AMA
AMERICAN MEDICAL ASSOCIATION

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The Honorable Mehmet C. Oz, MD, MBA
Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
Hubert H. Humphrey Building, Room 445–G
200 Independence Avenue, SW
Washington, DC 20201

Re: File Code CMS–1849–P: Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals (IPPS) and the Long-Term Care Hospital Prospective Payment System and Policy Changes and Fiscal Year (FY) 2027 Rates; Requirements for Quality Programs; and Other Policy Changes.

Dear Administrator Oz:

On behalf of the physician and medical student members of the American Medical Association (AMA), I appreciate the opportunity to offer our comments to the Centers for Medicare & Medicaid Services (CMS) on the fiscal year (FY) 2027 Notice of Proposed Rulemaking (Proposed Rule) on revisions to Medicare payment policies under the Hospital Inpatient Prospective Payment System (IPPS) and the Long-Term Care Hospital Prospective Payment System (LTCH PPS), as well as updates to quality reporting programs and other related policies, published in the Federal Register on April 14, 2026.

The AMA offers the detailed comments below to provide targeted feedback on key provisions. We look forward to working with the Administration on these important policy proposals.

Executive Summary

The AMA's comments on the FY 2027 IPPS/LTCH PPS proposed rule address proposals across payment policy, quality programs, and innovation models. Several themes recur throughout our comments and reflect long-standing AMA positions on Medicare hospital payment policy. Our comprehensive recommendations are set forth in the full letter below; the following summarizes our major positions.

Hospital Inpatient Quality Reporting (IQR) Program. The AMA does not support inclusion of the Excess Days in Acute Care After Hospitalization for Diabetes measure, the Hospital Harm-Postoperative Venous Thromboembolism electronic clinical quality measure (eCQM), or the proposed modifications to five condition- and procedure-specific mortality measures in the IQR Program, citing insufficient measure reliability at current case minimums, the absence of socio-economic risk adjustment, the lack of a phased approach to risk model and Medicare Advantage (MA) integration changes, and growing evidence that readmission-based measures may contribute to unintended patient harm. The AMA supports the concept of the Advance Care Planning eCQM with revisions to the specifications and additional testing. The AMA opposes mandatory reporting of the Malnutrition Care Score and Hospital Harm eCQMs until further testing across a wider range of electronic health records (EHRs) and facility types is complete and supports the proposed removal of the VTE-1, VTE-2, and STK-02 eCQMs.

Hospital Readmissions Reduction Program (HRRP). The AMA does not support inclusion of the Sepsis Readmission measure in the HRRP and urges CMS to sunset the program, or at a minimum remove its existing measures, given growing evidence that the program's measures may be leading to unintended patient consequences and no longer capture the appropriate patient population.

Hospital Value-Based Purchasing (HVBP) Program. The AMA does not support inclusion of the five modified mortality measures in the HVBP Program for the reasons set forth in our IQR comments, which are referenced briefly above. The AMA is more supportive of the Adult Community-Onset Sepsis Standardized Mortality Ratio measure than other 30-day mortality measures and recommends that, if pursued, the sepsis bundle measure (SEP-1) be proposed for removal at the same time.

Medicare Promoting Interoperability (PI) Program. The AMA supports the proposed administrative burden reductions, including removal of the Office of the National Coordinator for Health Information Technology (ONC) Direct Review and ONC-Authorized Certification Body (ONC-ACB) Surveillance attestations. The AMA opposes removing the Automated Numerator Recording and Automated Measure Calculation criteria from the Certified Electronic Health Record Technology (CEHRT) definition. The AMA recommends retaining the Electronic Referral Loops measures as a reporting option, delaying the "using CEHRT" change to the Electronic Prior Authorization measure, and including a reconciliation mechanism with ONC's HTI-5 rulemaking in the final rule.

Graduate medical education (GME). The AMA appreciates CMS' amendments to the criteria for new residency programs and recommends that programs already within their cap-building window also benefit from this proposal. The AMA urges CMS to withdraw the proposed anti-discrimination requirements applicable to approved medical residency training programs and to continue to rely on the Accreditation Council for Graduate Medical Education (ACGME) and other oversight organizations to develop and enforce evidence-based accreditation standards.

Comprehensive Care for Joint Replacement–Expanded (CJR-X) Model. The AMA recommends that participation in CJR-X be voluntary rather than mandatory, that physician practices be permitted to manage episodes, that hospitals be required to involve physicians through steering committees and episode data sharing, that distribution arrangements with physicians be mandatory, and that meaningful protections be afforded to rural hospitals, safety-net hospitals, and hospitals serving dual-eligible patients. The AMA also recommends that CMS use existing Current Procedural Terminology (CPT) codes for telemedicine services rather than creating new G-codes, and that quality measures be revised to address reliability, data collection burden, and survey response rate concerns before being used for accountability.

Requests for Information (RFIs). The AMA supports the Center for Medicare and Medicaid Innovation's (CMMI) consideration of a voluntary opt-in period for physician-owned hospitals (POHs) in the Transforming Episode Accountability Model (TEAM) and urges the agency to design the opt-in as broadly as the statute allows, including non-grandfathered POHs. On the Ambulatory Surgical Center (ASC) Episode RFI, the AMA reiterates that any ASC-specific TEAM program must allow for voluntary, not mandatory, participation and must include a pathway for surgeons to voluntarily participate as episode managers. On the Emergency Care Access and Timeliness RFI, the AMA highlights the importance of addressing the emergency department (ED) boarding and overcrowding crisis, but the measure as drafted requires modifications so that it weighs the 4-hour boarding threshold more heavily, and stratify data by patient type to improve the accuracy and impact of the measure.

Our comprehensive recommendations are set forth in the full letter below:

Quality Programs

1. Hospital Inpatient Quality Reporting Program

CMS proposes the following three new measures for use in the IQR Program. The AMA offers the following measure-specific comments on the new measures:

Excess Days in Acute Care After Hospitalization for Diabetes beginning with FY 2029 payment determination

Recommendation:

- The AMA does not support the *Excess Days in Acute Care After Hospitalization for Diabetes* measure due to potential unintended consequences that may cause patient harm, the absence of socio-economic risk adjustment, and the lack of testing on the proposed expansion of the measure to include Medicare Advantage (MA) patients, the updated risk adjustment model, and the two-year data collection timeframe.

The AMA is concerned of the potential unintended negative consequences to patients that may result from measures that include readmissions as they may not capture the appropriate patient population due to their structure and timeframe.[1] [2] For example, the literature is beginning to show that the 30-day readmission measures based on administrative claims in the Hospital Readmissions Reduction Program (HRRP) may lead to increased mortality.

The AMA believes that additional analyses are needed before any new measure that includes readmissions is implemented. For example, it remains unclear to what degree the reported association of lower readmissions with higher mortality is found over longer or shorter time periods, such as one year or one week, as compared to the first 30 days post discharge. Gupta and co-authors report that the inverse association was still evident at one year.[3] To what degree are any positive or negative correlations related to all-cause mortality and/or readmissions versus the condition-specific outcome? It is also worth examining whether trends exist based on unadjusted data and adjusted data. Most of the studies identified through our search of the literature, including Dharmarajan et al., used risk-adjusted data. Most individual patient care decisions are not made with risk-adjustment in mind.[4] To better understand the outliers (those who are readmitted), there is a need to investigate and determine whether there are small, but important, associations between reduced readmission rates and patient mortality. Therefore, are we masking the issue by only examining the adjusted rates? Examination of unadjusted and risk-adjusted rates could help address this concern. We also believe that the timeframe of the readmission measures and whether the post-discharge period is appropriate must be reexamined.

In addition, this measure includes some of the same changes that CMS has made to the readmission measures in HRRP; specifically, the risk adjustment model was updated to use individual ICD-10 codes rather than the CMS Hierarchical Condition Category (HCC) model; the measure now includes MA beneficiaries; and the data collection timeframe is two years. How each of these changes impact the reliability and validity of the measure has not been provided in this submission, and we are concerned that without a phased approach, it will be extremely difficult for hospitals to determine their impact (e.g., what is the effect of the expansion to MA beneficiaries as compared to the reduction in the number of years of data used to calculate the measure). We also recommend CMS provide data on how hospitals'

[1] Graham, Kelly. Et al (2018). Preventability of Early Versus Late Hospital Readmissions in a National Cohort of General Medicine Patients. Ann Intern Med. Doi. 10.7326/M17-1724.
[2] Gupta, Ankar, et al. Association of the Hospital Readmissions Reduction Program Implementation With Readmission and Mortality Outcomes in Heart Failure. JAMA Cardiol. 2017.
[3] See Gupta
[4] Dharmarajan, Wang, Lin, et al. Association of Changing Hospital Readmission Rates With Mortality Rates After Hospital Discharge. JAMA. 2017;318:270-278.

performance shifts, since the potential impact on each hospital is critical to ensure that the results can be used to drive further improvement in patient care.

Lastly, we also question the lack of socio-economic factors in the risk adjustment due to evidence that hospitals with larger populations of economically disadvantaged patients perform poorly on the measures. We recognize that some of the measures have been tested to consider economic related variables; however, we do not believe the appropriate risk models were tested. The traditional approach of risk adjusting at the patient level may not be appropriate for measures where the measurement period includes care that is outside of the control of the hospital and a 30-day post-acute phase where the availability of community support and other resources directly impacts a patient's care. We believe that there may be community-level variables that affect the risk of readmission during the days following hospital admission; however, these variables are not currently addressed. Measures that extend beyond the hospital stay or that are outside the locus of control of the measured entity should continue to have socio-economic adjustments addressed and analyzed at different levels (e.g., patient, hospital, and community).

Due to these concerns and unanswered questions, the AMA does not support inclusion of this measure in the IQR Program.

Advance Care Planning eCQM Beginning with the FY 2030 Payment Determination

Recommendation:

- The AMA supports the concept of the Advance Care Planning electronic clinical quality measure (eCQM) but recommends that CMS revise the measure specifications, build in flexibility for state requirements and religious or cultural exclusions, and complete additional testing across a wider range of EHRs and facility types before adoption in the IQR Program.

The AMA supports the inclusion of a measure on this important aspect of care but believes that revisions to the specifications and additional testing are needed. It will be critical to ensure that there is sufficient flexibility in the type of documentation to ensure that hospitals can be compliant with any state requirements or limitations. In addition, an exception or guidance allowing the documentation to account for those individuals for whom a discussion would be contrary to their religious and/or cultural beliefs must be incorporated. Also, validity of the individual data elements was only assessed in one EHR system, and reliability was evaluated in only 18 facilities, which is insufficient for a measure of this complexity. Further testing is needed to ensure that these data can be collected across a wider range of EHRs and facilities of differing sizes and locations before inclusion in any program.

Hospital Harm-Postoperative Venous Thromboembolism eCQM beginning with the FY 2030 payment determination

Recommendation:

- The AMA does not support the *Hospital Harm-Postoperative Venous Thromboembolism eCQM* in the IQR Program due to the lack of evidence and testing to support the measure. We are concerned that if finalized, it will lead to misrepresenting hospitals' performance scores.

The AMA has several concerns regarding the measure, including the lack of evidence to support the inclusion of 30 days after discharge, the limited data element validity testing provided, and the lack of social risk factors in the risk adjustment model testing. Regarding the evidence, neither the logic model nor the evidence summary discuss this timeframe specifically. In addition, the data element validity testing was limited to two vendor systems, and it was difficult to determine if it assessed the ability to accurately and completely capture a postoperative venous thromboembolism (VTE) after discharge. Based on previous experience with data derived from EHRs, we would assume that there could be a

higher degree of missing data for these events since the sole data source for the measure is electronic health record systems and it is difficult for hospitals to track events after discharge.

Because the measure includes the 30 days after discharge, we expected to see testing of social risk factors in the risk adjustment model, but this information was not provided, nor was there any discussion of these variables' potential effect in the conceptual model. Developers must continue to conduct these analyses to understand the degree to which any one factor may sufficiently impact a hospital's performance score and may justify its inclusion in the model.

We believe that there is significant potential for misrepresentation of hospitals' performance scores given the concerns we outlined. As a result, the AMA does not support inclusion of this measure.

2. Modifications

CMS proposes modifications to five mortality measures beginning with the FY 2028 payment determination. The AMA offers the following measure-specific comments on the mortality measures:

- *Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate Following Acute Myocardial Infarction (AMI)*
- *Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate Following Heart Failure*
- *Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate Following Chronic Obstructive Pulmonary Disease (COPD)*
- *Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate Following Coronary Artery Bypass Graft (CABG) Surgery*

Recommendation:

- The AMA does not support CMS' proposal to maintain the mortality measures in the IQR Program, even with the revisions made to the measures, given concerns about the lack of socio-economic risk adjustment, the absence of a phased approach to the simultaneous changes, and unresolved questions about the relationship between readmissions and mortality.

The AMA believes that additional analyses are needed before the revised measures are implemented. Like our concerns raised on the readmission and excess days in acute care measures, it is not clear to what degree the reported association of lower readmissions with higher mortality is found over longer or shorter time periods, such as one year or one week, as compared to the first 30 days post discharge. Gupta and co-authors report that the inverse association was still evident at one year.[5] To what degree are any positive or negative correlations related to all-cause mortality and/or readmissions versus the condition-specific outcome? It is also worth examining whether trends exist based on unadjusted data and adjusted data. Most of the studies identified through our search of the literature, including Dharmarajan et al., used risk-adjusted data.[6] Most individual patient care decisions are not made with risk-adjustment in mind. To better understand the outliers (those who died), there is a need to investigate and determine whether there are small, but important, associations between patient mortality and readmissions rates. Again, are we masking the issue by only examining the adjusted rates? Examination of unadjusted and risk-adjusted rates could help address this concern. We also believe that the timeframe of the mortality measures and whether the post-discharge period is appropriate must be re-examined.

In addition, this measure includes some of the same changes that CMS has made to the readmission measures in HRRP; specifically, the risk adjustment model was updated to use individual ICD-10 codes

[5] See Gupta infra
[6] See Dharmarajan infra

rather than the CMS HCC model; the measure now includes MA beneficiaries; and the data collection timeframe is two years. How each of these changes impact the reliability and validity of the measure has not been provided in this submission, and we are concerned that without a phased approach, it will be extremely difficult for hospitals to determine their impact (e.g., what is the effect of the expansion to MA beneficiaries as compared to the reduction in the number of years of data used to calculate the measure). We also recommend CMS provide data on how hospitals' performance shifts, since the potential impact on each hospital is critical to ensure that the results can be used to drive further improvement in patient care.

Lastly, we also question the lack of socio-economic factors in the risk adjustment due to evidence that hospitals with larger populations of economically disadvantaged patients perform poorly on the measures. We recognize that some of the measures have been tested to consider economic related variables; however, we do not believe the appropriate risk models were tested. The traditional approach of risk adjusting at the patient level may not be appropriate for measures where the measurement period includes care that is outside of the control of the hospital and a 30-day post-acute phase where the availability of community support and other resources directly impact a patient's care. We believe that there may be community-level variables that affect the risk of mortality during the days following hospital admission but are not currently addressed. Measures that extend beyond the hospital stay or outside the locus of control of the measured entity should continue to have socio-economic adjustments addressed and analyzed at different levels (e.g., patient, hospital, and community).

Due to these concerns and unanswered questions, the AMA does not support inclusion of these measures in the IQR Program or the Hospital Value-Based Purchasing (HVBP) Program.

Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate Following Pneumonia

Recommendation:

- The AMA does not support inclusion of the pneumonia mortality measure in the IQR Program, even with the revision, due to lack of reliability and ongoing concerns associated with the mortality measures.

We reiterate the same concerns we expressed about the other mortality measures. In addition, the minimum sample size must be increased for this measure to produce an intraclass correlation coefficient (ideally 0.6 or higher) for all hospitals, since we consider the minimum achieved with 25 admissions (0.264) to be too low. Due to these concerns and unanswered questions, the AMA does not support inclusion of this measure in the IQR Program or the HVBP Program.

3. Mandatory Reporting

CMS proposes mandatory reporting of the following measures starting with the FY 2030 payment determination. The AMA offers the following measure-specific comments:

- *Malnutrition Care Score eCQM beginning with the FY 2030 payment determination*
- *Hospital Harm eCQMs beginning with the FY 2030 payment determination*

Recommendation:

- The AMA does not support mandatory reporting of the two eCQMs due to the lack of EHR standardization and readiness, and recommends that CMS complete further testing and provide hospitals additional time to ensure the valid capture of the required data elements across the various EHRs.

We believe that CMS must complete further testing and provide hospitals additional time to report, to ensure the valid capture of the required data elements across the various EHRs. The initial testing processes completed for these measures were insufficient to identify the ongoing challenges with data captured by EHRs, and measure specifications frequently lack alignment with current workflows. These issues were first identified in the final rule for the Inpatient Prospective Payment System where many hospitals alerted CMS to the challenges with data collection and submission of measures that leveraged data from EHRs. CMS must ensure that these data can be collected across a wider range of EHRs and facilities of differing size and location before reporting on any of these eCQMs becomes mandatory.

4. Measure Removals

Recommendation:

- The AMA supports CMS' proposal to remove the Venous Thromboembolism Prophylaxis (VTE-1) eCQM, Intensive Care Unit Venous Thromboembolism Prophylaxis (VTE-2) eCQM, and Discharged on Antithrombotic Therapy (STK-02) eCQM beginning with the FY 2030 payment determination.

The AMA supports CMS' proposal to remove the Venous Thromboembolism Prophylaxis (VTE-1) eCQM, Intensive Care Unit Venous Thromboembolism Prophylaxis (VTE-2) eCQM, and Discharged on Antithrombotic Therapy (STK-02) eCQM beginning with the FY 2030 payment determination. We appreciate CMS' ongoing evaluation of the IQR Program.

Medicare Promoting Interoperability Program

Proposed Updates to the Definition of Certified Electronic Health Record Technology (CEHRT) in the Medicare Promoting Interoperability Program

CMS proposes to revise the definition of CEHRT by removing references to four Office of the National Coordinator for Health Information Technology (ONC) health IT certification criteria effective January 1, 2027: "family health history," "patient health information capture," "automated numerator recording," and "automated measure calculation." CMS asserts that the functionalities reflected in these criteria are fully embedded in certified health IT, will be retained by developers without a certification mandate, and that CMS may finalize these changes independent of whether ONC finalizes the corresponding HTI-5 proposals.

Recommendation:

- The AMA supports the proposal, with significant modifications for the functionality criteria and opposes the removal of the measure calculation criteria.

The AMA supports the deregulatory intent underlying the proposal and has long advocated for regulatory parsimony in health IT requirements. Alignment between the CEHRT definition and ONC certification criteria is a long-standing AMA priority, and we recognize this proposal as broadly consistent with that principle. The four criteria targeted for removal, however, are not equivalent in function or risk, and CMS' treatment of them should not be equivalent either. We address them in two groups.

Family Health History and Patient Health Information Capture

Recommendation:

- The AMA recommends that CMS finalize the removal of references to (a)(12) and (e)(3) only if the final rule includes a defined monitoring and reinstatement framework. Specifically, we recommend:

    1. Annual joint CMS and ONC reporting on developer retention of the functionalities associated with each removed certification criterion, using a representative sample of certified Health IT Modules and a published methodology; and
    2. A defined reinstatement trigger providing that CMS will reinitiate rulemaking to restore the certification requirement.

The AMA conditionally supports removal of references to these two criteria from the CEHRT definition. CMS correctly notes that these functionalities are not identified as supporting any specific Medicare Promoting Interoperability (PI) Program measure and that the capabilities are widely embedded in certified health IT. Support is conditional because the AMA's experience with the health IT vendor market documents a recurring pattern. When certification requirements are lifted, vendors have in practice sunset features, migrated previously standard functionality into paid add-on modules, and deprioritized ongoing maintenance. Small hospitals, rural hospitals, critical access hospitals (CAHs), and physicians who practice in those settings absorb these costs disproportionately because they have less negotiating leverage with EHR developers and fewer resources to procure replacement functionality. Although these criteria do not support specific PI measures, the underlying functionalities (structured family history capture, patient information intake) remain clinically important to the physicians who use these systems to deliver care in eligible hospitals and CAHs.

These mechanisms convert a simple deregulatory action into a supervised deregulatory action, preserving the burden reduction CMS seeks while giving CMS and ONC the information and authority to intervene if the vendor market does not behave as CMS predicts.

It is also important to note that ONC proposed removing or revising several other certification criteria that directly support Medicare PI Program measures, including public-health-related and privacy and security criteria. As CMS described, ONC is moving to update the certification criteria to focus on functional, rather than standards-based, requirements. In our February 27, 2026, comment letter to ONC on this proposal, we urged ONC to proceed cautiously in moving to these new certification requirements, as this will add to the technological intricacies that small hospitals, rural hospitals, CAHs, and physicians who practice in those settings will have to manage and place further burdens on them. As the new ONC certification program rules are finalized, it is imperative that ONC and CMS ensure complete alignment between these new certification requirements and Medicare PI measures.

Automated Numerator Recording and Automated Measure Calculation

Recommendation:

- The AMA recommends that CMS withdraw the proposal to remove *Automated Numerator Recording* and *Automated Measure Calculation* from the CEHRT definition.

The AMA opposes removal of *Automated Numerator Recording* and *Automated Measure Calculation* criteria from the CEHRT definition. CMS' own rationale contradicts its proposal. In the preamble, CMS states that "health IT developers seeking to support customers participating in the Medicare Promoting Interoperability Program will need to continue to support reporting of numerators and denominators for certain Medicare Promoting Interoperability Program measures, including the Electronic Prescribing measure and Providing Patients Access to Their Health Information measure." A functionality that CMS

itself considers not optional for program participation should remain subject to certification. Removing the certification floor while retaining the reporting obligation shifts the risk of calculation error from developers to physicians and hospitals, who have no independent means to verify that their vendor's numerator and denominator logic remains accurate over time. In the absence of certification, there is no uniform standard, no testing infrastructure, and no independent quality assurance mechanism to catch calculation drift. Inaccurate measure calculations would produce inaccurate scores and unjust payment adjustments, with the downstream effect borne by hospitals and by the physicians who practice within them.

CMS is simultaneously projecting a multiyear trajectory toward performance measurement in the Medicare PI Program. CMS has issued a request for information on a performance Electronic Prior Authorization measure and a second request for information on a performance Unique Device Identifier measure. Performance measurement requires certified numerator and denominator infrastructure. Dismantling that infrastructure at the same moment CMS is signaling a shift toward measures that depend on it is internally inconsistent and creates a foreseeable operational gap.

The AMA recommends that CMS withdraw the proposal to remove Automated Numerator Recording and Automated Measure Calculation from the CEHRT definition. The Medicare PI Program scores most of its measures as a percentage (numerator divided by denominator), and CMS is also signaling a shift toward performance-based measures, including the proposed Electronic Prior Authorization and Unique Device Identifier measures, which depend on that same numerator and denominator infrastructure. If CMS is unwilling to maintain the certification floor that ensures accurate calculation of those measures, CMS should concurrently commit to reducing the program's reliance on percentage-based and performance-based measures.

ONC Direct Review and ONC-Authorized Certification Body (ONC-ACB) Surveillance Attestations

Recommendation:

- The AMA supports removing the ONC Direct Review Attestation and the ONC-ACB Surveillance Attestation from the Medicare Promoting Interoperability Program and urges CMS to carry the same outcome-measure focus and burden-reduction approach into the CY 2027 Physician Fee Schedule Proposed Rule for eligible clinicians.

The AMA supports the removal of the ONC Direct Review Attestation and the ONC-ACB Surveillance Attestation from the Medicare PI Program. Under these attestations, eligible hospitals and CAHs must affirm their cooperation with ONC Direct Review of their CEHRT and attest that they supported providers in performing CEHRT activities. The ONC Direct Review attestation is currently a required element of the PI Program, and a "No" attestation response could result in an eligible hospital or CAH failing to meet the minimum program requirements and not be considered a meaningful EHR user for the EHR reporting period, subjecting it to a downward payment adjustment. The ONC-ACB Surveillance attestation is optional, any response is acceptable and will not change a provider's meaningful EHR user status for the EHR reporting period.

We agree with CMS' focus on high-value, outcome measures, and the need to reduce administrative burden in providers' measure and attestation set. As we have commented several times, PI reporting burden is real, and the AMA seeks every opportunity to minimize it. We oppose "check the box" reporting that adds no real value and further burdens providers with extra administrative and reporting tasks. While we continue to support ONC Direct Review and ONC-ACB Surveillance, we do not believe that these should be attestation measures that could result in a provider receiving a downward payment adjustment. The AMA urges CMS to carry forward the emphasis on high-value, outcome measures to the

upcoming CY 2027 Physician Fee Schedule Proposed Rule, so that eligible clinicians can also see a reporting burden reduction similar to what is being proposed for eligible hospitals and CAHs.

Action Ahead of HTI-5

Recommendation:

- The AMA recommends that CMS include in the final rule a reconciliation mechanism providing that, if ONC finalizes the HTI-5 provisions with material departures from the proposals on which CMS has relied, CMS will promptly reopen a targeted comment period or issue an interim final rule with comment period with the final ONC requirements.

CMS states in the proposed rule that it does not believe ONC must finalize its HTI-5 proposed rule for CMS to finalize the CEHRT definition changes proposed in this rule. The AMA recognizes that CMS retains independent regulatory authority. The AMA is nonetheless concerned about the precedent this sequencing sets for the public notice and comment process. Stakeholders, including physicians, hospitals, and patient advocates, submitted comments to ONC on the HTI-5 proposed rule with the reasonable expectation that those comments would be meaningfully considered before the proposed changes take effect. When CMS finalizes policies that track HTI-5 proposals ahead of ONC's review of the HTI-5 comment record, CMS creates the appearance that ONC's rulemaking process is a formality. Future interested parties will have a reduced reason to invest the resources required to participate substantively in ONC rulemaking if CMS is prepared to adopt ONC's proposals independently and on its own schedule.

The AMA recommends that CMS include in the final rule a reconciliation mechanism providing that, if ONC finalizes the HTI-5 provisions with material departures from the proposals on which CMS has relied, CMS will promptly reopen a targeted public comment period or issue an interim final rule with comment period with the final ONC requirements. This reconciliation mechanism preserves CMS' independent authority while protecting the integrity of the ONC comment process and avoiding an extended period in which the CEHRT definition is misaligned with the final ONC Health IT Certification Program requirements.

Proposal to Remove the Support Electronic Referral Loops by Sending Health Information and Support Electronic Referral Loops by Receiving and Reconciling Health Information Measures Beginning with the EHR Reporting Period in CY 2028

Recommendation:

- The AMA recommends that CMS retain the Electronic Referral Loops measures as a reporting option under the Health Information Exchange objective. If CMS proceeds with removal, the AMA recommends delaying the effective date to no earlier than the EHR reporting period in CY 2029 and conditioning removal on documented improvements in TEFCA coverage and Health Information Exchange (HIE) accessibility for small, rural, and Critical Access Hospitals.

CMS proposes to remove the Support Electronic Referral Loops by Sending Health Information measure and the Support Electronic Referral Loops by Receiving and Reconciling Health Information measure from the Health Information Exchange objective beginning with the EHR reporting period in CY 2028. Following removal, eligible hospitals and CAHs would satisfy the objective by attesting "Yes" to either the HIE Bi-Directional Exchange measure or the Enabling Exchange Under the Trusted Exchange Framework and Common Agreement (TEFCA) measure, together with the Electronic Prior Authorization measure requirement. CMS characterizes network exchange as a more comprehensive indicator of meaningful health information exchange than point-to-point exchange of Consolidated Clinical Document Architecture (C-CDA) summary of care documents.

The AMA supports the long-term policy direction of advancing network health information exchange. Broad, scalable interoperability through health information exchanges (HIEs) and Qualified Health Information Networks (QHINs) under TEFCA holds real promise for improving care coordination and making longitudinal patient records available across settings. The AMA does not dispute that this is where the healthcare system is headed. However, we oppose the proposal as structured because it does not reduce burden. It shifts burden from one exchange pathway to another and does so on a timeline that disproportionately falls on the facilities least able to absorb it.

The program data CMS provides support retention, not removal.

CMS' own data establishes the case for retaining the Electronic Referral Loops measures rather than eliminating them. For the most recent program year for which data are available (CY 2024), 26.6 percent of reporting eligible hospitals and CAHs reported on the Electronic Referral Loops measures. That is not a trivial residual population; it represents more than one in four reporting facilities. CAHs are disproportionately represented within this group, with 33.1 percent of CAHs reporting on these measures compared to 23.9 percent of eligible hospitals. CAHs are, by statutory definition, small and geographically isolated facilities serving communities with limited healthcare infrastructure. They are precisely the hospitals least equipped to absorb the cost and operational disruption of transitioning to a new exchange modality on a compressed timeline.

The same data CMS relies on also establishes that TEFCA is not yet a mature alternative. Only 4.6 percent of reporting hospitals used the Enabling Exchange Under TEFCA measure in CY 2024. A network that 4.6 percent of the reporting population can currently meet cannot be the pathway to satisfying the Health Information Exchange objective. CMS' proposal effectively narrows the field to HIE Bi-Directional Exchange for hospitals without TEFCA access, which is itself subject to regional availability constraints discussed below.

Barriers to HIE and TEFCA participation for small, rural, and Critical Access Hospitals.

CMS specifically invites comments on whether there are barriers beyond those identified in the preamble that small hospitals, rural hospitals, and CAHs may encounter in reporting either the HIE Bi-Directional Exchange or Enabling Exchange Under TEFCA measure. The AMA identifies the following barriers, which are real, mutually reinforcing, and underweighted in CMS' analysis.

1. Direct financial cost. HIE membership fees and QHIN participation costs can be substantial for facilities operating on thin or negative margins. CAHs, by definition, serve low-volume rural populations and often operate on Medicare cost reimbursement that does not contemplate discretionary investment in new exchange infrastructure.
2. Geographic availability of HIEs. HIE coverage is not uniform across the United States. In several regions, the available HIE does not support the scale of bi-directional exchange CMS' measure requires, or no functional regional HIE is available at all. CMS should not assume that HIE participation is a universally accessible alternative.
3. EHR vendor limitations. Not all certified health IT products offer affordable, seamless integration with HIEs or TEFCA networks. Hospitals with limited vendor options may face costly contract renegotiations, premium integration modules, or system upgrades to achieve the integration required. This is the same vendor dynamic the AMA addressed in our comments on the proposed CEHRT definition changes. When CMS narrows the permissible pathways for satisfying a program requirement, it concentrates market leverage with the entities that control access to those pathways. The AMA's experience with the health IT vendor market is that such concentration leads to documented cost increases, not cost reductions, for the hospitals and physicians who must comply.

4. Workforce capacity. Small and rural hospitals and CAHs operate with limited health IT staff. The operational knowledge needed to evaluate, procure, implement, and validate a new exchange pathway is often not available in-house, and the staff time required for a transition of this nature competes directly with staff time needed for patient care.
5. Lack of technical assistance. CMS has not paired this proposal with a defined technical assistance program. Absent such assistance, the hospitals that most need support to transition are the hospitals least likely to secure it.

Retention does not impede progress toward network exchange. The trend data CMS cites already demonstrates that hospitals ready and able to participate in HIE or TEFCA are doing so voluntarily. Retaining the option ensures that hospitals not yet able to transition are not penalized for circumstances outside their control.

If CMS is determined to proceed with removal despite these concerns, the AMA recommends a phased transition structured as follows:

1. CY 2027: Retain all three reporting options (Electronic Referral Loops, HIE Bi-Directional Exchange, Enabling Exchange Under TEFCA). Use this period to publish measure specification guidance clarifying the minimum level of HIE or TEFCA participation that satisfies the applicable measure, and to publish targeted technical assistance materials for small, rural, and CAH settings.
2. CY 2028: Retain the Electronic Referral Loops measures as an optional reporting pathway and commit to an annual CMS and ONC assessment of TEFCA coverage, HIE regional availability, and documented transition costs for small, rural, and CAH facilities.
3. CY 2029 or later: Remove the Electronic Referral Loops measures only upon documented findings that TEFCA coverage and regional HIE availability are sufficient to support a reasonable transition for the currently affected 26.6 percent of reporting facilities, and only after CMS has established a defined hardship exemption for facilities with documented barriers to HIE or TEFCA participation.

This phased structure aligns with the established AMA preference, reflected in our comments on the Electronic Prior Authorization measure, for phased implementation of new program requirements, with optional reporting preceding active engagement, followed by mandatory reporting only when infrastructure readiness has been documented.

Physicians practicing in the affected hospitals and CAHs rely on functional referral and care coordination workflows for their patients. A poorly paced transition risks interrupting those workflows during the period when hospitals are configuring new exchange pathways. A measured, phased transition with documented infrastructure readiness as the precondition for full removal is the approach most likely to preserve continuity of care while advancing the interoperability objectives CMS and the AMA share.

Modifications to the Electronic Prior Authorization Measure Description

Recommendation:

- The AMA opposes the revised "using CEHRT" measure language and the linked certification specification as proposed for the EHR reporting period in CY 2027.

CMS proposes modifications to the Electronic Prior Authorization measure description beginning with the EHR reporting period in CY 2027: revising the phrase "using data from CEHRT" to read "using CEHRT." CMS states that the revised phrase "using CEHRT" is consistent with the availability of certified Health IT Modules that must be used to complete the action specified in the measure, referencing

the electronic prior authorization certification criteria finalized in the HTI-4 final rule. CMS makes a parallel proposal to specify the use of health IT certified to those criteria as required for the Electronic Prior Authorization measure.

The AMA has long advocated for the reform of prior authorization and for the movement of prior authorization to interoperable, standard electronic workflows. The adoption of Health IT Modules certified to the Da Vinci criteria is a direction that the AMA supports. The AMA's concern with this proposal is operational and timing, not substantive, and we offer targeted recommendations below.

The "using CEHRT" change is not a clarification. It is a new compliance requirement that should not be imposed in CY 2027.

CMS' own preamble establishes that "using CEHRT" is functionally a requirement to use Health IT Modules. That is a materially different compliance requirement than the one CMS finalized in the 2024 CMS Interoperability and Prior Authorization final rule, in which CMS stated that "gathering structured data from CEHRT would be achievable without additional certification criteria specific to the measure." Eligible hospitals, CAHs, and their EHR developers have been planning their CY 2027 electronic prior authorization implementations against the 2024 rule's compliance premise. Reversing that premise through a measure-description change, executed concurrently with a certification specification, represents a mid-stream change to the measure's compliance requirements without the adequate lead time physicians, hospitals, and developers need to respond.

Multiple implementation realities compound the timing problem:

1. The Certified Health IT Product List (CHPL) data available at the time of this comment indicate that the population of Health IT Modules is limited, and deployment of those modules to production environments in eligible hospitals and CAHs is at an early stage. The AMA has received reports from member physicians and group practices indicating that EHR developers have, in several cases, deployed electronic prior authorization functionality based on proprietary workflows or on implementation approaches that predate or differ from the finalized Da Vinci Implementation Guides. A measure description that requires compliance via certified modules in CY 2027 will disadvantage hospitals and physicians whose developers have invested in nonconforming or nonstandard implementations, independent of those hospitals' or physicians' good faith efforts to adopt electronic prior authorization.
2. CMS is concurrently proposing, in the 2026 CMS Interoperability Standards and Prior Authorization for Drugs proposed rule, to adopt updated versions of the Coverage Requirements Discovery, Documentation Templates and Rules, and Prior Authorization Support Implementation Guides. Until those updated guides are finalized and incorporated into certified Health IT Modules, eligible hospitals and CAHs face a moving target: certify today against one version of the guides, then reconfigure or recertify when the updated versions are finalized. Requiring "using CEHRT" compliance in CY 2027 against an unsettled implementation guide foundation is premature.
3. CMS proposes to make the Electronic Prior Authorization measure optional for CY 2027, which the AMA supports in principle. The optional framework does not resolve the concern, because hospitals that do elect to attest in CY 2027 (to earn the proposed 10 bonus points) would still be held to the "using CEHRT" certification requirement. The AMA's concern is that hospitals willing to participate early should not be penalized by a compliance standard set against a certification infrastructure that is not yet reliably deployed.

Recommendations on the "using CEHRT" change

1. Withdraw the revised "using CEHRT" measure language from the CY 2027 measure description. Retain the original "using data from CEHRT" language for the CY 2027 EHR reporting period (consistent with the optional reporting framework CMS proposes and which the AMA supports). This preserves the incentive for early adoption without locking hospitals into a certification compliance standard during the period in which certified Health IT Modules are still being deployed.
2. Effective for the EHR reporting period in CY 2028, phase in the "using CEHRT" language in parallel with a transition provision permitting alternative compliance pathways for eligible hospitals and CAHs whose EHR developers have deployed electronic prior authorization functionality that is on a documented trajectory toward certification. CMS should define the documentation required to qualify for this transition pathway in sub-regulatory guidance, coordinated with ONC, and the transition pathway should remain available for no less than two EHR reporting periods.
3. Effective for the EHR reporting period in CY 2029 or subsequent years, fully sunset the transition pathway and require the "using CEHRT" standard as the sole compliance path, with the standard anchored to the finalized versions of the Coverage Requirements Discovery, Documentation Templates and Rules, and Prior Authorization Support Implementation Guides.

This phased structure is consistent with the AMA's preferred approach to implementation of new certification program requirements. It is also the same phased structure we recommend for the transition of the Electronic Prior Authorization measure from optional to mandatory reporting. The two timelines should align.

Health IT Certification Criteria to Support the Electronic Prior Authorization Measure

Recommendation:

- The AMA supports the modular flexibility framework, with specific clarifications and protections.

CMS proposes to specify the use of certified health IT as required for the Electronic Prior Authorization measure. CMS clarifies in the preamble that an eligible hospital or CAH may attest to the measure using only those certified Health IT Modules necessary to complete the measure action in its specific prior authorization scenario, and that adoption of Health IT Modules certified to all three criteria is not required. CMS provides hypothetical clinical scenarios (the cardiology transthoracic echocardiogram example and the oncology positron emission tomography and immunotherapy example) to illustrate how Health IT Modules certified to different combinations of the three criteria can satisfy the measure under different workflow conditions.

The AMA addresses the timing, deployment, and regulatory dimensions of the certification specification in our comments above. This section addresses the substantive design of the modular flexibility framework, the attestation and audit questions raised by that framework, and a recommendation for ongoing transparency on deployment of Health IT Modules certified to the relevant criteria.

The AMA's long-standing advocacy on prior authorization includes support for standard electronic workflows that reduce administrative burden on physicians, accelerate care, and align payer and provider technology around interoperable approaches. CMS' proposed modular flexibility framework, properly designed, supports those objectives by allowing eligible hospitals, CAHs, and the physicians practicing in them to adopt only the certified Health IT Module functionality their actual prior authorization workflows require.

Modular flexibility is a structural protection against vendor cost concentration.

Beyond the appropriateness of allowing hospitals to match certified module adoption to their actual workflows, modular flexibility is a structural protection against an outcome the AMA has consistently flagged across our comments on this proposed rule. When CMS narrows the permissible pathways for satisfying a program requirement, EHR developers face reduced competitive discipline and have repeatedly bundled previously distinct functionality into premium modules priced as a package. A regulatory framework that allowed CMS to require, directly or indirectly, that hospitals adopt all three Health IT Modules would create that bundling pressure. CMS' proposed approach, in which a hospital's CEHRT may include Health IT Modules certified to one, two, or all three of the criteria depending on workflow needs, preserves competitive market structure on the developer side and protects hospitals and physicians from forced procurement of functionality they will not use. The AMA recommends that CMS preserve and articulate this framework explicitly in the final rule.

Audit and documentation requirements should be minimized.

The modular flexibility framework will require eligible hospitals and CAHs to document, for audit purposes, which certified Health IT Modules they used to satisfy the measure. CMS has not specified the documentation requirements in the proposed rule. The AMA recommends that CMS, in coordination with ONC, develop documentation requirements that rely on existing CHPL information and on the hospital's standard CEHRT documentation, rather than imposing new prior authorization recordkeeping. New documentation requirements would shift administrative burden onto the physicians and hospital staff who use the certified Health IT Modules, in tension with CMS' stated goal of reducing administrative burden through electronic prior authorization. The documentation framework should be specified in sub-regulatory guidance issued before the relevant effective date so that hospitals and developers can incorporate it into their compliance planning.

Recommendation for ongoing transparency on certified module deployment.

Implementation of the Electronic Prior Authorization measure will depend on the actual availability and deployment of Health IT Modules in eligible hospitals and CAHs. CMS and ONC are positioned to provide structured visibility into that availability through the CHPL. The AMA recommends that ONC publish, not less than semiannually, the count of Health IT Modules certified to each of the three criteria, the count and identity of EHR developers offering modules certified to each criterion, and, to the extent available through ONC's existing reporting mechanisms, indicators of deployment status across the eligible hospital and CAH market. Recurring publication of this data would allow CMS, ONC, the AMA, and other stakeholders to assess whether the implementation environment is keeping pace with the measure's effective dates and would inform any subsequent CMS decisions about the timing or structure of the measure under the phased approach the AMA recommends.

<u>Hospital Readmissions Reduction Program (HRRP)</u>

HRRP Measures

Hospital 30-Day, All-Cause, Risk-Standardized Readmission Rate Following Sepsis Hospitalization

Recommendations:

- The AMA does not support inclusion of the Sepsis Readmission measure in the HRRP and urges CMS to sunset the program, or at a minimum remove its existing measures, given growing evidence that the program's measures may be leading to unintended patient consequences and no longer capture the appropriate patient population.

- CMS should adopt a phased approach to the risk model update, MA beneficiary inclusion, and two-year data collection timeframe, with hospital-specific performance impact data provided before finalization.

- CMS should increase the minimum sample size to produce an intraclass correlation coefficient of 0.6 or higher and incorporate socio-economic risk adjustment at the patient, hospital, and community levels.
- CMS should work with the AMA and the provider community to streamline the hospital quality reporting programs.

CMS proposes to add the *Hospital 30-Day, All-Cause, Risk-Standardized Readmission Rate Following Sepsis Hospitalization* to the HRRP beginning with an early look for the FY 2028 program year and use beginning with the FY 2029 program year. However, the AMA is concerned with CMS' proposal to add the measure. As outlined in our comments on the Excess Days in Acute Care After Hospitalization for Diabetes measure, and in previous years' comments on the HRRP, there is growing evidence that the measures used in the HRRP may be leading to negative unintended patient consequences and are no longer capturing the appropriate patient population due to the structure and timeframe of the measures. As we have previously highlighted, the literature is beginning to show that readmission measures based on administrative claims may be leading to increased mortality. For more specific details on our concerns with the measure, please see the **IQR Program** section of our comments.

In addition, this measure includes some of the same changes that CMS has made to the other readmission measures; specifically, the risk adjustment model was updated to use individual ICD-10 codes rather than the CMS Hierarchical Condition Category (HCC) model; the measure now includes MA beneficiaries; and the data collection timeframe is two years. How each of these changes impact the reliability and validity of the measure has not been provided in this submission, and we are concerned that without a phased approach, it will be extremely difficult for hospitals to determine their impact (e.g., what is the effect of the expansion to MA beneficiaries as compared to the reduction in the number of years of data used to calculate the measure). We also recommend CMS provide data on how hospitals' performance shifts, since the potential impact on each hospital is critical to ensure that the results can be used to drive further improvement in patient care.

We also recommend that the minimum sample size be increased to produce a higher intraclass correlation coefficient (ideally 0.6 or higher for all hospitals), since we consider the minimum achieved with 25 admissions (0.205) to be too low.

Lastly, we also question the lack of socio-economic factors in the risk adjustment due to evidence that hospitals with larger populations of economically disadvantaged patients perform poorly on the measures. We recognize that some of the measures have been tested to consider economic-related variables; however, we do not believe that appropriate risk models were tested. The traditional approach of risk adjusting at the patient level may not be appropriate for measures where the measurement period includes care that is outside of the control of the hospital and a 30-day post-acute phase where the availability of community support and other resources directly impact a patient's care. We believe that there may be community-level variables that affect the risk of readmission during the days following hospital admission but are not currently addressed. Measures that extend beyond the hospital stay or outside the locus of control of the measured entity should continue to have socio-economic adjustments addressed and analyzed at different levels (e.g., patient, hospital, and community).

Due to these concerns and unanswered questions, the AMA does not support inclusion of this measure in the HRRP. We also once again urge CMS to sunset the HRRP, or at a minimum remove the existing measures from the program, as they no longer capture the appropriate patient population due to the structure and timeframe of the measures and are leading to unintended patient consequences. Removal of

the measures would allow for resources to be redirected for use towards measures that address the Administration's goals on prevention of chronic disease and ensuring a strong rural health system, as well as allow providers to focus their quality improvement efforts on those priorities.

We continue to encourage CMS to work with the AMA and the provider community to further streamline the hospital quality reporting programs to reduce burden and better understand the impact CMS policies have on readmissions and patient outcomes.

Hospital Value-Based Purchasing (HVBP) Program

In the FY 2027 IPPS proposed rule, CMS proposes modifications to five condition-specific and procedure-specific mortality measures beginning with the FY 2032 program year. The specific mortality measures are the following:

- *Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate Following AMI Hospitalization*
- *Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate Following Heart Failure Hospitalization*
- *Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate Following Pneumonia Hospitalization*
- *Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate Following COPD Hospitalization*
- *Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate Following CABG Surgery*

Recommendation:

- The AMA does not support inclusion of the five modified mortality measures in the HVBP Program for the same reasons set forth in our comments on the IQR Program.

The changes to these mortality measures are the same as those proposed for these measures in the IQR Program. We refer CMS to the **IQR Program** section of our comments, specifically the "Modifications" subsection, for our recommendations.

Requests for Information (RFIs)

Potential Future Use of the Adult Community-Onset Sepsis Standardized Mortality Ratio Measure in the IQR Program

Recommendation:

- The AMA is more supportive of the Adult Community-Onset Sepsis Standardized Mortality Ratio measure than other 30-day mortality measures because it is limited to what occurs within the hospitalization, but recommends additional information on data element feasibility and validity testing, the establishment of a case minimum to achieve a reliability score of 0.6 or higher, and concurrent removal of the sepsis bundle (SEP-1) measure if this measure is adopted.

The AMA is more supportive of this mortality measure than the other mortality measures in CMS' inpatient quality programs since it is limited to what occurs within the hospitalization and may remove many of the negative unintended consequences that we believe the other 30-day mortality measures have. Due to this measure leveraging data from EHRs, we would like to see additional information on the feasibility for the required data elements, as well as details on what data element validity testing has been completed. We also recommend that a case minimum is set to ensure that the measure produces a reliability score (ideally 0.6 or higher for all hospitals) since we consider the minimum achieved with 25 admissions (0.081 with just 11 patients) to be too low. Finally, we believe that a measure that examines

the outcomes of patients with a diagnosis of sepsis is preferable to continuing to require reporting on measures such as the sepsis bundle (SEP-1), which is extremely burdensome to report and has not yet demonstrated a link to improving patient outcomes. As a result, if this measure were to be considered in a future proposed rule, SEP-1 must be proposed for removal at the same time.

Birthing-Friendly Hospital Designation Modification to Expand Designation Criteria

Recommendations:

- The AMA supports inclusion of the *PC02, Cesarean Birth eCQM* but recommends the program also include *PC06, Unexpected Complications in Term Newborns* and *PC01, Elective Delivery* to provide a complete picture of quality care.
- The AMA recommends that peer grouping be expanded beyond delivery volume alone to a structure that combines rural versus urban status with delivery volume.
- The AMA recommends that the Designation include explicit clarification on the data used to calculate the results for public awareness and confidence.

CMS seeks input on potential modifications to the Birthing-Friendly Hospital Designation, specifically on the inclusion of the Cesarean Birth eCQM and Severe Obstetric Complications eCQM in the criteria for awarding the Birthing-Friendly Hospital Designation, and a modified scoring methodology for the expanded designation.

Inclusion of PC02, Cesarean Birth eCQM and PC07, Severe Obstetric Complications

We support the inclusion of PC02, Cesarean Birth eCQM, but the program must recognize that facilities should not be striving for a nulliparous, term, singleton, vertex positioning cesarean rate of 0 percent, as there are times when a cesarean birth is medically necessary. We also recommend the program include additional measures as a necessary complement to PC02 to provide a complete picture of quality care, such as *PC06, Unexpected Complications in Term Newborns* and *PC01, Elective Delivery*. The measures work in tandem to examine the effect that a change in one part of the system (cesarean section rates, elective delivery) has on another part of the system (unexpected complications in newborns).

Peer grouping

Within the RFI, CMS is also seeking feedback on approaches to peer grouping, such as use of delivery volume for grouping, whether there should be a minimum number of births required in the peer grouping, and any other variables that would be appropriate for grouping. The AMA recommends that CMS policy for peer grouping be expanded beyond delivery volume peer grouping to a structure that combines rural versus urban status and delivery volume. Locality alone ignores the impact of resource availability and utilization. For example, in non-rural settings, birth volume is often correlated with outcomes, but that is not necessarily the case in rural settings.

Public reporting

Within the RFI, CMS also solicits feedback on public reporting of the Designation results. Therefore, we recommend that the Designation include explicit clarification on the data used to calculate the results for public awareness and confidence.

IPPS Payment Policies

1. **Modifications to criteria for new residency programs**

Recommendations:

- The AMA thanks CMS for removing the prior-employment criterion for faculty and program directors and urges CMS to extend this benefit to programs already within their five-year cap-building window as of October 1, 2026.
- The AMA appreciates the exceptions to the 90 percent resident-newness threshold, particularly for small programs, displaced residents, and residents admitted via binding matching programs.

This section consists of two major proposals. First, for programs started on or after October 1, 2026, CMS would no longer consider the previous employment of the faculty or program director in determining whether a residency program should be considered genuinely new for cap-building purposes. That is, a hospital would no longer have to demonstrate that the faculty and program director in a new program have not previously been employed in an existing program in the same specialty. However, for programs started on an earlier date that are still within the five-year cap-building period as of October 1, 2026, the newness criteria would still apply.

We thank CMS for adjusting this criterion and urge CMS to consider allowing programs that have started their cap-building window to also benefit from this proposal. We applaud CMS for adjusting its initial proposal and thank the Administration for its acknowledgement that a policy that restricts the prior experience of faculty members removes the ability for residency teaching programs to select the best candidates to lead and shape newly created programs. This adjusted criterion will be especially helpful for those programs outside of major metropolitan areas or those with highly specialized programs where there are a limited number of qualified physicians able to participate as staff or directors.

Second, CMS is proposing that, for programs started on or after October 1, 2026, in order for a residency program to be considered new, at least 90 percent of the individual resident trainees (not full-time equivalents (FTEs)) that enter the program during the five-year cap-building period must not have previous training in the same specialty as the new program. However, there are exceptions to this proposed definition including not counting residents that have been displaced, residents admitted via a binding resident matching program, or programs that have 16 or fewer resident positions.

We thank CMS for the exceptions that it has provided to this 90 percent threshold and note the immense benefit that this will hold for small programs. The stakes for new teaching hospitals and hospitals that start new programs eligible to receive FTE cap adjustments are incredibly high. The cost of developing new programs is completely assumed by the institutions; the Medicare program does not reimburse hospitals for these start-up costs, and hospitals do not receive reimbursement until residents rotate to the hospital. Moreover, the cost of developing new programs or becoming a new teaching hospital is significant, and as such, a considerable amount of resources are put into the development of new programs. Most new teaching hospitals rely on Medicare funding to help offset the substantial costs associated with training residents. However, if a program receives a determination that it is not new, the hospital may not count the resident FTEs participating in that program towards establishing its FTE caps. Accordingly, we applaud CMS for amending its original proposal and making it easier for programs to meet the 90 percent threshold during the cap-building period.

2. Anti-discrimination requirements for approved residency programs

Recommendations:

- The AMA urges CMS to withdraw the proposed restrictions on accreditor criteria related to diversity, equity, and inclusion.

- The AMA supports continued reliance on the Accreditation Council for Graduate Medical Education (ACGME) and other oversight organizations to develop and enforce accreditation standards that are evidence-based and designed to protect patient health.
- The AMA emphasizes the importance of professional self-regulation and opposes further federal involvement in medical education accreditation.

The proposed rule would require that an approved medical residency training program must not discriminate, or promote or encourage discrimination, on the basis of race, color, national origin, sex, age, disability, or religion, including the use of those characteristics or intentional proxies for those characteristics as a selection criterion for employment, program participation, resource allocation, or similar activities, opportunities, or benefits. The AMA respectfully opposes the addition of this limitation and instead encourages the Administration to continue to rely on the appropriate accreditors and oversight organizations to set reasonable standards and criteria that are evidence-based and support patient health. The Accreditation Council for Graduate Medical Education (ACGME) is the primary organization in the United States that currently conducts accreditation for Graduate Medical Education (GME) programs. An "approved graduate medical residency training program" is defined as "a residency or other postgraduate medical training program participation in which may be counted toward certification in a specialty or subspecialty and includes formal postgraduate training programs in geriatric medicine approved by the Secretary" and which meets the criteria for accreditation as established by ACGME. While ACGME accreditation is a voluntary process, programs that are not accredited by ACGME generally do not receive Medicare funding from CMS for Direct Graduate Medical Education and Indirect Medical Education . Additionally, if ACGME withdraws accreditation, residents generally must receive assistance to continue their education from another ACGME-accredited program.

The AMA supports the medical profession's ability to self-regulate and opposes the federalization of medicine. The ACGME is an important organization within the physician community that sets and monitors compliance standards for residency programs. The standards created by ACGME have been built over the past 45 years and are regularly reviewed and updated in accordance with best practices to ensure that they remain current and guarantee delivery of high-quality, patient-focused care. These standards are developed and overseen by a competent group of individuals within the physician community who have the necessary education and experience to safeguard patient safety and maintain a strong learning environment. Moreover, the addition of these restrictions could set a precedent for the federal government to overextend into the accreditation of residency programs, thereby undermining the profession's ability to self-regulate and potentially affecting patient and resident well-being. The AMA also believes that the proposed definitions will likely cause unnecessary confusion among GME residency programs and hospitals that rely on accrediting organizations for approved medical residency program status.

Only within the principles and processes of self-governance can physicians ensure that all treatment decisions remain insulated from interference motivated by commercial or other interests that may threaten high-quality patient care. The AMA believes that self-governance is essential to protect the ability of physicians to act in their patients' best interests, and that limiting federal involvement supports improvements in healthcare for all communities. Therefore, the AMA asks that this proposal be withdrawn and that residency programs continue to be regulated by profession-initiated ACGME standards.

Other Provisions

1. **Comprehensive Care for Joint Replacement–Expanded (CJR-X) Model**

CMS proposes to implement CJR-X as a nationwide mandatory model for most acute care hospitals using the Center for Medicare and Medicaid Innovation (CMMI) Section 1115A authority to "expand" a model.

The Comprehensive Care for Joint Replacement (CJR) model ended in 2024, and the proposed expansion includes modifications, some of which are intended to align its policies with the Transforming Episode Accountability Model (TEAM) that began in January 2026. The 2022–2024 version of CJR that forms the basis for CJR-X was implemented in hospitals located in 34 Metropolitan Statistical Areas (MSAs), mostly in the southeast and mid-Atlantic regions. These MSAs were explicitly selected because they were the MSAs with the highest average spending on joint replacement.

CJR-X would be implemented at the same time that the TEAM model is in effect in 190 randomly selected Core-Based Statistical Areas (CBSAs), plus 10 hospitals that voluntarily agreed to participate, and CJR-X covers the same joint replacement procedures as TEAM. Hospitals that are participating in TEAM are therefore excluded from participation in CJR-X. TEAM is scheduled to last for five years. Although some aspects of the proposed CJR-X will be the same as TEAM, others will be different. For example, CJR-X episodes include a 90-day post-discharge period whereas TEAM episodes have a 30-day post-discharge period, and the quality measures in CJR-X differ from those in TEAM.

Allow Physician Practices to Manage Episodes

Recommendation:

- CMS should allow voluntary CJR-X participation at the physician group level.

Many physician groups in communities that will be required to participate in CJR-X participated in the voluntary Bundled Payments for Care Improvement-Advanced (BPCI-A) model and successfully generated savings for Medicare and quality improvements for patients who received hip and knee replacements. More than 70 percent of BPCI-A hip and knee replacement episodes were managed by physician practices, not hospitals, and BPCI-A evaluations showed that hip and knee replacement episodes managed by physician practices produced greater Medicare savings than the episodes managed by hospitals. The BPCI-A model was terminated at the end of 2025, and there is no opportunity for the physician groups in BPCI-A to continue managing the same types of episodes under CJR-X or TEAM. CMS states that "it is most straightforward and appropriate for the hospital to be the model participant" in CJR-X "because it is the hospital that furnishes the surgical procedure." The AMA disagrees. Joint replacement surgical procedures are furnished by surgeons, and they should have the opportunity to choose to manage the CJR-X model at the hospital where they furnish these procedures.

Require Hospitals to Involve Physicians in Episode Management

Recommendations:

- CJR-X participating hospitals should be required to establish a CJR-X Steering Committee that includes physicians who perform joint replacement surgery at the hospital.

- CMS should release episode data to physicians who perform joint replacement surgery at the participating hospital.

As proposed, under CJR-X, the surgeons, anesthesiologists, and other physicians involved in delivering joint replacement surgery and rehabilitation services to their patients will be considered potential "CJR-X Collaborators." There is no requirement that they be involved in any decisions the hospital makes about how to manage costs or improve quality during the episodes. Even though physician groups performed better in BPCI-A than hospitals, CMS states that "…hospitals are more likely than other providers or suppliers to have access to the resources to appropriately manage and coordinate care through the episode…" In addition, CMS will provide data on episode expenditures to the hospitals, but physicians would not have access to those data unless the hospital shares the data with them. The AMA believes it is critical that the views of the physicians who are managing the patient's care, performing these major

surgical procedures, and directing their recovery and rehabilitation be included in the key decisions about how episode costs and quality of care will be managed in the model. They should also be able to access the data that CMS shares about the episodes; it should not only be available to hospital administrators.

Share Savings with Physicians

Recommendations:

- Make CJR-X distribution arrangements between participant hospitals and the surgeons and other physicians performing the procedures that trigger CJR-X episodes mandatory, not optional.
- Limit the maximum repayment share that a CJR-X participating hospital can require an individual CJR-X Collaborator to contribute to the percentage of upside revenue that the Collaborator is eligible to receive under the distribution arrangement.

Under CJR-X, the hospital will receive a share of savings that it generates for Medicare if it reduces spending on hip and knee surgery episodes below the target price set by CMS. The hospital is permitted to share those savings (as well as savings from reductions in the cost of the procedure or inpatient stay) with "CJR-X Collaborators" using a "distribution arrangement," but the hospital is not required to do so. In addition, if a hospital is required to make a repayment to CMS because the cost of episodes exceeded the CMS target price, the hospital is permitted to obtain up to 50 percent of the repayment from the "CJR-X Collaborators" (including physicians) under a "sharing arrangement."

This shifts the power dangerously on the side of the hospitals. As a result of this power imbalance, a hospital could use the CJR-X program as leverage to acquire independent physician practices or to create the equivalent of compensation arrangements with independent physicians without the need to employ them. A hospital could also seek to generate savings by reducing the number of services delivered by physicians during episodes without sharing any of those savings with the physicians who lost revenue as a result, which could also enable hospitals to more easily acquire physician practices.

To address this, and to prevent further forced market consolidation which can lead to higher prices for patients (in direct opposition to a goal of CJR-X), distribution arrangements with the surgeons and other physicians who perform joint replacement procedures should be a standard, not optional, feature of CJR-X. Further, while the AMA does support CMS limiting the share of repayments that hospitals can require physicians to make, this should be proportional to the share of savings that a hospital would be paying a physician collaborator under a distribution agreement. Considering that repayment that represents a small proportion of a hospital's revenue could represent a very large and unaffordable portion of the revenues of a physician practice, we believe it could be appropriate for CMS to put further parameters around the proportion of upside versus downside risk for physician collaborators.

Participation in CJR-X Should Be Voluntary

Recommendation:

- Participation in CJR-X should be voluntary, not mandatory.

There is no shortage of physicians who want to be part of well-designed payment models that will enable them to deliver better care. The reason many physicians have not participated in alternative payment models to date is not because the physicians are unwilling to accept different methods of payment, but because the models have not provided the support physicians need to improve the delivery of care to their patients while at the same time requiring the physician to accept an unsustainable level of financial risk. If a Medicare payment and care delivery program is designed with the patient at its core, with adequate support for improvements in care delivery coupled with appropriate levels of financial risk and accountability based on what is within the physician's ability to control, there will be no need to mandate

participation. By actively involving practicing physicians in the design of new models, accountability metrics can be appropriately calibrated and barriers to participation can be identified and overcome.

Avoid Potential Negative Impacts on Rural Patients

Recommendation:

- CMS should limit CJR-X to non-rural hospitals or the same types of hospitals that participated in CJR. At a minimum, CMS should test CJR-X with rural and smaller hospitals on a more limited scale.

IPPS hospitals located in all areas of the country, including rural and micropolitan areas, would be required to participate in CJR-X, whereas only hospitals located in metropolitan areas were required to participate in CJR. CMS has not provided any information to show that the same opportunities for savings exist in rural and non-metropolitan areas or that these hospitals will not be disproportionately penalized by the methodology. CJR-X includes a lower stop-loss limit for rural hospitals (five percent instead of 20 percent), but rural hospitals that already have small or negative margins may experience greater harm from small repayments than larger hospitals would experience from larger repayments.

The largest contributor to savings in the CJR model was reduction in the use of Inpatient Rehabilitation Facilities (IRFs), but IRFs are not in all parts of the country, and most IRFs are located in urban areas. Most rural areas do not have IRFs, and many very small rural areas do not have Skilled Nursing Facilities (SNFs) or even home health agencies, so post-acute care is often delivered in rural hospital swing beds, and the swing-bed services generally receive higher payments than SNFs. As a result, hospitals with a higher percentage of joint replacement patients from rural areas could be penalized under the CJR-X model because of the higher post-acute care costs for these patients. This could discourage hospitals from providing joint replacement services for rural patients.

Although Critical Access Hospitals (CAHs) are exempt from CJR-X, many CAHs provide swing-bed rehabilitation, and they could lose revenue if larger hospitals steer patients toward an urban SNF for rehabilitation instead of to a CAH swing bed in the patients' home community. This could cause some of these hospitals to close or to eliminate services, jeopardizing access to care for the residents of those rural communities.

Avoid Potential Negative Impacts on Dual-Eligible Patients and Hospitals that Serve Them

Recommendations:

- Adjust both quality measures and the episode spending measure based on the percentage of patients who are low-income or face other barriers to health access.
- Use a non-linear model to provide greater adjustments for hospitals with higher percentages of low-income patients instead of a purely linear model or a binary indicator for a "safety net hospital."

The evaluation of CJR found that dual-eligible patients had less favorable results across all outcome measures. It also found that safety-net hospitals (defined in the evaluation as those that served a high proportion of patients who were dual-eligible or qualified for the low-income Part D subsidy) consistently performed poorly in terms of reconciliation payments (i.e., shared savings), and they were twice as likely to be required to pay recoupments for high spending in the 30 days after the end of the episode.
In the CJR-X model, CMS proposes to adjust the expected episode spending if a hospital meets a CMS definition of "safety net hospital." CMS proposes to define a safety-net hospital as one that is in the top 25th percentile in its region for the percentage of inpatient lower extremity joint replacement (LEJR) episodes provided to dually eligible beneficiaries during the applicable baseline period. CMS recognizes

that this is an arbitrary cutoff and that it creates a large disparity between hospitals just above and just below the cutoff. CMS also says it recognizes that "for participants on the margin, their status as a safety net hospital may change from year to year due to random variance and that this may not reflect the more persistent nature of the underlying challenges that the risk adjustment is attempting to address." However, CMS is "concerned that the further segmentation of hospitals into smaller groups may result in sample size and accuracy problems." Statistical validity should not supersede patient safety and access concerns. Assuming that outcomes in CJR-X will be worse for low-income patients as they were in CJR, then hospitals with a higher percentage of low-income patients will do worse on quality measures, have higher spending, and earn lower shared savings payments. As a result, hospitals that reduce the number of low-income patients will do better in CJR-X than they would otherwise. This is a potentially dangerous precedent to set and requires more sophisticated calibration so that hospitals will not be unduly disadvantaged and be subject to even more resource constraints due to fulfilling their ethical responsibility to treat the patients that walk through their doors, regardless of economic or social circumstance.

Excluding Surgeries in Ambulatory Surgery Centers Could Distort Results

Recommendations:

- Adjust episode prices in CJR-X based on the percentage of all lower extremity joint replacements that are performed in ASCs in the community where a hospital is located.
- Enable physician groups to manage episode costs for all lower extremity joint replacements, regardless of the facility where they are performed.

The primary focus of CJR-X is elective hip and knee surgeries. These procedures are included regardless of whether they are performed as inpatient or outpatient procedures, but outpatient procedures are only included if they are performed in a hospital, not in an Ambulatory Surgery Center (ASC). Not only are the majority of hip and knee procedures for Medicare beneficiaries now performed on an outpatient basis, a growing number of these procedures are being performed in ASCs. However, CMS states that including ASCs would "introduce overwhelming uncertainty to the CMS Chief Actuary's certification." CMS also issued a Request for Information on including ASCs in the TEAM model but not in CJR-X.

Under CJR-X, if a hospital has a lower-than-average percentage of cases performed in its outpatient department, it will have a higher-than-average episode cost, because payments for inpatient surgery are much higher than outpatient. If patients in the community receive hip or knee surgery in ASCs instead of the hospital, it will reduce the number of cases in the hospital outpatient department, thereby increasing the average spending for hospital episodes. The impact on individual hospitals will vary depending on whether there are ASCs in the community, how many there are, whether orthopedic surgeons perform hip and knee surgeries at these facilities, and other factors.

CMS added a risk adjustment methodology to CJR in 2022 in an attempt to avoid penalizing hospitals that have lower percentages of outpatient hospital procedures because they serve higher-need patients. There is no clear evidence that the risk adjustment methodology successfully does this, but even if it does, it would only adjust for differences in the proportion of patients who qualify for outpatient surgery, not for the specific type of facility where that surgery is performed.

Estimates indicate that more than 10 percent of Medicare beneficiaries now receive hip and knee surgery in an ASC, but the percentage likely varies significantly from state to state because the number of ASCs varies widely from state to state. As a result, it is possible that hospitals in CJR-X will receive shared savings payments or owe repayments to Medicare based on the percentage of patients who receive surgery in an ASC in their community, not because of how well the hospital manages hospital-based

episodes. This, in turn, could lead to actions by hospitals that discourage the use of ASCs, which would result in higher overall spending by Medicare and higher patient cost-sharing.

Episode Target Prices Should Be Based on the Cost of Delivering Care

Recommendations:

- Calculate episode prices designed to adequately support the estimated cost of delivering the most appropriate combination of services to patients to meet their needs.
- Eliminate arbitrary discounts and increase episode prices from the base year using inflation factors rather than rebasing every year.
- Set different episode prices for different geographic areas if there are significant differences in the availability of services in those regions (e.g., home health, SNF services, ASCs).
- Provide bonuses for high-quality care and penalties for poor-quality care in a budget-neutral fashion, similar to the HVBP Program.

The evaluations of CJR and BPCI-A found that spending on LEJR episodes could be reduced without harming quality by reducing the use of expensive post-acute care services. However, the evaluations did not provide any evidence as to whether or how much additional savings could be achieved in the future. Under CJR-X, episode target prices are adjusted every year based on actual spending in prior years, so even if a hospital is able to reduce spending and avoid a penalty or receive a shared savings payment in one year, it could be penalized the following year if it merely maintains that lower level of spending and does not reduce spending even more.

In addition, under CJR-X, CMS reduces the episode target price below the estimated actual spending by an arbitrary "discount" of two percent. This guarantees that CMS will spend less each year than it otherwise would, regardless of whether actual spending on services is reduced, because a hospital that cannot reduce spending to match the discount is required to repay the difference to CMS. A new two percent discount is applied each year, so on top of the rebasing, hospitals will have to spend significantly less over time in order to avoid penalties. Hospitals may be forced to look for ways to avoid ordering or delivering services that patients need in order to stay within these arbitrary episode target prices. CMS provides no justification for using a two percent discount or for applying the same amount every year. This is a dangerous formula based on arbitrary spending cuts, rather than optimizing patient care, with either adverse patient safety or access consequences, or resource cuts for the hospitals that continue to do things the right way. The formula as-is is simply not sustainable.

CMS proposes to reduce or eliminate the discount for hospitals that have high scores on quality measures. However, these adjustments and the thresholds required to receive them are also arbitrary, and no justification is provided for them. Even tiny differences in the scores trigger significant financial implications. For example, a hospital with a quality score of 17.1 would not be subject to any discount, whereas a hospital with a quality score of 17.0 would be subject to a one percent discount. A hospital with a quality score of 12.0 would be subject to the two percent discount, but a hospital with a quality score of 12.1 would only be subject to a one percent discount.

Since spending will need to be higher for patients with higher needs, CMS plans to "risk adjust" the episode target prices using a regression model. The model only considers the number of chronic conditions, the patient's age, and whether the patient is dual eligible or lives in a distressed community. No adjustment is made for factors that directly affect whether the patient can receive outpatient surgery or the amount or type of post-acute care the patient should receive, such as whether the patient lives alone or has someone to assist them at home, whether the patient has disabilities, what types of post-acute care services are available in the community, and whether the patient has access to transportation. As a result,

episode target prices could be unrealistically low for some patients and some hospitals and unnecessarily high for others.

A separate episode target price would be established for each of the nine U.S. Census Regions based on the average episode spending in all of the CJR-X hospitals in that region. No justification is provided as to why target prices should be different in different census regions or why target prices should be the same for all hospitals in the same census region.

Problems with the Quality Measures

Recommendations:

- We urge CMS to delay implementation of CJR-X until quality measures can be developed that specifically target complications, outcomes, and patient experience associated with lower extremity joint replacements. The measures do not specifically assess all aspects of quality for joint replacement surgery, nor do they provide patients with information on whether the hospital has reduced the quality of care they provide to achieve lower spending on joint replacement surgery.
- At a minimum, CMS must not move forward with its proposal to include the *Hospital-Level Total Hip and/or Knee Arthroplasty (THA/TKA) Patient-Reported Outcome (PRO)-Based Performance Measure (CMIT ID #1618)* measure in the model until issues around reliability, feasibility, and refinements to measure specifications and exclusions are addressed.

The AMA is extremely concerned that the selected measures for this enhanced model will not provide sufficient information on the quality provided for joint replacement surgery. Overall, there are issues related to sufficient reliability at the current case minimums, overly broad measures and lack of alignment with the purpose of the model, and concerns around patient survey fatigue and decreasing response rates for the patient experience and satisfaction measures. We urge CMS to address our detailed concerns as outlined below before utilizing the measures as an indicator of quality of care for joint replacement surgery.

- **Hospital-Level Risk-Standardized Complication Rate (RSCR) Following Elective Primary Total Hip Arthroplasty (THA) and/or Total Knee Arthroplasty (TKA) (CMIT ID #350)**

The AMA believes that the case minimum must be increased above 25 individuals. This increase would ensure that the measure's minimum reliability is above 0.7, which is what we believe should be the standard for measures used for accountability purposes. In addition, the risk adjustment does not address important aspects that can predict an individual's ability to recover successfully at home, including income, level of home support, or access to outpatient care after discharge.

- **Hospital Visits Within 7 Days of Hospital Outpatient Department (HOPD) Surgery (CMIT ID #344, OP-36)**

The Hospital Visits Within 7 Days of Hospital Outpatient Department Surgery measure is a poor measure of outcomes of care for outpatient joint replacement surgery. It includes all types of surgery, not just joint replacement surgery. Therefore, we do not agree with CMS' assessment that because this measure could include joint replacement surgeries and is somewhat like the inpatient complications measures, it is acceptable to include it in the model. Any measure used should be one on which a hospital can make actionable improvements and inform patient decision making. We do not believe these goals can be accomplished with such an overly broad denominator, since differences between hospitals on the measure will not necessarily reflect differences in the quality of joint replacement surgery.

- **Hospital Consumer Assessment of Healthcare Providers and Systems Survey (HCAHPS) (CMIT ID #338)**
- **Outpatient and Ambulatory Surgery Consumer Assessment of Healthcare Providers and Systems Survey (OAS CAHPS) (CMIT ID #162)**

Over the last several years, the HCAHPS survey has been updated with new sub-measures and new modes of administration. While some of these changes should lead to improved response rates and improved relevance of the results, none of them have been evaluated by the Consensus-Based Entity (CBE) to ensure that the measures remain reliable and valid. Regrettably, the OAS CAHPS has not been submitted for CBE review, so we are unable to evaluate its appropriateness overall and for this model.

Furthermore, while the modes of administration were expanded to include Web First, we remain concerned with the generally low response rates for both surveys. Early analyses of response rates for HCAHPS are just over 30 percent, and an extremely small percentage (<1 percent) of facilities that administered the OAS CAHPS survey by mail with a follow-up by phone achieved a response rate of just over 36 percent, with the majority achieving between 17–26 percent across the remaining modes of administration.

Therefore, we remain concerned that these rates demonstrate the ongoing challenge of survey fatigue. It is especially concerning when three of the measures used to evaluate the quality of care provided in this model rely on patient-reported data. We question whether these data should be considered representative of the quality of care provided in the inpatient and outpatient settings.

- **Hospital-Level Total Hip and/or Knee Arthroplasty (THA/TKA) Patient-Reported Outcome (PRO)-Based Performance Measure (CMIT ID #1618)**

The AMA does not support inclusion of this measure in the model given ongoing concerns with the overall measure design, significant data collection burden, and the implementation challenges experienced by hospitals during its initial rollout.

Upon review of the patient-reported outcomes data from CMS released on February 25, 2026, roughly 40 percent of 111 hospitals that voluntarily reported this measure were able to successfully meet the 50 percent sample size requirements and achieve a score. In addition, an analysis of the characteristics of the hospitals that were able to report during the initial voluntary reporting period found that they were more likely to be urban, teaching, and with the number of beds exceeding 200. These initial results reinforce our ongoing concerns over the feasibility and data collection burden experienced both by the hospital and patient and raise more questions around the ability of hospitals that may be under-resourced and/or provide care in rural and medically underserved areas to successfully report on this Patient-Reported Outcome-Based Performance Measure (PRO-PM).

Based on our experience, no other measure that achieves such low successful reporting rates has ever been implemented in a CMS quality program, and this should serve as an indicator that the measure is not performing as expected and must be re-evaluated. We urge CMS to revisit the specifications and requirements of this measure before its implementation in any model and pause mandatory reporting in existing programs. Specifically, the measure does not currently include any case minimums, and as a result, the 50 percent response rate requirement is extremely burdensome and sets low-volume hospitals up to fail from the start. The measure testing also did not assess the timing and number of items solicited from the patient's perspective, nor do the specifications allow hospitals to exclude patients who chose to decline to participate. Given the fact that no other patient-reported outcome measure used by CMS and proposed within this expanded model comes close to achieving a response rate near 50 percent, we do not understand how hospitals can be expected to achieve that rate for this measure. This expectation is nearly impossible since each hospital must successfully achieve high rates pre-operatively if they have any

chance of achieving 50 percent by the end of the 425 days post-operatively. As a result, CMS must address the need for a case minimum, reduced sample size requirement, and additional exclusions and refinements to the measure specifications before this measure is used in programs or models on which hospitals can receive penalties.

Because these measures do not specifically assess all aspects of quality for joint replacement surgery, and because performance on the measures can be affected by good or poor quality care for other types of procedures, they cannot assure CMS or patients that a hospital has not reduced the quality of patient care in order to achieve lower spending on joint replacement surgery.

Problematic Approach to Quality Scoring

Recommendations:

Assign quality points based on performance compared to benchmarks established in the prior year.

- Add quality points if there was improvement in quality from the prior year.
- Assign points based on differences defined in terms of standard deviations from the mean or median rather than percentiles.
- Assign points in a continuous fashion based on quality measure performance rather than using arbitrary cutoffs and cliffs in scoring.
- Measure episode spending on a calendar year basis so it aligns with calendar year quality measures.

CMS proposes to use a "tournament model" for quality scoring, in which hospitals would be scored based on their performance relative to other hospitals during the same year, rather than scoring them compared to a predefined benchmark based on the performance hospitals were able to achieve during a prior year. In addition, unlike the CJR model, there would be no explicit reward for improvement in quality. As a result, even if a hospital had performed well on quality measures in the prior year and had improved its performance in the current year, it could receive a low-quality score if other hospitals had even higher performance on the quality measures. We recommend CMS add quality points if there is an improvement in quality from the prior year.

In addition, based on the proposed quality scoring policy, a hospital has no way to know what its quality score would be until well after the end of the year, and since the quality score would determine the discount applied to the target price, the hospital would have no way to know whether its quality score would be likely to result in a shared savings payment or a penalty. Therefore, we recommend CMS assign quality points based on performance compared to benchmarks established in the prior year.

Points would be assigned based on the percentile in which a hospital's quality measure performance fell compared to other hospitals. Most hospitals have very similar performance on the quality measures, so even a small difference in performance on a measure could result in a very large change in the points that a hospital receives. In addition, the same number of points is assigned to all scores in a particular decile, which means that scores would differ significantly for hospitals that fall just above or below a particular decile. CMS has moved away from this approach in other programs and is using standard deviations from the mean or median instead of percentiles, and awarding partial points for small differences in scores. We urge CMS to consider assigning points based on differences defined in terms of standard deviations from the mean or median rather than percentiles.

CMS also proposes to measure quality during calendar years but assess spending during fiscal years, so the quality scores will not represent the same patients as the spending. We recommend CMS measure episode spending on a calendar year basis, to align with calendar year quality measures.

Creation of Duplicative Telemedicine Codes

Recommendation:

- CMS should utilize the Current Procedural Terminology (CPT) codes for telemedicine visits instead of creating new G-codes for this purpose.

CMS proposes to create four new G-codes in CJR-X for telehealth services provided to patients in their home. CMS states that it "does not believe that the kinds of E/M services furnished to patients outside of healthcare settings via real-time, interactive communication technology are accurately described by any existing E/M codes." There have been CPT codes specifically for telemedicine E/M for several years, however, and CMS publishes the relative values for these codes, but the agency does not believe it has statutory authority to include these codes on the Medicare Telehealth List. There is no reason for CMS to create special G-codes for telemedicine E/M when precisely defined and valued CPT telemedicine codes are already available. The CPT codes for audio-video telemedicine visits are 98000–98007.

2. Hospital with Physician Ownership Request for Information

Recommendation:

- The AMA supports CMMI's consideration of a voluntary opt-in period for hospitals with physician ownership (POHs) in TEAM and urges the agency to design the opt-in as broadly as the statute allows, including non-grandfathered POHs.

The AMA has consistently opposed CMMI's use of mandatory model participation. A voluntary opt-in pathway, even one limited initially to POHs, is a constructive step toward the voluntary participation framework Congress envisioned for experimental model testing. We therefore support the agency's general direction and offer the following responses to the specific questions posed in the RFI.

Voluntary opt-in is appropriate and statutorily preferable.

Allowing POHs in Core-Based Statistical Areas (CBSAs) not selected for mandatory TEAM participation to opt in advances several goals: it expands the population of providers willing and able to participate in episode-based care, it incorporates physician-led care models into CMMI's portfolio, and it generates evaluation data from providers whose participation is genuinely informed and consensual. The agency's concern that voluntary participation could complicate evaluation should be weighed against the benefit of testing the model with physician-led delivery systems whose accountability, quality outcomes, and patient satisfaction are well documented. To address evaluation concerns, CMS can use standard methodological approaches to account for self-selection in its impact analysis.

Eligibility should not be limited to grandfathered POHs.

The AMA recommends that CMS make the voluntary opt-in available to all POHs, not just those grandfathered under Section 6001 of the Affordable Care Act. Limiting participation to grandfathered POHs would arbitrarily exclude physician-led hospitals that emerged after 2010 and would fail to capture the full range of physician-owned delivery models capable of contributing to TEAM's objectives. Section 1115A(d)(1) of the Act gives the Secretary broad authority to waive Medicare requirements as the Secretary determines necessary to test a model, and that authority can be applied to permit non-grandfathered POH participation for the duration of the model.

Geographic criteria should be applied flexibly.

POHs that voluntarily opt in should be required to meet the same beneficiary attribution and episode-construction rules as mandatory TEAM participants under 42 CFR 512.510, since those rules are integral to the model's clinical and financial design. The geographic eligibility criteria under 42 CFR 512.515, however, were developed to define the mandatory participant universe and need not be applied to voluntary opt-in participants. POHs located in any CBSA should be eligible to opt in, provided they satisfy the operational and reporting requirements of the model.

Necessary waivers should be granted.

For the voluntary opt-in to function as intended, CMS will need to use its Section 1115A waiver authority to address the Section 6001(a)(3) restrictions on facility-capacity expansion, the prohibitions on Medicare payment for designated health services referred by physician owners at non-grandfathered POHs, and related self-referral law constraints that would otherwise prevent POH participation. The AMA supports the grant of these waivers for the duration of the model. CMS should not require POHs to demonstrate, as a precondition of opt-in, that waivers will not allow Medicare payment that would otherwise be impermissible: the entire purpose of Section 1115A is to permit precisely such modifications for model-testing purposes.

Post-model compliance can be addressed through existing mechanisms.

The agency's concern about how POHs will remain compliant with applicable statutes after TEAM terminates is reasonable but manageable. CMS already requires participants in CMMI models to attest to their understanding that waivers are temporary, and Medicare's existing program integrity, audit, and enforcement infrastructure can address post-model compliance. With respect to the specific question of facility-capacity baseline, CMS should require participating POHs to document baseline operating rooms, procedure rooms, and beds at the start of the model and to attest, as a condition of participation, that any expansion permitted under waiver will be reduced to baseline at model termination if the underlying statutory restrictions are still in effect at that time.

Program integrity safeguards should rely on existing frameworks.

Beneficiary steering, cherry-picking, and lemon-dropping concerns apply to all TEAM participants, not POHs alone, and the existing TEAM program integrity provisions, together with Medicare's broader fraud and abuse enforcement framework, are sufficient to address these risks. To the extent CMS believes additional POH-specific safeguards are warranted, the AMA recommends that those safeguards be developed in consultation with physician organizations and POH stakeholders rather than imposed unilaterally, and that they be calibrated to the actual evidence of risk rather than the historical assumptions that drove the Section 6001 restrictions.

Episode categories and exclusions.

The AMA does not recommend excluding any current TEAM episode categories from POH participation. POHs treat the same Medicare beneficiaries as other TEAM participants, are subject to the same quality measurement, and should be evaluated on the same episode terms. With respect to additional episode categories that might be tested specifically through POHs, the agency should consider categories in which physician-led delivery systems have demonstrated efficiency and quality gains, including additional orthopedic, cardiovascular, and general surgical episodes, but should develop any new categories through the standard rulemaking and stakeholder engagement process rather than as a POH-specific carve-out.

3. Ambulatory Surgical Center Episode Request for Information

Recommendations:

- Any ASC-specific TEAM program must allow for voluntary, not mandatory, participation.
- The model must provide a way for surgeons to voluntarily participate as managers of these episodes.
- The current applicable ASC quality measures have not been tested in the ASC setting. Therefore, quality measurement should not be a core element for reimbursement as part of any bundled payment model.

CMS is exploring ASC participation in TEAM, beginning as early as CY 2028 (that is, Performance Year 3). CMS notes that the healthcare landscape has changed, and more procedures, including certain procedures that initiate episodes in TEAM, are being performed more regularly in the ASC setting. Therefore, in this proposed rule, CMS is soliciting feedback on inclusion of ASC episodes in TEAM.

The AMA appreciates the opportunity to provide feedback, and as we have highlighted regarding all alternative payment models or episode models, if CMS moves forward with an ASC-specific TEAM program, it must allow for voluntary, not mandatory, participation. The model must also allow for a way for surgeons to voluntarily participate as managers of these episodes, which should allow surgeons to develop key relationships with both ASCs and hospitals to achieve experience with and success in the model. We reiterate that participation must be voluntary for the physicians and the ASCs.

We are also concerned with CMS moving forward starting in CY 2028, as ASCs have not been the focus of any episode-based or advanced payment model, and as a result any such model should be tested prior to mandatory participation. In addition, there is wide variation in surgery center operational models (size, specialty focus, payer-mix, etc.), so the sampling for participation that was performed for acute care hospitals under the main TEAM program would likely not work for ASCs.

We offer the following responses to CMS' RFI questions. For more detailed responses, we refer CMS to the Ambulatory Surgery Center Association (ASCA) 2027 IPPS Comments:

What entity should be held financially accountable for episodes initiated at ASCs?

ASCs are not the appropriate convening entity for a 30-day episode of care. Although surgery centers may be the facility performing the index procedure, surgery centers are not necessarily involved in the initial site of service decision or post-operative care. ASCs are already paid significantly less per procedure than hospitals. For example, the ASC receives roughly 30 percent less in facility reimbursement than a hospital outpatient department would for a total knee replacement (HCPCS 27447). With lower margins, the opportunity for efficiency gains is much smaller. While ASCs may have relationships with post-operative care sites, they are generally not responsible for the efficacy and quality of care received at SNF, home health agency , hospice, and other long-term recovery care services that are part of TEAM.

What steps could CMS take to support ASC readiness to participate in episode-based payment models such as TEAM?

Although TEAM does not currently require CEHRT, hospitals that use CEHRT have access to more participation tracks and thus more flexibility within the model. Because ASCs were not included in the Health Information Technology for Economic and Clinical Health HITECH Act, ASC adoption of EHRs and health information technology generally lags behind hospitals and physician offices. The ASCA, in conjunction with industry-leading EHR vendors, estimates that ASC EHR penetration is roughly 50 percent. Among ASCs that are currently using EHRs, it is likely that very few are using certified

products. Therefore, we would encourage CMS to collaborate with ASCA and the Assistant Secretary for Technology Policy to ensure that industry standards are appropriately designed for the ASC setting.

What quality measures would reasonably capture performance and outcomes of TEAM ASC episodes?

The AMA supports an Ambulatory Surgery Center Quality Program, including within an ASC-TEAM that fosters facility improvement, but the current measures in the Ambulatory Surgical Center Quality Reporting Program urgently need to be reassessed. The current program lacks a focus on patient safety and does not provide the necessary information to patients to select an appropriate site of care. The current program includes several measures that were either not tested at the ASC-level or lack high reliability. Given the lack of appropriate focus, the measures in the program only increase administrative burden without any clear evidence that the measures improve the quality of care at healthcare facilities or provide benefits to patients.

While the following measure might appear appropriate for use within ASC-TEAM, *ASC-21: Risk-Standardized Patient-Reported Outcome-Based Performance Measure (PRO-PM) Following Elective Primary Total Hip Arthroplasty (THA) and/or Total Knee Arthroplasty (TKA) in the ASC Setting (THA/TKA PRO-PM)* is currently voluntary in the ASC setting until the CY 2028 reporting period and has not been tested in the ASC setting.

We also caution CMS against requiring the Consumer Assessment of Healthcare Providers and Systems OAS-CAHPS survey as part of the model, as ASCs continue to be challenged with meeting the case minimum requirement of 200 completed surveys and there is a high cost to administer the survey. ASCs are small facilities, and CMS' own testing has shown rates lower than 20 percent.

Until these measures are refined, tested, and proven in the ASC space, they should not be implemented as a core element for reimbursement as part of any bundled payment model.

4. Measuring Emergency Care Access and Timeliness in the IQR and HVBP

What are some of the key barriers and challenges faced by inpatient providers in supporting process changes that improve bed availability and reduce ED boarding?

The AMA appreciates CMS attention on the emergency department (ED) boarding and overcrowding crisis that our nation is facing, which continues to be an AMA priority. "Boarding" in the ED is a result of dangerous health system overload that puts patients in a holding pattern as they wait for an inpatient bed or transfer after their initial care. Boarding has become its own public health emergency. Addressing this challenge therefore requires system-wide inpatient and hospital-level throughput reforms, including staffing, discharge processes, and acceptance practices, rather than narrowly focused ED operational fixes that do not address the root cause. These inpatient bottlenecks have profound patient-safety and workforce consequences, increasing the risk of treatment delays, adverse events, preventable errors, and mortality, while also exacerbating ambulance diversion, workplace violence, clinician burnout, and hospital costs.

High-risk populations further illuminate these challenges, as critically ill patients awaiting intensive care unit beds and patients in behavioral health crisis often board for extended periods due to lack of appropriate inpatient placement or acceptance, underscoring that the barrier is frequently inadequate capacity rather than ED workflow. Finally, meaningful improvement depends on robust measurement and accountability; valid boarding and throughput measures can assist with diagnosing system failures and creating incentives for hospitals to prioritize inpatient capacity solutions that protect patient safety and improve outcomes.

Are there any elements of this measure that are not applicable (for example, numerator components, denominator, exclusions, etc.) to inpatient care, or for which an inpatient hospital should not be held accountable, which would warrant removal or modification if the measure is proposed in the Hospital

Inpatient Quality Reporting Program?

The Emergency Care Access and Timeliness measure calculates the proportion of four outcome metrics that quantify access to and timeliness of care in an ED setting against specified thresholds, including:

1. The patient waited longer than 1 hour after arrival to the ED to be placed in a treatment room or dedicated treatment area that allows for audiovisual privacy during history-taking and physical examination;
2. The patient left the ED without being evaluated;
3. The patient boarded in the ED for longer than four hours; or
4. The patient had an ED length of stay (LOS) of longer than eight hours.

An encounter is considered part of the numerator if it includes any one of the four numerator events, with events not being mutually exclusive and each contributing only once to the numerator. ED encounters with ED observation stays are excluded from components (3) and (4) but are included in the denominator. Patients who have a "decision to admit" after an ED observation stay remain excluded from criteria (3) calculations.

While a patient encounter begins in the outpatient setting with the arrival in the ED, long wait times or other forms of inefficiency, including boarding, are entirely outside the control of the emergency physicians, nurses, and other ED staff doing their best to provide equitable, high-quality, and safe care. Rather, these issues stem from broader health system dysfunction and hospital operations across outpatient and inpatient settings. For this reason, it is valuable to have continuity of the measure across settings (inpatient and outpatient) to identify and then address the root causes of boarding.

We appreciate that CMS incorporates the recommendations of the American College of Emergency Physicians (ACEP), along with those from The Joint Commission, in establishing clear and meaningful boarding thresholds, including adoption of a four-hour maximum timeframe for the period between the admission order (or documented intent to admit) and the patient's departure from the ED. It is essential that this definition remain tightly focused on this interval to ensure accountability for inpatient throughput, rather than diluting responsibility through broader or less precise measures. We strongly emphasize that the four-hour threshold must be treated as an absolute maximum limit, not as a mean or median performance target, and that hospitals should be expected to meet this standard for every admitted patient.

Consistent with long-standing ACEP policy, total time spent in the ED should never exceed eight hours. Maintaining clear, enforceable definitions and core thresholds is critical to driving meaningful system-level improvements that reduce boarding and protect patient safety. Therefore, we continue to encourage CMS to revise this measure to a composite where outcome three would be weighted more heavily than the other three outcomes (40 percent to 20 percent). This change would enable hospitals and others to evaluate performance across each of the outcomes, while also signaling that boarding times should always be no longer than four hours at a minimum.

If CMS chooses to modify measure specifications for inpatient programs, the AMA urges the agency to avoid any changes that would weaken hospital-wide accountability or undermine the core purpose of the measure. Specifically, we caution against limiting the reporting cohort solely to admitted or boarded patients, as ED boarding is a systemic problem that affects the functioning, access, and timeliness of care for the entire ED, not just those ultimately admitted.

CMS should implement stratifying boarding and access data by patient type. As the measure is implemented and data is collected, we suggest that it be parsed into stratified groups based on patient type: age group (pediatric, adult, or geriatric), psychiatric, and medical/surgical. This will help to discern the level of dysfunction (if any) within a particular hospital as compared to external factors outside of that hospital's control that contribute to patient boarding, such as regional specialized bed availability and community resources.

Given the overlap in patient cohort with the measure recently adopted for the Hospital Outpatient Quality Reporting Program, do stakeholders have concerns related to duplication of encounters in quality measures? Given the shared responsibility across units within the hospital, is it beneficial for the cohort (or a subset of the cohort) to be tracked across similar measures in both programs?

The AMA recognizes that the Emergency Care Access and Timeliness measure recently adopted for the Hospital Outpatient Quality Reporting Program may overlap in patient cohort with measures used in other CMS programs, and we acknowledge that stakeholders may have concerns about duplicative encounter reporting. However, the AMA believes that consistent, system-wide measurement of ED boarding and access-to-care metrics is essential to addressing a long-standing and worsening problem. Because ED boarding is driven by hospital-level capacity and throughput failures across inpatient and ancillary units, tracking a common cohort, or appropriate subsets of that cohort, across programs can reinforce shared accountability rather than silo responsibility within the ED. To reduce confusion and ensure accurate measurement, the AMA recommends that CMS be explicit about what each measure/program intends to measure, encounter attribution, and how performance should be interpreted when similar cohorts are measured across settings. Clear specifications will help prevent misattribution of responsibility and ensure that measures drive the intended incentives for improvement. The AMA further urges CMS to prioritize alignment across reporting programs to minimize administrative burden and avoid fragmented or constantly changing measures that obscure trends and limit accountability. Where differentiation is needed, CMS should consider stratification within a common measurement framework, for example, distinguishing admitted versus non-admitted patients or behavioral health versus medical and surgical patients, rather than creating divergent or duplicative measures. Consistent, aligned measurement across programs is more likely to illuminate root causes, support system-level solutions, and advance timely access to emergency and inpatient care.

Should CMS consider including this measure in the Hospital Value-Based Purchasing Program? If so, would it be beneficial to keep the current measure specifications as is, particularly as these programs may be better suited to capture broader, system-wide processes?

Since boarding is driven by inpatient capacity and system-level throughput constraints beyond the control of ED clinicians, any incorporation into HVBP must be carefully designed to reinforce enterprise accountability. If CMS elects to include the measure in a payment program, the AMA reiterates our suggestions to improve the accuracy of the measure, including weighting outcome three more heavily than the other measures. The AMA also cautions that HVBP adoption should avoid creating perverse incentives, such as encouraging inappropriate use of observation status to evade accountability, and that the four-hour boarding interval and eight-hour total ED length-of-stay limit should continue to be treated as absolute maximum safety limits, not permissive averages. Measure design should preserve the measure's core intent: driving hospital-wide solutions to a system-level patient-safety problem.

Are there any potential unintended consequences CMS should be aware of related to introducing this measure into the Hospital Inpatient Quality Reporting and Value-Based Purchasing Programs?

If CMS moves forward with the measure, we caution against incorporating exclusions or carve-outs related to observation status. There is widespread variation in the use of observation status from hospital to hospital, and we are concerned that fully excluding observation status patients could create a system where hospitals are incentivized to inappropriately convert patients to observation status until an inpatient

bed becomes available to avoid poor scores. Careful monitoring and consideration should be given to ensure that the use of observation does not increase as a replacement for hospitalization.

In addition, program design and measure interpretation must clearly place accountability at the hospital and health-system level. Framing boarding as an ED operational failure risks misdirecting improvement efforts away from the inpatient capacity constraints that are the true drivers of prolonged boarding. The AMA also cautions against long-term optional reporting structures, which may bias results toward higher-performing hospitals and understate the severity of the boarding crisis. The AMA recommends mirroring the implementation process used in the outpatient ECAT measure, phasing in the measure first through optional reporting, then, after inpatient and outpatient departments gain experience and our recommended improvements to the measure are implemented, moving to mandatory reporting.

Furthermore, CMS should avoid "wrong-facility" accountability for transfer-related delays and consider whether responsibility appropriately lies with the receiving facility when capacity or acceptance limitations drive prolonged boarding. Thoughtful implementation that maintains robust, aligned measurement and reinforces system-level responsibility is essential to preventing unintended harms while advancing patient safety and access to care.

Finally, CMS must ensure the measure does not adversely impact rural hospitals and further exacerbate the rural health crisis given the percentage of rural hospitals that have and continue to close. We support comparison by similar-volume ED, but calculation must also take into consideration locality and other potential factors that may make it difficult to "smooth" demand.

Are there other measure development/re-specification ideas or opportunities CMS should consider for how inpatient departments can address ED boarding and better measure patient outcomes, such as harm from delays to inpatient care?

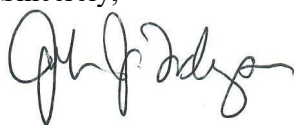
To better improve patient care and outcomes, there are additional steps CMS could take. First is stratifying boarding and access data by patient type. As the measure is implemented and data is collected, the AMA suggests that it be parsed into stratified groups based on patient type: age group (pediatric, adult, or geriatric), psychiatric, and medical/surgical. This will help to discern the level of dysfunction (if any) within a particular hospital as compared to external factors outside of that hospital's control that contribute to patient boarding, such as regional specialized bed availability and community resources. Having more detailed data will help drive system-level changes to address the areas that need it most, for example being able to distinguish between psychiatric and surgical patients.

Second, the AMA reiterates our recommendation to phase in the measure first through optional reporting, then, after departments gain experience reporting the measure and the measure is modified to address any unintended consequences, it would graduate to mandatory reporting. It is important that CMS be responsive to concerns raised by emergency physicians and other frontline stakeholders during the testing or optional period of reporting to address any patient care delays or other potential adverse consequences before the measure becomes mandatory. Offering incentives to report the measure while it is optional, such as pay-for-reporting credit, would also help to encourage reporting of the measure and facilitate the collection of robust data so that CMS can be put in the best possible position to ensure the measure is both accurate and enhancing of patient access to care, rather than harmful to it.

Additionally, CMS should consider phasing in complementary metrics to provide a more complete picture of emergency department access, boarding, and throughput. Such metrics could include time from arrival to placement in a dedicated ED treatment area and proportion leaving without evaluation by a licensed clinician.

Thank you again for the opportunity to offer our thoughts on these important issues, and please reach out to me directly at 312-464-5288 or John.Whyte@ama-assn.org with any questions.

Sincerely,



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