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Dr. Mehmet Oz
Administrator
Centers for Medicare & Medicaid Services, Department of Health and Human Services,
Attention: CMS-1807-P
P.O. Box 8016
Baltimore, MD 21244-8016

June 9, 2025

Re: Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Policy Changes and Fiscal Year 2026 Rates; Requirements for Quality Programs; and Other Policy Changes [CMS–1833–P]

Dear Administrator Oz,

The Robert J. Margolis, MD Institute for Health Policy at Duke University (Duke-Margolis Institute or the Institute) appreciates this opportunity to comment on Fiscal Year (FY) 2026 updates to payment policies under the Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System (IPPS) and other changes to inpatient payment and coverage policies, henceforth known as the proposed rule.

About the Duke-Margolis Institute

Established with a founding gift through the Robert and Lisa Margolis Family Foundation, the Duke-Margolis Institute aims to generate and analyze evidence across health policy and practice to support the triple aim of health care–improving the experience of care, the health of populations, and reducing per capita cost. The Duke-Margolis Institute's activities reflect its broad multidisciplinary capabilities, fueled by Duke University's entrepreneurial culture. It is a university-wide program with staff and offices in both Durham, North Carolina, and Washington, DC, and collaborates with experts on health care policy and practice from across the country and around the world.

The mission of the Duke-Margolis Institute is to improve health and the value of health care through practical, innovative, and evidence-based policy solutions. The Institute's work includes identifying effective delivery and payment reform approaches that support the transition to accountable care by collaborating with subject matter expertise to identify pathways to increase the value of biomedical innovation to patients – both through better health outcomes and lower overall health care spending. Duke-Margolis's evidence generation strategy relies on our quantitative expertise, leveraging a range of health-related datasets through a variety of mechanisms, as well as qualitative research that focuses on leverage our network of payers, providers, manufactures, other industry sectors, and thought leaders.

## Introduction

In this notice of proposed rulemaking, the Centers for Medicare and Medicaid Services (CMS or the Agency) proposes a number of important policy changes and continuations that impact the trajectory of health care transformation. Acute care hospitals and long-term care hospitals play an important role in the delivery system and developing more innovative approaches in tertiary care can reduce costs and improve access for Americans. Much of our comments are informed by a range of research work at the Duke-Margolis Institute, including:

- *Engaging Specialists in Value-Based Payment Models:* In recognition of the increasing role of specialists in managing care across the patient journey, we have released several reports including a vision paper for the future of specialty care, a two-part article in *Health Affairs Forefront* that provides strategies to increase specialist engagement in accountable care models and value-based payment arrangements. Additionally, we submitted a comment letter on CMS' 2023 Request for Information (RFI) on an Episode-Based Payment Model.
- *Evidence-based strategies to address non-medical drivers of poor health and chronic disease complications:* Our research has generated evidence on innovative care delivery and payment reforms to address non-medical drivers of health, including North Carolina's Healthy Opportunities Pilots program.
- *Multipayer state-based health care reforms:* Duke-Margolis is the neutral convener of the North Carolina State Transformation Collaborative, which leverages multistakeholder collaboration to advance shared goals of improving population health, addressing health disparities, enhancing patient experience, relieving provider burden, and reducing costs. Key priority areas include aligning quality measurement, strengthening coordinated and accountable primary care, enhancing health disparities data, and improving data exchange to enable advanced coordinated care models. Lessons from this initiative are informing health reform efforts in North Carolina, other states, and the federal government.

Our comments focus on three major components of the proposed rule:

- *Transforming Episode Accountability Model (TEAM) RFIs:* Our comments commend CMS's continued commitment to TEAM with a focus on standardizing episode definitions, aligning quality measures, and leveraging EHR data as a first step towards longitudinal specialty care.
- *Inpatient Quality Reporting (IQR) Proposed Measure Modifications:* Our comments provide feedback on the proposal to remove SDOH measures from the Hospital IQR Program.
- Digital Quality Measures (dQMs) in Quality Reporting RFI: Duke-Margolis plans to respond more comprehensively on dQMs, interoperability, and data infrastructure in our response to CMS' Request for Information Health Technology Ecosystem (CMS-0042-NC)

## Transforming Episode Accountability Model (TEAM) RFI

These comments refer to the request for information in section XI.A. of the preamble in the proposed rule. TEAM, finalized in the FY 2025 IPPS/LTCH PPS final rule (89 FR 68986), is a mandatory episode-based payment model targeting five surgical episode categories—coronary artery bypass graft surgery,

lower extremity joint replacement, major bowel procedure, surgical hip and femur fracture treatment, and spinal fusion. TEAM aims to address inefficiencies in current hospital reimbursement system, Diagnosis Related Groups (DRGs), that often result in fragmented, uncoordinated, and/or duplicative care by further bundling payments for a greater number of services and holding participating practices accountable for cost and quality to a greater degree than in DRGs.

We share CMS' goal of leveraging payment reforms, like TEAM, to improve beneficiary care through care coordination, investment in health care infrastructure, redesigned care processes, and financial accountability for episode categories to reduce Medicare expenditures. We continue to support the timely development and testing of models that better integrate primary care with and specialty care providers and promote longitudinal co-management of patients to avoid high-acuity events, in particular those that nest within broader population-health reforms like accountable care organizations, which are best positioned to coordinate with specialists to reduce expenditures and improve outcomes. TEAM provides a foundation to build on for future longitudinal, condition-specific models. The TEAM model can inform future directions for specialty care by identifying patterns of inefficient utilization of health care services, improving beneficiary experience during care transitions of care, and incentivizing quality improvements for key surgical episodes. TEAM implementation could be further strengthened by integrating it within a broader strategy to advance longitudinal, person-level models.

TEAM presents an opportunity for developing standard ways to track and report a larger range of episodes, inclusive of quality measures, risk adjustment, and leveraging EHR data for an aligned approach to specialty care. One promising opportunity CMS could explore as a method for industry alignment on standardizing episodes is through using episode grouper software, like Patient-Centered Episodes of Care System™ ("PACES"), which assigns claims data to standardized episodes of care. There is also an opportunity to capture more longitudinal, condition-specific or person-level measures, including elective procedures and admission rates. By integrating episode-based data into CMS' shadow bundles, for example, payers and providers can gain aligned insights into resource use and clinical outcomes across specific conditions or procedures. While not a long-term solution, these shared data and "shadow bundles" can provide insight into where and how specialists are contributing to longitudinal patient outcomes and spending – and thus can become essential tools for primary care providers in delivering whole-person, coordinated care.

The proposal to align TEAM with the Hospital IQR Program for the Hybrid HWR measure and including claims- and EHR-based elements for quality measurement aligns with the CMS goals of creating a more meaningful and efficient quality measure set to reduce administrative burden. As noted in our 2026 MA Advance notice comments, we believe that better alignment – which will likely require legislative steps to build on administrative actions – will reduce participation burden, encourage comparability, and level the playing field across programs. Such a quality measurement strategy aligns well with our proposed transition to the use of electronic health data systems integral to such care systems, rather than FFS-based claims and encounter data which are not. Similar, aligned policy reforms could be leveraged in specialty care models, that utilize more meaningful outcome measures to engage these clinicians. For example, CMS could explore the use of accurate and standardized electronic data related to key beneficiary health risks for both more accurate risk adjustment and the "denominator" data for electronically based quality measures. This complementarity could both substantially reduce

administrative burdens, support needed data infrastructure investments to help practices get timely and accurate risk data to manage beneficiaries' care and go much further in supporting care improvement.

## Inpatient Quality Reporting (IQR) Social Determinants of Health Measures

These comments refer to the proposed removal of two social drivers of health (SDOH) measures beginning with the CY 2024 reporting period/FY 2026 payment determination: the Screening for Social Drivers of Health (SDOH-1) measure (adopted at 87 FR 49201 through 49215); and the Screen Positive Rate for Social Drivers of Health (SDOH-2) measure (adopted at 87 FR 49215 through 49220). These measures assess screening for all patients that are 18 years or older at the time of hospital admission for five health-related social needs (HRSNs): food insecurity, housing instability, transportation needs, utility difficulties, and interpersonal safety. CMS proposes to remove these measures under removal Factor 8, the costs associated with the measure outweigh the benefits of its continued use in the program.

We appreciate CMS' efforts to reduce administrative burden and advance meaningful measurement for providers and patients. However, we believe that removing the SDOH measures will be detrimental to CMS' priorities, the CMS Innovation Center's strategic vision to promote evidence-based prevention, and the Administration's priorities to Make America Healthy Again, while reducing waste and driving efficiencies. SDOH and HRSNs are estimated to account for up to 80 to 90 percent of the modifiable contributors to healthy outcomes for a population, particularly related to chronic disease risks. Evidence shows that identifying and addressing these factors can lead to improvements in primary prevention, empowering people to achieve their health goals, and reducing costly disease complications. Instead, we recommend that CMS develop a pathway to link SDOH screening measures to concepts related to well-being and nutrition, of interest to CMS as signaled by the RFI in section X.C.2.a of this proposed rule. For example, food insecurity screening results can help inform efforts to improve nutritional status and related health issues. Further, capture of SDOH measures also advances CMS' interoperability and digital Quality Measure (dQM) strategic roadmap by encouraging novel data sharing between and across health systems, behavioral health providers, and social services entities. Removing these measures will impede efforts to integrate and improve prevention-oriented health risk data, and stifle momentum on a key dQM goal, working towards integrating data across multiple sources.

We acknowledge that manually collecting and storing SDOH screening data can be costly and administratively burdensome for providers. Despite this, studies show that most health care providers believe that screening for HRSNs should be a standard part of care in hospitals, and a wide range of health care organizations are working on ways to reduce burden of data collection and improve their supports for addressing these nonmedical drivers. Rather than removing measures related to SDOH and HRSN screening, CMS should leverage this work by health care organizations to take steps to reduce the administrative burden associated with screening. Many hospitals are already using structured electronic screening tools, rather than manual processes, to collect data related to social needs. To further support hospitals in adopting less burdensome screening methods, especially for lower resourced hospitals, CMS could consider providing incentives and supporting technical assistance for hospitals to improve their digital infrastructure to collect, store, and share data related to SDOH. Leveraging best practices and lessons learned from initiatives involving screening for HRSNs and SDOH, including the CMS Innovation Center's Accountable Health Communities Model and state-based models like North Carolina's Healthy

Opportunities Pilots, could also be valuable for reducing administrative burden. Importantly, several existing initiatives support infrastructure for identifying needs, but also better link these efforts to accountability for addressing non-medical drivers of poor health.

## Quality Reporting RFI

As a follow up to previous, related RFIs, the Agency seeks input on a multitude of questions as it continues its path forward in the dQM transition. The questions range from eCQM challenges related to the transition to FHIR to data standardization and quality reporting, to provider-specific transition issues. As Duke-Margolis noted above, we respond to many of these questions in the Agency's technology RFI. Generally, we support a clear and effective path towards bulk FHIR-based standard measures for quality reporting and other applications, leveraging actionable use-cases in a clear vision of how it intends to move from its current eCQM strategy to Bulk FHIR based reporting. Implementation of FHIR will help expand access to health data and reduce administrative burden in the long-term. However, CMS should be mindful of the challenges some providers – especially rural, safety net, and other small providers – may face, including lacking the capital necessary to implement these certified technologies (many of which are also applicable to outpatient facilities). Additionally, some providers may require more than 24 months for the transition depending on the number of measures, other payers aligned with CMS' efforts, and other incentives that could support implementation.

## Conclusion

We appreciate the opportunity to comment on these important issues. If you have questions or require additional information, please contact Frank McStay at Frank.McStay@Duke.edu.

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