June 10, 2025

The Honorable Dr. Mehmet Oz
Administrator
Centers for Medicare and Medicaid Services
U.S. Department of Health and Human Services
Attention: CMS-1833-P
Submitted electronically to: https://www.regulations.gov/

RE: Fiscal Year 2026 Medicare Hospital Inpatient Prospective Payment System and Long-Term Care Hospital Prospective Payment System Proposed Rule

Dear Administrator Oz:

The National Association of ACOs (NAACOS) appreciates the opportunity to submit comments in response to the Fiscal Year (FY) 2026 Medicare Hospital Inpatient Prospective Payment Systems (IPPS) proposed rule, which includes a request for information (RFI) on digital quality measurement and proposed changes to the mandatory Transforming Episode Accountability Model. NAACOS is a member-led and member-owned nonprofit of nearly 500 accountable care organizations (ACOs) in Medicare, Medicaid, and commercial insurance working on behalf of health care providers across the nation to improve quality of care for patients and reduce health care costs. Collectively, our members are accountable for the care of over 9.5 million beneficiaries through Medicare's population health-focused payment and delivery models, including the Medicare Shared Savings Program (MSSP) and Direct Contracting/ACO REACH, among other alternative payment models (APMs). Our comments below reflect the concerns of our members and our shared goals to advance accountable care and improve access to and use of health care data.

TOWARD DIGITAL QUALITY MEASUREMENT IN CMS QUALITY PROGRAMS

Transforming care delivery and improving quality are cornerstones of accountable care. ACOs and providers in accountable care regularly leverage data and technology, integrating claims and clinical data, to enhance clinical outcomes through innovative solutions and population health improvement. Our members want to move to a quality measurement approach that leverages interoperable data sources seamlessly integrated at the point of care. This would increase efficiency, reduce administrative burden, and empower patients and providers to make informed care decisions. We strongly encourage CMS to focus on a more direct pathway to digital quality measurement (dQM) rather than implement many costly, low-value interim steps to bring this approach to fruition.

We appreciate CMS' acknowledgement in this RFI of the challenges that ACOs face with aggregating, deduplicating, and matching necessary to report quality data using the electronic clinical quality measure (eCQM) and Merit-based Incentive Payment System (MIPS) CQM options. Unfortunately, current requirements force ACOs to make investments in infrastructure that do not facilitate the shift to

the HL7 Fast Healthcare Interoperability Resources (FHIR) standard. In addition, FHIR-based eCQMs are inherently limiting to entities like ACOs that use data sources beyond electronic health record (EHR) systems to support quality measurement and improvement.

ACOs should be able to leverage a broad set of digital data to enable:

(1) Bi-directional capture of data that is seamlessly integrated at the point of care, and
(2) Use of clinical interactions and associated data to measure understand an ACO's quality in a way that assesses population health and evaluates the accountable entity using appropriate benchmarks.

We look forward to continuing our engagement with CMS on a thoughtful transition to FHIR-based reporting that supports population health and accountable care. We will provide additional recommendations in our response to the RFI that CMS plans to include in the Physician Fee Schedule proposed rule.

Timeline Under Consideration

NAACOS urges CMS to allow sufficient time and avenues by which ACOs can successfully transition to digital quality measures (dQMs). While we are aligned with CMS' goal to shift to seamless data exchange leveraging the digital sources that are increasingly available, it will require both vendor readiness and additional education and resources for those reporting to understand and implement what is required. ACOs and their associated practices must be knowledgeable of the current and future capabilities and technologies of their EHRs and other sources of digital data. While progress has been made, this shared understanding between providers and vendors is not yet at the level to support an immediate transition to FHIR-based reporting. We anticipate that ACOs will need at least five years from the time that FHIR-based reporting is finalized in rulemaking to work with their many EHR and IT vendors to achieve accurate, seamless digital reporting.

The five-year timeframe will allow CMS to focus on the direct transition to FHIR dQMs rather than creating partial solutions like FHIR eCQMs, and therefore more quickly advance the journey to digital data, as well as reduce data collection and reporting burden, compared with the proposed phased approach. Because we view FHIR eCQMs as a component of FHIR dQMs, entities such as hospitals or practices that may not be ready to use additional digital data sources would still be able to leverage primarily EHR data while others, such as ACOs and health plans, could use additional sources available to them (e.g., administrative claims, labs, health information exchange data). Broadening to FHIR dQMs will provide the flexibilities that would allow groups to tailor their efforts based on where they are in collecting and reporting digital data and still shift to the optimal standard for data exchange.

FHIR Transition Activities for ACOs

We urge CMS to create and release a detailed timeline with milestones indicating when critical steps and activities have been achieved and what factors and deliverables must be met to indicate that the industry is sufficiently ready to move to the next step. For example, this process and timeline could outline when the technical requirements for FHIR-based reporting will be made available, with adequate time for vendors to integrate them into their products, and when these requirements will be incorporated into certification requirements. We note that it is critical for vendors to support Bulk FHIR as it is an essential component to enable effective and efficient reporting, and we support CMS' ongoing efforts to promote its use. At the same time, CMS should also build the internal capabilities needed to

receive these data through FHIR-based APIs and release guidance and education to assist practices and ACOs in this transition, including for working with their vendors. Subsequently, once CMS determines that vendors are ready and certified to support this reporting and CMS can receive the data, a reasonable timeframe during which practices and ACOs must begin reporting these measures to CMS should be proposed.

This glidepath must include appropriate incentives to support ACOs and their participating practices through each step of the transition in a thoughtful way. By using a stepwise approach with initial activities focused on building the required infrastructure, followed by data collection and reporting by practices and ACOs, we believe that all can be successful. It will be essential for each step to provide adequate time and resources. Additionally, it will be critical to evaluate ACOs and their vendors for readiness to move from one step to the next, with input from the community on whether there is agreement that most participants are poised to successfully report FHIR dQMs. When considering what ACOs will need to successfully embark on this transition, CMS should:

Allow groups to transition directly to FHIR dQMs rather than the current proposed approach of first moving to FHIR eCQMs and then FHIR dQMs. NAACOS believes that the proposed phased approach of moving to FHIR eCQMs followed by FHIR dQMs, rather than shifting directly to FHIR dQMs, limits ACOs' ability to advance how data are captured and used at the point of care and for quality measurement, because FHIR eCQMs only allow use of EHRs data. Moving forward first with FHIR eCQMs adds new work with limited value. Moving directly to FHIR dQMs will allow those entities that are only able to leverage EHR data to do so, and also enables groups such as ACOs that have access to additional data sources to begin leveraging various data sources as they transition to the FHIR standard. More importantly, it will reduce unnecessary efforts to identify ways to integrate existing additional data sources, such as health information exchange (HIE) data, into EHRs for FHIR eCQMs. Rather, each reporting entity would be able to leverage what digital data are available to them immediately and without additional burden.

Continue to support current reporting options, including Medicare CQMs and Web Interface, until all ACOs can successfully report dQMs. Retaining existing reporting options until the pathway to dQMs is established will enable ACOs to focus on the steps needed for that transition rather than expending time and resources to shift to interim reporting approaches. We also believe that supporting Medicare CQM reporting will facilitate ACOs' shift to dQMs.

Shift to pay for reporting, provide appropriate incentives for the transition, and ensure ACOs will not risk losing shared savings they would have otherwise earned. As ACOs move to dQMs, it will initially be difficult to determine whether the performance scores produced reflect true differences in quality rather than the degree of data completeness and validity, and vendor capabilities. Based on our members' current experiences with existing eCQMs, significant time and resources are required to ensure that the data are captured in discrete fields. It can take several years working with providers and others on documentation practices and workflow to confirm that the data are consistently captured as intended.

CMS should offer sufficient incentives to encourage ACOs to begin the transition to dQMs. During this transition, CMS should adjust the requirements by which quality performance is assessed since ACOs should not have to expend unnecessary resources and funds to support reporting multiple collection types (e.g., Medicare CQMs and dQMs) to minimize the risk of losing earned shared savings. Many of the initial differences in performance scores and associated benchmarking will be due to differences in data sources rather than true variations in the quality of care provided. A lower quality performance standard

threshold during this transition will ensure ACOs are not arbitrarily penalized for being early adopters. In addition, measure benchmarks should be set based on the relevant population, statistically appropriate, and stabilized prior to linking quality scores to penalties.

Maintain the APP Plus set as currently finalized without adding measures until this transition is complete. ACOs, their participating practices, and vendors will need sufficient time to implement these new technologies and specifications. During this transition, we urge CMS to maintain the current set of measures as finalized for 2025. Adding additional measures would only increase the data collection burden and costs.

As CMS seeks to align quality measures across programs, future measure sets should be FHIR-enabled and designed for population health. Rather than aligning back to individual clinician measures in MIPS, CMS should seek to align measures across programs that are responsible for total cost of care (i.e., aligning ACO and Medicare Advantage quality approaches), which will ultimately reduce administrative burden for accountable care providers.

TRANSFORMING EPISODE ACCOUNTABILITY MODEL

The mandatory Transforming Episode Accountability Model (TEAM) will launch on January 1, 2026, and run for five years, ending on December 31, 2030. CMS proposes modifications to certain aspects of TEAM that are largely technical in nature. While NAACOS supports many of these improvements, we remain concerned that the model will be challenging for low-volume, safety-net, and rural providers.

Participation

CMS proposes two modifications to the participation options for TEAM. First, CMS proposes a limited deferment for new hospitals. Hospitals must have been formed by December 31, 2024, to participate in TEAM when it starts on January 1, 2026. Any new hospital located in a selected core-based statistical area (CBSA) will have at least one full performance year of participation deferment before being required to participate. Additionally, CMS will discontinue participation for any hospital that no longer satisfies the definition of a TEAM participant (e.g., hospital reclassified to Critical Access Hospital (CAH)). **NAACOS supports this proposal which acknowledges the time and resources needed to prepare for the model.**

Second, CMS addresses potential expiration of the Medicare Dependent Hospital (MDH) program. Safety net hospitals, rural hospitals, Medicare-dependent hospitals, sole community hospitals, and essential access community hospitals may elect up to three years without downside financial risk, followed by a lower risk track (Track 2) for the remainder of the model. In recognition that the MDH program is not authorized beyond September 30, 2025, CMS proposes to honor MDH classifications as long as the MDH program is active at the time participation track selections are due to CMS. In addition, CMS is seeking comment but not proposing that the agency offer technical assistance to MDH programs if the program expires. NAACOS appreciates that CMS has addressed the uncertainty regarding MDH hospital status. **Should the MDH program expire, we believe CMS should offer additional technical assistance and consider prior qualification as an MDH hospital as meeting criteria for remaining in Track 1 or 2.**

NAACOS appreciates that CMS finalized TEAM with a more gradual on-ramp to risk for rural and safety-net hospitals, however, we remain concerned that requiring these hospitals to participate in downside risk models would have an adverse impact on patients and access to care in these

communities. Many rural and safety net hospitals do not have the resources to invest in the infrastructure necessary to implement care transformation effectively and already face access issues. CMS runs the risk of placing additional financial burden on hospitals that are not well resourced, perpetuating access issues for the patients they serve. We request that CMS reconsider this requirement to move to Track 2 if rural and safety-net hospitals struggle to be successful in the model.

Quality Measures

Alignment of Readmissions Measure with IQR

CMS previously finalized inclusion of the *Hybrid Hospital-Wide All-Cause Readmission Measure with Claims and Electronic Health Record Data* in the composite quality score (CQS). CMS recognizes that changes to the Hospital Inpatient Quality Reporting (IQR) program for this measure mean that the first year of mandatory reporting serves as the baseline performance period for TEAM. NAACOS urges CMS to closely monitor hospitals' ability to collect and report the data required for the Hybrid Hospital-Wide All-Cause Readmission measure and continue refining the measure specifications to better align with clinical workflows. It is essential that this measure generates reliable and valid scores. Given the ongoing concerns about the completeness of EHR data, we question whether this measure should currently be tied to any payment incentives or penalties. Further, we do not support the alternate proposal of only using claims-based measures because the risk model is improved with the hybrid approach. CMS should delay use of this measure at least one year so that the first year of mandatory reporting is before the baseline performance period for use in the TEAM CQS.

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

CMS proposes to add this measure to have an outpatient PRO that aligns with mandatory reporting requirements under the IQR program. This PRO-PM will first be mandated under IQR in 2027. Therefore, CMS proposes to apply it to all outpatient episodes starting in PY3 (2028), to give organizations one year of mandatory reporting experience before it's introduced to the scoring methodology. We have substantial concerns about CMS continuing to include PRO-PMs in this model since hospitals report that collecting the necessary surveys is both burdensome and costly, performance scores are not yet available, and their impact on improving care remains unproven. **As a result, we urge CMS not to finalize this measure and encourage CMS to remove the existing *Patient-Reported Outcome-based Performance Measure (PRO-PM) for Elective Primary Total Hip Arthroplasty (THA) and/or Total Knee Arthroplasty (TKA)* from this model.**

The number of surveys required for the Information Transfer PRO-PM (a minimum of 300) is unrealistic, and challenges increase for low volume facilities as they must have a 100% response rate. Similarly, the THA/TKA PRO-PM requires tracking patient-reported outcomes for over a year after surgery. Hospitals struggle to obtain accurate patient contact information and note that the 50% survey completion threshold is nearly impossible to achieve.

Ensuring that hospitals have reliable contact information requires significant staff time and resources and fails to account for barriers in rural areas, such as limited internet and cell service. Implementing these measures requires additional staffing and new workflows, diverting clinical resources and placing undue burden on rural and small hospitals. For example, one hospital reported paying an external vendor $40 per survey just to fulfill the initial pre-surgery requirement for the THA/TKA PRO-PM and additional costs will be incurred to complete the follow-up surveys.

Most importantly, these PRO-PMs do not provide timely or actionable feedback to drive improvements in patient care. We believe that they serve more as administrative burdens than meaningful quality measures as currently constructed. **Given these serious concerns, we urge CMS reconsider inclusion of these PRO-PMs in the model.**

Application of a Neutral Quality Measure Score for TEAM Participants with Insufficient Quality Data
CMS proposes that organizations with missing or incomplete quality measure data be assigned a neutral score for that measure, rather than removing the measure from the calculation entirely. This aligns with the precedent set by the Comprehensive Care for Joint Replacement (CJR) model. **NAACOS supports this change.**

Pricing Methodology

CMS proposes several changes to the pricing methodology.

Changes to coding methodologies. CMS proposes a methodology for adjusting target prices when changes in the definition of diagnostic related groups (DRGs) and healthcare common procedure coding system (HCPCS) codes occur between the baseline and performance period. The proposed process, which remaps baseline period DRGs and HCPCS codes into the applicable codes for the performance period and adjusts the performance period target prices, is similar to that used by CMS in its Bundled Payment for Care Improvement Advanced (BPCIA) model. **NAACOS supports this policy as it ensures that there is not a drop in episode volume due to changes in the underlying codes**. It also creates target prices for DRGs and HCPCS codes that did not exist in the baseline period.

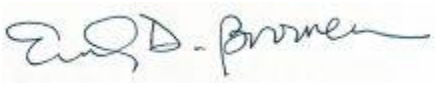
Normalization and prospective trend factors. CMS proposes a new methodology for calculating the prospective trend factors to update TEAM episode target prices from the baseline period to the performance period. The original methodology simply calculated the trend for each DRG between baseline year (BY)1 and BY3 and applied this trend between BY3 and the performance year. The new method uses five years of historical data and calculates the annual change using a log-linear regression model. **NAACOS supports this as the new methodology is expected to result in a more reliable prospective trend factor.** A more reliable and accurate prospective trend factor reduces the likelihood of large retrospective trend adjustments which could result in unanticipated changes in the financial performance of model participants.

Low volume exclusions. Currently, CMS has no low-volume episode policy, given that Track 1 has no downside risk. CMS is considering but not proposing a policy to set the low-volume threshold for hospitals at 31 episodes in the baseline period for each episode category, which would be similar to the policy in BPCIA. Hospitals that fall below that threshold would have upside-only risk for episodes in this episode category. Volume would be reassessed annually as the baseline years are updated. CMS indicated that they are considering this policy based on the feedback they received on the 2025 IPPS proposed rule, in which they proposed a minimum of 31 episodes across all episodes. Like other commenters, NAACOS expressed strong concern that this threshold was too low because it was aggregated across all episode categories. We continue to believe that it is critical that hospitals are protected against large financial losses due to random variation from assessing a small number of cases. **We reiterate our recommendation that CMS establish a low-volume threshold at 40 episodes in the baseline period for each episode category.**

CONCLUSION

Thank you for the opportunity to provide feedback on the transition to dQM and proposed changes to TEAM in the FY 2026 IPPS proposed rule. NAACOS and its members are committed to providing the highest quality care for patients while lowering costs. We look forward to our continued engagement on improving accountable care approaches. If you have any questions, please contact Aisha Pittman, senior vice president, government affairs at aisha_pittman@naacos.com.

Sincerely,



Emily D. Brower, MBA
President and CEO
NAACOS