Catholic Health Association of the United States

A Passionate Voice for Compassionate Care

June 10, 2025

The Honorable Mehmet Oz, M.D.
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-1833-P

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

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 30, 2025 (90 FR 18002). 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) 2026. This rate update equals the hospital market basket of 3.4 percent less 0.8 percentage points for productivity.

CHA believes that CMS should adjust the FY 2026 hospital update for forecast error in the FY 2021 through FY 2023 hospital market baskets. In each of these years, the difference between the hospital market basket used for the update and actual increase exceeded 0.5 percentage points. For FY 2022 alone, the understatement was 3.0 percentage points. The combined understatement of the update in these three years was 4.3 percentage points as shown in this table:

IPPS Market Basket	FY 2021	FY 2022	FY 2023
Forecast Used in the Update	2.4	2.7	4.1
Actual Based on Later Utilization	3.0	5.7	4.8
Difference	-0.6	-3.0	-0.7

For the Skilled Nursing Facility (SNF) prospective payment system (PPS) update, CMS makes an adjustment for forecast error where the difference between update applied and the actual increase in the market basket exceeds 0.5 percentage points.[1] **Consistent with the CMS' policy for the SNF PPS, CHA requests that CMS adjust for forecast error in the FY 2021 through FY 2023 IPPS market baskets as forecast error exceeded 0.5 percentage points in each of these years.**

The combined 4.3 percentage point understatement of the FY 2021 through FY 2023 market basket results in a permanent reduction in IPPS payments below the rate of inflation. To avoid this permanent reduction in IPPS payments below the rate of inflation, CMS must make an adjustment for forecast error consistent with the policy it has adopted under the SNF PPS.

CHA believes the extraordinary circumstances of the pandemic and the large difference between the FY 2021 through FY 2023 updates and the market basket justify CMS making at least a 3.0 percentage point adjustment to the FY 2026 hospital market basket update.

- **Productivity Estimates**

As required by law, the Secretary reduces the IPPS market basket increase by 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)." (Social Security Act section 1886(b)(3)(B)(xi)(II).) 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.

CHA questions the assumption that hospitals can recognize the same kinds of productivity gains as the general economy, an assumption CMS itself has taken issue with. 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]

[1] 90 FR 18593
[2] Paul Spitalnic, Stephen Heffler, Bridget Dickensheets and Mollie Knight, "Hospital Multifactor Productivity: An

CHA is also concerned about the unexplained increase in the productivity adjustment. The average offset for productivity between FY 2016 and FY 2025 has been 0.4 percent. The productivity adjustment proposed to be applied for FY 2026 is double this figure, 0.8 percent, yet CMS does not explain its calculation.

CHA requests that CMS explain the large increase to the productivity offset relative to its historical average application in the final rule. Further, CHS requests CMS consider its own view that hospitals cannot achieve the same level of productivity as the general economy when evaluating our request to apply a forecast error correction to the FY 2025 IPPS update.

- **Changes to the Wage Index**

Low Wage Index Policy

For several years beginning in FY 2020, CMS increased the wage index values for the lowest quartile wage index hospitals by one-half the difference between the wage index and the 25th percentile wage index value. This policy was intended to allow low-wage hospitals to use the higher wage index to increase wages that would become part of the hospital's succeeding fiscal year's wage index. As there are four years between the data year and the payment year used for the wage index, CMS intended to keep this policy in place for four years. The policy included a budget neutrality adjustment, thereby affecting all hospitals.

On July 23, 2024, the Court of Appeals for the D.C. Circuit Court held that the Secretary lacked authority to adopt the low wage index hospital policy and the related budget neutrality adjustment.[3] To comply with the decision, CMS published an interim final rule with comment (IFC) in the *Federal Register* on October 3, 2024.[4] 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 low wage hospitals affected by the change to prevent their wage indices from being reduced more than 5 percent in FY 2025. CMS did not apply budget neutrality in FY 2025 for the transitional policy.

CMS proposes to continue the transitional policy for low wage index hospitals in For FY 2026 but now intends to the policy budget neutral.

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

Update Presentation of Two Methodologies Using Data through 2019." Hospital Multifactor Productivity: An Updated Presentation of Two Methodologies Using Data through 2019 (cms.gov).

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

[4] 89 FR 80405.

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, CHA's view is that 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 CMS' 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.

CMS estimates that the amount available to distribute as uncompensated care will increase from $5.8 billion in FY 2025 to $7.2 billion in FY 2026, an increase of $1.5 billion or 26.0 percent. While CHA supports CMS' proposal to increase uncompensated care payment, we have two concerns about the proposed increase.

First, CMS uses projections from the latest National Health Expenditure Accounts (NHEA) historical data to determine Medicare's uncompensated care pool. For FY 2024, CMS proposed a decrease of 2.3 percent in uncompensated care payments but finalized a decrease of 13.6 percent that was largely influenced by lower estimates of the uninsured between the proposed and final rules. For FY 2025, CMS proposed an increase of 9.4 percent in uncompensated care payments but finalized a decrease of 3.9 percent that also was largely influenced by lower estimates of the uninsured between the proposed and final rules.

We understand that the estimates of the uninsured using the NHEA are updated annually with the Medicare Trustees Report between the IPPS proposed and final rule. Given the large change in these estimates, **CHA requests CMS consider an earlier update to its estimates of the uninsured that could make the proposed rule a more reliable figure upon which to predict the change in uncompensated care payments for the next fiscal year.**

Second, CHA hopes CMS will consider the impact of expiration of enhanced premium tax credits and other legislative and regulatory proposals that are expected to reduce insurance coverage. For instance, the Affordable Care Act provides enhanced premium tax credits (EPTCs) will expire on December 31, 2025 absent a change in law. Together the EPTC expiration and

provisions of the pending reconciliation bill, if enacted as currently written, are projected to result in significant increases in the number of the uninsured. It is imperative that CMS account for both these changes to the potential rate of uninsured in determining the final rule uncompensated care pool.

We appreciate and support CMS' proposal to use audited Worksheet S-10 data and a three-year average in calculating the uncompensated care distribution. We believe this approach will allow for less year over year variation in distributions at the hospital level and encourage CMS to finalize this as proposed.

- **Nursing and Allied Health**

Changes to Indirect Costs

On November 17, 2017 CMS issued cost reporting instructions to subtract revenues from tuition and student fees from the costs of nursing and allied health education prior to allocating indirect costs.[5] On February 9, 2024, the U.S. District Court for the District of Columbia issued a ruling that CMS' cost report instruction was inconsistent with 42 CFR §413.85, which requires revenues from tuition and student fees to be subtracted from the cost of educational activities after the indirect cost allocation is completed.[6] CMS now proposes to amend the regulation to allow subtracting revenues received from tuition, student fees, textbooks purchased for resale and other revenue from or on behalf of students before completing the indirect cost allocation, effective October 1, 2025. If student related revenues reduce direct education costs to zero, no indirect costs would be allocated, but hospitals could request an alternative method from their MAC to mitigate the reduction in reasonable cost paymens.

CHA believes CMS should not finalize its proposed changes as they are inconsistent with the purpose of the indirect cost allocation. The purpose of the indirect cost allocation is to allocate administrative and general costs that support the entire institution to each direct cost center on the Medicare cost report. The step-down process is the method used in the Medicare cost report for allocating indirect costs to each of the direct cost centers to recognize that administrative and general costs that cannot be attributed to any single department, nevertheless, remain essential to the functioning of each direct cost center. Under the step-down, the cost reporting process recognizes how each indirect cost center is supported in relationship to the costs incurred by each direct cost center. CMS' proposed policy will distort this relationship, and the nursing and allied health education cost center will receive less than its share of the allocation of indirect costs than are being used to support the department.

[5] Transmittal 12, which contained updates to the hospital cost report instructions at CMS–2552–10, Pub. 15– 2, chapter 40. R12P240.pdf
[6] (Mercy Health—St. Vincent Medical Center LLC d/b/a Mercy St. Vincent Medical Center, et al., v. Xavier Becerra, Case No. 22–cv–3578

While CMS provides for an alternative allocation of indirect costs if subtracting revenues before allocating indirect costs results in no nursing and allied health education payments, **CHA believes this alternative, by definition, will result in no indirect costs being allowable**. The proposed rule indicates that for an indirect cost to be allocated to the nursing and allied education cost center, its costs must "directly attributable" to the operation of an approved educational activity. However, the fundamental principle of an indirect cost is that it *cannot* be attributed to any individual cost center because it supports operation of the hospital as a whole. By definition, CMS' policy will disallow all indirect costs attributed to the nursing and allied health education cost center.

- **Quality Programs**

Proposals to Integrate Medicare Advantage (MA) Beneficiaries into Certain Measure Cohorts

CMS is proposing substantive updates to certain measures in the Hospital Inpatient Quality Reporting (HIQR) Program, Hospital Value-Based Purchasing (HVBP) Program, and Hospital Readmissions Reduction Program (HRRP) to include MA beneficiaries in the measure cohorts and to shorten the applicable reporting periods of the respective measures from three years to two years. The proposed cohort expansion would roughly double the cohort size. CMS believes the inclusion of MA data would improve measure reliability and more accurately reflect quality of care for all Medicare beneficiaries. CMS believes the proposed shortened reporting period (from three years to two years) would allow measure results to reflect more recent hospital performance and consequently provide more actionable data for quality improvement.

For the HIQR Program, the affected measures are the Total Hip/Knee Arthroplasty (THA/TKA) Complications and Ischemic Stroke Mortality measures and the proposed changes would be implemented with the FY 2027 payment determination. The THA/TKA complications measure is scheduled to be removed from the HIQR program and included in the HVBP program in 2030. The inclusion of the MA cohort in the HVBP measure would begin in the FY 2033 program year. This allows for the statutorily required one year of public reporting of the updated measure in the HIQR Program before adoption in the HVBP Program.

CMS proposes to include Medicare Advantage patients in the index admissions for each of the six measures in the HRRP beginning with the FY 2027 program year and to shorten the applicable reporting period 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.

While we support and agree with 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 including MA beneficiaries in the measures would have for the respective quality programs.** 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 are especially concerned about understanding the implications and effects of using MA encounter data and expanding the measure cohort to MA beneficiaries *before* adopting the modifications to any measure with respect to a pay-for-performance program, specifically the THA/TKA complications measure in the HVBP Program or any of the measures included in the HRRP measure set.

We strongly believe that measures and measure updates should be developed based upon well-documented outcomes. We appreciate that the existing THA/TKA complications measure is already scheduled to be removed from the HIQR Program for adoption in the HVBP Program, but we are concerned about adopting these proposed modifications into the HVBP Program before having the data and experience of the modified measure with the expanded cohort in the HIQR Program. Similarly, since the inclusion of MA beneficiaries and use of MA encounter data is not a tested concept in the inpatient hospital quality programs, CHA believes that it would be beneficial to gain the experience and understanding of the implications of such an expansion and the use of MA encounter data in the HIQR Program, which is a pay for reporting program, *before* inclusion of MA beneficiaries is considered for ANY measure within a pay for performance program. This will allow a better understanding of how the inclusion of MA beneficiaries and MA encounter data may impact measures, generally, before such expansion is applied within a quality program, such as the HVBP Program or HRRP, in which performance on measures that include MA beneficiaries will directly impact hospital fee-for-service payments. We believe an analysis of the quality of the MA encounter data is essential before applying changes with such potential consequences.

CHA continues to believe that only measures endorsed by the consensus-based entity (CBE) should be considered for inclusion in quality program measure sets, and therefore we believe that adoption of any updated measure should be delayed until such updated measure receives endorsement by the CBE. We are encouraged to see that the modified measures proposed for the HIQR program have recently been CBE-endorsed. We are concerned, though, that the updated measures being proposed for the HRRP have not yet been CBE-endorsed. **Especially given the statutory emphasis for CBE endorsement for measures used in the HRRP, we strongly recommend delaying inclusion of any measure or modified measure in the HRRP measure set until after it has been endorsed by the CBE.**

Proposals to Make Updates to Extraordinary Circumstances Exception Policies

CMS is proposing updates to the Extraordinary Circumstances Exception (ECE) policy under several of the quality programs. The ECE policy allows for exceptions to data reporting requirements under extraordinary circumstances, such as natural disasters or systemic problems with CMS data collection systems that directly affect facilities' ability to submit data. Similar ECE proposals are being made for the HRRP, HIQR Program, HVBP Program, HAC Reduction Program, and PCHQR Program. CMS is proposing that it would grant reporting deadline extensions, as well as exceptions, as it found appropriate. An extraordinary circumstance would be defined as an event beyond the control of the hospital. The agency is also proposing that a hospital would have to request an ECE within 30 calendar days from the event, a change from the current policy allowing requests within a 90-day window.

CHA and our members support the availability of ECE policies under the quality programs. Our members rely on and appreciate the availability of an ECE when events beyond the control of a hospital impede a hospital's ability to comply with the requirements of a quality program. **We support the proposal to provide for an additional form of an ECE in the form of an extension to a deadline** to allow a hospital additional time to comply with a requirement.

However, CHA opposes reducing the period during which a hospital may request an ECE from 90 days to 30 days from the date of extraordinary circumstance. ECEs are by definition granted for unforeseen events, such as natural disasters, which can affect performance metrics and the ability of hospitals to comply with reporting and other requirements. In these circumstances 30 days is often not sufficient time to respond effectively to the extraordinary event (a hospital's immediate concern), assess the effect on data collection and systems, and submit a request for an ECE.. Reducing that period from 90 to 30 days is a substantial shortening of the submission period that will impose additional burden and harm on hospitals struggling to address a crisis and in most need of administrative flexibility.

CHA asks CMS to consider an additional modification. We urge CMS to clarify explicitly tht cyber-attacks are an acceptable reason for granting an ECE. These attacks are becoming more frequent in the health care industry and they can debilitate data systems for weeks or months. We believe this is the kind of event the ECE policy was created for, since it prevents an entity from submitting measure data or completing other program requirements until the cyber-attack is resolved and systems are cleared of fraudulent data.

Proposal to Remove the Health Equity Adjustment (HEA) from the HVBP Program

The HEA is scheduled to apply to the HVBP Program beginning with the FY 2026 program year to reward top performing hospitals that serve higher proportions of patients with dual eligibility status (DES). CMS is proposing to remove the HEA beginning for the FY 2026 program year, pointing to its efforts streamline regulations and reduce burdens.

While we understand and appreciate the goal of reducing burden and simplifying requirements, **we supported the HEA when it was proposed and urge CMS to reconsider its removal**. We believe CMS should continue to take steps towards eliminating health disparities in line with its goal of improving health for all patients. Our members support the advancement of strategies that will make a real difference in ending health disparities and achieving health equity. While measurement and reporting are powerful tools, we urge CMS to proceed in a manner that prioritizes collaboration over competition. This is work that the entire health care community should be doing together. We strongly encourage the agency to work together with hospitals and other providers to support and implement collaborative strategies by the entire health care community to achieve the goal of high-quality care for everyone, including vulnerable and underserved populations. We believe these goals could collectively be achieved and emphasize that efficiency, burden reduction, and regulatory simplification can and should be achieved without any detriment to the societal goal of individual and community health and quality of care for everyone.

Proposal to Remove Four Measures from the HIQR Program

CMS is proposing, beginning with the FY 2026 payment determination, to remove from the HIQR Program measure set the Hospital Commitment to Health Equity (HCHE), COVID-19 Vaccination Coverage among Healthcare Personnel (HCP COVID-19 Vaccination), Screening for Social Drivers of Health (SDOH-1), and Screen Positive Rate for Social Drivers of Health (SDOH-2) measures. Removal of each of these measures would be made on the basis of Removal Factor 8 – the costs associated with achieving a high score on the measure outweigh the benefits of its continued use in the program.

CHA supports removal of the COVID-19 measure. We urge CMS to reconsider removing the HCHE and two screening measures.

The goal of the HCHE measure is to identity and address health disparities – that is, to collect and use data to see if any particular populations routinely have poorer health outcomes and to try to understand and address the underlying causes. To that end it asks hospitals to attest to their commitment to health equity across five domains: Strategic Priority, Data Collection, Data Analysis, Quality Improvement, and Leadership Engagement. The SDOH measures ask hospitals to collect data essential to understanding the health needs of their patients and to identifying factors that contribute to health disparities. Hospitals are to seek information from all adult patients admitted about five health related social needs (HRSN), food insecurity, housing instability, transportation needs, utility difficulties, and interpersonal safety, and to calculate positivity rates for each HRSN among the screened population.

CHA and its members are firmly committed to providing holistic and compassionate care to all patients, including attention to their health-related social needs, and we endorse the value and

importance of screening for such needs. Indeed, many of CHA's members have been pioneers and leaders in the screening and collection of HRSN data from their patients and working with community partners to ensure patients have access to resources to address their needs. While we supported the screening measures when they were proposed, we did express the concern that the measures alone would not necessarily promote linkages with relevant community-based services that would address those needs and support improvements in health outcomes following hospitalization. Screening for social needs, when done in an appropriate manner as part of a larger community-wide system to provide the services needed, is a valuable goal that should be encouraged and supported. Rather than ending the current measures. CMS should work with stakeholders to develop technical support and education in the most effective way to both screen for social needs and work with community and other organizations to meet those needs.

Should CMS finalize its proposal to sunset these three measures, we urge CMS to engage stakeholders on alternative strategies to identify and address health disparities, including ways to help patients with health-related social needs to connect with community partners who can help them meet those needs.

Proposal to Change Reporting and Submission Requirements for Two Hybrid Measures in the HIQR Program

CMS is proposing changes to the reporting and submission requirements for the Hybrid Hospital-Wide All-Cause Readmission (HWR) and Hybrid Hospital-Wide All-Cause Risk Standardized Mortality (HWM) Measures in the HIQR Program. For both measures, under current regulations, hospitals must report core clinical data elements (CCDEs) on 90 percent of discharges and submit four linking variables on 95 percent of discharges for each reporting period, beginning with mandatory reporting for the FY 2028 payment determination. Hospitals are required to report 13 CCDEs for the Hybrid HWR and 10 CCDEs for the Hybrid HWM. The agency found that three-fourths of the hospitals that submitted measure data during the 2024 voluntary reporting period did not meet these submission thresholds. CMS is therefore proposing, beginning with the FY 2028 payment determination for both measures, to (i) lower the submission thresholds for CCDE and linking variables to require at least 70 percent of discharges, and (ii) lower the number of required CCDE data elements to allow for up to two missing laboratory results and up to two missing vital signs.

CHA appreciates and supports the agency's proposal to lower the submission thresholds and required elements for the Hybrid HWR and Hybrid HWM measures. We agree with CMS that these changes will significantly improve hospitals' ability to meet the reporting thresholds while still demonstrating good reliability for measure calculation. We encourage the agency to continue to monitor hospitals' experiences on satisfying the reporting thresholds and to continue to provide the necessary time and resources to support hospitals in effectively and successfully reporting on the measures before adopting mandatory reporting on the measure with payment consequences.

- **Request for Information: Toward Digital Quality Measurement in CMS Quality Programs**

CMS requests comment on each of the following four components of the digital quality measures (dQMs) transition to FHIR (Fast Healthcare Interoperability Resources)-based electronic clinical quality measure (eCQM) for the Hospital Inpatient Quality Reporting Program (HIQR) Program, Hospital Outpatient Quality Reporting Program (HOQR) Program, and Medicare Promoting Interoperability Program: (i) eCQM FHIR conversion activities, (ii) data standardization, (iii) timeline for FHIR-based eCQM reporting, and (iv) measure development and reporting tools. CHA believes that hospitals will require significant time, education, and support over multiple years to fully transition to FHIR-based eCQMs. A change of this magnitude will impact not only vendors but also internal hospital teams, including IT departments, quality reporting coordinators, and clinical and administrative staff, all of whom need to understand their roles in the new reporting process. To facilitate this transition, CMS should provide resources such as converters that translate existing Quality Reporting Document Architecture (QRDA) files into FHIR-based formats for advance testing. These tools should be accessible to both hospitals and the quality reporting vendors that support them.

Additionally, there are concerns about the practicality, feasibility, and overall readiness across the industry for this transition. We encourage CMS to gather input from stakeholders and consider conducting a comprehensive landscape scan of Certified Electronic Health Record Technology (CEHRT) capabilities in partnership with the Association for the Advancement of Structured Information Standards (ASTP) to better assess readiness and inform implementation strategies.

- **Transforming Episode Accountability Model (TEAM)**

CMS makes a number of proposals related to the five-year mandatory episode payment model, the Transforming Episode Accountability Model (TEAM), that was finalized during the 2024 rulemaking cycle under its Centers for Medicare and Medicaid Innovation Center (CMMI) authority (section 1115A of the Act). The model will test five surgical episode types: lower extremity joint replacement, surgical hip/femur fracture treatment (SHFFT), coronary artery bypass graft (CABG), spinal fusion, and major bowel procedure. All acute-care hospitals in the 25 percent of core-based statistical areas (CBSAs) identified for participation in the model (out of roughly 800 eligible CBSAs) are required to participate in TEAM.

Mandatory Model

CHA continues to be concerned with the mandatory nature of the model, its potential impact on safety-net hospitals serving vulnerable populations and its overall scope. As we have stated previously, we understand that at least part of CMS' rationale for implementing TEAM as a mandatory model is to offset selection bias that can affect voluntary models. But a mandatory

model will also force participation by hospitals that are likely to "lose" under the model, an implication reinforced by CMS' own impact analysis estimating program savings (or, from a different perspective, hospital losses) in performance years two through five of the model. Given CMS' stated intention to oversample core-based statistical areas (CBSA) with a large proportion of safety-net hospitals, CHA remains extremely concerned that the anticipated program savings will disproportionately come from penalizing safety net hospitals who may not perform well under TEAM. **CHA strongly urges CMS to make TEAM a voluntary program**.

Refinements to TEAM

While CMS has finalized TEAM as a mandatory model, CHA still believes the model can be improved in ways that do not jeopardize the mission of safety net hospitals that serve among the most vulnerable of the nation's citizens.

Track 1 should be available for a minimum of two years, at least for a subset of participant hospitals

TEAM includes three risk "tracks," which represent varying levels of either the risk of financial losses or the opportunity for financial rewards. All TEAM participants are permitted to start TEAM in Track 1 in the first Performance Year (PY) of the model during which participants can earn bonuses for good performance but are not at risk for losses should they fail to meet TEAM cost and quality objectives. Track 2 (asymmetrical upside (up to 10 percent) and downside (up to 15 percent) risk is available to certain hospital participants in PYs 2-5, while other TEAM participants will be required to move into Track 3 (up to 20 percent upside and downside risk) beginning in PY 2.

CHA continues to be concerned that the one-year duration of Track 1 of upside only risk is too short before participating hospitals would be exposed to downside risk (i.e., the risk of losses). We are particularly concerned given CMS' stated intention of over-sampling CBSAs with high numbers of safety-net hospitals and with limited exposure to prior bundled payment models to select hospitals for participation in TEAM (see above). We are also concerned that even safety net hospitals are required to take on downside risk beginning in PY 2. As noted above, we understand CMS' rationale for making TEAM a mandatory model. However, hospitals in general, and safety net hospitals in particular, exhibit precarious financial performance under Medicare's IPPS even at unreduced payment rates, and safety net hospitals will struggle under a track that puts them at downside risk under episode payment rates that include a 3 percent discount.

CHA urge CMS to lengthen the duration of Track 1 to a minimum of two years. Ideally all hospitals would be eligible to stay in Track 1 for two years given that TEAM is distinct enough from prior bundled payment models that prior participation in those models may not be enough to guarantee successful performance under TEAM. However, if CMS continues to maintain that

broad eligibility for a second year in Track 1 would substantially undermine the objectives of TEAM, at a minimum, CHA recommends that at least safety-net hospitals be allowed to continue in Track 1 for at least an additional year beyond PY 1.

Recognizing hospitals' burden of treating patients with high social needs risk

In the FY 2025 IPPS/LTCH PPS final rule (89 FR 68986), CMS finalized a social need risk adjustment factor for beneficiary-level risk adjustment in the construction of the preliminary and reconciliation TEAM target prices. This variable included an element based on the Area Deprivation Index (ADI. At that time, CMS stated that the agency would continue to explore whether standardization of the ADI variables would be appropriate for the purposes of TEAM's risk adjustment approach and would propose any such changes in future rulemaking.

Based on additional analyses, CMS is now proposing several changes to the social need risk adjustment factor in TEAM, one of which would replace the use of the ADI in the construction of this factor with a similar index, the Community Deprivation Index (CDI).

CHA supports this change. We have in the past expressed concerns about certain analytic weaknesses of the ADI, and we are cognizant of health services research literature that suggests the CDI is better correlated with certain health and wellbeing outcomes.

Waivers of Medicare Program Requirements

CMS previously finalized a proposal to waive the three-day rule for discharges to SNFs for SNFs with at least a three-star rating on the Nursing Home Compare website. As CMS noted at the time, there may be instances where a TEAM participant would like to use the three-day SNF rule waiver, but the TEAM beneficiary receives inpatient post-acute care through swing bed arrangements in a hospital or critical access hospital (CAH), which is not subject to the Five-Star Quality Rating System. **CHA supports CMS' current proposal to expand the three-day rule waiver to hospital swing beds.** We agree that allowing TEAM participants to use the three-day SNF rule waiver for hospitals and CAHs operating under swing bed agreements may support beneficiary freedom of choice and provide greater flexibility to TEAM participants for their care coordination efforts.

In last year's IPPS/LTCH proposed rule for 2025 CMS discussed, but did not propose, waiving the "homebound" requirement as a condition for beneficiaries to receive Medicare-covered home health care. CMS similarly discussed, but did not propose, waiving the "incident to" billing rules to allow physicians or non-physician practitioners to provide services in a beneficiary's home who is not otherwise eligible for the Medicare home health benefit. At that time, CHA recommended that CMS waive both these requirements. While CMS has neither proposed nor discussed these rules for FY 2026, CHA again recommends these requirements be waived.

Health Equity

CHA maintains a strong institutional commitment to policies that advance and improve health equity in all CMS programs, whether through permanent payment system policies and value-based purchasing arrangements, or through testing of alternative payment models such as TEAM fielded through CMMI. We thus supported in our comments on the 2025 IPPS/LTCH proposed CMS' proposed beneficiary social risk adjustment under TEAM, under which TEAM episode target prices would be adjusted to reflect the social risk factors of the beneficiary incurring a TEAM episode. Last year, CHA supported CMS' proposal to require that TEAM participants develop and report to CMS health equity plans. Such plans would have value in helping TEAM participants to identify specific health disparities, develop interventions for addressing those disparities, and measuring their progress in achieving stated goals.

Given this commitment, we are disappointed to see that in this proposed rule CMS has withdrawn its previously finalized plans to require TEAM participants to submit health equity plans and related data collection. We believe as part of our core mission that serving vulnerable populations is a public policy priority, and that this service is most effective when driven by explicit goals and informed by empirical data on progress towards those goals.

Decarbonization and Resilience Initiative

CMS had previously finalized in TEAM a voluntary Decarbonization and Resilience Initiative to assist hospitals in addressing the threats to the nation's health and its health care system presented by climate change and the effects of hospital carbon emissions on health outcomes, health care costs and quality of care. Under this initiative, hospitals would voluntarily report data on defined categories of greenhouse gas emissions, and in return receive technical assistance from CMS in reducing those emissions.

Catholic health care is committed to protecting the environment, to minimizing environmental hazards and to reducing our contribution to the problem of climate change. We care for those who are harmed by the environment, we strive for internal practices to ensure environmental safety and we advocate public policies and private actions that bring solutions. With our members, CHA is working to raise the issue of environmental stewardship as a mission-based clinical and public policy imperative. We act as responsible stewards of God's creation as we respond as a ministry to building healthier communities.

CHA thus supported including the voluntary Decarbonization and Resilience Initiative in the model, and we are disappointed that CMS has withdrawn it in this proposed rule. Despite this withdrawal, we note that several CHA members have been voluntarily working on reducing their greenhouse gas emissions for the past several years, driven by their commitment to care for creation and vulnerable populations the least prepared to deal with climate change. We expect these efforts will continue, and CHA would stand ready to provide CMS with information on the

experience of these members should the agency revisit the Decarbonization and Resilience Initiative in future rulemaking.

- **Request for Information: Regulatory Relief**

On Jan. 31, 2025, President Trump issued Executive Order 14192, "Unleashing Prosperity Through Deregulation," which states the administration's policy to significantly reduce the private expenditures required to comply with federal regulations. In this proposed rule CMS is soliciting public input on approaches and opportunities to streamline regulations and reduce administrative burdens on providers, suppliers, beneficiaries and other interested parties participating in the Medicare program.

We appreciate CMS' efforts to eliminate unnecessary and burdensome administrative requirements that can create barriers to access to care across the health care continuum. Excessive regulatory and administrative burdens add unnecessary cost to the health care system, reduce patient access to care and stifle innovation.

Below are the suggestions we submitted to CMS' designated website Unleashing Prosperity Through Deregulation of the Medicare Program https://www.cms.gov/medicare-regulatory-relief-rfi.

- Eliminate the critical access hospital (CAH) 96-hour rule, which requires an annual average length of stay of 96 hours or less, as a Medicare Condition of Participation and eliminate the 96-hour Medicare Condition of Payment rule that requires physicians in CAHs to certify upon admission that an inpatient can reasonably be expected to be discharged or transferred to another hospital within 96 hours.

- Eliminate the requirement that a hospital operate for at least six months under the prospective payment system before converting to CAH status.

- Eliminate the three-day hospital inpatient stay requirement for Medicare skilled nursing facility coverage or at a minimum align the waiver requirements between TEAM and MSSP

- Review and repeal outdated reporting requirements related to the COVID-19 public health emergency.

- Replace the sepsis bundle measure with a measure of sepsis outcomes.

- Remove telehealth originating site restrictions within the Medicare program to enable patients to receive telehealth in their homes, not just at a clinical site of care.

- Remove telehealth geographic site restrictions within the Medicare program to enable beneficiaries in non-rural areas to have the same access to virtual care as those in rural areas.

- Remove the in-person visit requirements for behavioral health telehealth to end disparity between physical and mental health services.

- Remove requirements that require hospice recertification to be completed in person so recertification to be completed via telehealth.

- Streamline care plan documentation requirements to reflect team-based care and interdisciplinary care plans.

- Eliminate the currently waived telehealth physician home address reporting requirement, which compromises the privacy and safety of physicians.

- Eliminate nurse practitioner and other advanced practice practitioner (APP) limitations so APPs can practice to the full extent of their state licenses which will allow greater patient access to care.

- Rescind the Minimum Staffing Standards for Long-Term Care Facilities final rule which exceeds statutory authority and imposes a one-size-fits all rule regardless of the assessed needs of the unique resident population or the skills and competencies of the existing staff.

- Repeal the Program for All-Inclusive Care for the Elderly (PACE) effective date of enrollment rule that limits enrollment to the first day of the month instead of upon meeting eligibility requirements, which puts the wellbeing of people with notable physical or cognitive limitations in jeopardy and can cause significant health decline before a PACE program is allowed to accept the person.

- End the limit on the total number of PACE programs that can be operational, a threshold set 25 years ago.

- Eliminate provisions that limit the ability of PACE organizations to engage in direct marketing. Unlike Medicare Advantage and Special Needs Plans, PACE programs are not listed on the Medicare Plan Finder. As a result, Medicare beneficiaries who could benefit from PACE are not fully informed of all their options.

- Eliminate 42 CFR Part 2 requirements that require the separation of records pertaining to substance abuse information, which prevents the integration of behavioral and physical health care because the patient data cannot be used and disclosed like all other health care

data, and protect patient privacy under the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

In closing, thank you for the opportunity to share these comments in regard to the proposed FY 2026 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,

Lisa A. Smith
Vice President
Advocacy and Public Policy