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VIA ELECTRONIC TRANSMISSION

June 9, 2026

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

RE: 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 [CMS-1849-P]

Dear Administrator Oz:

On behalf of the American Association of Neurological Surgeons (AANS) and the Congress of Neurological Surgeons (CNS), representing more than 4,000 neurosurgeons nationwide, we appreciate the opportunity to submit comments to the Centers for Medicare & Medicaid Services' (CMS) fiscal year (FY) 2027 Hospital Inpatient Prospective Payment Systems (IPPS) proposed rule published in the *Federal Register* on April 14, 2026.

The proposed rule addresses several issues of significant importance to neurosurgical patients and providers. In particular, the AANS and CNS comment on CMS's proposal to establish a new family of MS-DRGs for extensive and complex spinal fusion procedures, as well as the Agency's Request for Information regarding physician-owned hospitals (POHs) and participation in the Transforming Episode Accountability Model (TEAM). Collectively, these proposals present important opportunities to improve the accuracy of Medicare payment policy, strengthen the evaluation of value-based care models, and ensure that reimbursement and accountability frameworks appropriately reflect clinical complexity, resource utilization, and patient outcomes.

In summary, the AANS and CNS:

- Support the creation of MS-DRGs 523–525 to better distinguish highly complex spinal deformity and reconstruction procedures from routine spinal fusion services;
- Encourage CMS to refine the proposed DRG methodology by replacing device-specific triggers with clinically grounded definitions of procedural complexity and ensuring comprehensive capture of comparable high-resource spinal reconstruction procedures;

- Oppose the immediate inclusion of MS-DRGs 523–525 within TEAM until sufficient historical claims experience exists to support reliable target-price calibration, meaningful risk adjustment, and accurate benchmarking of episode expenditures;
- Support voluntary participation by qualified POHs in TEAM and oppose limiting participation solely to facilities grandfathered under the Affordable Care Act's rural provider or whole hospital exceptions;
- Encourage CMS to ensure that TEAM is supported by rigorous model design, reliable evaluation methodologies, meaningful quality measures, and appropriate risk adjustment; and
- Recommend that CMS focus on strengthening the methodological foundation of existing TEAM episode categories before considering expansion into additional clinical areas.

The AANS and CNS appreciate CMS's consideration of these comments and look forward to continued engagement on policies that affect patient access, physician-led innovation, hospital reimbursement, and value-based care.

PROPOSED CHANGES TO MEDICARE SEVERITY DIAGNOSIS-RELATED GROUP (MS-DRG) CLASSIFICATIONS AND RELATIVE WEIGHTS

Spinal Fusion and Pelvic Fixation Procedures

Spinal fusion surgery encompasses a broad continuum of procedures that differ profoundly in operative complexity, physiologic burden, implant utilization, and total hospital resource consumption. Despite these dramatic clinical and resource differences, the existing MS-DRG classification system has historically grouped many of these procedures, resulting in payment rates that inadequately reflect the true costs and clinical intensity of the most complex cases. The AANS and CNS have long advocated for a more granular and clinically grounded spinal fusion DRG hierarchy that aligns Medicare reimbursement with actual procedural complexity and supports sustained institutional investment in high-acuity spine care programs.

For FY 2027, CMS received two separate but related manufacturer requests that collectively prompted the Agency's proposal to establish a new family of "Extensive or Complex Spinal Fusion" MS-DRGs. These requests built upon a significant restructuring CMS undertook in the FY 2025 IPPS final rule, when the Agency created new MS-DRGs 402, 426–428, 447–448, and 450–451 to distinguish single-level from multi-level combined anterior/posterior spinal fusion procedures and to account for procedures involving the aprevo® Intervertebral Body Fusion Device — an acknowledgment that the prior DRG structure inadequately captured the resource heterogeneity within this patient population.¹

- **aprevo® Intervertebral Body Fusion Device.** A device manufacturer requested reassignment of cases involving the aprevo® Intervertebral Body Fusion Device from MS-DRG 402 to either MS-DRG 450 or, alternatively, to higher-severity combined fusion DRGs. The aprevo® device previously received New Technology Add-on Payment (NTAP) status for FYs 2022 through 2024.²
- **iFuse Bedrock™ Granite Implant System.** A device manufacturer requested reassignment of cases involving the iFuse Bedrock™ Granite Implant System from lower-severity spinal fusion DRGs to higher-severity major complication or comorbidity (MCC)-level DRGs. The Agency previously deferred requests from the manufacturer to reassign cases involving the iFuse

¹ 89 Fed. Reg. 68986

² 90 Fed. Reg. 36781-36784

Bedrock™ Granite Implant System to higher-severity spinal fusion MS-DRGs, citing the need for additional claims analysis and evaluation of the downstream impact on existing DRG relative weights.^{3, 4}

CMS analyzed FY 2025 Medicare Provider Analysis and Review (MedPAR) claims data across MS-DRGs 402, 426, 427, 428, 447, 448, 450, 451, 456, 457, and 458, evaluating costs and lengths of stay (LOS) associated with: (1) cases involving the aprevo® device; (2) cases involving the iFuse Bedrock™ Granite Implant System; and (3) cases involving “extensive fusion” procedures as defined under International Classification of Diseases, 10th Revision, Procedure Coding System (ICD-10-PCS) coding conventions. The Agency found that cases involving either named technology consistently demonstrated materially higher average hospital costs relative to other cases assigned to the same DRG. Similarly, extensive fusion procedures demonstrated significantly higher resource utilization, with the highest average costs observed in cases involving both extensive fusion and one or both named devices.⁵

Based on this analysis, CMS concluded that the resource profile associated with these cases could not be adequately addressed through simple upward reassignment within the existing hierarchy. Instead, the Agency proposes creation of the following distinct DRG family intended to capture extensive spinal fusion procedures and/or cases involving the aprevo® or iFuse Bedrock™ Granite Implant System.

Table 1. Proposed MS-DRG Family: Extensive or Complex Spinal Fusion

DRG	Description	Cases	Avg. LOS	Avg. Cost
523	Extensive or Complex Spinal Fusion Except Cervical with MCC	1,613	11.1 days	\$117,743
524	Extensive or Complex Spinal Fusion Except Cervical with CC	3,997	6.4 days	\$87,683
525	Extensive or Complex Spinal Fusion Except Cervical without CC/MCC	692	3.8 days	\$65,891

CMS also proposes reassignment of qualifying cases from existing spinal fusion DRGs into the new DRG family and proposes corresponding revisions to the titles of MS-DRGs 426, 447, 450, 456, 457, and 458. In addition, the Agency intends to add MS-DRGs 523–525 to the Transforming Episode Accountability Model (TEAM) spinal fusion episode category immediately upon implementation.

The AANS and CNS support CMS’ broader efforts to modernize the spinal fusion DRG hierarchy so that Medicare payment policy more accurately reflects the substantial clinical, operational, and resource differences between routine degenerative fusion procedures and highly complex spinal deformity and reconstruction surgery. More refined classification of complex spinal fusion procedures can improve alignment between Medicare reimbursement and actual hospital resource utilization, enhance the integrity of benchmarking and quality measurement efforts, support continued institutional investment in high-acuity spine and deformity programs, and help preserve beneficiary access to advanced spinal reconstruction services—particularly as Medicare increasingly transitions toward episode-based and value-based payment methodologies. **However, as described in detail below, the AANS and CNS urge CMS to address several important structural and policy issues before finalizing its proposal to establish the new family of “Extensive or Complex Spinal Fusion” MS-DRGs.**

³ 90 Fed. Reg. 18002

⁴ 90 Fed. Reg. 36537

⁵ Centers for Medicare & Medicaid Services (CMS), *Medicare Provider Analysis and Review (MedPAR) File*, FY 2025 claims data.

- **Qualifying Criteria for MS-DRG Assignment.** The AANS and CNS believe the qualifying criteria for assignment to MS-DRGs 523–525 should be grounded in objective indicators of procedural complexity, physiologic burden, and hospital resource consumption rather than reliance on the use of specifically identified proprietary implant systems. Medicare payment policy should remain clinically neutral with respect to device selection and should avoid creating financial incentives that could inadvertently influence physician decision-making, distort market dynamics, increase coding ambiguity, or produce inconsistent reimbursement outcomes for clinically comparable procedures.
- **Defining “Extensive” and “Complex.”** The AANS and CNS are concerned that the proposed MS-DRG descriptors may inadvertently exclude numerous clinically comparable, high-complexity spinal reconstruction procedures that do not involve the named devices or do not meet the current definition of “extensive” or “complex.” We urge CMS to collaborate with neurosurgical and orthopedic specialty societies to develop clinically grounded, procedure-based definitions of “extensive” and “complex” spinal fusion that comprehensively capture the full spectrum of high-acuity spinal reconstruction care, regardless of the specific implant technology utilized or the number of levels fused.
- **Inclusion in TEAM.** The AANS and CNS strongly oppose the proposed immediate inclusion of MS-DRGs 523–525 within the TEAM spinal fusion episode category. Because these MS-DRGs would represent newly established classifications without directly corresponding to historical claims experience, insufficient data would initially exist to support reliable target price calibration, meaningful risk adjustment, or accurate benchmarking of episode expenditures. Premature incorporation into TEAM could therefore expose hospitals treating the most medically and surgically complex patients to inappropriate financial risk and potentially undermine beneficiary access to specialized spinal reconstruction services. Should CMS ultimately proceed with TEAM inclusion, we encourage adoption of meaningful transitional safeguards, including delayed implementation until sufficient claims experience has accumulated under the new DRG structure.

The AANS and CNS are committed to working constructively with CMS to achieve a spinal fusion DRG framework that is clinically grounded, administratively workable, and durable. As such, we urge the Agency to:

- **Finalize the creation of MS-DRGs 523, 524, and 525** to establish a meaningful distinction between highly complex deformity and spinopelvic reconstruction procedures and routine spinal fusion, **while revising the qualifying criteria as described above** to ensure the DRGs are grounded in clinical complexity rather than device selection;
- **Revise the proposed DRG logic to eliminate device-specific triggers** in favor of clinically grounded, procedure-based definitions of “extensive” and “complex” spinal fusion developed in consultation with neurosurgical and orthopedic specialty societies;
- **Ensure comprehensive capture of clinically equivalent high-resource procedures**—including complex revision reconstructions, three-column osteotomies, tumor reconstructions, and infection-related spinal surgeries—regardless of the specific implant system utilized;
- **Protect the reimbursement integrity of standard spinal fusion procedures** by ensuring that budget neutrality adjustments do not inappropriately reduce payment for lower-complexity but clinically appropriate and commonly performed spine procedures; and
- **Delay inclusion of MS-DRGs 523–525 in TEAM** until sufficient historical claims data exist to support reliable target price benchmarking, meaningful risk adjustment, and appropriate transitional safeguards.

We believe these modifications are essential to ensuring that the new MS-DRG family fulfills its intended purpose: accurately recognizing the complexity and resource intensity of the most demanding spinal reconstruction procedures, supporting hospitals that invest in the specialized infrastructure required to care for these patients, and preserving beneficiary access to high-quality, advanced spinal care as Medicare payment policy continues to evolve.

HOSPITAL WITH PHYSICIAN OWNERSHIP REQUEST FOR INFORMATION

The AANS and CNS strongly support CMS's willingness to explore additional opportunities to promote competition, expand patient access, and encourage physician-led innovation through this RFI. The Agency's consideration of physician-owned hospitals (POHs) comes at a particularly important moment for the US health system. Over the past decade, the health care marketplace has experienced substantial consolidation among hospitals, health systems, insurers, and physician practices, contributing to growing concerns regarding competition, patient choice, affordability, and access to care. According to a recent analysis by the Physicians Advocacy Institute and Avalere Health, 82 percent of physicians are now employed by hospitals or other corporate entities, and nearly two-thirds of physician practices are no longer physician-owned.⁶ Between 2018 and 2026 alone, more than 253,000 physicians transitioned from independent practice to employment, while approximately 85,000 physician practices were acquired by hospitals or other corporate entities.⁷

Against this backdrop, CMS appropriately recognizes in this proposed rule that POHs may offer an important countervailing model. As the Agency notes, an expanding body of evidence suggests that POHs may help control costs, maintain or improve quality, enhance patient satisfaction, and promote competition within increasingly concentrated health care markets. The proposal also builds on CMS' prior efforts to provide targeted flexibility where statutory and regulatory authority permitted, including actions that recognized the important role POHs and physician-led care can play in expanding patient access, promoting competition, and delivering high-quality care. Notably, some of the most significant policy advancements for physician-led care in recent years occurred during President Trump's first administration. In the CY 2021 Hospital Outpatient Prospective Payment System (OPPS) Final Rule, CMS removed restrictions on facility expansion for qualifying high-Medicaid POHs, allowing more frequent expansion requests and eliminating certain limitations on operating room, procedure room, and bed capacity.⁸ Likewise, through the Regulatory Sprint to the Coordinated Care Final Rule, CMS modernized Stark Law regulations to promote care coordination, innovation, and value-based care.⁹ Specifically, CMS clarified that physician interests arising through qualified employee stock ownership plans do not constitute ownership or investment interests for purposes of the physician self-referral law.

At a time when policymakers, regulators, and antitrust authorities across the federal government are actively examining the effects of consolidation on health care spending and patient access, CMS's willingness to further evaluate the role of POHs through TEAM is both timely and warranted. At the same

⁶ Physicians Advocacy Institute, Avalere Health, Physician Employment Trends and Practice Acquisitions: 2018–2026 (2026), <https://www.physiciansadvocacyinstitute.org/PAI-Research/PAI-Avalere-Health-Report-on-Physician-Employment-Trends-and-Practice-Acquisitions-2018-2026>.

⁷ *Ibid.*

⁸ Centers for Medicare & Medicaid Services, *Medicare Program: Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems and Quality Reporting Programs; Final Rule*, 85 Fed. Reg. 85866, 86107–86115 (Dec. 29, 2020), <https://www.federalregister.gov/documents/2020/12/29/2020-26819/medicare-program-hospital-outpatient-prospective-payment-and-ambulatory-surgical-center-payment>.

⁹ Centers for Medicare & Medicaid Services, *Medicare Program; Modernizing and Clarifying the Physician Self-Referral Regulations*, 85 Fed. Reg. 77492, 77588–77589, 77665 (Dec. 2, 2020), <https://www.federalregister.gov/documents/2020/12/02/2020-26140/medicare-program-modernizing-and-clarifying-the-physician-self-referral-regulations>.

time, however, the AANS and CNS strongly encourage CMS to ensure that the TEAM Model is designed to produce meaningful, reliable, and scalable results.¹⁰ This is particularly important given prior evaluations of the Center for Medicare and Medicaid Innovation (CMMI) activities. In 2023, the Congressional Budget Office found that CMMI's activities increased federal spending by approximately \$5.4 billion during its first decade of operation and identified challenges associated with participant self-selection, attrition, and model design that may affect model performance and evaluation.¹¹ Similarly, the Government Accountability Office reported that CMMI obligated approximately \$11.4 billion and tested 70 payment and delivery models between 2011 and 2024, while only four models ultimately advanced to nationwide expansion.¹² Given both the significance of this opportunity for POHs and the limited number of demonstrations that have successfully generated scalable evidence for broader adoption, CMS should ensure that TEAM is structured to rigorously evaluate whether POHs can improve quality, reduce costs, and enhance value for Medicare beneficiaries through appropriate risk adjustment, sound evaluation methodologies, and incentives that accurately reflect provider performance rather than avoidable flaws in demonstration design. To that end, we encourage CMS to maintain an ongoing dialogue with participating providers and remain responsive to implementation challenges that emerge during model testing. As demonstrated through CMMI's willingness to solicit stakeholder feedback and make iterative refinements to the Wasteful and Inappropriate Service Reduction (WISeR) Model, successful demonstrations often require flexibility and adaptation as operational realities become apparent.

The following responses address the RFI questions most relevant to the neurosurgical community and to broader issues of patient access, physician-led care, competition, and value-based payment reform.

1. *Should CMS allow a voluntary opt-in period to include POHs in TEAM; why or why not? Should the option to participate in TEAM be limited to those POHs that are grandfathered under the Affordable Care Act to use the rural provider or whole hospital exception to the physician self-referral law?*

The AANS and CNS support allowing POHs to voluntarily participate in TEAM and can identify no policy, programmatic, or evidentiary rationale for limiting participation solely to hospitals grandfathered under the Affordable Care Act's rural provider or whole hospital exceptions. Nor are we aware of any evidence suggesting that a hospital's ability to participate successfully in a value-based payment demonstration is determined by whether its ownership structure existed before March 23, 2010. Notably, CMS acknowledges in this proposed rule that approximately 15 POHs are already participating in TEAM as mandatory participants. Their participation demonstrates that POHs can meet the model's operational requirements and collaborate with traditional hospitals in episode-based payment arrangements. Restricting future participation opportunities exclusively to grandfathered facilities would unnecessarily narrow the demonstration and limit CMS's ability to evaluate the performance of physician-led care models across diverse markets, geographic regions, and practice settings.

¹⁰ American Association of Neurological Surgeons, Congress of Neurological Surgeons, Comments on CMS-1832-P, Medicare and Medicaid Programs; CY 2026 Payment Policies under the Physician Fee Schedule and Other Changes to Part B Payment and Coverage Policies; Medicare Shared Savings Program Requirements; and Medicare Prescription Drug Inflation Rebate Program, September 12, 2025, <https://www.aans.org/wp-content/uploads/2025/06/AANS-CNS-FY-2026-Medicare-Hospital-IPPS-Proposed-Rule-Comments.pdf>.

¹¹ Congressional Budget Office, *Federal Budgetary Effects of the Activities of the Center for Medicare & Medicaid Innovation*, September 2023, <https://www.cbo.gov/system/files/2023-09/59274-CMMI.pdf>.

¹² Government Accountability Office, *CMS Innovation Center: Obligations and Model Testing Progress*, GAO-26-107953, March 2026, <https://www.gao.gov/products/gao-26-107953>. See also, House Committee on the Budget, GAO Confirms CMMI Failures: Chairman Arrington Calls for Accountability and Reform Under Trump, Press Release, April 22, 2026, available at <https://budget.house.gov/press-release/gao-confirms-cmmi-failures-chairman-arrington-calls-for-accountability-and-reform-under-trump>.

Available evidence suggests that POHs may be particularly well-positioned to advance the objectives underlying TEAM. As CMS acknowledges in this proposed rule, multiple studies have found that POHs frequently achieve strong quality outcomes, high patient satisfaction, and efficient resource utilization. Of note, in a 2023 analysis of Medicare claims data on the 20 highest-cost DRGs, POHs delivered care at significantly lower cost than traditional hospitals across all DRGs studied, even after adjusting for patient demographics, comorbidities, and regional payment differences.¹³ The study found that total Medicare and beneficiary payments at POHs were between 8.6 percent and 15.2 percent lower than those at traditional hospitals for the same services. At the same time, patient populations were largely comparable in age, race, sex, and clinical complexity. The authors estimated that Medicare spending on these 20 DRGs alone would have been reduced by approximately \$1.1 billion in a single year – a 12.2 percent reduction – if traditional hospitals had achieved the same cost profile as POHs. These findings are particularly relevant to TEAM, which is designed to improve quality and accountability while reducing episode spending. Allowing POHs to participate would provide CMS with an opportunity to evaluate whether the efficiencies observed under traditional Medicare payment systems translate into similar or greater value under a prospective episode-based payment model, and could generate meaningful savings for Medicare beneficiaries and taxpayers.

2. *Should POHs that wish to opt into TEAM voluntarily be required to meet the geographic eligibility criteria described previously and in 42 CFR 512.515 and be subject to participation requirements described in 42 CFR 512.510? What inclusion criteria, if any, should be added for POHs opting to participate in TEAM?*

The AANS and CNS support applying the participation requirements set forth at 42 C.F.R. § 512.510 to voluntarily participating POHs. Applying the same requirements governing data submission, quality reporting, beneficiary attribution, target price methodology, reconciliation, and other operational aspects of the model will help preserve the integrity of the demonstration and facilitate meaningful comparisons across participating facilities. POHs should be evaluated under the same performance framework as other TEAM participants, and we do not determine that separate participation standards are necessary solely because of a facility's ownership structure.

However, we do not find that the geographic eligibility criteria at 42 C.F.R. § 512.515 should be applied to limit voluntary participation to hospitals located within previously selected TEAM Core-Based Statistical Areas. By definition, a voluntary participation pathway is intended to expand the population of facilities available for evaluation. Restricting participation to existing TEAM geographies would substantially limit CMS's ability to assess whether physician-led hospitals can improve quality, reduce costs, enhance patient experience, and expand access in markets where POHs are currently absent, including rural communities, Health Professional Shortage Areas, and regions characterized by significant provider consolidation. CMS should therefore adapt the geographic eligibility framework to permit participation by qualified POHs regardless of whether they are located within a mandatory TEAM region, while continuing to use appropriate local and regional benchmarks for target pricing and performance evaluation.

If CMS elects to establish additional inclusion criteria for voluntarily participating POHs, those criteria should be objective, measurable, and directly related to the demonstration's goals. Potential criteria

¹³ Aseltine RH Jr., Matthews GJ., *A Study of the Cost of Care Provided in Physician-Owned Hospitals Compared to Traditional Hospitals: Analysis of 20 High-Cost Diagnostic-Related Groups Using 2019 Medicare Claims Data*, Technical Report prepared for the Physicians Advocacy Institute and The Physicians Foundation, October 2023, <https://www.physiciansadvocacyinstitute.org/Portals/0/assets/docs/PAI-Research/Physician-Owned%20Hospitals%20Report%20-%203-11-24%20-%20for%20PAI.pdf?ver=3PXqdp1jqxCMxMwL2i9Bgg%3d%3d>.

could include Medicare certification and compliance with applicable Conditions of Participation, demonstrated emergency services capability or appropriate transfer arrangements, satisfactory performance on publicly reported quality measures, and agreement to participate in enhanced transparency and reporting requirements. Such criteria would help ensure participating facilities are capable of meaningfully contributing to the demonstration while avoiding arbitrary distinctions based on ownership status or historical grandfathering provisions. Most importantly, any additional eligibility requirements should be designed to strengthen the validity of the evaluation rather than limit CMS's ability to test physician-led care models across diverse patient populations and health care markets.

- 3. What programmatic waivers may be necessary to ensure POHs have successful participation in TEAM (for example, restrictions on expansion of facility capacity, service limitations, etc.)? Provide justification for any waiver that you believe may be necessary. Please explain how the waiver will not undermine the TEAM model by allowing Medicare payment for services furnished by POHs where such payments are not currently allowed because the POHs are not grandfathered in to use the rural provider or whole hospital exception to the physician self-referral law.*

The AANS and CNS recognize that limited, model-specific waivers may be necessary to ensure meaningful participation by POHs in TEAM and to allow CMS to fully evaluate the model. CMS should strongly consider targeted flexibility related to facility-capacity restrictions imposed by Section 6001 of the Affordable Care Act, where such restrictions would otherwise impede participation in TEAM. As described above, CMS has previously recognized the value of this approach through reforms to the high-Medicaid facility expansion process, finalized in the CY 2021 OPPS Final Rule, which reduced barriers that limited qualifying POHs' ability to expand capacity and meet community needs. Similar flexibility may be warranted where existing restrictions on operating rooms, procedure rooms, licensed beds, or service-line development would prevent participating POHs from fully engaging in TEAM or furnishing additional episode categories included within the model.

The AANS and CNS also recognize that CMS may determine additional waivers are necessary to permit participation by otherwise qualified non-grandfathered POHs. To the extent such waivers are required, they should be tailored to the activities necessary to facilitate meaningful participation in TEAM and permit CMS to evaluate the physician-led hospital model on its merits rather than through the lens of statutory and regulatory restrictions that do not apply to other participating facilities.

While AANS and CNS do not seek to prescribe the specific design of any waivers, we encourage CMS to carefully consider the detailed recommendations submitted by Physician-Led Healthcare for America, whose members possess substantial expertise regarding the operational and regulatory challenges facing POHs and the flexibility that may be necessary to facilitate meaningful participation in TEAM.

- 4. Waivers of law, if provided and necessary to test a model, are temporary and generally end when the model expires or the participant's agreement is terminated. How will POHs continue any successful actions taken under TEAM once they must comply with all applicable statutes and regulations, including the physician self-referral law?*

Because TEAM is intended to evaluate the effectiveness of episode-based payment and care redesign, CMS should ensure that statutory and regulatory restrictions unique to POHs do not prevent meaningful participation or bias the results of the demonstration. As discussed above, CMS has previously demonstrated a willingness to revisit longstanding restrictions affecting POHs when evidence and experience support reform. Through the CY 2021 OPPS Final Rule, the Agency permanently expanded flexibility for qualifying high-Medicaid POHs. Through the Regulatory Sprint to Coordinated Care initiative,

CMS modernized aspects of the physician self-referral framework to reduce unnecessary barriers to innovative care delivery models. These actions demonstrate that CMS has meaningful authority to reevaluate existing policies that unnecessarily impede access, competition, care delivery, or value-based care.

Accordingly, if TEAM demonstrates that participating POHs improve quality, reduce costs, enhance patient experience, expand access to care, or otherwise advance the objectives of value-based payment, CMS should proactively issue rulemaking to make successful waivers or policy changes permanent wherever regulatory authority exists. The Agency should engage the Office of the General Counsel and other relevant components of the U.S. Department of Health and Human Services (HHS) to identify administrative pathways that could enable successful reforms to continue beyond the model's life. To the extent that statutory limitations constrain CMS's authority, the Agency should clearly identify those barriers and work collaboratively with Congress to explore legislative solutions informed by the demonstration's results.

Importantly, Congress has demonstrated growing interest in the role of POHs in promoting competition, affordability, and patient access. Bipartisan legislation has been introduced to expand opportunities for physician-led hospitals, including the Patient Access to Higher Quality Health Care Act of 2025 (H.R. 4002) and the Physician-Led and Rural Access to Quality Care Act (S. 1390/H.R. 2191).^{14, 15} Congressional committees have likewise devoted increasing attention to provider consolidation and the effect of market structure on health care costs and access. More recently, the House Committee on Energy and Commerce has undertaken a series of hearings examining health care affordability and the changing provider landscape. During a March 2026 hearing before the Subcommittee on Health, Anthony DiGiorgio, DO, MHA, a member of the AANS/CNS Washington Committee and appointee to the National Committee on Vital and Health Statistics within HHS, detailed POHs as one of the few remaining physician-led alternatives to consolidation, arguing that federal policies restricting POHs have reduced market competition and limited lower-cost options for patients.¹⁶

Given the above, successful demonstrations should serve as a foundation for broader regulatory and legislative reforms that preserve proven innovations and expand opportunities for POHs to contribute to Medicare's goals of improving quality, increasing competition, expanding access, and lowering costs.

5. *What additional program integrity requirements should CMS consider to avoid beneficiary steering, cherry-picking, and lemon-dropping, and ensure beneficiary choice is not compromised if waivers are offered to POHs?*

The AANS and CNS do not recommend imposing POH-specific program integrity requirements beyond those already applicable to TEAM participants. Participating POHs should remain subject to the same quality reporting, accountability, beneficiary protection, compliance, audit, and oversight requirements that govern all hospitals participating in the model. Imposing unique requirements on POHs could introduce unnecessary differences in participation and complicate the Agency's ability to assess whether POHs are on an equal footing with other providers.

¹⁴ H.R. 4002, Patient Access to Higher Quality Health Care Act of 2025, 119th Cong. (2025).

¹⁵ H.R. 2191, Physician-Led and Rural Access to Quality Care Act, 119th Cong. (2025).

¹⁶ Anthony M. DiGiorgio, DO, MHA, FAANS, Assistant Professor of Neurological Surgery, University of California, San Francisco, Testimony Before the U.S. House Comm. on Energy & Commerce, Subcomm. on Health, *Lowering Health Care Costs for All Americans: An Examination of the U.S. Provider Landscape* (Mar. 18, 2026), https://d1dth6e84htgma.cloudfront.net/03_18_2026_HE_Hearing_Witness_Testimony_Di_Giorgio_02a0b47eaa.pdf.

To the extent CMS maintains concerns regarding beneficiary steering, cherry-picking, or lemon-dropping, those concerns should be evaluated through objective performance data generated during the demonstration rather than presumed based upon ownership structure alone. Existing federal fraud-and-abuse laws, Medicare participation requirements, quality reporting programs, EMTALA, and TEAM accountability mechanisms already provide substantial oversight of participating facilities. The AANS and CNS are unaware of evidence demonstrating that additional POH-specific requirements are necessary to protect beneficiaries or ensure program integrity within the model.

6. *Should any episode categories be excluded from episode initiation, or should any items and services be excluded from target prices for POHs in TEAM? If so, include evidence to support this exclusion.*

The AANS and CNS do not recommend excluding any TEAM episode categories solely based on hospital ownership structure. POHs should be permitted to participate in the same episode categories and be evaluated under the same accountability framework as other TEAM participants. Excluding episode categories based on ownership status would unnecessarily limit CMS's ability to evaluate POHs and diminish the demonstration's comparative value.

At the same time, CMS should remain willing to modify episode definitions, delay implementation of newly established categories, or exclude specific services where insufficient data, inadequate risk adjustment, methodological limitations, or other design concerns may compromise the validity of the demonstration. As discussed previously, the AANS and CNS have consistently encouraged CMS and CMMI to ensure that value-based payment models are designed to produce meaningful, reliable, and actionable results. This is particularly important given the Agency's own acknowledgment that successful model design and evaluation remain critical to achieving the objectives of Innovation Center demonstrations.

Consistent with comments elsewhere in this rule, the AANS and CNS strongly oppose the immediate inclusion of newly proposed MS-DRGs 523, 524, and 525 within the TEAM spinal fusion episode category. Because these classifications would represent newly established DRGs with insufficient historical claims experience, their immediate inclusion would not support reliable target-price calibration, meaningful risk adjustment, or accurate benchmarking of episode expenditures. Premature incorporation could expose hospitals treating the most medically and surgically complex spine patients to inappropriate financial risk and potentially undermine beneficiary access to specialized spinal deformity and reconstruction services. CMS should delay inclusion of these DRGs until sufficient claims experience exists to support reliable evaluation and appropriate transitional safeguards.

More broadly, CMS has recently demonstrated through modifications to the WISeR model that stakeholder feedback can identify circumstances in which particular services, procedures, or methodologies warrant removal, delayed implementation, or additional refinement before testing. Following stakeholder engagement and supporting documentation, CMS removed deep-brain stimulation for Parkinson's disease from the model, delayed implementation of percutaneous image-guided lumbar decompression, removed spinal arthrodesis (Current Procedural Terminology code 22585) from the targeted procedure list, revised documentation requirements, and adopted several other refinements to improve implementation. The AANS and CNS encourage a similar willingness to make data-driven adjustments to TEAM where necessary to ensure that model performance reflects the quality and efficiency of care delivery rather than avoidable methodological limitations.

7. *What episode categories, beyond the episode categories currently tested in TEAM, should CMS consider testing for POHs?*

The AANS and CNS do not recommend expanding TEAM to additional episode categories until CMS demonstrates that existing episode categories are supported by reliable target-price methodologies, meaningful quality measures, and risk-adjustment approaches that accurately account for patient complexity and case mix.

As discussed throughout these comments, the AANS and CNS have consistently advocated for value-based payment models that are supported by rigorous design, appropriate risk adjustment, and reliable evaluation methodologies. Expanding the scope of TEAM before addressing methodological concerns within the existing model risks compounding those challenges and reducing the interpretability of demonstration results. This concern is particularly relevant in complex procedural specialties, where substantial differences in patient acuity, revision burden, medical comorbidity, and resource utilization may not be fully captured through existing benchmarking and risk-adjustment methodologies.

Accordingly, CMS should focus first on ensuring that currently tested episode categories generate meaningful, reliable, and actionable results before considering broader expansion. Any future expansion should be informed by demonstrated model performance, supported by sufficient clinical and claims experience, and developed in consultation with affected specialty societies and other stakeholders.

Conclusion

The AANS and CNS appreciate the opportunity to comment on the FY 2027 IPPS Proposed Rule and look forward to continued engagement with CMS on these important issues. If additional information would be helpful or questions arise regarding these comments, please contact Lauren M. Foe, MPH, Director of Regulatory Policy for the AANS/CNS Washington Office, at lfoe@neurosurgery.org. Thank you for considering these recommendations and for your continued efforts to improve care for Medicare beneficiaries.

Sincerely,



E. Antonio Chiocca, MD, PhD
President
American Association of Neurological Surgeons



Martina Stippler, MD
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