Catholic Health Association of the United States

A Passionate Voice for Compassionate Care

June 9, 2026

Mehmet Oz, MD
Administrator
Centers for Medicare & Medicaid Services
Department of Health & Human Services
Room 445-G Herbert H. Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201

REF: CMS-1849-P

Re: 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 Dr. Oz:

The Catholic Health Association of the United States (CHA) is pleased to submit these comments on the referenced Centers for Medicare & Medicaid Services' (CMS) proposed rule published in the *Federal Register* on April 14, 2026 (91 FR 19312). We appreciate the ongoing efforts of CMS to administer and improve the payment systems for acute inpatient hospital services, especially considering the agency's many competing demands and limited resources. CHA offers the following comments on the proposed rule.

- **Proposed Changes to Payment Rates under the Inpatient Prospective Payment System (IPPS)**

CMS is proposing to update hospital IPPS rates by 2.4 percent in fiscal year (FY) 2027. This rate update equals the hospital market basket of 3.2 percent, lessc0.8 percentage points for the productivity adjustment.

CHA remains concerned that CMS is underestimating the hospital market basket during a time of high inflation and global uncertainty. As the update to hospital rates is based on an estimate of the hospital market basket and CMS does not make a future adjustment for forecast error, any understatement results in hospital receiving a payment update less than the rate of inflation with the effect of exacerbating Medicare payment rates that are already below hospital costs.

Earlier this decade, CMS vastly underestimated the hospital market basket during a period of global price instability caused by the COVID-19 pandemic. From FY 2021 to FY 2024, CMS underestimated the IPPS market basket by a combined 4.2 percentage points. In FY 2022, CMS

underestimated the hospital market basket by 2.6 percentage points. As inflation stabilized post-pandemic, the difference between CMS' forecast of the market basket and its actual measurement based on later available data has narrowed. However, CHA is concerned that the United States is entering another period of economic instability due to high tariffs and global events.

Recent data from the Bureau of Labor Statistics indicates that the all-items Consumer Price Index rose 3.8 percent over the 12 months ending April 2026.[1] While CHA recognizes that the CPI measures a different set of goods and services than the hospital market basket, we remain concerned about general economy wide inflation is growing more rapidly than suggested by CMS' estimate of the FY 2027 hospital market basket. **Given past underestimates of the inflation update, CHA requests that CMS adopt a prospective forecast error correction policy for the FY 2027 update if CMS again understates the hospital market basket during a period of considerable economic instability when accurately predicting hospital inflation is more uncertain.**

- **Productivity Estimates**

The Affordable Care Act requires the IPPS payment update is reduced by a productivity factor equal to the "10-year moving average of changes in annual economy-wide private nonfarm business multi-factor productivity (as produced by the Secretary for the 10-year period ending with the applicable fiscal year)." The theory behind the offset for economy wide total productivity is that the hospital sector should be able to realize the same productivity gains as the general economy.

However, CMS' Office of the Actuary (OACT) itself takes issue with the assumption that hospitals can recognize the same kinds of productivity gains as the general economy. In a memorandum dated June 2, 2022, OACT stated: "over the period 1990-2019, the average growth rate of hospital TFP using the two methodologies ranges from 0.2 percent to 0.5 percent, compared to the average growth of private nonfarm business TFP of 0.8 percent." The memorandum also indicates that an assumed future rate of hospital industry productivity growth of 0.4 percent per year remains reasonable compared to an assumed rate of productivity growth in the private nonfarm business sector of 1.0 percent.[2]

CHA recognizes that the statute requires CMS is required to apply the total factor productivity offset. **Nevertheless, CHA requests that CMS consider OACT's analysis and encourage Congress to change the law to change the productivity offset to one that is achievable by the hospital sector.**

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[1] 12-month percentage change, Consumer Price Index, selected categories

[2] Paul Spitalnic, Stephen Heffler, Bridget Dickensheets and Mollie Knight, "Hospital Multifactor Productivity: An Update Presentation of Two Methodologies Using Data through 2019." Hospital Multifactor Productivity: An Updated Presentation of Two Methodologies Using Data through 2019 (cms.gov).

- **Outlier Threshold**

To qualify for outlier payments for high-cost cases, a case must have costs greater than the sum of the prospective payment rate for the MS-DRG (including any add-ons) plus the "outlier threshold" or "fixed-loss" amount, which is $40,397 for FY 2026. CMS proposes adopting an outlier threshold for FY 2027 of $51,704, an increase of 28 percent and $11,307 from the FY 2026 amount, the largest single year increase in the outlier threshold in at least two decades if not ever.

CHA further notes that CMS has deviated from its normal methodology to set the outlier threshold for long term care hospitals in the FY 2027 IPPS proposed rule because of concerns about using anomalous data in its methodology. CMS expresses concern about how the data being used in its traditional model is affecting the determination of the cost outlier threshold for LTCHs. As a result, CMS has proposed maintaining the current threshold of $78,936.[3]

Given large and potentially unprecedented increase in the IPPS outlier threshold, CHA requests that CMS carefully analyze its methodology to determine why its model for projecting outlier payments in FY 2027 is resulting in a much greater increase in the outlier threshold than is typical**. Like the LTCH outlier threshold, CHA requests CMS to maintain the outlier threshold at $40,397 for FY 2027 if the anomalous data is driving the large increase under its model.**

- **MS-DRGs**

Under the MS-DRGs, designation of a secondary diagnosis code as a complication or comorbidity (CC) or a major complication and comorbidity (MCC) signifies increased resource use for the patient in the absence of a CC or MCC. Accordingly, if a CC or MCC is coded on the inpatient claim, CMS will classify the patient into a higher paying MS-DRG.

In the FY 2024 IPPS proposed rule, CMS finalized changes to the severity levels for diagnosis codes Z59.00 (Homelessness, unspecified), Z59.01 (Sheltered homelessness), and Z59.02 (Unsheltered homelessness) and for seven diagnosis codes that describe inadequate housing and housing instability from non-CC to CC. CHA supported these changes. CMS is now proposing to change the severity level designations of the codes back to non-CC for FY 2027.

CHA disagrees with this proposal and asks that CMS not finalize it. If the underlying data associated with the patients being treated suggest that homelessness contributes to higher cost to treat clinically similar patients that are not homeless, CHA believes the higher cost of treating those patients should be recognized by classifying homelessness as a CC.

[3] 71 FR 19380

- **Changes to the Wage Index**

Low-Wage Index Policy

On July 23, 2024, the Court of Appeals for the D.C. Circuit Court held that the Secretary lacked authority to adopt a low-wage index hospital policy that allowed low-wage hospitals to use a higher wage index to increase hospitals wages which then became part of the low-wage hospital's succeeding fiscal year's wage index. The Court also rejected the related budget neutrality adjustment.[4] To comply with the Court's decision, CMS recalculated FY 2025 IPPS rates to remove the low-wage index hospital policy and the related budget neutrality adjustment. In addition, CMS applied a transitional policy for hospitals benefiting from the low wage index hospital policy that would prevent their wage index from being reduced more than 5 percent in FY 2025. CMS did not apply budget neutrality in FY 2025 for the transitional policy but beginning with the FY 2026 wage index, CMS' transitional adjustment is budget neutral. CMS proposes to continue both the transitional policy and the application of budget neutrality in FY 2027.

CHS requests that CMS adopt the transitional low wage index policy on a non-budget neutral basis. CMS is adopting the transitional adjustment using the authority of section 1886(d)(5)(I)(i) of the Social Security Act (the Act). There is no provision for budget neutrality under this authority. The only authority for budget neutrality is under section 1886(d)(5)(I)(ii) of the Act when making adjustments for transfer cases. Therefore, CMS may not apply budget neutrality for its transitional policy under the statute.

In the past, CHA supported CMS' policy for assisting low wage index hospitals. While we are disappointed that the policy may not continue for legal reasons, CHA appreciates CMS' efforts to assist low wage index hospitals. **We request that CMS continue to consider other policies that will assist low wage index hospitals in the future**.

- **Disproportionate Share Hospitals (DSH) and Uncompensated Care Payments**

Hospitals that qualify for Medicare DSH payments receive two separately calculated payments. The first payment equals 25 percent of the amount they would have received under the Medicare DSH formula required by statute prior to the Affordable Care Act. The second payment is based on the remaining 75 percent of the total Medicare DSH payments that would have been paid under the old formula (Factor 1), adjusted by the change in the number of uninsured individuals since FY 2013 (Factor 2). The hospital's uncompensated care payment will equal its share of total uncompensated care costs using Worksheet S-10 of the Medicare cost report.

[4] *Bridgeport Hosp.*, 108 F.4th 882, 887–91 & n.6 (D.C. Cir. 2024).

CMS estimates that the amount available to distribute as uncompensated care will decrease from $7.7 billion in FY 2026 to $7.4 billion in FY 2027, a decrease of $252.9 billion or 3.3 percent. **CHA is concerned about the potential decrease in uncompensated care payments at a time when the number of uninsured individuals in the United States can be expected to increase**. For example, CMS estimates an average enrollment decline of between 1.2 and 2 million in 2027 ACA enrollment.[5] A decline in ACA enrollment can be expected to be correlated with an increase in the uninsured. As these estimates of the decline in ACA enrollment were included in a May 20, 2026 *Federal Register* notice after CMS' FY 2027 IPPS proposed rule was completed, this enrollment decline may not have been included in CMS' 2027 uninsured estimate.

In addition, Public Law (Pub. L.) 119-21, the "Working Families Tax Cut" (WFTC) legislation, includes several health care provisions that impact the financing of Medicaid programs and limit eligibility for Medicaid and Marketplace coverage. The WFTC legislation is anticipated to result in fewer individuals and families being eligible for Medicaid. With fewer people being eligible for Medicaid, it is inevitable that the uninsured population will increase and hospitals will be treating more uncompensated patients.

CHA requests CMS update its estimate of the uninsured in the FY 2027 IPPS final rule to take into consideration the impact of ACA enrollment declines and Medicaid coverage losses on Factor 2 of the UCP calculation.

1115 Waiver Days in the Medicaid Fraction for Medicare Disproportionate Care

CHA would like to take this opportunity to address an issue not included in the FY 2027 proposed rule but one we hope CMS will nonetheless consider in the final rule.

In the FY 2024 Hospital IPPS and LTCH PPS final rule, CMS adopted a policy that excludes patients receiving uncompensated care pool benefits authorized by a section 1115 demonstration from the DSH Medicaid Fraction numerator, beginning with discharges on October 1, 2023. 88 Fed. Reg. 58640, 59332 (Aug. 28, 2023). CHA believes this policy is contrary to the plain language of the statute enacted by Congress and penalizes safety net hospital providers in states that chose to use uncompensated care pools as an alternative to expanding Medicaid. Indeed, the U.S. District Court for the Northern District of Texas concluded that the rule contradicts the plain text of the Medicare statute. See *Baylor All Saints Med. Ctr., et al. v. Becerra*, Case No. 4:24-cv-00432 (N.D. Tex. Aug. 15, 2024) (citing *Forrest Gen. Hosp. v. Azar*, 926 F.3d 221 (5th Cir. 2019)). While the case was remanded by the Fifth Circuit Court of Appeals on jurisdictional grounds, we find the District Court's legal argument on the substantive issue compelling.

The rule is also unfair in that it penalizes states that seek to offer medical assistance in a manner other than Medicaid expansion but approved by the Secretary. The purpose of the DSH

[5] 91 FR 29854.

adjustment is "to recognize the higher costs to hospitals of treating low-income individuals covered under Medicaid." 88 Fed. Reg. at 59013. Uncompensated care pools promote this purpose and the objectives of Medicaid, as the Secretary found when he approved the pools, because they "help hospitals that treat the uninsured and underinsured stay financially viable so they can treat Medicaid patients." Id. at 59015.

Fundamentally, this rule poses harm to safety net hospitals and the vulnerable communities and patients they serve. Despite CMS finalizing a rule to exclude these patient days from the DSH Medicaid Fraction numerator, and the resulting partial or total loss of Medicare DSH payments, our affected members continue to serve those who are low-income and uninsured.

The rule has a further serious consequence. It creates an enormous hurdle in states utilizing this model for hospitals' participation in the 340B Drug Pricing Program, which requires a Medicare DSH percentage of 11.75%. The loss of 340B resources further undermines health care safety net hospitals and their communities in affected states and CMS failure' to acknowledge the disparate impact from this policy is disappointing.

CHA urges CMS to reconsider and revoke the policy excluding patients receiving uncompensated care pool benefits authorized by a section 1115 demonstration from the DSH Medicaid Fraction numerator.

- **Graduate Medical Education**

Since Medicare pays hospitals for direct graduate medical education (DGME) and indirect medical education (IME) costs based on the number of full-time equivalent (FTE) residents they train. Generally, the greater the number of FTE residents a hospital counts, the greater the amount of Medicare DGME and IME payments the hospital will receive.

Since 1997, the law has limited the number of residents a hospital may count for DGME and IME (other than dental and podiatric residents) to the amount they counted in 1996. The law authorizes CMS to establish rules for applying the IME and DGME caps in the case of medical residency training programs established on or after January 1, 1995. Current regulations define a "new medical residency training program" as a "medical residency that receives initial accreditation by the appropriate accrediting body or begins training residents on or after January 1, 1995." To be considered a "new" program for which new cap slots would be created, a previously non-teaching hospital would have to ensure that the program meets three primary criteria: the residents are new, the program director is new and the teaching staff are new.

In rulemaking for FY 2025, CMS proposed to define the above three criteria with more specificity but did not finalize its proposals. Under the current policy CMS considers a

program to be new for cap adjustment purposes if the "overwhelming majority" of the residents and staff are not coming from previously existing programs in that same specialty.

CMS now proposes that it will no longer consider the previous employment of the faculty or program director in determining whether a residency program should be considered new for cap-building purposes. CMS also proposes that at least 90 percent of the individual resident trainees (not FTEs) must not have previous training in the same specialty as the new program. CMS would also create a limited exception to the counting rules for certain residents admitted via the National Resident Matching Program (the Match) or other third-party resident matching programs whose results are binding on hospitals. Finally, CMS proposed an exception to the 90 percent requirement for small residency programs defined as those accredited for 16 or fewer residents. For these programs, CMS is not proposing an alternative threshold to 90 percent but only that these programs must have an initial accreditation after January 1, 1995.

CHA supports the proposal to allow new medical residency programs to recruit experienced program directors and faculty. CHA supports the proposed exceptions to the 90 percent requirement, but requests CMS consider allowing more flexibility when a program is clearly new but may not meet the 90 percent threshold. There may be cases, particularly with smaller programs but above 16 residents, where experienced residents transfer or do not complete a program after the first year of specialty or subspecialty training and must be replaced with a resident that is beyond their first year of training. In these and other situations where the 90 percent threshold is not met but it is clear that the program is new and has not been transferred from an existing teaching hospital, it would be appropriate to allow the MAC and CMS y to consider the individual circumstances of the situation to determine whether the medical residency program is new or has been transferred from another hospital.

- **Nursing and Allied Health**

Medicare pays for provider-operated nursing and allied health education programs on a reasonable cost basis. A hospital's reasonable costs for NAH education are net of revenues received from tuition, student fees, sale of textbooks, etc.

In the FY 2026 IPPS proposed rule, CMS proposed that revenues received from students is subtracted before completing the indirect cost allocation. CMS received many comments objecting that its proposed policy was inconsistent with general cost-finding principles and would result in the NAH education cost centers receiving less than their share of institutional overhead. Due to the number and nature of the comments, CMS decided not to finalize the proposed changes and said it expects to revisit the treatment of NAH education costs in future rulemaking.

CMS makes two proposals affecting the indirect cost allocation for nursing and allied health education in the FY 2027 proposed rule.

The first proposal involves detailed cost reporting procedures that would effectively have hospitals subtract revenues received from students from total NAH costs on Worksheet A-8 of the Medicare cost report and then add those revenues back to NAH costs on Worksheet B-1 only for purposes of the overhead allocation. This procedure would result in the NAH cost center receiving its share of administrative and general expenses in the indirect allocation without NAH costs being used in subsequent steps of the indirect cost allocation that allocate costs for non-patient care cost centers like NAH to other patient care cost centers on the Medicare cost report. **CHA supports this proposal and asks CMS to finalize it without change.**

The second proposal would only allow indirect costs to be allocated to the NAH education cost center to the extent those costs benefit the hospital's nursing and allied health education programs. Further, as the regulations prohibit a hospital from receiving reasonable cost payment for related party costs (such as a home office), the provider would have to further distinguish between administrative costs incurred directly by the hospital and a related party such as a home office. **CHA opposes this proposal and asks CMS not to finalize it.**

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

CMS is proposing a new nationwide, mandatory Comprehensive Care for Joint Replacement Expanded Model, or CJR-X. The new model is based on the prior Comprehensive Care for Joint Replacement (CJR) model fielded by the Center for Medicare and Medicaid Innovation (CMMI) between April 2016 and December 2024. The agency proposes this expansion based on its assessment that in its final years of operation the CJR model reduced Medicare spending without compromising quality of care and thus met the applicable statutory criteria for model expansion. If finalized, the new model would begin on October 1, 2027. All acute care hospitals that are located in the 50 states, the District of Columbia and the U.S. territories and are paid under both the inpatient and outpatient PPSs would be required to participate, except for hospitals located in Maryland and those participating in the Transforming Episode Accountability Model (TEAM) but only until their TEAM participation ends.

CHA understands CMS' rationale for implementing CJR-X, and as a matter of principle we support measures that appropriately reduce Medicare spending while not negatively impacting quality of care. We share CMS' desire to reduce Medicare spending and thus improve the financial sustainability of the program, ensuring its continued ability to provide essential health care coverage for our nation's most vulnerable citizens. **However, CHA does not support the mandatory nature of the model and urges CMS to make participation voluntary**. Hospitals, especially those serving in a safety-net capacity, are financially strained right now, and CHA's members are preparing for further financial losses in the next few years, in the face of inflationary pressures on purchased services, pharmaceuticals and supplies; inflationary pressure

on salaries and benefits; and inadequate government reimbursement for Medicare and Medicaid services. Implementing a new model is an expensive endeavor, even for those facilities that previously participated in CJR. Mandatory participation in CJR-X would create real barriers, particularly for hospitals that do not have the scale, capital or operational capacity to support significant transformation efforts. We are particularly concerned that safety-net hospitals and those serving higher proportions of dual-eligible beneficiaries may not have the infrastructure and resources necessary to succeed under this model.

We also have several other serious l concerns about the proposed mandatory CJR-X model.

Approach to Risk

CMS proposes to expose all CJR-X participants to downside risk from the beginning of the program. **If the program remains mandatory, CHA urges that it begin with a year of data-sharing, followed by a period of upside-only-risk before payments are at risk**. This will give hospitals, especially those with no previous experience with a bundled payment model, time to prepare for implementation of the full model. They will need to establish relationships with doctors and post-acute care facilities, establish procedures, crate systems and educate staff.

In addition, **we believe the discount factor should be eliminated or reduced**. The structure of the program suggests CMS has overestimated the ability of many hospitals to achieve additional efficiencies and savings, in particular those that have already participated in the CJR or similar programs. There is a ceiling after which the goal of efficiency begins to compromise patient quality and care. CMS should include a mechanism to consider when improvement is "topped out."

Beneficiary Notification

CMS proposes that hospitals provide each CJR-X beneficiary with detailed written notification of their inclusion in the model, and do so prior to discharge from the hospital. Entities collaborating with the hospital in model must also provide detailed written notice to beneficiaries. CHA believes this will create onerous administrative burdens on hospitals and providers and contribute information overload for beneficiaries. As proposed, this model is permanent and mandatory. All patients receiving these procedures will be affected. **CHA urges CMS not to finalize the beneficiary notification requirement and instead to provide annual notice directly to Medicare beneficiaries of their potential inclusion in the model, their rights and their responsibilities.**

Excluded Items and Services

CMS proposes to define the CJR-X episodes as including all Medicare Part A and B items and services (except those specifically excluded) furnished to a CJR-X beneficiary from the date of

the beneficiary's admission to an anchor hospitalization or procedure and ending 90 days following discharge. The proposed rule provides a list of services included in an episode, such as physicians' services, hospital inpatient and outpatient services, post-acute care, clinical labs, durable medical equipment, drugs and biologics, and hospice, but it also notes this list is non-exhaustive. Items and services that are clinically unrelated to an LEJR procedure would be excluded, such as certain categories of diagnoses, new technology add-on payments, outpatient PPS transitional pass-through payments for medical devices, hemophilia clotting factors and certain high-cost drugs and biologics as well as low-volume drugs.

We urge CMS to provide additional clarity on what services are included and excluded from a CJR-X episode. The list of clinically unrelated items and services only provides board categories. Furthermore, there are other services and situations that should be excluded as clinically unrelated, such as patients leaving against medical advice, emergent cases, conditions present on admission and dialysis and other treatments for unrelated chronic conditions.

CHA urges CMS to only include services that are clinically related to the LEJR in the CJR-X episode. We urge CMS to define a comprehensive list of services that will be included in the CJR-X episode, and to develop scenarios or vignettes illustrating when specific services would or would not be included. CMS should ensure that only defined clinically related services are included in the calculation of the CRJ-X episode target amounts, and also the calculation of CJR-X participants' actual episode spending.

Low-volume Threshold

CMS proposes that low-volume hospitals, defined as those with fewer than 31 LEJR episodes during the three-year baseline period, would be excluded from the program. The purpose of a low-volume threshold is multifaceted, but at its core it should ensure that hospitals have enough cases to integrate changes in care delivery to determine if they had a statistically significant impact. Additionally, it should ensure that the costs associated with standing up the infrastructure for model participation (like analytics and staffing) can be offset by potential gains in the model. Financially, it should provide protection against outliers and volatility inherent with small sample sizes. Setting the threshold at 31 cases is too low. Performing less than one case per month is insufficient to sustain the infrastructure necessary to engage in the model and fails to ensure statistical significance or offset the costs of model participation. **CMS should substantially increase the low volume threshold.**

CHA would like to respectfully take this opportunity to make a broader comment on CMS' episode-based payment models. We do understand CMS' motivation and rationale for pursuing such models – instilling providers' focus on the entirety of the care provided to a patient during the course of a clinical episode, rather than a more narrow focus on the care that any single actor provides. Such an approach is consistent with one of CHA's core values, that "every human being is a unity of body, mind, and spirit." However, from an operational perspective, attempting

to achieve a holistic view of an episode of care through bundled payment can lead to undesirable outcomes.

From the CJR-X participant's perspective, this approach holds the participant accountable for the actions of other providers involved in the episode over which the participant has no control. Even in the first-order transition from acute hospital care to post-acute care, the ability of the CJR-X participant to control the trajectory of the episode is limited – a hospital can *recommend* that a patient use a preferred post-acute care provider, but it cannot *direct* that patient to that provider. And, once additional providers are involved in an episode, the CJR-X participant has very limited influence over (or even knowledge of) the services they provide to the CJR-X beneficiary. Bundled episode payment puts the CJR-X at considerable financial risk, with limited tools to mitigate that risk. Thus, bundled / episode payments may create strong incentives for providers to consolidate and vertically integrate, upsetting local health care ecosystems in undesirable ways. As CMS continues to explore bundled payment models such as CJR-X and TEAM, CHA strongly recommends participation be voluntary and urges the agency to simultaneously investigate how such models can be refined to mitigate the creation of negative incentives.

Impacts on safety net providers

CMS projects that CJR-X will reduce Medicare spending in each of the first five years that it would be in operation, for a total of approximately $725 million.[6] These savings estimates reflect CMS' projection that it will receive more dollars from CJR-X participants in the form of repayment amounts (hospitals paying CMS because their actual episode spending exceeded their target amounts) than it will pay out in the form of reconciliation payments, among other factors. CMS does not break out these projected impacts by type of hospital / CJR-X participant (*e.g.*, rural hospitals, teaching hospitals, DSH status, *et cetera*).

We understand that CMS proposes to include hospitals' safety net status as an element of the risk adjustment of CJR-Xs target prices. CMS also proposes to apply a 5 percent stop loss to certain categories of hospitals, including rural hospitals generally, Medicare-dependent small rural hospitals (MDH), sole-community hospitals (SCH), and safety net hospitals, ensuring that they would not face losses (repayments) of more than 5 percent under CJR-X in the reconciliation for any given year.

CHA appreciates CMS' concerns regarding safety net hospitals, and we appreciate the measures that the agency has proposed as components of CJR-X that are designed to mitigate impacts on these hospitals. These hospitals, which include CHA members, serve the most vulnerable of the nation's Medicare beneficiaries, and they warrant protections to ensure that their mission is not

[6] CMS notes that "these projections represent a portion of the potential savings to Medicare that CJR–X may produce since the model does not have an end date" (91 FR 19866).

unduly compromised by Medicare's payment policies. **Nevertheless, we remain very concerned that the proposed protections for safety net hospitals may be insufficient**. Safety net hospitals tend to be small, and many are located in rural areas, and they do not have extensive financial resources that are available to larger hospitals and other, better-resourced hospitals. Tracking and managing the care their Medicare patients receive from other providers post LEJR discharge may be beyond the capacity of many of these providers, and thus the odds are stacked against them with respect to succeeding under CJR-X.

CHA respectfully asks that CMS conduct a more detailed impact analysis of CJR-X, that would stratify the impacts of the model on various classes of hospitals, including safety net hospitals. CMS should publish the results of this analysis in the FY 2017 IPPS/LTCH final rule, should the agency decide to proceed to implement CJR-X. If that more refined analysis indicates a disproportionate negative impact on safety net hospitals, we urge CMS to delay the implementation of CJR-X until greater protections for safety net hospitals could be developed and implemented. Such protections could include a period of time in one-sided risk for safety net hospitals, a smaller stop loss percentage (*e.g.*, 2 percent), and/or a phase-in to the full risk exposure of CJR-X. We do understand and support CMS's desire to reduce Medicare spending to the benefit of the beneficiaries and taxpayers who fund the program, CHA strongly believes that CMS should recognize the limits of the hospitals that provide care to the nation's most vulnerable Medicare beneficiaries to contribute to that goal.

- **Hospital Readmissions Reduction Program (HRRP)**

Proposed Addition of the Sepsis Readmission Measure

CMS proposes to add the Hospital 30-Day, All-Cause, Risk-Standardized Readmission Rate Following Sepsis Hospitalization (Sepsis Readmission) measure to the HRRP measure set, with a phased approach that would use "early look" reports for FY 2028 prior to adoption into the FY 2029 payment adjustment. The early look reports would provide sepsis readmission rates and estimated HRRP payment adjustments. The measure tracks hospital-level rates of sepsis readmission, including both fee-for-service and Medicare Advantage beneficiaries in its cohort.

CHA applauds the advancement of patient and workforce safety, including through quality initiatives aimed at reducing high-cost and avoidable events. We believe that, as guiding principles, any safety measure adopted into the HRRP measure set should be data-driven, actionable, have utility, give feedback, and be feasible.

While CHA supports CMS in its goals of advancing safety, we have concerns with the measure being adopted directly into the HRRP. We urge that before CMS considers adoption of the measure into the HRRP it first gathers sufficient information from use of the measure under the Hospital IQR program so that hospitals are provided sufficient time to adapt before payment consequences are implemented. While we appreciate the agency's proposal for a period

of early look reports we believe that a longer period for early look reports would be needed to provide hospitals with sufficient experience with the measure and for there to be enough data collected on the measure to understand how its inclusion within the HRRP affects hospitals' overall payment adjustments under the program. We particularly bring the agency's attention to the concerns raised during the PRMR process during consideration of measure resulting in no consensus for adoption.

- **Cross-Program Proposals**

Proposed Adoption of the Advance Care Planning eCQM for the Inpatient QRP, PPS-exempt Cancer Hospital QRP, and Medicare Promoting Interoperability Program

CMS proposes to adopt the Advance Care Planning eCQM for the Inpatient QRP, PPS-exempt Cancer Hospital QRP, and the Medicare Promoting Interoperability Program. The eCQM calculates the proportion of adult patients with one or more inpatient hospitalization during the measurement period who, by the time of hospital discharge for at least one encounter, have an advance care planning document or documentation of an advance care planning discussion resulting in a documented decision in the patient's electronic health record (EHR). There would be no exclusions. The PRMR reached consensus to recommend adoption of the eCQM for all three programs for which the eCQM is being proposed, but the consensus-based entity (CBE) has not yet endorsed the eCQM.

Our mission as Catholic health care providers leads us to serve a large population of vulnerable patients, including the senior population. Our members are committed to compassionately serving the elderly and chronically ill, including by providing holistic, person-centered care. CHA commends CMS for its consideration of measures that acknowledge the importance of measures that advance a person-centered process that aligns care with patient values and desires and dignity of life. We believe health care is an ongoing conversation between patients and their care providers. **However, CHA continues to believe that only CBE-endorsed measures should be considered for inclusion in the measure set, and therefore we believe that adoption of any measure should be delayed until such measure receives endorsement by the CBE.** We strongly believe that measures adopted into the measure set should not detract from what is most important for the patient – time spent with the patient providing quality health care – and therefore have concerns with a measure that does not have any exclusions and has the potential to be overly burdensome.

Proposed Modifications to Five Mortality Measures

CMS proposes to adopt modified versions of five mortality measures in the IQR program measure set beginning with the FY 2028 payment determination and then include the modified versions of these measures in the HVBP (and remove them from the IQR) beginning with the FY

2032 payment determination. As proposed, the modified mortality measures would be publicly reported in the IQR program for at least one year before adoption into the HVBP.

The proposed measure updates are to expand the measure inclusion criteria to include MA beneficiaries (in addition to FFS beneficiaries) and shorten the performance period from three to two years.

Generally, CHA supports measure updates that are aimed at improving measure reliability and more accurately reflecting quality of care for all individuals. We understand that by 2030 it is projected that nearly two-thirds of all Medicare beneficiaries will be enrolled in MA plans. Quality of care is deserved by all and we agree there is value to having all Medicare beneficiaries (not only fee-for-service beneficiaries) represented in the measure cohorts. CHA also strongly supports proposals that strive to provide more actionable data for quality improvement, which we understand the agency seeks to achieve with the proposed timing change to the performance period for the measures.

While we understand the reasons for expanding the measure cohort to include MA beneficiaries, **we believe more time and analysis is needed to fully understand the impact that inclusion of the MA data will have for each of the proposed updated measures**. In particular, we urge the agency to review the quality of MA encounter data to ensure the use of such data will not pose any unintended consequences. We strongly believe that measures and measure updates should be developed based upon well-documented outcomes.

In the FY 2026 IPPS final rule, CMS adopted proposals to include MA enrollees in the cohort for several quality measures, effective for FY 2027 payment determination (with a shortened performance period). It is too early to have meaningful information about the effect of the measure cohort expansion and performance period change. **We encourage CMS to delay implementation of its proposal to include MA data in the five mortality measures** until we have a better understanding of the impact of including MA beneficiaries and MA encounter data in quality measures.

In addition, since the current (non-updated) measures would be in use in the VBP program at the same time the updated measures would be in use in the IQR program, we suggest that CMS provide appropriate outreach and training to reduce confusion, including by providing distinct names for the updated measures with the modified cohort and performance periods.

- **RFI: Measuring Emergency Room Access and Timeliness in the Hospital IQR and HVBP**

CMS is considering adopting into the IQR (and subsequently HVBP) the Emergency Care Access & Timeliness eCQM, which was finalized for adoption in the 2026 OPPS for voluntary reporting followed by mandatory reporting beginning with the 2028 reporting period, and in the

Rural Emergency Hospital Quality Reporting Program (REH QRP) as an optional alternative measure beginning with the 2027 reporting period. The measure describes the proportion of emergency department (ED) patients that either waited longer than one hour to be placed in a private treatment area, left the ED without being seen, boarded in the ED for longer than four hours, or had an ED length of stay longer than eight hours.

CHA agrees that patient safety should be improved wherever possible, and we appreciate the difficulty in measuring emergency room access and timeliness. While this measure has been finalized for outpatient and rural hospital settings, reporting has not begun so there is no information to inform its use in additional programs. Furthermore, CHA has concerns regarding the applicability of an Emergency Care Access/Timeliness eCQM in the inpatient setting. While timeliness is an important dimension of care, inpatient populations often include patients whose length of stay is influenced by factors outside the hospital's immediate control.

For example, patients requiring placement in residential or long-term care settings, as well as those experiencing severe psychiatric conditions, frequently encounter delays due to limited availability of community resources and placement options. These systemic constraints can significantly extend length of stay and affect timeliness metrics for reasons unrelated to delays in clinical care delivery. As a result, these measures may unintentionally skew performance results and disadvantage hospitals serving higher proportions of complex patient populations.

Before considering any potential adoption of the eCQM further, we urge the agency to first collect sufficient data from the Hospital OQR program and REH QRP to identify any unintended consequences, determine whether the measure is successful in providing actionable data, and consider modifications that would be needed to for the measure to be appropriate in the inpatient setting.

- **Hospital IQR Program Proposals**

Proposed Adoption of the Excess Days in Acute Care After Hospitalization for Diabetes (Diabetes EDAC) measure

CMS proposes to adopt the Diabetes EDAC measure beginning with the July 1, 2025, through June 30, 2027, performance period, associated with the FY 2029 payment determination. The measure is a risk adjusted outcome measure that assesses the number of days a patient spends in acute care within 30 days of discharge from an inpatient hospitalization for a diagnosis of diabetes mellitus with complications.

CHA generally supports measures that prioritize holistic patient care and outcomes, and particularly supports EDAC measures as a comprehensive, patient-centered approach to evaluating hospital performance. **We urge, however, the agency to ensure there are not unintended consequences, reflecting concerns raised during the PRMR review.**

The PRMR Hospital Committee did not reach consensus on the measure, raising concerns (which we share) about hospitals not having control over outpatient access or follow-up care, the 30-day post-discharge period, whether the risk adjustment was sufficient, the need for additional testing, and whether CBE-endorsement should be sought. Particularly, we note the suggestion to add socio-demographic risk factors. We strongly believe that proper sociodemographic risk adjustments are essential to ensuring that hospitals serving large populations of low-income or uninsured patients are not unfairly penalized. We also believe that all measures should receive CBE endorsement before adoption.

Proposed Adoption of the Hospital Harm—Postoperative Venous Thromboembolism eCQM

CMS is proposing a risk-adjusted outcome measure, proposed initially as an eCQM option for hospital selection beginning with the CY 2028 reporting period/FY 2030 payment determination and then as a mandatory eCQM beginning with the 2030 reporting period/FY 2032 payment determination. The measure assesses the proportion of inpatient hospitalizations for patients at least 18 years of age who have at least one surgical procedure performed inside the operating room (OR) during the admission and have a postoperative VTE during hospitalization or during the 30 days after the first surgical procedure. There are two VTE eCQMs in the current IQR measure set, both of which are process measures that hospitals may self-select: Venous Thromboembolism Prophylaxis (VTE-1) eCQM and Intensive Care Unit Venous Thromboembolism Prophylaxis (VTE-2) eCQM. CMS believes that a single comprehensive outcome measure instead of these two process measures would reduce burden.

CHA agrees with the goal of the measure, which is to encourage hospitals to implement processes to reduce the occurrence of postoperative VTE. We also appreciate the agency's efforts to reduce burden by removing two process measures and replacing them with one comprehensive measure.

However, we have strong concerns about the ability to implement the measure, and we are particularly concerned about the multitude of issues raised by the PRMR committee in its review of the measure, especially with only 35 percent of the members recommending adoption of the measure into the IQR program. The committee expressed a number of concerns, which we share, including potential unintended consequences, technical implementation problems within EHR systems, the measure's ability to meaningfully advance quality, need for methodological refinements (specifically for clearer diagnostic criteria for VTE), and lack of CBE endorsement. These are extremely concerning issues that must be addressed before further consideration of adoption of the measure. We strongly believe that a measure must have the ability to meaningfully advance quality before being considered for inclusion in a quality program. We are also deeply concerned about the implementation problems raised and urge the agency to ensure that performance on a measure is not impacted by incomplete data or systems not being able to

capture data. **The measure should be adopted into the IQR until these concerns are addressed.**

Proposal For Changes to the Reporting and Submission Requirements for eCQMs and Structural Measures in the Measure Set

CMS is proposing that there be mandatory reporting for hospital harm eCQMs after two years of self-selected reporting.

CHA supports measures that are intended to improve patient safety. Our members continue to experience challenges with reporting on new eCQMs and eCQM implementation and maintenance remains very time consuming and costly for hospitals. We continue to believe that inclusion of eCQMs as optional self-selected measures is extremely helpful given these challenges and we are very concerned about the number of eCQMs that will become mandatory in a short period.

Given the continued challenges experienced by our members with reporting on eCQMs, we are extremely concerned about the extent of burden and cost that will be placed on hospitals in order to implement and maintain the substantial increase in mandatory eCQMs If CMS proceeds with finalizing a policy to transition optional hospital harm eCQMs to mandatory eCQMs, CHA recommends phasing in such a policy over a greater number of years.

We are also concerned about the substantial cost and time burden faced by hospitals when adopting eCQMs since CMS has indicated actively working to move from eCQMs to digital quality measures (dQMs). CMS also has stated that revising eCQMs to dQMs will be an early step in the agency's plan for transitioning to digital quality measurement. CHA continues to recommend that CMS coordinate its strategies to expand eCQMs in its quality and PIP programs with its plan for revising those same measures to dQMs to avoid unnecessary and costly overlap and conflicts.

- **RFI on Modifications to the Birthing Friendly Hospital Designation Criteria**

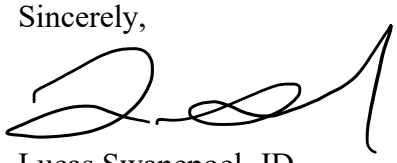
CMS is seeking input on potential modifications to Birthing-Friendly Hospital Designation (the Designation), specifically on the inclusion of the Cesarian Birth eCQM and Severe Obstetric Complications eCQM in the criteria for awarding the Birthing-Friendly Hospital Designation, and a modified scoring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

CHA continues to strongly support the Birthing Friendly Hospital Designation. We are strong advocates for improving maternal and infant health outcomes. Many of our health systems have earned the designation by actively integrating perinatal safety measures and collaborating on maternal mortality reduction. Catholic health care is committed to our advocacy for caring for women, babies, and children and our providers are devoted in their care provided to mothers and their families.

We support modifications to the designation to the extent they accurately represent the care provided and the meaning of the proposed variations in birthing friendly icons discussed are clearly explained and communicated to women and their families to inform their decision-making. We encourage efforts that drive improvements in maternity care and support the

In closing, thank you for the opportunity to share these comments in regard to the proposed FY 2027 IPPS rule. We look forward to working with you on these and other issues that continue to challenge and strengthen the nation's hospitals. If you have any questions about these comments or need more information, please do not hesitate to contact me or Kathy Curran, Senior Director Public Policy, at 202-721-6300.

Sincerely,



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