

June 2, 2026

Dr. Mehmet Oz  
Administrator  
Centers for Medicare & Medicaid Services  
Department of Health and Human Services  
7500 Security Boulevard  
Baltimore, MD 21244-1850

Re: Health Care Transformation Task Force Comments on the FY 2027 Hospital Inpatient Prospective Payment System (IPPS) and Long-Term Care Hospital Prospective Payment System (LTCH PPS) Proposed Rule (CMS-1849-P)

---

The Health Care Transformation Task Force (HCTTF) appreciates the opportunity to share recommendations on the FY 2027 Hospital Inpatient Prospective Payment System (IPPS) and Long-Term Care Hospital Prospective Payment System (LTCH PPS) Proposed Rule (CMS-1849-P). HCTTF believes these recommendations will help the Centers for Medicare & Medicaid Services (CMS) achieve the goal of increasing access to high-quality, value-based care (VBC) while eliminating waste, fraud, and abuse.

HCTTF is a non-profit collaborative dedicated to accountable care to drive outcomes, access, and affordability. Representing a diverse set of organizations from various segments of the industry – including providers, payers, purchasers, and consumer/patient advocacy organizations – we share a common commitment to transform our respective businesses and clinical models to deliver better health through high-quality care at reduced costs. We strive to provide a critical mass of policy, operational, and technical support that, when combined with the work being done by CMS and other public and private stakeholders, can increase the momentum of delivery system transformation.

Our comments address (1) Updates to the Hospital Inpatient Quality Reporting (IQR) Program (section IX of the proposed rule), (2) electronic Prior Authorization (ePA) within the Medicare Promoting Interoperability Program (section IX of the proposed rule), and (3) Expansion of the Comprehensive Joint Replacement (CJR-X) Model (section X of the proposed rule).

## **Inpatient Quality Reporting (IQR) Program**

---

### **I. Program and Measure Updates**

#### *Background & Proposal*

CMS proposes several updates to the Hospital Inpatient Quality Reporting (IQR) Program measure set intended to advance the agency's transition toward more digital, outcomes-focused quality measurement. Specifically, CMS proposes the addition of three new measures, including an Acute Care following Hospitalization for Diabetes beginning in FY 2029, as well as an

Advance Care Planning eCQM and Postoperative Venous Thromboembolism eCQM beginning in FY 2030. CMS also proposes to modify eight existing measures, primarily related to mortality and claims-based outcomes, and remove three measures from the program.

Figure: Proposed Hospital Inpatient Quality Reporting (IQR) Program Measure Updates

<b>New Measures</b>	
Excess Days in Acute Care After Hospitalization for Diabetes measure (FY 2029)	
Advance Care Planning eCQM (FY 2030)	
Hospital Harm-Postoperative Venous Thromboembolism eCQM (FY 2030)	
<b>Modified Measures (FY 2028)</b>	
Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate Following Acute Myocardial Infarction (AMI) Hospitalization measure	<b>Mortality Measures</b>
Hospital 30-Day, All-Cause, Risk Standardized Mortality Rate Following Heart Failure Hospitalization measure	
Hospital 30-Day, All-Cause, Risk Standardized Mortality Rate Following Pneumonia Hospitalization measure	
Hospital 30-Day, All-Cause, Risk Standardized Mortality Rate Following Chronic Obstructive Pulmonary Disease (COPD) Hospitalization measure	
Hospital 30-Day, All-Cause, Risk Standardized Mortality Rate Following Coronary Artery Bypass Graft (CABG) Surgery measure	
Excess Days in Acute Care after Hospitalization for Acute Myocardial Infarction	<b>Claims-based Measures</b>
Excess Days in Acute Care after Hospitalization for Heart Failure	
Excess Days in Acute Care after Hospitalization for Pneumonia	
<b>Removed Measures (FY 2030)</b>	
Venous Thromboembolism Prophylaxis (VTE-1) eCQM	
Intensive Care Unit Venous Thromboembolism Prophylaxis (VTE-2) eCQM	
Discharged on Antithrombotic Therapy (STK-02) eCQM	

## *HCTTF Recommendations*

HCTTF is broadly supportive of CMS's proposed updates to the IQR Program, including the agency's continued transition toward more digital, outcomes-focused quality measurement. HCTTF appreciates CMS's efforts to modernize hospital quality reporting through the adoption of additional electronic clinical quality measures (eCQMs), refinement of existing measures, and removal of measures that may no longer provide meaningful differentiation in performance. HCTTF supports CMS's broader goal of aligning quality measurement across programs while reducing fragmentation and promoting more actionable, patient-centered quality reporting.

HCTTF appreciates the opportunity to highlight several key considerations:

- **CMS should ensure that implementation timelines remain feasible and that hospitals are provided sufficient transition periods, technical assistance, and flexibility during phased implementation**, particularly for hospitals with more limited infrastructure or health information technology (IT) infrastructure and capacity.
- **CMS should maintain appropriate exception and hardship policies for rural, safety-net, and resource-constrained providers** as the agency continues transitioning toward mandatory digital reporting requirements. While HCTTF supports the long-term direction of digital quality reporting, providers may face operational and technical challenges associated with eCQM reporting and data standardization. Creating exception policies for rural and safety net providers ensures their continued engagement in Accountable Care Organizations (ACOs).
- HCTTF is broadly supportive of CMS's proposal to incorporate Medicare Advantage beneficiaries into quality measures used across the Hospital IQR Program in order to better reflect the full Medicare patient population treated by hospitals. Additionally, incorporating MA patient experience into inpatient hospital quality measures will become increasingly important over time as enrollment in the MA program continues to grow as a proportion of overall Medicare enrollment. **However, HCTTF emphasizes that these measures are designed to assess hospital quality and outcomes – not health plan performance – and therefore recommend these not be stratified or publicly reported by insurance type in ways that could inadvertently imply plan-level quality comparisons.**

**As CMS considers future measure development and refinement, HCTTF encourages the agency to prioritize measures that are clinically meaningful, appropriately risk-adjusted, and designed to minimize unintended consequences for hospitals serving medically complex or underserved patient populations, particularly in rural communities.**

## Medicare Promoting Interoperability Program

---

### II. Electronic Prior Authorization (ePA)

#### *Background & Proposal*

CMS is proposing to modify and phase in the existing Electronic Prior Authorization (ePA) measure under the Medicare Promoting Interoperability Program, including making electronic prior authorization reporting initially optional before transitioning to a required measure.

#### *HCTTF Recommendations*

HCTTF supports CMS's continued effort to advance interoperability and encourage more standardized, electronic prior authorization processes across the healthcare system. Payers actively continue to work towards improved data interoperability, and HCTTF encourages CMS to continue moving these efforts forward as improvements in data interoperability has proven benefits for patients, providers and care outcomes. The movement to ePA will reduce turnaround times to approve appropriate services and improve timely access to care, while maintaining appropriate controls to prevent fraud.

Although payers are required to implement and maintain ePA APIs, current policy does not require certified EHR vendors to enable connectivity, presenting challenges for payers that seek to reduce the provider burden associated with ePA. In order for electronic prior authorization (ePA) APIs to deliver on their promise, provider adoption must concurrently be addressed. Provider adoption remains limited in part due to a lack of certified capabilities within EHR systems. **The Task Force urges CMS to implement stronger provider-facing incentives and clear interoperability requirements for EHR vendors to ensure that providers can consistently use and benefit from the ePA API infrastructure.**

## Expansion of the Comprehensive Joint Replacement Model (CJR-X)

---

### III. Model Proposal and Structure

#### *Background & Proposal*

CMS proposes the Comprehensive Care for Joint Replacement – Extension and Expansion (CJR-X) model as a mandatory, nationwide episode-based payment model for lower extremity joint replacement (LEJR) procedures. This proposal is intended to build upon CMS's previous Comprehensive Care for Joint Replacement (CJR) model and further advance CMS's objectives of promoting value-based care, improving care coordination across the surgical episode, and enhancing accountability for cost and quality outcomes. A central feature of the proposed CJR-X model is the transition toward regional benchmarking for establishing episode target prices. Under this approach, hospital-specific target prices would be increasingly informed by regional spending patterns, with the intent of better reflecting local market conditions and encouraging performance alignment within geographic peer groups.

In addition, CMS seeks broad stakeholder input through a request for information (RFI) regarding the potential future inclusion of ambulatory surgical centers (ASCs) in episode-based payment models such as CJR-X and TEAM.

#### *HCTTF Recommendations*

HCTTF appreciates the opportunity to provide input on the structure of CMS's proposed CJR-X model. HCTTF recognizes CMS's continued efforts to advance episode-based payment models as a mechanism to promote value-based care, improve care coordination across the surgical episodes, and enhance accountability for cost and quality outcomes in Medicare.

HCTTF is broadly supportive of CMS's use of episode-based payment models, including the continued evolution of the CJR initiative. At the same time, stakeholders emphasize that the success of mandatory models is highly dependent on whether program design provides a realistic opportunity for providers to succeed across diverse market contexts.

In this regard, HCTTF highlights several key considerations for CMS as it finalizes the CJR-X model:

- **Regional benchmarking:** HCTTF urges CMS to carefully assess the implications of increased reliance on regional target pricing. While regional benchmarking may improve alignment with local market conditions, it also carries the risk of disadvantaging under-resourced hospitals or those with limited prior experience in bundled payment models. HCTTF is particularly concerned that, absent appropriate safeguards, some providers could experience sustained financial penalties without sufficient mechanisms for improvement or recovery, potentially creating a reinforcing cycle of underperformance. CMS should ensure that benchmark design appropriately accounts for variation in hospital resource levels, patient populations, and market dynamics. In particular, we urge CMS to offer meaningful safeguards to rural and under-resourced hospitals.
- **Financial sustainability of administrative benchmarks:** Orthopedic episodes are particularly prone to the "ratchet effect," in which costs are driven below sustainable levels due to previous cost savings being baked into current targets. While CMS's proposal to use regional rates – a form of administrative benchmarking – will somewhat mitigate this effect on the individual hospital level, the preponderance of orthopedic episodes across regions and payers for over a decade has driven down costs for these procedures at a market level. As a result, both historic benchmarks and even regional rates have baked in previous cost containment efforts, making it more challenging to find new ways to drive savings. Therefore, CMS must be particularly cognizant of setting administrative benchmarks at a sustainable level to ensure patient access for appropriate orthopedic procedures.
- **Support for transition and improvement pathways:** HCTTF encourages CMS to incorporate meaningful transitional support mechanisms and improvement-based adjustments within the model design. This includes consideration of lower CMS discounts for included rural and safety-net providers, performance improvement opportunities, and guardrails that allow hospitals with limited infrastructure or prior bundled payment experience to meaningfully adapt to the model over time.

- **Trend factor methodology and provider heterogeneity:** HCTTF recommends that CMS carefully evaluate whether proposed trend factor methodologies adequately capture variation across hospital types, geographic markets, and baseline cost structures. Ensuring methodological rigor and transparency in these adjustments will be critical to maintaining model credibility and fairness.
- **Operational readiness and implementation feasibility:** HCTTF emphasizes the importance of ensuring that hospitals have sufficient infrastructure, data capabilities, and technical support to succeed under mandatory participation. This is particularly important for rural, safety-net, and resource-constrained providers that may face greater challenges adapting to episode-based payment requirements.
- **Ambulatory surgical center (ASC) inclusion considerations:** HCTTF appreciates CMS's solicitation of feedback regarding the potential inclusion of ASCs in episode-based payment models such as CJR-X and TEAM. Similar to the hospital outpatient episodes that would be included in CJR-X, ASC patients are generally lower acuity and healthier than hospital-based populations. CMS has long included orthopedic procedures in previous episode-based models, including CJR, Bundled Payments for Care Improvement Advanced, and TEAM. This experience shows that outpatient procedures have structural differences in cost drivers and savings opportunities, particularly given the role of post-acute care in generating bundled payment savings. In addition, adding ASCs will introduce technical complexities related to the introduction of a third payment system for ASCs, in addition to the inpatient and outpatient hospital payments that are already included in CJR-X. Given these complexities, **HCTTF urges CMS to test the inclusion of these episodes for at least three years prior to introducing downside risk. This would give CMS time to test distinct benchmarking and risk adjustment methodologies to appropriately reflect differences in patient mix and care settings, while giving ASC participants time to evaluate their performance and implement quality improvement initiatives.**

HCTTF encourages CMS to focus on targeted refinements that enhance operational feasibility and provider sustainability. Such refinements will be essential to ensuring that CJR-X achieves its intended goals while preserving access to high-quality care across diverse hospital settings.

\*\*\*

The Task Force appreciates the opportunity to provide feedback on the FY 2027 Hospital IPPS and LTCH PPS Proposed Rule. Please contact Theresa Dreyer, the CEO of HCTTF ([theresa.dreyer@hcttf.org](mailto:theresa.dreyer@hcttf.org)) and David Goldstein, HCTTF Director of Policy and Strategic Initiatives ([david.goldstein@hcttf.org](mailto:david.goldstein@hcttf.org)) with questions related to these comments.

**Katie Boyer, MPPA**

Senior Director of Policy and Government Affairs  
agilon health

**Sean Cavanaugh, MPH**

Head of the Aledade Policy Institute  
Aledade, Inc.

**Keith Shah, MBA, PhD, FACHE**

Chief Network Officer  
Amazon One Medical

**Karen Johnson, PhD**

Vice President, Practice Advancement  
American Academy of Family Physicians

**Kevin Joyce**

Vice President, Insurance Networks and  
Business Advisory Services  
Atlantic Health

**Ashley Yeats, MD**

Vice President of Medical Operations  
Blue Cross Blue Shield of Massachusetts

**Todd Van Tol, MBA**

Executive Vice President, Health Care Value  
Blue Cross Blue Shield of Michigan

**Paul Hendley**

AVP of Value Program Strategy and  
Operations  
Blue Cross Blue Shield of North Carolina

**Zak Ramadan-Jradi, MD, MBA**

Head of Network Management & Strategy  
Cambia Health Solutions

**Rhonda Quintana, MBA**

Chief Revenue Officer  
Ceresti Health

**George Aloth, JD**

Co-Founder & CEO  
Chamber Cardio

**Eli Muhrer, MD**

Senior Medical Director  
Charlie Health

**Jessica Hohman, MD**

Associate Chief Medical Officer  
Cigna Healthcare

**Todd Gottula**

Founder, President  
Clarify Health

**Derek Novak, MBA**

System Senior Vice President of Population  
Health  
CommonSpirit Health

**Brandon Wilson, PhD, MHA**

Senior Director of Health Innovation, Public  
Health, and Equity  
Community Catalyst

**Allen Miller, MPH**

Principal & CEO  
COPE Health Solutions

**Joshua Habib, MBA**

Senior Vice President  
Covera Health

**James Hutchinson**

Director of Strategic Initiatives  
Curana Health

**Mark McClellan, MD, PhD**

Director  
Duke Margolis Center for Health Policy

**Erin Smith, JD**

Vice President of Payment Innovation  
Strategy  
Elevance Health

**Ashley Ridlon, MS**

Vice President of Health Policy  
Evolent

**Sophia Tripoli, MPH**

Senior Director of Health Policy  
Families USA

**Kendall Pittinger**

Managing Principal of Payer Partnerships  
Headway

**Chris Stanley, MD, MBA**

President of Populance  
Henry Ford Health

**Richard Lipeles, MPH**

Chief Operating Officer  
Heritage Provider Network

**Aaron DeBoer, MBA**

Executive Vice President  
Honest Medical Group

**David Nace, MD**

Chief Medical Officer  
Innovaccer

**Julie Stoss, JD**

Vice President of Government Relations  
Kaiser Permanente

**Ryan Anderson, MD**

Vice President, Clinical Care Transformation  
MedStar Health

**Shawn Gremminger, MPP**

President & CEO  
National Alliance of Healthcare Purchaser  
Coalitions

**Sinsi Hernández-Cancio, JD**

Senior Fellow for Health Justice  
National Partnership for Women & Families

**Alan Balch, PhD**

CEO  
National Patient Advocate Foundation

**Michael Eaton**

Senior Vice President of Strategy, Interim  
Boston Market President  
Navvis

**Dan Tasset**

Founder & Chairman  
NueHealth

**Joy Burkhard, MBA**

Executive Director & CEO  
Policy Center for Maternal Mental Health

**Seth Edwards, MHA**

Vice President, Population Health and  
Value-Based Care  
Premier

**Melanie Matthews, MS**

CEO  
PSW

**Sam Holliday, MBA**

CEO  
Oshi Health

**Christopher Riopelle, JD, MBA**

Co-founder, CEO  
Strive Health

**Jim Sinkoff, MBA, CPA**

Deputy Chief Executive Officer and Chief  
Financial Officer  
Sun River Health

**Julia Ivanova, MBA**

Senior Vice President of Growth and  
Partnerships  
Thyme Care

**Jessica Gubing, MS**

CEO  
UAW Retiree Medical Benefits Trust

**Judy Zerzan-Thul, MD, MPH**

Chief Medical Officer  
Washington State Health Care Authority

**Dan McDonald**

Co-Founder & CEO  
86Borders

**TASK FORCE MEMBERS:** agilon health • Aledade • Amazon One Medical American • Academy of Family Physicians • American Heart Association • Atlantic Health System • Blue Cross Blue Shield of Massachusetts • Blue Cross Blue Shield of Michigan • Blue Cross Blue Shield of North Carolina • Cambia Health Solutions • Ceresti Health • Chamber Cardio • Charlie Health • Cigna • Clarify Health • CommonSpirit Health • Community Catalyst • COPE Health Solutions • Covera Health • Curana Health • Elevance Health • Evolent • Families USA • Headway • Henry Ford Health • Heritage Provider Network • Honest Health • Innovaccer • Kaiser Permanente • Mark McClellan • MedStar Health • National Alliance of Healthcare Purchaser Coalitions • National Partnership for Women & Families • National Patient Advocate Foundation • Navvis • NueHealth • Oshi Health • Policy Center for Maternal Mental Health • Premier • PSW • Strive Health • Sun River Health • Thyme Care • Washington State Health Care Authority • UAW Retiree Medical Benefits Trust • 86Borders