mistakes of the past.**

To that end, **the ACS strongly urges CMS to maintain structural measures, such as the Age Friendly Hospital measure** which was developed by the ACS with collaboration from the American College of Emergency Physicians (ACEP) and the Institute for Healthcare Improvement (IHI). The Age Friendly measure, designed based on the Geriatric Surgery Verification (GSV) Program, is well aligned with CMS priorities to improve care for older adults.[5,6,7] In a 2025 document titled *CMS Innovation Center Strategy to Make America Healthy Again,* CMS lays out the future of value-based care, including embedding preventative care in all model designs.[8] It is known that inpatient stays are frequent drivers of physical and cognitive decline in elderly patients, especially when they experience **preventable complications** such as delirium or unnecessary polypharmacy.[9,10] By requiring routine medication reconciliation, delirium screening, and goal setting, the Age Friendly measure helps to target and reduce preventable complications, improving care and reducing unnecessary healthcare spending. The Age Friendly Hospital measure's emphasis on shared decision-making (SDM) also fits with *CMS's Meaningful Measures 2.0* framework and its emphasis on Person-Centered Care.[11] Finally, and importantly, there are no other geriatric specific measures in the Hospital IQR, cementing the importance of the Age Friendly measure, for ensuring high-quality inpatient care for older Americans.

The Age Friendly measure is well supported by a growing body of evidence **demonstrating that system-level structural interventions can drive measurable improvements in clinical outcomes**. The Age Friendly Hospital measure incorporates elements of IHI's Age-Friendly Health Systems program known as the 4Ms (What Matters, Medications, Mentation, Mobility), standards from the Geriatric Emergency Department Accreditation (GEDA) framework developed by ACEP, and ACS GSV standards. The ACS GSV Program is a national quality improvement initiative designed to improve surgical care for older adults and is analogous to the Age Friendly measure. The Age Friendly measure follows the programmatic approach that is modeled after ACS quality programs, which leads to demonstrable improvements in patient outcomes across a broad range of

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[2] Konetzka RT, Polsky D, Werner RM. Shipping out instead of shaping up: rehospitalization from nursing homes as an unintended effect of public reporting. *J Health Econ*. 2013;32(2):341-52. doi: 10.1016/j.jhealeco.2012.11.008.
[3] Werner RM, Asch DA, Polsky D. Racial profiling: the unintended consequences of coronary artery bypass graft report cards. Circulation. 2005;111(10):1257-63. doi: 10.1161/01.CIR.0000157729.59754.09.
[4]Roth S, Gonzales R, Harding-Anderer T, et al. Unintended consequences of a quality measure for acute bronchitis. *Am J Manag Care*. 2012;18(6):e217-24.
[5] Institute for Healthcare Improvement. Age-Friendly Health Systems. Institute for Healthcare Improvement. Accessed May 27, 2025. https://www.ihi.org/networks/initiatives/age-friendly-health-systems.
[6] American College of Emergency Physicians. Geriatric Emergency Department Accreditation Program. Accessed May 27, 2025. https://www.acep.org/geda/.
[7] American College of Surgeons. Geriatric Surgery Verification Program. Accessed May 27, 2025. https://www.facs.org/quality-programs/accreditation-and-verification/geriatric-surgery-verification/.
[8] Centers for Medicare & Medicaid Services (CMS). CMS Innovation Center Strategy to Make America Healthy Again. Published May 2025. Accessed May 24, 2025. https://www.cms.gov/priorities/innovation/about/cms-innovation-center-strategy-make-america-healthy-again
[9] Goldberg TE, Chen C, Wang Y, Jung E, Swanson A, Ing C, Garcia PS, Whittington RA, Moitra V. Association of Delirium With Long-term Cognitive Decline: A Meta-analysis. JAMA Neurol. 2020 Nov 1;77(11):1373-1381. doi: 10.1001/jamaneurol.2020.2273. Erratum in: JAMA Neurol. 2020 Nov 1;77(11):1452. doi: 10.1001/jamaneurol.2020.3284. PMID: 32658246; PMCID: PMC7358977.
[10] Stel VS, Smit JH, Pluijm SM, Lips P. Consequences of falling in older men and women and risk factors for health service use and functional decline. Age Ageing. 2004 Jan;33(1):58-65. doi: 10.1093/ageing/afh028. PMID: 14695865.
[11] Centers for Medicare & Medicaid Services (CMS). Cascade of Meaningful Measures. Published May 20, 2025. Accessed May 24, 2025. https://www.cms.gov/medicare/quality/cms-national-quality-strategy/cascade-measures

populations. Early adopters of the GSV program have noted reductions in inpatient costs, discharge to post-hospital rehabilitation, patient and staff satisfaction, and post-operative length of stay.[12,13,14,15]

Many hospitals have invested substantial time and resources in redesigning care for older adults as a result of this measure. Many institutions, motivated by CMS's prioritization of person-centered care, have aligned their strategies with the 4Ms framework and broader geriatric care transformations.

The ACS-appreciates CMS' efforts to focus on high-impact measures that meaningfully affect patient outcomes and experiences, while minimizing the burden and costs associated with data collection. At the same time, we believe that while outcome metrics are important, structure and process are equally important. High quality outcomes are nearly impossible to achieve without the supporting infrastructure of hospital structures and processes of care. To that effect, the Age Friendly measure is a low-burden, evidence-based measure that will positively impact care for our older adult patients and should be preserved in the program. **By reaffirming its commitment to the Age Friendly measure as a composite of structure and process measures, CMS can send a strong signal to hospitals that care for our elder patients remains at the forefront of regulatory focus, and that investment in upstream quality improvement is not only worthwhile, but expected for hospitals.**

OTHER PROVISIONS INCLUDED IN THIS PROPOSED RULE

Proposed Changes to the Transforming Episode Accountability Model (TEAM)

ACS Introductory Comments

The TEAM, if implemented appropriately, represents a major opportunity to advance value-based care in surgery. TEAM is an incremental improvement over prior surgical bundled payment models, and we acknowledge the willingness on the part of CMS to make adjustments to the model to improve its accuracy and incentives for team-based, patient-centered care. In addition to commenting on several of the proposed changes to the model, the ACS would like to take this opportunity to reiterate some of our prior comments on the model in relation to the mandatory nature, the definition of the Major Bowel Procedure episode, and other aspects which we encourage CMS to revisit in future rulemaking.

- **Mandatory Participation Requirement:** TEAM is mandatory for hospitals in selected geographic areas. The ACS remains a strong advocate for using episodes to incentivize high-value care; however, the ACS strongly favors the creation of new voluntary models that achieve participation through better design rather than through mandatory participation. The misaligned quality indicators and the broad regional target prices will create the potential for unintended consequences, which could be evaluated and mitigated if CMS first tests this as a voluntary model.

  In addition, we highlight that making a model mandatory should not be the solution for increasing participation and fulfilling payer goals for sample size. If the model makes a difference to patients and their referring physicians; facilitates team-based improvement; and/or helps to drive down complications, waste, and cost, then facilities will voluntarily join the model. Besides mandates, creating transparency and other market incentives would be more effective. Patients wish to find the best care available to them,

[12] Ehrlich AL, Owodunni OP, Mostales JC, Efron J, Hundt J, Magnuson T, Gearhart SL. Implementation of a Multispecialty Geriatric Surgery Pathway Reduces Inpatient Cost for Frail Patients. Ann Surg. 2023 Oct 1;278(4):e726-e732. doi: 10.1097/SLA.0000000000005902. Epub 2023 May 19. PMID: 37203587; PMCID: PMC10524651.
[13] Katlic MR, Wolf J, Demos SJ, Rosenthal RA. Making a Financial Case for the Geriatric Surgery Verification Program. Ann Surg Open. 2024 May 13;5(2):e439. doi: 10.1097/AS9.0000000000000439. PMID: 38911623; PMCID: PMC11191881.
[14] Jones TS, Jones EL, Richardson V, Finley JB, Franklin JL, Gore DL, Horney CP, Kovar A, Morin TL, Robinson TN. Preliminary data demonstrate the Geriatric Surgery Verification program reduces postoperative length of stay. J Am Geriatr Soc. 2021 Jul;69(7):1993-1999. doi: 10.1111/jgs.17154. Epub 2021 Apr 7. PMID: 33826150.
[15] Kipley S, Pollitt K. GSV Implementation Improves Rate of Patients Discharged Home After Surgery. Bull Am Coll Surg. February 5, 2025. Accessed May 24, 2025. https://www.facs.org/for-medical-professionals/news-publications/news-and-articles/bulletin/2025/february-2025-volume-110-issue-2/gsv-implementation-improves-rate-of-patients-discharged-home-after-surgery/

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however, the lack of trusted and meaningful information is a limiting factor.

The ACS also believes that models, such as the ACS-Brandeis Advanced Alternative Payment Model (APM) Proposal previously recommended by the Physician-focused Payment Model Technical Advisory Committee (PTAC), hold promise for encouraging voluntary participation in episode-based payment models. The ACS-Brandeis model would avoid some of the potential for unintended consequences in TEAM by creating risk-adjusted target prices at the individual level rather than at the broad regional level. This means that hospitals wouldn't be disadvantaged for treating more high-risk patients or for serving patients in higher-cost geographic areas. Participants would essentially be competing against themselves to become more efficient and provide higher quality care to patients. The incorporation of a discount factor similar to that in TEAM also essentially guarantees savings to CMS. The ACS encourages CMS to consider testing the proposed ACS model or incorporate some of these concepts in a future voluntary pilot.

- **Definition of Major Bowel Procedure Episode:** The ACS remains concerned that the Major Bowel Procedure episode included in TEAM does not differentiate between scheduled and emergent cases. In order for the Major Bowel Procedure episode to be most successful, the ACS recommends that CMS split the episode into elective and emergent cases. As currently structured, the model may inadvertently disadvantage facilities who care for a disproportionate share of high-risk, emergent cases. Closer inspection of the other procedures in TEAM demonstrates the procedures in each episode are very homogeneous when compared to the Major Bowel Procedure episode. The procedures and relevant diagnoses assigned to those TEAM episodes are much tighter and related compared to the diverse set of procedures and relevant diagnoses that exist in the Major Bowel Procedure episode. Creating more specific episode groupings better aligns with clinical care and is better suited for determining the value of an episode, assigning quality metrics, informing patients, providing information to referring PCPs, and aiding health plans seeking to contract for episodic-specific services.

- **Risk Adjustment Methodologies for TEAM:** TEAM includes several different variables under its risk adjustment methodology. Risk adjustment is critical to accurately compare costs and outcomes of surgical procedures across diverse patient populations. The ACS asserts that the current methodology is limited and will likely not be adequate for supporting clinical decisions for care teams and patients. We recommend CMS consider a number of additional variables, including demographic factors, clinical factors, and procedure-specific factors.

- **Alignment Between Quality and Cost Measures:** The ACS emphasizes the need for alignment between quality and cost models to ensure that TEAM incentivizes high-value, coordinated care. CMS has made great strides in price transparency, but the current federal quality initiatives lack relevancy and transparency around quality of surgical care. If a patient, PCP, MA plan, or Accountable Care Organization seeks coverage for surgical care, they should be able to find the episode or total cost of all the services for that care and understand the outcomes and quality that go along with it. **It is critical that episode-based cost measures map to episode-based quality measures to ensure quality is maintained alongside payment-based rewards.**

- **Quality Measure Incentives:** In our comments on the FY 2025 IPPS/LTCH proposed rule, we expressed our concern about the lack of accountability for quality in the TEAM model. We maintain this position. As currently structured, TEAM places a disproportionately small emphasis on quality in the value equation. Whereas the amount of financial risk or reward faced by participants can be up to 20 or even 30 percent of the total target price depending on participation track, quality can at most account for 3 percent. The ACS, working with Brandeis University and the Institute for Accountable Care, conducted an analysis that looked at the simulated performance of twelve TEAM participants, which assumed the model had been in effect in 2023 using actual Medicare data. We then looked at how the financial performance would differ given the highest possible and lowest possible quality score adjustment. **As**

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illustrated in Figure 1, among the 13 hospitals we looked at, the impact ranged from 1 percent to 0.001 percent of the total target price for all episodes, as expressed below. The hospitals were selected at random and represent 8 states from different parts of the country. They will primarily be Track 3 participants, but the sample includes a rural hospital and two safety net hospitals who will qualify for Track 2. On an individual episode basis, this equated to potential adjustments of between $266.05 and $0.29 per episode.

Figure 1: Financial Impact of TEAM Quality Score

Hospital Examples (Track 3 unless otherwise noted)	Episode Count	Target Price	Charges	Base Incentive (Adjusted for Cap)	Incentive with Max Positive or Negative Quality Adj.	Max Total Quality Adjustment	Max Quality Adjustment Per Episode	Quality Adj as % of Target
Hospital A	3167	$100,597,407	$104,639,697	($4,042,291)	($3,638,062)	$404,229	$127.64	0.402%
Hospital B	1505	$37,023,349	$41,027,362	($4,004,013)	($3,603,612)	$400,401	$266.05	1.081%
Hospital C	1638	$45,202,875	$47,408,317	($2,205,442)	($1,984,898)	$220,544	$134.64	0.488%
Hospital D	1580	$48,825,822	$50,438,167	($1,612,345)	($1,451,111)	$161,234	$102.05	0.330%
Hospital E	1341	$36,614,836	$37,022,962	($408,126)	($367,313)	$40,812	$30.43	0.111%
Hospital F	1646	$47,407,400	$47,402,561	$4,839	$4,355	($484)	($0.29)	-0.001%
Hospital G (Safety Net, Track 2)	583	$19,075,203	$19,027,699	$47,503	$42,753	($4,750)	($8.15)	-0.025%
Hospital H	239	$5,302,533	$5,253,735	$48,799	$43,919	($4,880)	($20.42)	-0.092%
Hospital I	1441	$41,806,571	$41,285,250	$521,321	$469,189	($52,132)	($36.18)	-0.125%
Hospital J (Rural, Track 2)	762	$19,530,110	$18,360,640	$976,505	$878,855	($97,650)	($128.15)	-0.500%
Hospital K (Safety Net, Track 2)	1915	$66,559,846	$65,373,826	$1,186,020	$1,067,418	($118,602)	($61.93)	-0.178%
Hospital L	753	$22,302,955	$20,903,163	$1,399,792	$1,259,813	($139,979)	($185.90)	-0.628%
Hospital M	1519	$36,347,491	$34,437,039	$1,910,452	$1,719,407	($191,045)	($125.77)	-0.526%

	High Quality Score Reducing Repayment Amounts
	Low Quality Score Reducing Incentive Payments
	Base Incentive Adjusted for Track 2 Cap

The ACS is also concerned that the measures in the TEAM quality framework will not be informative or actionable for purposes of improving a hospital's performance in the model. As mentioned above, these measures do not align with the episodes defined in the model (with exception of the THA/TKA patient-reported outcome measure [PROM]) and are aggregated across the entire hospital, which will not accurately reflect the quality of the episodes that are the targets of this model test.

With the lack of informative metrics and the low impact of the quality score, we expect this will limit investments in improving patient outcomes as hospitals focus more on financial outcomes. This is a flaw in the model. Instead, the model should use episode-specific, specialty-developed quality measures intended to ensure that patient goals of care were achieved and to increase transparency for patients and their referring PCPs about where to seek the highest quality care. **Without giving equal weight to quality, any payment model that rewards reduction in spending through strict cost analysis threatens to underfund critical services or quality improvement efforts, resulting in a race to the bottom, including limits to patient access to care**. Quality information should be transparent, align with the episode, and serve the following objectives:

- Increase transparency and empower patients and caregivers to make effective decisions about where to receive care that best fits their needs.
- Support collaboration across the care team to meet a shared goal by defining and operationalizing a clinical unit-based system.
- Create resource and protocol standardization, evidence-based and data-driven processes, and functional strategies for providers to achieve improved care and outcomes.
- Provide payers with information that they can use to ensure their beneficiaries will receive high quality care with the most efficient cost savings.

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As a replacement to the current metrics, the ACS supports a unified "quality program" that reflects real-world practice and is not constrained by the limitations of Medicare payment systems. We envision a program with a structural foundation, a set of processes, and accountable metrics, including metrics that focus on patient goal identification; episode-specific, risk-adjusted clinical outcomes; and structural measures to verify episode readiness at the facility level, episode-based cost of care, and tracking of adverse events. The program would be data-driven, transparent, and include improvement cycles. **Therefore, we urge CMS to further develop measures to include episode-specific measures around patient goals, clinical outcomes, and verification of episode readiness.**

The Age Friendly Hospital measure, which CMS adopted for use under the Hospital IQR Program beginning with the 2025 performance year, is an example of a measure that focuses on patient goals and provides a clinical framework to effectively care for the older adult population. **The ACS recommends CMS consider implementing this measure as part of TEAM in upcoming years of the model.** Older adults (aged 65 and over) represent a growing proportion of the population, and healthcare spending for this demographic is notably high and growing rapidly. Use of targeted interventions such as geriatric assessments, mobility protocols, medication reconciliation, and discharge planning can all reduce preventable complications such as delirium, falls, readmissions, and adverse drug events which harm our older patients and increase wasteful utilization.[16, 17, 18, 19] The Age Friendly measure follows the model used across ACS quality programs, which have proven to improve patient outcomes and can be applied across numerous healthcare settings. Standardizing hospital care for older adults through geriatric-specific initiatives has demonstrated improved patient outcomes and reduced spending.[20, 21] Through its five domains—Eliciting Patient Healthcare Goals, Responsible Medication Management, Frailty Screening and Intervention, Communal Vulnerability, and Age-Friendly Care Leadership—targeting geriatric specific healthcare issues, the Age Friendly measure aligns payer, hospital, and patient priorities to enhance the quality of geriatric hospital care. With the positive impacts of participation in a geriatric quality program and the alignment with the patient cohort captured in TEAM, the ACS feels that this measure is well-suited for inclusion in TEAM.

Information Transfer Patient Reported Outcome-based Performance Measure (Information Transfer PRO-PM)

CMS stated that they would like to incorporate more PRO-PMs into TEAM as well as measures that capture care in the outpatient setting. To follow through on this goal, CMS proposes the addition of the Information Transfer PRO-PM for all episode categories initiated in the hospital outpatient department (HOPD) in TEAM.

The ACS supports the addition of the Information Transfer PRO-PM in TEAM. We believe it is important that patients have a clear understanding of key information post-discharge from a surgical procedure. If a patient does not have clear guidance or understanding of the next steps after discharge, it could be harmful to their recovery. In some instances, patients may not have ready access to their care team after discharge, and this information can serve as a proxy. This measure is also important to help hospitals identify the post-discharge

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information that is most useful to patients and where patients may need more information to optimize their recovery.

We also highlight the importance of patient-reported outcome measures (PROMs) and PRO-PMs as they can offer meaningful insight from the patient's perspective, which is foundational to determining the value of care based on what matters to the patient. When you think about surgical care, measuring rare or adverse events is important, but it only affects a limited number of patients. On the other hand, patient-reported outcomes (PROs) assess every surgical patient and offer the opportunity for a patient to express their experience, satisfaction, level of goal attainment, and so forth. Where few other measures help to inform referring physicians and patients, PROs fill a gap. They provide valuable insights into patients' perspectives on their health, quality of life, and functional status. Patient-reported measures are especially important in the outpatient setting where procedures and patients are typically less complex compared to the inpatient setting, and therefore, there is less variation in care for rare events.

The ACS recently submitted a measure, *CollaboRATE Shared Decision-Making Tool for Outpatient or Ambulatory Surgery Patients,* that we feel closely aligns with the goals CMS stated in this proposed rule about incorporating measures that focus on the outpatient setting and incorporating more PROs in TEAM quality metrics. The *CollaboRATE Shared Decision-Making Tool for Outpatient or Ambulatory Surgery Patients* measure was developed to assess the quality of patient SDM for surgery in the ambulatory setting to improve patient-centricity, patient outcomes, and unnecessary care. This measure fills a gap in many of CMS' programs that lack metrics that focus on patient preferences or the appropriateness of surgical decisions, which is increasingly important in the outpatient setting where complications are infrequent. **Where the Information Transfer PRO-PM collects important information about experience and safe recovery, we believe an SDM measure, such as the *CollaboRATE Shared Decision-Making Tool for Outpatient or Ambulatory Surgery Patients* measure, should be a top priority to assess and promote alignment between an individualized decision to operate and patient goals. Given the goals CMS has set with TEAM, we suggest the Agency consider the incorporation of the *CollaboRATE Shared Decision-Making Tool for Outpatient or Ambulatory Surgery Patients* measure in relevant quality programs, and in future years of TEAM.**

Approach for when TEAM Participant has No Quality Measure Performance Data

CMS acknowledges that there are instances where a TEAM participant may not have a complete measure set during the performance period. In the proposed rule, the Agency cites multiple examples for how this might occur, including that some quality measures in TEAM (Hospital Harm – Falls with Injury and the Hospital Harm – Postoperative Respiratory Failure) are eCQMs, which are available for self-selection in the Hospital IQR program. To account for this, CMS proposes to assign a neutral quality measure score to TEAM participants with no or an incomplete raw quality measure score for a given quality measure. This means that a TEAM participant that does not have a raw quality measure score for a given quality measure would be assigned a scaled quality measure score of 50, which is the midpoint on the composite quality score (CQS) scale of 0-100.

While we understand CMS' intent with this proposal, our analysis shows that applying a neutral score for quality will just continue to lessen the role quality has in this model. As we have stated, the quality framework within this model lacks accountability and is not optimal for making comparisons between hospitals based on quality. Ultimately, this quality framework is made for payment and not for quality. To reiterate our previous comments, CMS should rethink the quality components and incentives of the model so quality metrics map to each specific episode to address the relevant goals, outcomes, cost profiles, risk, and overall quality of care.

Hierarchical Condition Categories (HCC) in Risk Adjustment

In the FY 2025 IPPS/LTCH PPS final rule, CMS finalized the use of beneficiary-level variables that are episode category-specific, however they did not finalize the lookback period duration for capturing these variables. CMS selected beneficiary level variables from the HCCs used in the CMS-HCC risk adjustment model that informs

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MA capitation rates and Part D payment policies. CMS is proposing to conduct a 180-day lookback for each beneficiary, beginning with the day prior to the anchor hospitalization or anchor procedure and switch to HCC version 28 for risk adjustment in TEAM.

While we have not had the opportunity to conduct a full analysis of the effects of the updated risk adjustment proposal, our initial analysis indicates that the change is positive, but the overall risk adjustment in the model remains limited and will likely not be adequate for supporting clinical decisions for care teams and patients. **We recommend CMS consider a number of additional variables, including demographic factors, clinical factors, and procedure-specific factors. Each of these risk factors is needed to accurately represent the risk profiles of the patient cohort being treated within the hospital. This becomes even more important when trying to compare hospitals' performance within an episode-based model.**

The ACS is currently conducting research on the potential benefits of using clinical data from the ACS National Surgical Quality Improvement Program (NSQIP) as an alternative risk adjustment methodology. We feel that such clinical risk adjustment will be more accurate while providing meaningful information for care optimization and efficiency efforts. Risk adjustment under a payment model (which will influence clinical decisions) should be tied to clinical variables and not just charges. We feel that such clinical risk adjustment will be more accurate while providing more meaningful information for care optimization and efficiency efforts.

Health Data Reporting

In the FY 2025 IPPS/LTCH final rule, CMS finalized voluntary reporting of health equity plans, demographic data, and health related social need data. The agency states that it still believes that it is important to understand and address the health needs of all TEAM beneficiaries. However, due to the new Administration's priorities and concern over placing additional burdens on TEAM participants in a mandatory model, it recognizes the need to remove the voluntary health equity plan and the health-related social needs data. Therefore, they propose to remove the health equity plan and health related social needs data policies from TEAM. The Agency also proposes to remove the voluntary collection of health-related social needs screening and reporting.

While we understand that reporting the health equity plans and collection of health-related social needs screening were voluntary components of TEAM, we want to remind CMS that environmental and social factors are important to understanding the health of the whole patient. Understanding all factors that contribute to a patient's health, including potential risk factors, is important to providing patients with good care. CMS states that its goal is to optimize the episode of care. To do this looking at all relevant factors—procedural risk, condition risk, and social determinants—that contribute to the patient's success before, during, and after an operation is essential.

Referral to Primary Care Services

CMS is proposing to maintain the requirement for the referral to primary care as originally proposed and seeks comments on alternative approaches to achieve the goal of "integrating care during the transition from an acute event … back to longitudinal care relationships, such as primary care." The ACS acknowledges the importance of improving care coordination through improved transition to longitudinal care and appreciates the careful consideration of the potential for administrative burden or unnecessary costs demonstrated in CMS' discussion of the requirement.

Specifically, CMS notes that surgeon specialists have the expertise that primary care may lack to manage the clinical follow-up, leading to unnecessary care such as the example given of an unnecessary referral to the emergency department for wound assessment. The ACS would note that surgical episodes often emerge from underlying chronic conditions that may in some cases be managed by a specialty other than primary care, such as a cardiologist in the case of coronary artery bypass graft (CABG) episodes. In some cases, the surgeon may also have been managing the underlying condition prior to the surgery. **The ACS recommends that the requirement for referral be expanded to require that the patient be referred back to primary care *and/or* to the**

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specialist who had previously managed the underlying condition as is most appropriate, especially if the patient had already been seeing a specialist as their source of regular care due to management of their underlying health condition. This would best achieve the goals of improved coordination while reducing the chances of unnecessary care due to lack of familiarity with the patient's specific care needs.

The ACS appreciates the opportunity to provide feedback on this proposed rule and looks forward to continuing dialogue with CMS on these important issues. If you have any questions about our comments, please contact Jill Sage, Chief of Quality Affairs, at jsage@facs.org.

Sincerely,

Patricia L. Turner, MD, MBA, FACS
Executive Director and CEO

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