



Charles N. Kahn III  
President and CEO

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**Via electronic submission at <http://www.regulations.gov>**

The Honorable Chiquita Brooks-LaSure  
Administrator  
Centers for Medicare & Medicaid Services  
Department of Health and Human Services  
Hubert H. Humphrey Building  
200 Independence Avenue SW  
Washington, DC 20201

RE: Medicare and Medicaid Programs and the Children's Health Insurance 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 2025 Rates; Quality Programs Requirements; and Other Policy Changes (CMS-1808-P; CMS-1808-CN)

Dear Administrator Brooks-LaSure:

The Federation of American Hospitals (FAH) is the national representative of more than 1,000 leading tax-paying hospitals and health systems throughout the United States. FAH members provide patients and communities with access to high-quality, affordable care in both urban and rural areas across 46 states, plus Washington, DC and Puerto Rico. Our members include teaching, acute, inpatient rehabilitation, behavioral health, and long-term care hospitals and provide a wide range of inpatient, ambulatory, post-acute, emergency, childrens', and cancer services.

We are writing in response to the recent Centers for Medicare & Medicaid Services' (CMS) IPPS/LTCH PPS proposed rule published in the *Federal Register*.<sup>1</sup> In this rule, CMS (through the Center for Medicare and Medicaid Innovation, under its 1115A waiver authority) proposes a new 5-year mandatory episode payment model, the Transforming Episode Accountability Model (TEAM). The model would test five surgical episode types: lower extremity joint replacement, surgical hip / femur fracture treatment (SHFFT), coronary artery

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<sup>1</sup> *Federal Register*, Vol. 89, No. 86:35934-36649, May 2, 2024.

bypass graft (CABG), spinal fusion, and major bowel procedure. All acute-care hospitals in the ~25 percent of core-based statistical areas (CBSAs) identified for participation in the model (out of roughly 800 eligible CBSAs) would be required to participate in this mandatory TEAM. This letter addresses FAH's comments related to the TEAM demonstration. The FAH will file comments on the IPPS and LTCH provisions of the Proposed Rule in a separate letter.

The FAH has serious concerns with CMS' TEAM approach and the mandatory nature of the model. A mandatory model will require participation by hospitals that are not prepared for this type of risk-based approach and will ultimately reduce access to elective services for care for Medicare beneficiaries due to the excessive administrative burden, increased financial volatility by assuming the costs of unrelated providers, and requiring a 3 percent discount on payment rates that are already well below the cost of care. With the TEAM demonstration's focus on communities with less experience participating in bundled payment models, and higher safety net needs, the reduction in access to elective surgical care is likely to fall on some of the most underserved in the community.

Furthermore, the model appears to be simply an extension of CMS' previous bundling models – CJR, BPCI, and BPCI Advanced with surprisingly little new model innovations to “test” under a mandatory approach. CMS acknowledges in the Proposed Rule that those programs have not generally saved money for the Medicare Trust Funds and we question what CMS expects to learn from this demonstration that it hasn't already learned from the BPCI and CJR programs. In the Proposed Rule, CMS asserts that through TEAM, the agency is testing primary care transitions, impact of health equity and a “refined” payment methodology. However, these all seem incidental to the program, not necessarily warranting a new 5-year mandatory test. This is particularly true of the PCP coordination requirements since the new program involves procedural bundles that are specialist-focused.

The FAH questions whether this revised approach really qualifies as a true “test.” Given that (1) many of the provisions of the bundled payment program, including the financial model components, are copied or adapted from BPCI and CJR; (2) the proposed bundle types have been tested in previous models (some of them like LEJR in essentially all previous models); and (3) the excessive mandatory expansion of the scope of bundled payments under this rule to 25% of CBSAs, the FAH questions whether TEAM would “test” a model versus implement a new payment approach for a large swath hospitals.

In addition, the combined impact of the new, overly burdensome reporting requirements for quality reporting, primary care referrals, sharing with ACOs, and beneficiary notices layer on a set of requirements and cost increases that are incongruent with the savings that CMS is trying to drive from these hospital episodes.

We recommend that CMS utilize the TEAM approach as a way to extend or provide options in BPCI Advanced on a voluntary basis, rather than move forward with a mandatory model.

## **X.A. TRANSFORMING EPISODE ACCOUNTABILITY MODEL (TEAM)**

### **CMS Lacks the Authority to Mandate Provider Participation in CMMI Models**

The FAH is concerned with the proposed national, mandatory demonstration of the Transforming Episode Accountability Model (TEAM) and strongly opposes mandatory provider participation in any CMMI testing. The FAH has repeatedly expressed significant legal and policy concerns with mandatory CMMI models and has urged HHS to ensure that CMMI acts only within its designated authority to test voluntary alternative payment models. These objections to mandatory demonstrations are particularly acute with respect to the TEAM proposal in light of its extraordinarily wide proposed breadth—both in terms of the proportion of subsection (d) hospitals that will be mandated to participate and in terms of the proportion of surgical encounters that fall within the five surgical episode categories.

Mandatory provider and supplier participation in CMMI models affects an impermissible mandatory change to the Medicare program and runs counter to both the letter and spirit of the law that established the CMMI. CMMI’s demonstration authority is limited to the *testing* models under section 1115A and the making of *recommendations* to Congress, but Congress reserved for itself the authority to make permanent or mandatory changes to the Medicare program and the IPPS through legislation.

The language, structure, intent, and requirements of section 1115A of the Social Security Act (SSA) clearly indicate that Congress did not delegate broad lawmaking authority to the Secretary and CMMI. Under section 1115A(a)(1), CMMI tests innovative payment and service delivery models to maintain or reduce program expenditures while preserving or enhancing quality of care, with an emphasis on models that improve coordination, quality, and efficiency of health care furnished to Medicare and Medicaid beneficiaries. The statute directs the Secretary to select “from models where the Secretary determines that there is evidence that the model addresses a defined population for which there are deficits in care leading to poor clinical outcomes or potentially avoidable expenditures” (SSA § 1115A(b)(2)(A)). The law further directs CMS to evaluate each Phase I CMMI model, and only after taking into account this evaluation, if appropriate, the model may continue to be tested in Phase II to expand “the duration and the scope,” provided certain requirements are met (§ 1115A(c)), including a requirement for a separate notice and comment rulemaking for any expansion. Finally, CMS is required to report periodically to Congress on CMMI models and provide *recommendations* for *legislative* action “to facilitate the development and expansion of successful payment models” (SSA § 1115A(g)).

The statutory text thus broadly makes clear that CMMI models must be limited in scope and that Congress reserved for itself the authority to make mandatory changes in Medicare payment systems (*see* § 1115A(g)). Nowhere does the law permit mandatory provider participation in the testing of CMMI models, which would eviscerate the IPPS and other payment systems mandated by statute.

CMS nonetheless proposes to adopt TEAM, a five-year “mandatory model tested under the authority of section 1115A of the Act” (89 Fed. Reg. at 35,939). Recent case law, however, confirms that CMS’ assertion of authority under section 1115A to mandate a demonstration

model is misplaced. In recent years, courts have continued to make clear that Constitutional limits inform the scope of agency authority. In particular, grants of authority to agencies must be narrowly construed and delegations of broad authority should not be presumed to exist. For example, the Supreme Court has been explicit that agencies must have clear Congressional authorization to exercise extraordinary regulatory authority (*W. Virginia v. Env't Prot. Agency*, 597 U.S. 697, 732 (2022)). “Agencies have only those powers given to them by Congress, and ‘enabling legislation’ is generally not an ‘open book to which the agency [may] add pages and change the plot line.’” *Id.* at 723. As such, Congress does not typically use “modest words,” “vague terms,” “subtle devices,” or “oblique or elliptical language” to empower an agency to make a fundamental change to a statutory scheme. *Id.* (citing *Whitman v. American Trucking Assns., Inc.*, 531 U.S. 457, 468 (2001); *MCI Telecommunications Corp. v. American Telephone & Telegraph Co.*, 512 U.S. 218, 229 (1994)). See also *Biden v. Nebraska*, 143 S. Ct. 2355, 2372–75 (2023) (Congress did not provide “clear congressional authorization” for the Secretary to act in ways that would in effect fundamentally revise the statutory scheme).

Mandating provider participation in TEAM (and other CMMI models) transforms the methodology through which providers receive Medicare payments from the statutorily mandated, predictable prospective payment system to interim, uncertain payments, and potentially recoupable losses. No such authorization exists or should be presumed to exist here—Congress has not included in the authorizing statute any statements indicating that it intended to and actually did delegate its lawmaking role to CMS to require providers to accept this different, unpredictable payment scheme in lieu of full IPPS payments for these services. Rather, § 1115A(g) indicates Congress reserved the authority to adopt such fundamental alterations for itself.

Notably, were Congress to have clearly articulated such a broad delegation of authority to CMS to alter the Medicare reimbursement scheme (again, it has not), it would need to provide intelligible principles defining the scope of its delegated authority to ensure such a delegation to the agency was constitutionally sound. This is especially true because Congress precluded administrative or judicial review of a substantial number of matters of CMMI demonstration authority under section 1115A(d)(2) to permit the testing of models.

Separately, requiring Medicare providers to participate in TEAM Track 2 or 3, which require participants to be held financially accountable if spending on specified episodes of care exceeds the model’s reconciliation target price, means that Medicare providers will be required to furnish medically necessary services to Medicare beneficiaries without payment. CMS has previously taken the position that mandatory demonstrations with two-sided risk do not reduce guaranteed Medicare benefits because model participants are required to provide medically necessary covered services even if such services are not separately payable.<sup>2</sup> But, this approach fails to justly compensate Medicare providers for the use of their services by Medicare beneficiaries in violation of the Fifth Amendment of the United States Constitution and the Medicare Act.

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<sup>2</sup> *E.g.*, 85 Fed. Reg. 61,114, 61,141 (Sep. 29, 2020) (noting that the proposed model would not result in a reduction of guaranteed Medicare benefits because participants are required to continue to make medically necessary covered services available to beneficiaries to the extent required by law.”).

The Proposed Rule briefly addresses a fully voluntary model as an alternative considered but concludes that it “would not lead to meaningful evaluation findings especially since the CMS Innovation Center has tested voluntary episode-based payment models for over a decade” (89 Fed. Reg. at 36,390). If CMMI has exhausted meaningful, voluntary testing and believes that an expansion to a mandatory model is appropriate, the appropriate path is not implementation of a mandatory CMMI demonstration. Rather, the Secretary’s authority under section 1115A in such a case is limited to providing appropriate recommendations to *Congress* for “legislative action to facilitate the development and expansion of successful payment models.”

In sum, CMS’ proposal of the mandatory TEAM demonstration is an overreach of agency authority that contradicts the statutory mandate of section 1115A and raises concerns about impermissible delegation of lawmaking authority to the executive branch and unjust compensation for services provided to Medicare beneficiaries. These concerns are particularly acute in light of the extraordinary breadth of the proposed demonstration: Approximately 25 percent of eligible CBSAs would be selected and all subsection (d) hospitals within selected CBSAs would be required to participate in all five episode-based payment models that are part of the TEAM demonstration. **Because section 1115A does not authorize mandatory payment demonstrations, we strongly oppose the implementation of the TEAM demonstration as proposed. Instead, we urge CMS to ensure that all CMMI models are voluntary and designed to test—at an appropriate scale—alternative payment models.**

### ***REFINEMENTS TO TEAM***

As articulated above, the FAH’s first-order of concern is that CMS does not have adequate statutory authority to implement a mandatory model of the scope proposed for TEAM. We also, however, describe concerns about the TEAM proposal, and recommend improvements to address those concerns, in the event CMS chooses to proceed with implementing TEAM as proposed. Additionally, if CMS moves forward with a voluntary model, we think many of the following revisions would be appropriate for any version of TEAM moving forward.

### **EPISODE SELECTION AND DESIGN**

CMS is proposing to create TEAM using a 30-day bundle for five surgical episode categories, including:

- Coronary Artery Bypass Grafting (CABG)
- Lower Extremity Joint Replacement (LEJR)
- Surgical Hip / Femur Fracture Treatment (SHFFT)
- Spinal Fusion
- Major Bowel Procedure

Each hospital participating in the TEAM demonstration would be held accountable for costs during a 30-day period after discharge or procedure for all five surgical episodes. CMS proposes similar exclusions as in BPCI-A and would cancel an episode if the patient dies during the admission or procedure.

While episodes vary based on complexity and nature of post-acute care needs, the FAH supports CMS testing of a 30-day episode length but encourages CMS to give hospitals flexibility to choose which surgical episode they will participate in. The FAH encourages CMS to exclude from TEAM patients that expire anytime in the 30-day episode. In addition, the costs for patients that typically receive inpatient rehabilitation can be higher due to the intensive therapy and care provided in inpatient rehabilitation facilities (IRF). However, the nature of the 30-day bundle would not incentivize using this care – even when it may be the best for the patient. We urge CMS to adjust the episode target amounts to address MS-DRGs or cases where IRF care is needed but where the benefits and potential long-term savings of receiving IRF care falls outside of the 30-day bundle.

The FAH also has specific concerns about changes to the DRGs for the spinal fusion and bowel procedure episodes, as well as concerns about lumping inpatient and outpatient procedures together in the LEJR and spinal fusion episodes.

#### *Proposed MS-DRG Changes in Spinal Fusion*

CMS initially proposed to include spinal fusion episodes commencing with an inpatient anchor admission under MS-DRGs 453, 454, 455, 459, 460 471, 472, or 473, or an anchor outpatient procedure identified by HCPCS codes 22551, 22554, 22612, 22630, or 22633. However, elsewhere in the proposed rule,<sup>3</sup> CMS proposed extensive changes to a broad range of spinal fusion and related MS-DRGs. Proposed changes include changes to the MS-DRG grouper logic for some spinal fusion MS-DRGs (MS-DRGs 456, 457, and 458), changes to ICD-10-PCS codes for spinal fusion procedures, wholesale modifications to some of the spinal fusion MS-DRGs proposed for inclusion in the TEAM spinal fusion episode (MS-DRGs 459 and 460), the elimination of certain spinal fusion MS-DRGs proposed for inclusion in the TEAM spinal fusion episode (MS-DRGs 453, 454, and 455), and the creation of new spinal fusion MS-DRGs.

On May 31, 2024, CMS issued a correction to the 2025 IPPS/LTCH proposed rule that also addressed the disconnect between the spinal fusion episode proposed for TEAM, and the spinal fusion MS-DRG changes proposed for Fiscal Year 2025.<sup>4</sup> The agency clarified that if the proposed changes to the spinal fusion MS-DRGs are finalized, those definitions will govern the services and procedures that compose the spinal fusion TEAM episode (by implication, if those proposed changes are not finalized, the TEAM spinal fusion episode would be constructed from the current configuration of spinal fusion MS-DRGs).

The proposals are major changes to the MS-DRG logic that add single and multiple levels to the MS-DRG consideration. There is not a 1-to-1 mapping with this changing for the various single and multiple levels within the MS-DRGs that are new, deleted or revised. Comparisons between FY 2025 and any prior year would not be an “apples to apples” comparison. The proposed changes will create a disconnect between the data used to set the target prices for the spinal fusion episode, which will be based on the prior composition of these MS-DRGs, and the MS-DRGs which hospitals will submit for payment under traditional FFS Medicare. Further,

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<sup>3</sup> Sections II(C)(6)(a) and II(C)(6) (b), pp. 35970-35985.

<sup>4</sup> *Federal Register*, Vol. 89, No. 108:47884, June 4, 2024.

given that each PY's target prices will be set using a rolling three-year period of claims data, if the proposed MS-DRG changes are finalized, several of these three-year periods will contain a mix of MS-DRGs under prior definitions and current definitions. This has the potential to reduce transparency of how the target prices are calculated, introduce heterogeneity and volatility in the data used to calculate those prices, and in the most extreme cases, result in target prices that are set based on a different mix of services than those actually provided in TEAM spinal fusion episodes.

The FAH believes CMS should describe how it will crosswalk prior and current spinal fusion MS-DRGs, and how the agency will approach year-over-year volatility in TEAM target prices that may occur given changes in the definitions of the spinal fusion definitions over time. MS-DRG changes often lead to volatility and potential future refinements, selecting spinal fusion for inclusion in the TEAM demonstration seems like an added complexity that could lead to difficulty for hospitals trying to manage care under the proposed model. We recommend that CMS consider delaying the incorporation of a spinal fusion episode in TEAM until the agency is able to monitor the impact of the new MS-DRGs and has three years of data based on the new groupings, in order for TEAM participants to understand the applicable target prices and needed efforts to manage 30 days of care post-discharge.

**If CMS moves forward with a mandatory model, the FAH urges CMS to remove the spinal fusion episode.**

#### *Proposed MS-DRG Changes in Bowel Procedures*

CMS also proposes a TEAM episode for major bowel procedures, identified as inpatient anchor admissions under MS-DRGs 329, 330, and 331. Here, the FAH has concerns similar to those we articulate with respect to the spinal fusion TEAM episode, above, given CMS' proposed shift in procedures from MS-DRGs 347, 348, and 349 to MS-DRGs 329, 330, and 331 (the MS-DRGs that compose the TEAM major bowel procedure episode, in its entirety). We similarly urge CMS to reconcile the different composition of these MS-DRGs for purposes of setting TEAM episode prices, and to delay the inclusion of this episode in TEAM if the agency is unable to do so timely.

#### *Setting Episode Target Amounts Using both Inpatient and Outpatient Procedures*

For episodes that include both inpatient and outpatient cases (LEJR and spinal fusion) CMS proposes to create a single target price for use with either the outpatient case and the inpatient case for MS-DRGs without major complications and comorbidities. CMS proposes this methodology because they say such inpatient and outpatient cases have "similar clinical characteristics." However, the clinical characteristics of such patients are not similar: patients who need to remain in the facility overnight are ones who are clinically not able to have the procedure on a purely outpatient basis. In addition, the cost structure of these two types of cases is not similar. The FAH recommends that CMS set target prices for the inpatient cases without MCC separately from the targets for the outpatient cases for LEJR and spinal fusion.

### *Risk Adjustment for Emergency Cases*

FAH members have raised significant concerns about the substantial cost difference in those procedures that are done on a scheduled basis, compared to those that are done on an emergent basis. In establishing episodes under TEAM, CMS proposes at §512.525(f) to exclude certain services, including MS-DRGs that group to the “trauma medical” category of diagnoses. However, the agency proposes no similar exclusion for emergent surgical cases. To ensure that TEAM major bowel procedure episode prices reflect those costs most in the ability of hospitals to control, **the FAH recommends that CMS adjust for emergency cases in the calculation of TEAM episode target prices and in the calculation of spending against which the TEAM participant would be held accountable.**

### **DEFINITION OF SAFETY NET HOSPITAL**

For the purposes of the TEAM demonstration, CMS defines safety net hospitals and rural hospitals, and flexibilities that would be afforded to these providers. CMS considered several definitions of safety net providers including the CMMI Strategy Refresh definition (acute care and critical access hospitals whose patient mix of beneficiaries with dual eligibility or Part D LIS exceeds the 75th percentile threshold for all congruent facilities who bill Medicare), MedPAC’s Medicare Safety Net Index (MSNI, calculated as the sum of (1) the share of the hospital’s Medicare volume associated with low-income beneficiaries; (2) the share of its revenue spent on uncompensated care; and (3) an indicator of how dependent the hospital is on Medicare), and using the Area Deprivation Index to identify hospitals in geographic areas with socioeconomic challenges. After considering the options, CMS proposes to use the CMMI Strategy Refresh definition of safety net hospitals within TEAM.

The FAH appreciates CMS’ concern and consideration of safety net and rural hospitals and the impact the model could have on their financial stability. Hospitals play a crucial role as safety-net providers by making essential services available to the uninsured, underinsured, and other populations that face barriers to accessing healthcare. Hospitals are uniquely obligated to open their doors to patients and provide emergency services regardless of income or coverage under the Emergency Medical Treatment and Active Labor Act (EMTALA), and hospitals serve their communities well beyond the scope of their legal obligations, providing services that would not otherwise be available in the community, supporting outreach and coverage expansion efforts, and supplementing safety nets with charity and uncompensated care. Particularly in rural areas, hospitals are lifelines to care, providing vital access to a broad continuum of services, and recruiting and retaining professionals in underserved communities. These safety-net activities are undertaken by hospitals regardless of ownership type.

The FAH supports a broad understanding that reflects the full range of safety-net activities undertaken by hospitals, especially the provision of uncompensated care. While the FAH appreciates the aspects of safety net that are captured by hospitals treating high levels of dually eligible individuals and Medicare beneficiaries receiving low-income subsidies for Part D, we think a broader definition encompassing a hospital’s charity care and/or uncompensated care should also be considered to acknowledge hospitals safety net mission beyond Medicare.



**We urge CMS to consider a participating hospital a safety net hospital based on the following three criteria:**

- **Hospitals whose patient mix of beneficiaries with dual eligibility exceeds the 75th percentile threshold for all hospitals; or**
- **Hospitals whose Part D LIS exceeds the 75th percentile threshold for all hospitals; or**
- **Hospitals whose uncompensated care as a percentage of total costs exceeds the 75th percentile threshold of all hospitals.**

## **LOWER DISCOUNT RATE**

The FAH is concerned that the proposed discount rate of 3 percent is too large. **We recommend that CMS consider a lower discount rate if the agency proceeds to implement TEAM.**

As noted in this proposed rule, CMS has extensive experience fielding bundled payment models, such as Bundled Payments for Care Improvement (BPCI), BPCI-Advanced, and the Comprehensive Care for Joint Replacement (CJR) model. In TEAM, CMS proposes at §512.537 that episodes would begin with an anchor (inpatient) hospital admission or an anchor (outpatient) hospital procedure, end 30 days after discharge from the anchor admission or the date of the anchor procedure, and include most Part A and Part B covered services related to the anchor admission / procedure provided during that period.<sup>5</sup> CMS also proposes that the prices calculated for each TEAM episode would be subject to a 3 percent discount rate in the target price formula to ensure that CMS achieves savings of at least this amount on the program.

We are concerned that hospitals participating in TEAM will have undue difficulty keeping their episode costs under the discounted target price. Requiring a 3 percent discount before calculating shared savings/losses is very challenging in a model where the initial surgical procedure – that cannot be changed – is the biggest portion of the spending. For example, in the CABG and spinal fusion episodes, the vast majority of the 30-day cost is in the initiating procedure. For CABG, 87 percent of the target price would be accounted for in the MS-DRG payment and for spinal fusion 82 percent is based on the initial MS-DRG payment. This leaves minimal opportunity to lower costs after the discharge once the 3 percent discount is applied. The initial procedure spending and discounts leave little room for any needed variation in care and puts hospitals at too much risk.

The Medicare Payment Advisory Commission (MedPAC) projects 2024 Medicare margins are at near all-time lows at *negative* 13%. Importantly, MedPAC’s analysis also found that even for its group of relatively “efficient” hospitals’ median Medicare margins in 2022 were *negative* 3%. For a hospital forced to participate in TEAM that is unable to drive down post-discharge spending by more than 3 percent, that hospital’s payments would be further reduced by the TEAM demonstration. None of the other providers involved in providing care to patients during the 30-day bundle would be impacted, but the hospital – that is likely already losing money treating Medicare patients -- would be cut even more. The mandatory nature of this

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<sup>5</sup> Excluded services are defined at §512.525(f), and include admissions / procedures for certain diagnoses, new technology add-on payments, payments for certain drugs covered under Part B, *et cetera*.

model forces hospitals that are not financially able to withstand the added administrative costs and risk of payment cuts into a highly volatile financial quandary.

If CMS proceeds with the TEAM demonstration as proposed, the FAH urges CMS to require a lower discount rate to reflect the significant risk and potential financial jeopardy the model could create. **The FAH recommends that CMS use no more than a 1 percent discount in each of the years, or alternatively, a 2 percent discount in each of the first 2 years of the program followed by 1 percent thereafter to account for the compounding nature of a rolling baseline.**

## **ALLOW MORE TIME IN TRACK 1 WITHOUT DOWNSIDE RISK**

CMS proposes three risk tracks under TEAM (§512.520). All TEAM participants may start TEAM in Track 1 in the first Performance Year (PY) of the model; Track 1 is an “upside-only” track in which TEAM participants can earn bonuses for good performance but are not at risk for losses should they fail to meet TEAM objectives. Track 2 (asymmetrical upside risk (up to 10 percent) and downside risk (up to 15 percent)) is available to certain safety net and rural hospital participants<sup>6</sup> in PYs 2-5, while other TEAM participants would be required to move into Track 3 (up to 20 percent upside and downside risk) beginning in PY 2.

The FAH is concerned that the duration of Track 1 is too short before participating hospitals would be required to take on downside risk (*i.e.*, be exposed to the risk of losses). We are particularly concerned given CMS’ stated intention of over-sampling core-based statistical areas (CBSAs) with limited exposure to prior bundled payment models to select hospitals for participation in TEAM. We are also concerned that even safety net hospitals would be required to take on downside risk beginning in PY 2. We understand that part of CMS’ rationale for making TEAM a mandatory model is explicitly to avoid selection issues that come into play in voluntary models and ensure that safety net (and similar) hospitals will be included in TEAM. However, hospitals exhibit precarious financial performance under Medicare’s IPPS even at unreduced payment rates and hospitals with limited exposure to prior bundled payment models may unduly struggle under a track that puts them at downside risk under episode payment rates that include a 3 percent discount.

**We recommend that CMS expand an option for Track 1 to a minimum of two years for all participating hospitals.** Ideally all hospitals would be eligible to stay in Track 1 for two years given that, as proposed, TEAM is distinct enough from prior bundled payment models that prior participation in those models may not be enough to guarantee successful performance under TEAM. A longer glide path is needed for hospitals to succeed in the program. However, if CMS decides to deny hospitals a second year in Track 1, **at a minimum, the FAH strongly recommends that hospitals eligible to elect Track 2 (defined at §512.520) and hospitals in CBSAs with limited exposure to prior bundled payment models (identified at §512.515(c)(3)) be allowed to continue in Track 1 for at least an additional year beyond PY 1.**

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<sup>6</sup> Medicare-Dependent Hospitals, rural hospitals, Sole Community Hospitals, safety net hospitals, and Essential Access Community Hospitals.

## **LOW-VOLUME THRESHOLD**

CMS proposes a low-volume threshold policy under TEAM for purposes of reconciliation. This low-volume threshold would apply to total episodes across all episode categories in the baseline period for a given program year (PY). If a TEAM participant did not meet the proposed low-volume threshold of at least 31 total episodes across all episodes in the baseline period for PY1, CMS would still reconcile their episodes, but the TEAM participant would be subject to the Track 1 stop-loss and stop-gain limits for PY1. If a TEAM participant did not meet the proposed low-volume threshold of at least 31 total episodes in the applicable baseline periods for PYs 2-5, it would be subject to the Track 2 stop-loss and stop-gain limits for PY 2-5.

The FAH is concerned that the low-volume requirement is too low for allowing TEAM participants to effectively manage episodes with such small numbers. If CMS will not exclude them from the model, the FAH urges CMS to keep low-volume providers in Track 1 with only upside opportunity and no downside risk.

## **MODEL OVERLAP**

CMS proposes that a beneficiary could be in an episode in TEAM and be attributed to a provider participating in a total cost of care or shared savings model or program. This proposal would allow any savings generated on an episode in TEAM and any contribution to savings in the total cost of care model to be retained by each respective participant. The FAH supports this proposal and believes it may help coordinate care across models.

However, CMS also seeks comment on whether to require TEAM participants to notify ACOs and related entities that one of their aligned beneficiaries would be included in a model episode. The FAH opposes this administrative burden and urges CMS not to include as a program requirement for multiple reasons, including:

- CMS does not issue custom Medicare ID cards to ACO beneficiaries, they are not identifiable at admission by the hospital.
- ADT electronic delivery to an ACO entity costs approximately \$50K per instance to establish. With multiple ACOs in a market, implementation costs for individual ACO interfaces would be a financial burden on hospitals.
- CMS already has robust interoperability requirements regarding data sharing in other rules and should not need to duplicate those in the rules for this program.

## **BENEFICIARY NOTICE AND PRIMARY CARE REFERRALS**

As in CJR and BPCI, CMS proposes to require hospitals to provide the TEAM beneficiary with a notice prior to discharge. CMS provides the form and content for the notice. These notices are usually confusing for beneficiaries and most ignore them. For ER patients, patients with short stays, and patients with multiple conditions whose DRG can change from day to day, it is not physically possible to identify all of the beneficiaries who will be subject to the program prior to discharge. The FAH recommends that CMS provide information directly to all beneficiaries about the program in the impacted geographies and not require the hospital to

undertake the administrative burden of doing so. If CMS maintains this requirement, we urge CMS to allow hospitals to provide notices through multiple means of communication, including in-person forms, mail, email, and text communications.

CMS also is proposing to require participating hospitals to be able to produce on demand a list of all patients that received a beneficiary notice from the hospital. This requirement is overly burdensome and creates a significant administrative challenge for hospitals that may provide notices across multiple departments and sites, including emergency department patients that may not easily be identifiable as episode patients upon admission.

Additionally, CMS proposes to require hospital discharge plans for TEAM beneficiaries to include a referral to a primary care provider. CMS acknowledges that this requirement is not a part of the hospital conditions of participation and this requirement seems out of place given that the bundles covered under the TEAM program are procedural bundles where the surgeon is the most appropriate clinician needed for follow-up within 30 days. While instructions for patients to follow-up with their primary care provider may be common after discharge at most hospitals, the FAH recommends that this provision, which adds an administrative burden on TEAM hospitals, be removed from the TEAM demonstration.

## **RECONCILIATION WITH QUALITY PERFORMANCE SHOULD BE ASYMMETRICAL IN TRACK 2**

CMS proposes to use performance on the TEAM selected quality measures to create a composite quality score (CQS), that would be used to adjust reconciliation payments and repayments upwards or downwards, depending on the participant hospital's performance on the measures, with the percentage adjustment varying as a function of the TEAM participant's risk track. CMS' rationale for applying asymmetrical risk corridors in TEAM Track 2 – up to a 10 percent positive CQS adjustment, and up to a 15 percent negative adjustment – is that:

“We believe the CQS adjustment percentage of up to 15% for negative reconciliation amounts, is appropriate for Track 2 because it further limits a TEAM participant's financial risk given that a higher CQS adjustment percentage for negative reconciliation amounts results in a lower repayment amount.”<sup>7</sup>

However, we do not follow the logic behind this statement. By our read, such an asymmetrical risk arrangement would result in greater penalties for poor performance, relative to rewards for good performance, and we do not intuitively understand why this would be a desirable policy, especially given the composition of hospitals (e.g., safety net) that would likely elect Track 2. If the goal of Track 2 is to provide a more constrained risk arrangement for vulnerable hospitals compared to Track 3 (which is up to 20 percent upside and 20 percent downside risk), we believe a symmetrical 10 percent upside and 10 percent downside arrangement for Track 2 would be preferable. Therefore, **we urge CMS to reconsider Track 2's proposed risk arrangement, and we recommend that the agency implement parallel upside and downside risk of 10 percent for that track should the agency proceed with TEAM.**

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<sup>7</sup> *Federal Register*, Vol. 89, No. 86:36393, May 2, 2024.

## **FFS RULE WAIVERS UNDER TEAM**

Given the potential of TEAM to reduce Medicare spending and improve quality of care, CMS proposes to use its waiver authority under section 1115A of the Act to waive certain Medicare program rules for providers and suppliers furnishing services to TEAM beneficiaries, including telehealth waivers and the skilled nursing facility 3-day rule requirement. The FAH supports these waivers.

In addition, the FAH recommends that CMS offer a partial waiver of the IRF 60% Rule. The IRF 60% Rule requires that 60 percent of an IRF's patients fall within 13 conditions to qualify as an IRF. The FAH recommends that TEAM cases which are referred to an IRF and that do not qualify towards the 60% Rule under CMS-13 should not be counted in the denominator of the IRF's 60% Rule calculation. This recommendation is due to the view that a FFS facility classification rule should not interfere with the clinical discharge decisions of an at-risk acute hospital bundle participant in a value-based care framework. Similar to the rationale underlying CMS' proposal to waive the SNF 3-day stay rule in TEAM, the 60% Rule is a FFS "limiting" rule. TEAM, and other bundled models, establish inherent validity in the care decisions of the organizations and clinicians operating under an at-risk framework, and those decisions should not be encumbered by rules that would result in an IRF having to turn down the opportunity to treat a TEAM patient.

## **QUALITY MEASURES TO SUPPORT TEAM**

CMS is proposing the first three quality measures due to their: (1) Alignment with the goals of TEAM; (2) hospitals' familiarity with the measures due to their use in other CMS hospital quality programs, including the Hospital IQR and HAC Reduction Programs; and (3) alignment to CMS priorities, including the CMS National Quality Strategy which has goals that support safety, outcomes, and engagement. CMS believes the three quality measures reflect these goals and accurately measure hospitals' level of achievement on such goals. The three measures are:

1. Hybrid Hospital-Wide All-Cause Readmission Measure with Claims and Electronic Health Record Data (CMS Measure Inventory [CMIT] ID #356)
2. CMS Patient Safety and Adverse Events Composite (CMS PSI 90) (CMIT ID #135)
3. Hospital-Level Total Hip and/or Total Knee Arthroplasty (THA/TKA) Patient-Reported Outcome-Based Performance Measure (PRO-PM) (CMIT ID #1618)

The first two measures would be applicable to all episodes, while the third measure (THA/TKA PRO-PM) would only be applicable to LEJR episodes. CMS proposes that participants would use existing Hospital IQR program processes to report data and that performance would be publicly reported with a one-year lag (e.g., PY 1 performance would be reported in 2027). As noted below, CMS will adjust reconciliation amounts based on participants' quality performance, beginning in PY 1.

CMS also seeks comment on additional measures for future adoption, including three measures that are currently proposed for adoption in the Hospital Inpatient Quality Reporting (IQR) Program:

1. Hospital Harm – Falls with Injury electronic clinical quality measure (eCQM)
2. Hospital Harm - Postoperative Respiratory Failure eCQM
3. 30-day Risk-Standardized Death Rate among Surgical Inpatients with Complications (Failure-to-Rescue), a claims-based measure

If adopted, these measures would replace the CMS PSI 90 measure beginning in 2027.

***Recommendation: CMS should utilize measures that reflect the model patient population.***

The FAH appreciates CMS proposing measures that are already in use under other programs and which would not require participants to report new measures. Reporting quality measures requires resources and time that participants must absorb. Use of existing measures and reporting processes can significantly reduce burden and resource costs for participants.

However, the FAH is concerned that the proposed measures do not directly measure performance under the model. For measures to be meaningful, those selected must be focused on what the model is trying to accomplish and limited to the model's patient population to ensure participants have meaningful opportunities to improve quality and are held accountable under the model for care that is relevant to their care improvement efforts.

The proposed measures utilize hospital-wide measures. For example, the PSI-90 measure includes adverse events that are not generally linked to the proposed episodes and which historically have low volumes. This has been a similar challenge under past episodic models, like the CJR model. CJR participants have been highly frustrated that – given the breadth of hospital-wide measures such as the HCAHPS measure – they have limited opportunities to drive improvement, yet they are held financially accountable for performance on the measure. As a result, even if patients under TEAM had no readmissions or adverse events, this would have minimal impact on the hospital-wide measures due to the episodes representing only a portion of total hospital volume.

Additionally, since the inclusion of the hybrid measures into the IQR program, FAH members have experienced challenges with the data submission and reporting requirements and we request that CMS reconsider not only the timing sensitivities with the HWS and HWM measures but also the expected percentage threshold for submission. Most of the deficits uncovered are due to the timing of vital signs, patient body weight, and various lab tests being conducted and captured in the EHR within the rigid time frames specified within the measures. For example, we have found the following patient admission scenarios to be problematic:

- Surgical cohort patients who are scheduled for a procedure with an anticipated admission. This population of patients proves to be problematic because of the following:
  - Laboratory diagnostics are mainly captured in an outpatient setting before surgery.
  - Weight may be captured through the PAT screening prior to the surgical procedure date.

- Time-sensitive documentation elements such as weight, vital signs, and labs are impacted by the admission date/time, which can occur at any time during the surgical process at the surgeon's request. The problem with this scenario is that the patient can be under the care of the anesthesia team and surgeon mid-surgery while the admission takes place. The documentation of vital signs does not occur within an integrated system, as the anesthesia staff utilizes a standalone application. Furthermore, the patient may not be under the care of a clinician who would be documenting vital signs in the certified EHR until many hours later in some cases.
- Patient transfers from facilities in and outside of the organization.
  - For patients transferring from facilities within the organization, clinicians look at vital signs and lab values documented at the previous facility and exercise clinical judgment in many cases as to when to capture the next set of vital signs based on acuity.
  - For the patients transferring in from facilities outside the organization, the pattern of data missingness is unclear throughout the enterprise.
- Patients who are directly admitted through their PCP or otherwise.
- Patients in an observation status prior to inpatient admission.
  - Vital signs, weights, and pertinent lab tests are often captured in the ED prior to observation status.
  - Patients may remain in observation status for greater than 24 hours for clinical decision-making prior to an inpatient admission.
- Patients were admitted to inpatient rehabilitation within the facility. It is unclear at what point this population is excluded from the measure.

In the cases reviewed, there was not an overall omission of these core clinical elements for patients; instead, our members find the majority did receive the necessary assessments and lab values to guide clinicians in the plan of care and provide safe and effective patient care. However, there are often scenarios where the appropriate care does not match the measure's specifications.

It is also important to highlight that pre-anesthesia laboratory testing completed no later than 30 days before the planned surgical procedure is an industry-standard that is supported by the Association of periOperative Registered Nurses (AORN), particularly in the case of surgical cohort patients. Additionally, CMS has stated that surgical patients require "A pre-anesthesia evaluation completed and documented by an individual qualified to administer anesthesia, performed within 48 hours before surgery or a procedure requiring anesthesia services" in the CFR §482.52 Conditions of participation: Anesthesia services. According to the American Society of Anesthesiologists (ASA), a pre-anesthesia evaluation often comprises a variety of components, one of which is diagnostic laboratory testing; the details of this practice parameter can be viewed here. At this time, we believe there should be further due diligence to ensure that the specification accurately reflects data capture, clinical expectations, and industry standards.

Moreover, this issue is affecting other healthcare entities as well. A review of the ONC-JIRA CMS Hybrid Measure issue tickets on the ONC Project website reveals that many other

organizations are experiencing similar issues with the measure's complexity and the narrow timeframes in which these data elements can be captured in the EHR.

In addition to the items previously mentioned, there is significant apprehension around the lack of understanding and transparency as it relates to the calculation and output of results on the feedback reports. Specifically, there is a lack of understanding around when this will occur and how this impacts the percentage threshold for eCQM submission of core clinical data elements and linking variables. Several other healthcare entities have voiced concern about what is being produced within the output of their feedback reports on the ONC Jira Board, as well. Our members report that it takes several submission cycles to expose potential issues around submission calculation.

In bringing these concerns to light, **we urge CMS to review and reconsider not only the timing sensitivities with the HWS and HWM measures but also the expected percentage threshold for submission.** We understand that in an effort to acquire meaningful data, submission of these measures should be required. Additionally, we believe there is value in the submission of this data to identify any additional opportunities around the specification and calculation. Our concern is specifically around the IQR submission requirement for the expected percentage threshold associated with core clinical data elements and linking variable submission, as well as the potential update penalty for failure.

Additionally, the proposed hybrid readmissions and the THA/TKA PRO-PM measure are currently in their first mandatory reporting period for the hospital IQR program and should not transition to a pay-for-performance program prematurely. Specifically, the THA/TKA PRO-PM has been very difficult to collect and report due to:

- The degree of data collection burden and potential survey fatigue resulting in reduced response rates during the endorsement and rulemaking reviews.
- Hospitals are just gaining experience with this measure and are finding it extremely challenging and burdensome.
- The length of time over which data must be collected beginning with 90 pre-op to 425 days post-op.
- The measure involves fielding several pre-op surveys for risk adjustment purposes.
- Hospitals must achieve a minimum 50% response rate for the post-op survey.
- Patient eligibility (particularly if the patient meets an exclusion and therefore will not be included in the measure) is completed at the end of data collection. Because hospitals do not know who may or may not be excluded, each hospital will need to collect all information on every patient in order to achieve the minimum response rate.

**We urge CMS to delay the mandatory reporting of this measure in IQR from July 1, 2024, to January 1, 2025, at the earliest, to give hospitals more time to prevent the payment penalties that potentially hundreds of hospitals will incur because CMS failed to properly specify, and field test this measure. We also urge CMS to lower the 50% response rate requirement and include a minimum threshold.**



Another challenge with the proposed measures is they are a measure of inpatient performance, whereas the model includes both inpatient and outpatient episodes. For procedures that can be furnished in either the inpatient or outpatient setting, typically the patients who continue to receive care in the inpatient setting tend to be higher risk and with higher prevalences of complications, which can negatively impact performance on measures. A similar challenge has occurred in the CJR model.

There has been a significant shift in the volume of joint replacement procedures performed in outpatient settings. While CMS modified the CJR model to allow for outpatient procedures to trigger episodes, it did not update the quality measures included in the model. As a result, CJR participants are held accountable for complication rates for elective joint replacements that are conducted in the inpatient setting, but not outpatient. Patients who continue to receive elective joint replacements in the inpatient setting tend to be higher risk, which has negatively impacted performance on the complications quality measure.

Additionally, the shift to outpatient has also resulted in significantly lower inpatient volume, which can create volatility in quality measurement. **The FAH urges CMS to develop measures that are applicable to the episodes included under the model, including both inpatient and outpatient settings.** As part of this, CMS could consider alternative data sources, such as registry-based data, which are available for all proposed clinical episodes, except major bowel. CMS could adopt a similar approach to BPCI Advanced, allowing participants to select registry-based measures rather than claims-based measures.

CMS is considering the adoption of three new measures for TEAM that are also being proposed for adoption into the Hospital IQR Program. This includes two new electronic clinical quality measures (eCQMs), which are being added to the Hospital IQR Program as measures that hospitals can self-select to meet eCQM reporting requirements. **The FAH cautions CMS from adopting these new measures until such a time hospitals have had an opportunity to report and receive feedback under the Hospital IQR Program.**

While the measures are proposed for adoption into the Hospital IQR Program for the 2026 reporting period, it is important to note that the Hospital IQR Program is a pay-for-reporting program, which means hospitals will not be evaluated for their performance on these measures. Typically, CMS adopts the measures into the Hospital IQR Program prior to their adoption into its Hospital Value-Based Program (VBP), which provides hospitals with time to receive feedback on their performance and implement any necessary quality improvement changes. Adoption into TEAM will immediately transition these measures from pay-for-reporting into pay-for-performance measures, as participants under TEAM are held accountable for their performance.

Additionally, providers have faced a number of challenges with eCQM reporting. Feedback to hospitals about their performances on eCQMs is infrequent and seldom helpful as a basis for performance improvement. While the FAH is supportive of ongoing efforts by CMS to advance digital quality measurement, we caution CMS from adopting these measures into a pay-for-performance programs until such time it is able to address the eCQM data reporting challenges. These include difficulties extracting data from “production-ready” eCQM products delivered by developers and insufficient time to complete testing, validation, staff education and

rollout of eCQMs before their reporting is required. Costs to hospitals also remain a substantial obstacle to eCQM adoption.

Finally, the three measures under consideration are not specific to the episodes under the TEAM model and have not been collected in IQR. As a result, FAH is not supportive of CMS adopting the three measures into TEAM until such time hospitals have had time to report the measures for several years under the Hospital IQR Program.

## **HEALTH EQUITY**

In alignment with the Administration's goals, CMS proposes several policies focused on advancing health equity.

### *Health Equity Plans and Reporting*

CMS proposes that participants would be required to submit health equity plans to CMS in a form and manner and by the date(s) specified by CMS. Under this proposal, submission of a health equity plan would be voluntary in PY1 but would be mandatory in PY2 and subsequent years.

### *Demographic Data Reporting*

CMS proposes that participants would be required to report demographic data on aligned beneficiaries. Under this proposal, reporting would be voluntary in PY1. However, beginning in PY2 and subsequent performance years, participants would be required to report demographic data in a form and manner and by a date specified by CMS. CMS proposes that the demographic data would also be required to conform to USCDI version 2 data standards, at a minimum.

### *Screening for Health-Related Social Needs*

Beginning in PY1, CMS proposes that participants would be required to screen attributed beneficiaries for at least four health-related social needs (HRSN), such as but not limited to: *food insecurity, housing instability, transportation needs and utilities difficulty*. CMS also proposes that participants would need to report aggregated HRSN screening data and screened-positive data for each HRSN domain to CMS in a form and manner and by date(s) specified by CMS beginning in PY1 and for all following performance years. As part of this reporting, participants would also be required to report on policies and procedures for referring beneficiaries to community-based organizations, social service agencies or similar organizations that may support patients in accessing services to address unmet social needs.

CMS acknowledges that participants may already report some of this HRSN screening data through other CMS initiatives. For example, the Hospital IQR Program, which began mandatory reporting of two HRSN measures in CY 2024: the Screening for Social Drivers of Health measure and the Screen Positive Rate for Social Drivers of Health measure. CMS seeks comment on reporting processes that would streamline reporting of aggregated HRSN screening data for attributed beneficiaries, including potential use of the Hospital IQR Program measures.

*Recommendations:*

**CMS should not require the reporting of two additional health-related social needs (HSRN) measures outside of what is already being collected in IQR.** Two of the screening measures are not being collected in IQR, which means CMS would be increasing the data collection burden just for the TEAM population. Hospitals are still figuring out how to report the screening and screen positive measures, which are difficult to collect. The additional reporting requirements would be enforced unfairly through a pay-for-performance model without allowing hospitals to adjust to the reporting before holding them accountable for their performance.

CMS is also proposing to require hospitals to detail policies and procedures for referring beneficiaries to community-based organizations. CMS does not require this information in IQR nor has CMS detailed what the agency plans to do with the demographic data. Without a rationale for requiring the additional data, CMS is creating a data collection burden without a purpose.

CMS should focus on improving data collection and standardization, which is vital to providers' success in driving toward health equity. This would include utilizing standards that hospitals already have in place to advance health equity. CMS should also streamline its requirement for reporting health-related social needs data by allowing hospitals to fulfill this requirement through the reporting they are already doing for the Hospital IQR Program. As CMS notes, hospitals already are required to report the two screening measures as part of the quality reporting program. Requiring hospitals to report this data again through TEAM is duplicative of these efforts and asking hospitals to report additional demographic data not being collected elsewhere for accountability creates undue burden on participants.

## **GAINSHARING ARRANGEMENT**

Similar to the CJR Model, CMS is proposing that certain financial arrangements between a TEAM participant and a TEAM collaborator be termed “sharing arrangements.” These arrangements would be to share reconciliation payment amounts or repayment amounts. Where a payment from a TEAM participant to a TEAM collaborator is made pursuant to a sharing arrangement, CMS proposes to define that payment as a “gainsharing payment.”

Gainsharing payment eligibility for TEAM collaborators would be conditioned on two requirements: (1) quality of care criteria; and (2) the provision of TEAM activities. In this regard, CMS proposes that the amount of any gainsharing payments must be determined in accordance with a methodology that is solely based on quality of care and the provision of TEAM activities. CMS discusses that it considered whether this methodology could substantially, rather than solely, be based on quality of care and the provision of TEAM activities, but ultimately determined that basing the methodology solely on these two elements creates a model safeguard where gainsharing aligns directly with the model goal of quality of care and with TEAM activities.<sup>8</sup>

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<sup>8</sup> 89 Fed. Reg. 36,456 (May 2, 2024).

**The FAH urges CMS to reconsider this proposal and permit gainsharing payments to be based substantially, rather than solely, on quality of care and the provisions of TEAM activities.** This would permit more flexibility for TEAM participants to develop a gainsharing program that provides appropriate incentives for TEAM collaborators to meaningfully engage while ensuring quality of care and avoiding any potential fraudulent practices. It is critical that hospitals, as TEAM participants, be given flexibility to construct their gainsharing programs in ways most likely to succeed in their local environments. Further, many hospitals that would be TEAM participants already have developed programs using the “substantially based” criteria and maintaining that standard for the TEAM program would ensure consistency and familiarity. It also would be less burdensome across TEAM participants and collaborators that already have adopted effective practices based on the “substantial” threshold. Finally, meeting the “solely based” threshold may not practically be feasible because it is unclear how a methodology can be both “solely based” on quality and TEAM activities.

## DECARBONIZATION AND RESILIENCE INITIATIVE

CMS discusses a proposal for a voluntary Decarbonization and Resilience Initiative within TEAM to assist hospitals in addressing the threats to the nation’s health and its health care system presented by climate change and the effects of hospital greenhouse gas emissions on health outcomes, health care costs and quality of care. The voluntary initiative would have two elements: technical assistance for all interested TEAM participants and a proposed voluntary reporting option to capture information related to Scope 1 and Scope 2 emissions as defined by the Greenhouse Gas Protocol (GHGP) framework<sup>9</sup> with the potential to add Scope 3 in future years. CMS asserts that the surgical episodes under TEAM represent opportunities for hospitals to become more energy efficient, pointing to studies showing that although operating rooms represent a relatively small proportion of hospitals’ physical footprint, they typically consume 3-6 times more energy per square foot as the hospital as a whole, account for 40-60 percent of the hospital’s supply costs, and produce 30 percent of the hospital’s waste.<sup>10,11</sup>

While we understand that hospitals can be sources of emissions and add to global warming pressures, we believe that the importance of addressing climate issues through this voluntary climate initiative seems out of place and unrelated to the episode bundling program. That said, the effort appears to offer resources that hospitals generally, not just those in the model, might be able to pursue. We appreciate CMS’ deliberate intent to support hospitals in

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<sup>9</sup> Janet Ranganathan, Laurent Corbier, Pankaj Bhatia, Simon Schultz, Peter Gage, & Kjeli Oren. The Greenhouse Gas Protocol: A Corporate Accounting and Reporting Standard (Revised Edition). World Business Council for Sustainable Development and World Resources Institute. 2004. <https://ghgprotocol.org/sites/default/files/standards/ghg-protocol-revised.pdf>

<sup>10</sup> Andrea J. MacNeill, Robert Lillywhite, & Carl J. Brown. The Impact of Surgery on Global Climate: A Carbon Footprinting Study of Operating Theatres in Three Health Systems. *Lancet Planetary Health*, vol. 1, no. 9, pp. E381-E388. December 2017. [https://www.thelancet.com/journals/lanplh/article/PIIS2542-5196\(17\)30162-6/fulltext](https://www.thelancet.com/journals/lanplh/article/PIIS2542-5196(17)30162-6/fulltext)

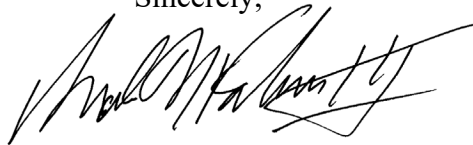
<sup>11</sup> Maya A Babu, Angela K Dalenberg, Glen Goodsell, Amanda B Holloway, Marcia M Belau, & Michael J Link. Greening the Operating Room: Results of a Scalable Initiative to Reduce Waste and Recover Supply Costs. *Neurosurgery*, vol. 85, no. 3, pp. 432-437. September 1, 2019. <https://pubmed.ncbi.nlm.nih.gov/30060055/>

their efforts to minimize their global footprint and we encourage the agency to look at other ways to make these resources available in a voluntary basis to all hospitals.

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The FAH appreciates the opportunity to offer these insights. We are committed to working with CMS to improve value and access to care for America's seniors. If you have any questions or would like to discuss further, please do not hesitate to contact me or a member of my staff at (202) 624-1534.

Sincerely,

A handwritten signature in cursive script, appearing to read "Michael R. ...". The signature is written in black ink and is positioned below the word "Sincerely,".