

## **Rainfall Health**

Offices of the Vice President, Clinical AI Strategy; Vice President, Compliance & Care Coordination

June 8, 2026

The Honorable Mehmet Oz, MD  
Administrator, Centers for Medicare & Medicaid Services  
U.S. Department of Health and Human Services  
Attention: CMS-1849-P  
P.O. Box 8013, Baltimore, MD 21244-8013

### **Re: Comments on the FY 2027 IPPS/LTCH PPS Proposed Rule (CMS-1849-P ), including Proposed Changes to the TEAM Composite Quality Score Methodology and the Request for Information Regarding TEAM Model Extension to Ambulatory Surgery Centers**

Dear Administrator Oz:

Rainfall Health is an AI-powered clinical operations and compliance company focused on helping hospitals deliver high-quality, cost-effective surgical care for Medicare beneficiaries, particularly in safety net, rural, Medicare Dependent, and Sole Community Hospitals. Our platform reduces the administrative burden of CMS value-based care participation by integrating episode cost analytics, quality performance monitoring, post-acute network optimization, and electronic care coordination across hospitals, skilled nursing facilities, home health agencies, and primary care providers.

Purpose-built for mandatory models such as the Transforming Episode Accountability Model (TEAM), our platform enables hospitals to manage the full 30-day surgical episode as a coordinated continuum of care rather than a series of disconnected encounters. By leveraging existing CMS data sources and workflows, we help organizations improve care transitions, reduce avoidable post-acute spending, and identify actionable opportunities to improve quality and outcomes during the episode itself.

Our mission aligns closely with CMS's transition from fee-for-service reimbursement to episode-based accountability by: (1) reducing participation barriers for smaller and resource-constrained hospitals; (2) improving cost-efficient care delivery across the entire 30-day episode, including post-acute care; and (3) strengthening patient outcomes through timely information exchange and proactive care coordination.

Rainfall Health works directly with TEAM participants across diverse hospital settings, providing firsthand insight into the operational and financial impacts of the model for all five TEAM procedures: lower extremity joint replacement, surgical hip and femur fracture treatment, spinal fusion, coronary artery bypass grafting, and major bowel procedures. The recommendations that follow are informed by our experience supporting these hospitals in real-world implementation.

### **Purpose of This Letter**

Rainfall Health appreciates the opportunity to comment on the proposed changes to TEAM set forth in the FY 2027 IPPS/LTCH PPS Proposed Rule.<sup>1</sup> Our goal in submitting these comments is the same goal we believe CMS is pursuing in this Administration: helping hospitals not only comply with TEAM, but realize its intended benefit for patients, which is recovering safely at home rather than being readmitted within 30 days. The comments below are offered in that spirit, in support of CMS's continued shift from fee for service reimbursement to value based, episode-based accountability for more cost efficient, high quality, patient centered care.

Our comments address two sections of the Proposed Rule. The first concerns the construction of the Composite Quality Score (CQS) using data from the Hospital Inpatient Quality Reporting (IQR), Hospital Outpatient Quality Reporting (OQR), and Hospital Acquired Condition (HAC) Reduction programs, and the proposed shift from a fixed historical baseline to a rolling window of performance data that updates annually. The second responds to CMS's Request for Information regarding the potential extension of TEAM to ambulatory surgery centers (ASCs). The two issues are closely interconnected. The quality and cost measurement framework that governs mandatory TEAM hospitals cannot be evaluated fairly without also examining how the growing migration of surgical volume to ASCs, currently operating outside TEAM's accountability structure, affects the patient populations and benchmarks against which mandatory participants are measured.

### **Summary of Key Recommendations for CMS Modification**

To assist CMS in focusing on the areas where we are requesting modifications to the Proposed Rule (as distinct from the provisions we support), we have summarized our principal recommendations below. Each is developed in the body of this letter.

#### **Composite Quality Score (CQS) methodology**

- **Shorten the lag between performance and CQS update** so that within Performance Year improvements in 30-day readmissions, patient safety events, and care transitions are reflected in the quality adjusted reconciliation amount for the year in which they occur, using hybrid claims plus eCQM data already submitted under IQR.
- **Preserve a higher of achievement or improvement scoring path** within the rolling baseline CQS for at least Performance Years 1 through 3, with a minimum CQS floor for hospitals demonstrating defined year-over-year improvement, so that safety net, rural, and high acuity hospitals are not penalized for starting further behind.
- **Incorporate at least one cross setting care coordination measure into the CQS**, for example documented structured electronic care plan transfer to the receiving SNF or home health agency within 24 hours of discharge, completion of the Information Transfer PRO PM, and a patient centered home time outcome, because the 30 day episode is won or lost outside the hospital's walls.
- **Refine the spinal fusion risk adjuster** to include functional and disability status as the MS DRG list is expanded, so that hospitals caring for more complex spine patients are not disadvantaged.
- **Revisit the neutral (50) score for missing data in Performance Years 4 and 5** to ensure it does not become a long-term substitute for measure completion.

## **Extension of TEAM to Ambulatory Surgery Centers (ASCs)**

- **Develop ASC specific, risk adjusted episode benchmarks before PY3** using Medicare Advantage style patient level risk stratification, pilot the methodology on a subset of ASC LEJR cases, and publish the results for public comment before finalizing.
- **Publish market level (CBSA) analyses** showing how ASC episode inclusion affects benchmarks for co located mandatory TEAM hospitals and revise the methodology before PY3 if benchmarks shift in ways that disadvantage hospitals serving more complex patients.
- **Complete ASC quality measure development before ASC participation begins**, with proposed ASC measures published for separate notice and comment rulemaking at least one full performance year in advance rather than as a parallel effort during active performance years.
- **Publish clear, prospective episode attribution rules for ASC initiated episodes before PY3**, covering attribution across multiple facilities, treatment of subsequent inpatient admissions within the 30-day window, multiple qualifying procedures, and exclusions for non compliance or unrelated emergencies.
- **Publish a comprehensive TEAM Year 1 analysis before finalizing ASC expansion**, including episode cost trends, quality score distributions, and post acute utilization by CBSA, so that structural design issues are identified and corrected before the model is expanded.

## **Part One: TEAM Composite Quality Score Methodology**

### **I. We Support the Rolling Baseline Methodology**

Surgical quality does not improve in discrete five-year intervals. It improves continuously, as teams learn from each case, refine handoffs between settings, and incorporate new evidence-based practices into perioperative care. A fixed historical baseline rewards a one-time process change and then plateaus. A rolling baseline that updates annually against the most recent performance of the national field, as CMS proposes,<sup>2</sup> aligns the measurement framework with the way clinical improvement occurs at the bedside. Under a static baseline, a patient operated on in 2029 is, in effect, being cared for against a standard set by clinical practice from 2023 or 2024. Under the proposed rolling baseline, the standard moves with the science and the emerging evidence. That is the right answer for Medicare beneficiaries, and it is an approach that hospitals and quality teams using modern reporting infrastructure, including the Rainfall Health platform, are well positioned to operationalize without adding to clinical reporting burden.

We also strongly support CMS's decision to construct the CQS from data hospitals already submit under IQR, OQR, and the HAC Reduction Program. This is consistent with TEAM's stated quality goal of "reducing participant burden by aligning measures and reporting infrastructure from existing CMS hospital quality programs,"<sup>3</sup> and it is consistent with the position taken by hospitals and their national associations in prior IPPS comment cycles, which have consistently urged CMS to minimize new and duplicative reporting requirements. Every hour clinical and quality staff spend on duplicative reporting is an hour not spent on the bedside coordination that drives the outcomes CMS is trying to measure. We urge CMS to preserve this alignment as the model evolves.

## **II. Three Amendments to Strengthen the Patient Care Impact of the Proposed CQS**

We respectfully request that CMS consider three refinements to the proposed methodology. Each is intended to ensure that the financial signal the CQS creates flows through to the patient level decisions that determine 30-day outcomes.

### **Amendment 1. Shorten the lag between performance and CQS update so that patient centered improvements are reflected within the same Performance Year**

Under the IQR, OQR, and HAC reporting timelines on which the proposed CQS baseline relies, performance data is typically not finalized in a participant's score until the calendar year following the performance period, and for several measures, two years later.<sup>2</sup> For a hospital that invests in a new sepsis detection workflow, a new SNF transition protocol, or a new patient reported recovery survey in Performance Year 1, the resulting reduction in readmissions or improvement in patient reported recovery may not appear in the CQS until Performance Year 3. From a patient perspective, this is the gap that matters most. The beneficiaries whose readmission was prevented in Year 1 do not benefit if the system that prevented their readmission cannot demonstrate the gain and therefore cannot sustain the investment.

**Recommendation.** CMS should permit interim CQS updates within a Performance Year using hybrid claims plus electronic clinical quality measure (eCQM) data already submitted under IQR, for example the Hybrid Hospital Wide Readmission measure,<sup>3</sup> so that documented within year improvements in 30 day readmissions, patient safety events, and care transition measures can be reflected in the quality adjusted reconciliation amount for the Performance Year in which they occurred.

### **Amendment 2. Preserve both achievement and improvement scoring so that hospitals serving higher risk patient populations are not penalized for starting further behind**

A rolling baseline that rewards only absolute achievement against the national field will, by construction, place hospitals serving lower income, higher acuity, and rural Medicare populations at a persistent disadvantage, even when those hospitals are demonstrating the largest year over year improvements. The evidence published on this point is unambiguous. A safety net health system that deployed AI enabled and EHR based readmission prevention tools reduced its 30 day all cause readmission rate from 27.9% to 23.9% ( $P < .004$ ), eliminated a previously documented readmission gap between Black and African American patients and the general population, and demonstrated a reduction in all cause mortality (HR 0.82; 95% CI 0.68 to 0.99).<sup>4</sup> Yet under an achievement only scoring construct, that same health system would have remained below the national median for the duration of its improvement period. The purpose of a CMS quality program is to drive better care for Medicare beneficiaries, including, and especially, beneficiaries cared for at hospitals that begin the measurement period at the bottom of the distribution.

**Recommendation.** CMS should preserve a higher achievement or improvement scoring path within the rolling baseline CQS, modeled on the Hospital Value Based Purchasing Program methodology, for at least Performance Years 1 through 3. A minimum CQS floor should also be

made available to hospitals demonstrating defined year-over-year improvement above a specified threshold.

**Amendment 3. Recognize cross setting care coordination in the CQS, because that is where the 30 day episode is actually won or lost**

The current CQS measure set evaluates quality almost entirely through measures attributable to the acute care hospital, even though the 30-day episode that hospitals are financially responsible for occurs largely outside their walls. Recent national data show that approximately 34% of total episode costs for inpatient TEAM episodes, and approximately 21% for outpatient episodes, are incurred after discharge, with roughly 39% of post anchor inpatient spend going to skilled nursing facilities (SNFs), 33% to inpatient rehabilitation facilities, 11% to unplanned readmissions, and 6% to home health.<sup>5</sup> This is precisely the surface area on which the Medicare beneficiary's recovery or readmission is determined.

The published evidence on coordinated post discharge care is consistent and clinically meaningful. A meta analysis of 45 studies of postsurgical mobile telemonitoring found a pooled reduction in hospital admissions (OR 0.47; 95% CI 0.29 to 0.79) and emergency department visits (OR 0.42; 95% CI 0.23 to 0.79).<sup>6</sup> A separate evaluation of home digital monitoring demonstrated a reduction in average hospitalizations from 0.45 to 0.19 per patient and ED visits from 0.48 to 0.06 per patient over three months of follow up.<sup>7</sup> Bundled payment evaluations have repeatedly found that documented savings concentrate in the post acute setting, including a 10% reduction in episode spending and a 30% reduction in return hospital admissions for outpatient spine surgery under BPCI Advanced,<sup>8</sup> and BPCI Advanced as a whole reduced per episode payments by \$1,014 (approximately 4%) in Model Year 5 without harming readmission or mortality outcomes.<sup>9</sup> In the outpatient setting, the Information Transfer PRO PM developed by Yale CORE found that "the lack of consistently written documentation in the outpatient setting is associated with worse patient understanding and lower patient involvement in their recovery."<sup>10</sup> Patients cannot recover safely at home from a major surgical procedure if the information they need to do so has not been transferred reliably from the operating surgeon to the home, the SNF, the home health agency, and the primary care physician.

CMS should also consider incorporating a home time measure as a post discharge outcome, defined as days alive and spent out of healthcare facilities over a defined post surgical window (for example, 30 days post surgery minus inpatient days minus SNF days minus days lost to death). Home time captures healthcare utilization and survival in a single, intuitive, patient centered outcome, and has been shown to discriminate post discharge outcomes in Medicare surgical populations.<sup>13</sup> For the Medicare beneficiaries TEAM is designed to serve, days at home is the outcome they themselves prioritize, and it directly reflects the cross setting coordination work the episode model is intended to reward. Importantly, this measure can be constructed from Medicare claims data CMS already holds, and can be enriched through AI enabled clinical platforms, including the Rainfall Health platform, which means adoption would not impose meaningful additional data collection burden on participating hospitals.

**Recommendation.** CMS should incorporate at least one cross setting care coordination measure into the CQS. Candidates include the share of episodes with documented structured

electronic care plan transfer to the receiving SNF or home health agency within 24 hours of discharge, completion of the Information Transfer PRO PM across both the hospital outpatient and post acute touchpoints of the episode, and a 30-day home time outcome.

### **III. Additional Observations**

**Spinal fusion MS DRG expansion.** We support the proposed addition of MS DRGs to the spinal fusion episode category.<sup>1</sup> To ensure this expansion does not disadvantage hospitals caring for more complex spine patients, we encourage CMS to refine the risk adjuster to include functional and disability status, a gap previously identified in stakeholder comments on TEAM.<sup>11</sup>

**Neutral scoring for missing data.** The policy of assigning a neutral (50) score to participants with insufficient quality data appropriately protects low volume hospitals during the early years of the model. We recommend CMS revisit this provision in Performance Years 4 and 5 to ensure it does not become a long term substitute for measure completion.

**SNF 3-day rule waiver.** We support continued expansion of the SNF 3-day rule waiver under TEAM. Allowing clinically appropriate direct to SNF discharge improves patient access to the right post acute setting and reduces avoidable inpatient days, which is one of the clearest levers available to mandatory participants managing 30-day episode costs.

### **Part Two: Extension of TEAM to Ambulatory Surgery Centers**

#### **Position: Support ASC Inclusion, Beginning No Earlier Than PY3, With Conditions**

Rainfall Health supports the incorporation of ambulatory surgery centers into TEAM, beginning no earlier than Performance Year 3 (calendar year 2028), as CMS has proposed.<sup>2</sup> This position is consistent with that of provider organizations that have urged CMS to bring outpatient surgical volume into bundled payment accountability structures, including comments submitted by the American College of Surgeons in prior IPPS cycles.<sup>20</sup> We believe ASC inclusion is ultimately necessary, not only for the structural integrity of the model, but for the patients whose care is increasingly divided between inpatient and outpatient settings without a unified accountability framework governing either side. However, we urge CMS to resolve four significant issues, namely adverse selection, risk adjustment, quality measurement, and episode attribution, before ASC participation is implemented.

#### **I. Adverse Selection Is Already Undermining Mandatory TEAM Participants**

The most urgent reason to include ASCs in TEAM is the adverse selection problem that CMS's own site of care policies have created for mandatory TEAM hospitals.

CMS has for several years pursued policies that encourage the migration of lower extremity joint replacement (LEJR) procedures to outpatient and ASC settings.<sup>14</sup> That migration is accelerating. As healthier, lower acuity LEJR patients shift to ASCs, the inpatient LEJR cases remaining at TEAM mandated hospitals increasingly represent higher complexity, higher cost patients, including those with greater comorbidity burden, higher baseline readmission risk, and greater dependence on post acute services. This pattern distorts the episode cost comparisons

on which TEAM reconciliation is based. Mandatory hospitals appear less efficient not because they are delivering worse care, but because their patient mix has grown systematically more complex while ASCs serving the same markets face no accountability under TEAM.

This dynamic has direct patient implications. When the financial signal attached to a LEJR episode rewards ASC based volume rather than outcomes, it creates pressure to move patients to outpatient settings that may not be appropriate for their clinical profile. A patient with significant cardiac comorbidities or limited post discharge support who is directed to an ASC LEJR to preserve hospital margins under TEAM is not being served by the model's incentives. Leaving ASCs outside TEAM does not preserve a level playing field. It actively tilts that field against the hospitals caring for the patients with the most complex needs.

## **II. Risk Adjusted Episode Benchmarks Are Essential**

ASC patients differ from inpatient LEJR patients in ways that go well beyond the procedures themselves. They are, on average, younger, have fewer comorbidities, carry lower baseline Medicare expenditures, and experience substantially lower rates of readmission and post acute utilization.<sup>5</sup> Any episode benchmark methodology that does not explicitly account for these population differences will produce results that are misleading rather than informative.

CMS should develop ASC specific episode benchmarks that incorporate patient level risk stratification using Medicare Advantage risk adjustment methodology or a comparable approach.<sup>1</sup> Benchmarks derived from historical inpatient episode costs must not be applied to ASC episodes without significant adjustment. We strongly urge CMS to pilot this methodology with a subset of ASC LEJR cases in advance of full PY3 inclusion and to publish the results for public comment before finalizing the approach.

Additionally, CMS should commit to publishing market level analyses showing how ASC episode inclusion affects episode cost benchmarks for mandatory TEAM hospitals in the same Core Based Statistical Area (CBSA). If the introduction of ASC episodes, with their systematically lower costs, causes CBSA level benchmarks to shift in ways that disadvantage co located mandatory hospitals, CMS should revise the benchmark methodology before PY3 implementation.

## **III. Quality Measure Development Must Precede Participation, Not Run Concurrently With It**

CMS has acknowledged that quality measurement for ASC based episodes requires further development.<sup>15</sup> We share this concern and urge CMS to complete that work before ASC participation begins, not as an ongoing parallel effort during active performance years.

Several of TEAM's existing CQS measures were designed for inpatient settings and cannot be straightforwardly applied to ASC episodes. Readmission measurement after ASC procedures is complicated by the absence of an inpatient anchor event. The THA/TKA Patient Reported Outcome Performance Measure (PRO PM) was built around hospital-based collection mechanisms that will require significant adaptation for ambulatory settings, which is precisely

the kind of information transfer gap that Yale CORE's work has documented as central to poor patient recovery outcomes.<sup>10</sup>

CMS should publish proposed ASC quality measures for separate notice and comment rulemaking at least one full performance year before ASC participation begins.<sup>16</sup> Introducing ASC participants with placeholder or unadapted quality measures would compromise the integrity of the CQS based reconciliation process and expose all participants, hospitals and ASCs alike, to arbitrary and inequitable performance adjustments.

#### **IV. Episode Attribution Rules Must Be Defined Clearly Before PY3**

TEAM episodes currently trigger on an inpatient admission and run for 30 days post discharge. This structure assumes an inpatient anchor event that provides a clean start date, a defined discharge, and well understood post discharge cost categories. ASC episodes lack this anchor, and the downstream care coordination implications are significant.

CMS is encouraged to develop and publish, in advance of PY3, clear rules governing how ASC initiated episodes will be:

- Attributed to a specific ASC when a patient has recent encounters at multiple facilities;
- Bounded for cases in which the patient is subsequently admitted to a hospital within the 30 day window due to a complication;
- Handled when multiple qualifying procedures occur within a short timeframe; and
- Excluded or adjusted when patient noncompliance, unrelated emergency events, or other exogenous factors affect post episode costs.

Without clear, prospectively published attribution rules,<sup>17</sup> ASCs and their beneficiary populations will be subject to unpredictable reconciliation outcomes, undermining both program integrity and participant confidence in the model.

#### **V. Publish Year 1 Data Before Finalizing Expansion**

TEAM is only in its first year of operation.<sup>18</sup> Before finalizing ASC inclusion through subsequent rulemaking, CMS should publish a comprehensive analysis of Year 1 mandatory participant performance, including episode cost trends, quality score distributions, and post acute utilization patterns by CBSA. Expanding the model significantly before CMS has validated Year 1 benchmarks and reconciliation outcomes risks compounding structural design flaws before they are identified and corrected.<sup>19</sup>

#### **Conclusion**

The proposed rolling baseline CQS methodology is a meaningful step toward measurement that tracks how clinical quality actually improves over time. CMS has estimated that TEAM will generate approximately \$481 million in Medicare program savings over the five performance years of the model.<sup>12</sup> Whether that estimate is realized, and, more importantly, whether the Medicare beneficiaries undergoing the five TEAM surgical procedures recover at home rather than in a hospital bed, will depend on whether the measurement framework rewards within year

improvement, recognizes the work of hospitals serving the most vulnerable patients, and captures the cross setting coordination that determines 30 day outcomes.

The extension of TEAM to ASCs is a necessary complement to that measurement framework. Without it, the model's financial incentives will continue to reward site of care migration over patient centered care, and mandatory hospitals caring for the most complex patients will bear the cost. Our support for ASC inclusion is contingent on CMS resolving the four structural issues described above before PY3 implementation.

Both sets of recommendations above, on the CQS methodology and on ASC inclusion, share a common purpose. They aim to ensure that the accountability framework CMS has built serves the Medicare beneficiaries it is designed to protect, wherever they receive their surgical care and however long their recovery takes.

We thank CMS for its continued work to align payment with patient outcomes and would welcome the opportunity to provide additional clinical and operational input as the methodology is finalized.

Respectfully submitted,

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