

June 9, 2026

The Honorable Dr. Mehmet Oz
Administrator
Centers for Medicare and Medicaid Services
U.S. Department of Health and Human Services
Attention: CMS-1849-P
Submitted electronically to: <https://www.regulations.gov/>

RE: FY27 Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals (IPPS) Proposed Rule

Dear Administrator Oz:

The National Association of ACOs (NAACOS) appreciates the opportunity to submit comments in response to Fiscal Year (FY) 2027 Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals (IPPS) proposed rule. NAACOS is a member-led and member-governed nonprofit of nearly 500 accountable care organizations (ACOs) and value-based care entities in Medicare, Medicaid, and commercial insurance working on behalf of health care providers across the nation to improve the quality of care for patients and reduce health care cost. Collectively, our members are accountable for the care of more than 10 million beneficiaries through Medicare's population health-focused payment and delivery models, including the Medicare Shared Savings Program (MSSP) and the Accountable Care Organization Realizing Equity, Access, and Community Health (ACO REACH) Model.

NAACOS is pleased to see the Centers for Medicare & Medicaid Services (CMS) providing additional opportunities for specialists to engage in alternative payment models (APMs). If structured appropriately, episodic models can support system changes and engage specialists in accountable care. **NAACOS supports the concept of expanding the Comprehensive Care for Joint Replacement Expanded (CJR-X) model as the prior iteration (CJR) was successful in generating Medicare savings, redesigning care delivery, and maintaining and improving beneficiary outcomes. However, we have concerns that the proposed framework does not adequately account for evolving care patterns and may not create meaningful opportunities for reinvestment in care redesign. We encourage CMS to implement the model as an upside-only model for at least one year while continuing to refine the approach.** Our comments below reflect the concerns of our members and our shared commitment to advancing value-based care and expanding meaningful specialist participation in APMs.

COMPREHENSIVE CARE FOR JOINT REPLACEMENT EXPANDED (CJR-X)

The CJR Model was a mandatory APM for lower extremity joint replacement (LEJR) procedures tested by the CMS Innovation Center between April 1, 2016 and December 31, 2024 in select geographic regions. CMS is proposing to expand the CJR Model to all eligible acute care hospitals nationwide beginning October 1, 2027.

Participants

CMS proposes that hospitals would be model participants in CJR-X, excluding certain specialty hospitals, such as psychiatric and cancer hospitals. CMS also proposes excluding hospitals from CJR-X if they participated – either mandatorily or voluntarily – in the Transforming Episode Accountability Model (TEAM) model, as well as Maryland hospitals due to the state’s rate setting authority.

NAACOS supports this approach and encourages CMS to consider exclusions for other hospitals.

Safety-net and rural hospitals face unique resource constraints, patient complexity, and market dynamics that may not be fully captured in current benchmarking and risk structures. As we discuss below, changes to the low volume threshold and risk progression may help protect these hospitals. Without these protections, requiring participation would impose undue financial strain on these institutions and could threaten access to care for the patients these facilities serve. Therefore, in addition to the changes detailed below, we urge CMS to consider making participation in CJR-X voluntary for rural and safety-net hospitals in recognition of the unique challenges they face and the patient populations they serve.

Additionally, we support the exclusion of Maryland hospitals. As CMS implements Geo Achieving Healthcare Efficiency through Accountable Design (AHEAD) in other states, we ask that CMS consider excluding hospitals in those states from both CJR-X and TEAM to allow the hospital to prepare for the AHEAD global budget payment methodology.

Beneficiary Notifications

CMS proposes that CJR-X participants must provide written notification to each CJR-X beneficiary of their inclusion in the model. The notification would explain the model, advise patients of their clinical needs and care delivery choices, and clearly identify any CJR-X collaborators. **CMS should eliminate this requirement and directly provide notifications to beneficiaries.** Given that both CJR-X and TEAM will cover LEJR procedures for hospitals nationwide, we believe it would be appropriate for CMS to provide written notification to all traditional Medicare beneficiaries that LEJR procedures are included under an episodic payment model and what this means for their care. This could be accomplished through an existing annual communication vehicle, such as the Medicare & You Handbook, minimizing administrative burden while ensuring broad beneficiary awareness.

Across APMs, we have found that the beneficiary notification process leads to beneficiary confusion and is burdensome as it is disconnected from communication about ongoing care. NAACOS has long [recommended](#) that CMS better support APM participants with education to beneficiaries on payment models. A CMS-led approach would promote consistency, reduce duplicative communications, and alleviate significant administrative burden and costs associated with maintaining, updating, and translating model-specific notifications at the hospital level. At a minimum, participant-level notifications should provide hospitals with the flexibility in beneficiary notification approaches; allowing hospitals to include required information while customizing the communication.

Episode

CMS proposes LEJR episodes in CJR-X would include inpatient hip, knee, and ankle replacement procedures paid through the IPPS under select Medicare Severity Diagnosis Related Groups (MS-DRGs) and hospital outpatient hip and knee replacement procedures billed under select Healthcare Common Procedure Coding System (HCPCS) codes through the OPPS. CMS proposes to exclude total ankle arthroplasty (TAA) performed in the outpatient setting. CMS proposes a 90-day episode for an LEJR

episode would begin when a beneficiary is admitted for an anchor hospitalization for one of the included MS-DRGs or an anchor procedure indicated by one of the included HCPCS.

NAACOS supports CMS' proposal to maintain a 90-day episode for CJR-X, recognizing that longer episode durations provide greater opportunity to drive meaningful care coordination, manage post-acute utilization, and capture the full impact of care redesign.

Pricing and Payment Methodology

CMS proposes setting target prices using three years of rolling 100 percent regional baseline data, adjusted forward to the performance year (weighting recent data more heavily), and grouped by episode type (MS-DRG/HCPCS) and region, with safeguards like outlier caps and standardized spending benchmarks. These prices would then be adjusted using trend, discount, and risk factors (accounting for hospital and patient characteristics) while applying a normalization factor to ensure fairness and prevent inflation in overall target prices.

Despite the overall approach for setting target prices aligned with prior known approaches used in CJR and TEAM, **we are concerned that the model does not adequately address long-term sustainability of participation.** CMS acknowledges this concern noting that spending on LEJR episodes has been decreasing over time and “may reach a point where further decreases in spending could compromise quality and patient safety.” Additionally, CMS notes that spending has stabilized in recent years, “suggesting that there may no longer be as much of an opportunity for participant savings as there was in the early years of CJR.”

We concur that savings opportunities have largely been exhausted and prior model participants have already implemented substantial care redesign, post-acute optimization, and efficiency improvements. Moreover, learnings from the CJR model demonstrated a need to consider long-term approaches for shifting payment for LEJR. Participants demonstrated strong early performance and savings but faced increasing financial pressure as procedures shifted to the outpatient setting, changing the case-mix of inpatient procedures in the model and ultimately requiring participants to outperform their own prior success to maintain performance in the model.

NAACOS requests that CMS address the long-term sustainability of the model prior to mandating participation. We appreciate the use of regional target prices as a mechanism to address ratcheting benchmarks; however, additional approaches are needed. First, CMS should consider setting target prices for multiple years rather than annual rebasing. CMS adopted similar policies with a 10-year benchmark approach for Long-term Enhanced ACO Design (LEAD) Model and a five-year benchmark approach in MSSP. Longer term benchmarks provide a clear goal for hospitals and sustained opportunity for success in the model. **At a minimum, CMS should establish a three-year target price methodology at the start of CJR-X, allowing additional time to design other approaches to address the long-term ratchet effect.** For example, CMS could explore long-term approaches, such as administratively set target prices, or an administratively set floor for target prices, to ensure prices do not fall below clinical and operational realities.

CMS should also reconsider the discount approach, which applies a blanket two percent discount to all hospitals with the opportunity to reduce the discount based on quality. We are concerned that the model is a penalty-only framework. NAACOS encourages CMS to consider a lower or more flexible discount factor, calibrated to realistic savings potential within the episode, as a mandatory two percent discount could constrain hospitals' ability to reinvest in care management infrastructure and quality

improvement initiatives necessary for long-term success. Additionally, as we discuss below, the current quality measure set is an inadequate tool for adjusting discounts. CMS should consider other hospital-specific factors, such as historical spending compared to the regional target price, to define discounts. For example, hospitals performing below regional spending targets could receive reduced or zero discount factors, while those above regional averages could take on a higher discount factor. This approach would recognize the progress already made by efficient providers, avoid reinforcing the “race to the bottom” dynamic, and better align financial incentives with true performance improvements rather than continuously lowering reimbursement rates across all participants.

Recognizing that these changes would require significant revisions to the model, we offer comments on the proposed model approaches:

Prospective Trend Factor. For CJR-X, CMS proposes to apply a “prospective trend factor,” which would be a multiplier incorporated into the preliminary target price to estimate changes in spending patterns between baseline period and the performance year. CMS also proposes to apply a +/- three percent capped “retrospective trend factor,” which would be a multiplier incorporated into the reconciliation target price to estimate realized changes in spending patterns during the performance year. **NAACOS supports this approach.**

CMS discusses other approaches for trending prices and seeks comments on the application of Accountable Care Prospective Trend (ACPT) in CJR-X. While the ACPT is designed to move to administratively set benchmarks and address the overall ratchet effect that occurs from widespread participation, the approach has underestimated spending increases resulting in artificially lowered benchmarks in the Medicare Shared Savings Program (MSSP) that are not reflective of true cost of care. **CMS should not expand use of this policy in other models until CMS has established and tested guardrails for the policy.**

Discount Factor. CMS proposes to apply a two percent discount on the benchmark price when calculating preliminary target prices. CJR-X participants that provide high-quality care will have the opportunity to reduce the discount factor. As noted above, we believe the combination of the target price ratcheting and a two percent discount will leave participants with little opportunity to achieve success in the model.

CMS should lower the discount and establish a gradual progression to risk for all participants. First, NAACOS recommends that CMS designate Performance Year One of CJR-X as upside-only for all participants, recognizing the nearly three-year gap since the conclusion of the original CJR model and the need for hospitals, including prior participants, to rebuild infrastructure, reengage care redesign strategies, and reanalyze data before assuming downside risk. This approach is consistent with the transition phase in both the original CJR model and TEAM. Additionally, the first performance year would allow time to provide data to participants and assess what are reasonable discounts for later performance years.

Next, CMS should adopt a tiered glidepath to risk, similar to TEAM, providing extended transition periods with delayed or reduced downside risk for safety-net, rural, and resource-constrained hospitals to account for structural resource constraints and promote equitable participation. These providers face distinct structural challenges, including limited access to capital, workforce constraints, and reduced operational scale, making rapid assumption of downside risk particularly difficult. Without tailored transition support, these providers may be

disproportionately disadvantaged, undermining their ability to succeed under the model and their long-term financial viability, with potential consequences for patient access to care.

Finally, CMS should ensure that transitional policies are complemented by sufficient technical assistance, timely and actionable data access, and streamlined reporting requirements. Together, these supports will enable providers to build sustainable care redesign strategies and fully engage in value-based care, while minimizing administrative burden and promoting long-term success across diverse provider types.

Special Considerations for Low-Volume Hospitals. CMS proposes to define a “low-volume hospital” as a hospital with fewer than 31 LEJR episodes performed during the applicable baseline period. CMS proposes that low-volume hospitals would be excluded from reconciliation for the performance year. **NAACOS recommends that CMS establish a statistically meaningful eligibility threshold by adopting more robust volume-based criteria, such as establishing a minimum threshold of at least 31 LEJR episodes per performance year per participating hospital, ensuring that only hospitals with sufficient episode volume are included.** A threshold of only 31 episodes over a three-year baseline is insufficient and increases year-to-year volatility, making results more sensitive to random variation and case mix differences -- particularly for hospitals with smaller volumes or complex referral patterns. Establishing a higher annual minimum volume threshold would help ensure that participating providers have adequate case volume to support statistically reliable quality and cost performance, while also generating meaningful savings opportunities that can engage and align downstream providers.

Risk Adjustment. CMS proposes to risk adjust target prices at the hospital level using a hospital bed size risk adjustment factor and a safety net risk adjustment factor. While NAACOS supports the inclusion of beneficiary-level and hospital-level risk adjustment factors, such as bed size and safety-net status, these adjustments alone may not fully capture the evolving distribution of patient complexity in inpatient settings. CMS should therefore ensure that its risk adjustment methodology adequately accounts for shifts in care delivery (i.e., impacts of case mix migration as procedures shift from outpatient settings to ambulatory surgical centers) to preserve fairness, payment accuracy, and alignment with real-world clinical practice.

Quality Measures and Scoring

CMS proposes to retain the existing CJR quality measure set for inpatient LEJR episodes in CJR-X while placing greater weight on patient-reported outcomes and adding two new measures to better account for outpatient procedures, with performance combined into a composite quality score (CQS) that adjusts the discount factor.

Measures

NAACOS is concerned that the measures for this model are not specific to LEJR and are challenged by other issues such as sufficient reliability at the current case minimums, patient acuity changes with procedures shifting to outpatient and Ambulatory Surgical Centers (ASC) settings, and concerns around patient survey fatigue and decreasing response rates for the patient reported outcome and satisfaction measures. While we appreciate that the measure set relies on measures currently reported by hospitals to reduce overall burden, **CMS should better align the quality measure set to target care related to LEJR. At a minimum, CMS should not include the use of Hospital-Level Total Hip and/or Knee Arthroplasty (THA/TKA) Patient-Reported Outcome (PRO)-Based Performance Measure.**

Below we highlight specific challenges with the measures included in the set:

- Hospital-Level Risk-Standardized Complication Rate (RSCR) Following Elective Primary Total Hip Arthroplasty (THA) and/or Total Knee Arthroplasty (TKA): The low case minimum undermines score reliability, CMS should increase the case minimum. Additionally, the risk adjustment methodology does not account for aspects that contribute to complication rates such as income, level of home support, and access to outpatient care post discharge.
- Hospital Visits Within 7 Days of Hospital Outpatient Department (HOPD) Surgery: The measure uses an overly broad denominator that includes all outpatient surgeries rather than joint replacements. As a result, hospitals cannot drive targeted quality improvement in joint replacement care from this measure data. Ultimately, this measure creates unfair accountability for hospitals in the payment model.
- Hospital Consumer Assessment of Healthcare Providers and Systems Survey and Outpatient and Ambulatory Surgery Consumer Assessment of Healthcare Providers and Systems Survey HCAHPS & OAS CAHPS Patient Surveys: Measures derived from the surveys lack validated review (or have outdated validation), suffer from critically low response rates, and therefore raise concerns about their reliability and appropriateness for ties to financial accountability.
- Hospital-Level Total Hip and/or Knee Arthroplasty (THA/TKA) Patient-Reported Outcome (PRO)-Based Performance Measure: NAACOS recommends removing PRO-based measures from the model until data specifications, response rates, and reliability improve. The current performance includes data that is limited, disproportionately excludes rural and safety-net hospitals, lacks feasible case minimums, penalizes hospitals due to patient choice, and imposes significant operational burden. These challenges warrant a pause and reassessment before application to CJR-X.

Composite Quality Score (CQS)

CMS proposes a CQS methodology for linking quality and payment in CJR-X that is similar to, but not the same, as the CJR methodology. Notably, the CJR-X methodology includes outpatient quality measures. CMS proposes to assign each CJR-X participant's measure score to a percentile based on the national distribution of results, with the comparison group including IPPS-eligible hospitals that meet minimum case or survey count requirements.

NAACOS is concerned that this approach will unfairly penalize participants. Beyond the specific measure challenges that we note above, the current quality measure set has limited variation in performance across IPPS-eligible hospitals. Implementing a percentile ranking approach with lack of variation in performance will create artificial winners and losers. We believe that **the CQS should not be used to modify the discount, but rather, the CQS should only set a performance threshold that should be achieved to be eligible for payment for a positive net payment reconciliation amount.** Maintaining only the performance threshold portion of the CQS would be similar to the methodology used in MSSP, where a quality gate determines eligibility for shared savings.

Quality Improvement

CMS considered, but is not proposing, a policy to provide participants quality improvement points as it believes CJR-X is structured to emphasize absolute quality performance, rather than short-term year-over-year change that may reflect random variation or changes in case mix. Additionally, CMS believes excluding improvement points supports transparency and predictability in quality scoring and aligns with the TEAM approach, which does not include quality improvement points. NAACOS supports this approach because the current quality measure set is composed of measures with known challenges or

low variation in performance resulting in little opportunity for improvement. However, if CMS develops quality measures targeted to LEJR, inclusion of improvement points may be warranted.

Financial Arrangements

CMS proposes several flexibilities designed to allow CJR-X participants to share all or some reconciliation payment amount (or repayment responsibility) with non-model participants, as well beneficiary incentives to encourage engagement and adherence. **NAACOS supports these policies and requests that CMS provide additional guidance on use of the waivers and how these flexibilities vary across APMs.** With many providers operating in multiple payment models and the flexibilities varying between models, the burden of understanding and tracking differences between models may prohibit use.

TRANSFORMING EPISODE ACCOUNTABILITY MODEL (TEAM)

As part of the FY 2027 IPPS/LTCH proposed rule, CMS proposed additional changes to TEAM.

Ambulatory Surgical Center Episode RFI

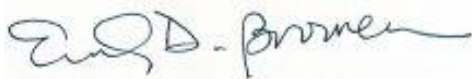
CMS is exploring ASC participation in TEAM, beginning as early as CY 2028 (PY 3). CMS seeks input on model structure, participant roles and financial accountability, episode and target price construction, and quality measurement. Any future incorporation of ASCs in TEAM would be pursued through notice-and-comment rulemaking.

NAACOS appreciates CMS' interest in exploring the inclusion of ASCs in TEAM. **Inclusion of any ASC episodes should be tested in a voluntary nature before mandatory participation.** ASC patients generally have lower acuity and are healthier than hospital-based populations. Additionally, ASCs have structural differences in cost drivers and savings opportunities, particularly given the role of post-acute care in generating bundled payment savings. Accordingly, CMS should not create blended target prices for inpatient, outpatient, and ASCs; inclusion of ASCs in CJR-X or TEAM should be treated as a separate track within the model.

CONCLUSION

Thank you for the opportunity to provide feedback on the FY27 IPPS Proposed Rule. NAACOS and its members are committed to providing the highest quality care for patients while advancing population health goals for the communities they serve. We look forward to our continued engagement in driving sustainability and advancing accountable care within specialty care models. If you have any questions, please contact Aisha Pittman, senior vice president of government affairs at NAACOS at aisha_pittman@naacos.com.

Sincerely,



Emily D. Brower
President and CEO
NAACOS