American Hospital Association™
Advancing Health in America

Washington, D.C. Office
800 10th Street, N.W.
Two CityCenter, Suite 400
Washington, DC 20001-4956
(202) 638-1100

June 9, 2026

The Honorable Mehmet Oz, M.D.
Administrator
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244-1850

RE: CMS-1849-P, Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals (IPPS) and the Long-Term Care Hospital Prospective Payment System and Policy Changes and Fiscal Year (FY) 2027 Rates; Requirements for Quality Programs; and Other Policy Changes, (Vol. 91, No. 71), April 14, 2026.

Dear Administrator Oz:

On behalf of our nearly 5,000 member hospitals, health systems and other healthcare organizations, our clinician partners — including more than 270,000 affiliated physicians, 2 million nurses and other caregivers — and the 43,000 healthcare leaders who belong to our professional membership groups, the American Hospital Association (AHA) appreciates the opportunity to comment on the Centers for Medicare & Medicaid Services (CMS) hospital inpatient prospective payment system (PPS) proposed rule for fiscal year (FY) 2027. We are submitting separate comments on the agency's proposed changes to the long-term care hospital (LTCH) PPS and the Comprehensive Care for Joint Replacement Expanded Model.

America's hospitals and health systems are the backbone of the U.S. healthcare system, providing 24/7 care to patients and communities. Hospital care today is more advanced, more effective and more resource-intensive than ever, reflecting major gains in medical innovation, as well as the highly skilled workforce, technology and infrastructure required to deliver it. Patients are living longer, recovering faster and receiving treatments that would have been unimaginable just a generation ago. As communities across the country face demand for health services, it is essential that Medicare payment policies support the sustainability and availability of these providers.

To that end, we support several of the inpatient PPS proposed rule provisions, including the proposed updates to define "new" residency programs under the graduate medical

education policies. We also support the removal of measures from the quality reporting program that are no longer providing useful information to improve patient outcomes and are optimistic about CMS' work to develop a more robust measure of sepsis mortality.

At the same time, we continue to have strong concerns about the proposed payment update. The proposed net payment update of 2.4% is not adequate given the unrelenting financial headwinds hospitals and health systems face. We are particularly concerned with the inappropriately large proposed productivity cut. **Therefore, we ask CMS to work with Congress to reduce the magnitude of the productivity adjustment.**

We also have serious concerns over the agency's estimates to calculate disproportionate share hospital (DSH) and uncompensated care payments. These proposed payments are half a billion less than what hospitals received last year. We expect the uninsured rate to be higher than what CMS currently proposes. However, the lack of transparency on these estimates severely limits our ability to sufficiently comment on the agency's methods and calculations. We urge CMS to publish a detailed methodology so that stakeholders can sufficiently comment on the issue.

Finally, we also are concerned that CMS has not provided adequate analysis to demonstrate that the inclusion of Medicare Advantage enrollees in quality measure denominators will not result in unfair comparisons across providers based on the markets in which they serve rather than on the quality of care they provide. This is particularly troubling in the Hospital Readmissions Reduction Program, where performance influences payment adjustments.

We appreciate your consideration of these issues. Our detailed comments are attached. Please contact me if you have questions or feel free to have a member of your team contact Shannon Wu, AHA director for payment policy, at (202) 626-2963 or swu@aha.org.

Sincerely,

/s/

Ashley Thompson
Senior Vice President
Public Policy Analysis and Development

American Hospital Association
Detailed Comments on the Inpatient Prospective Payment System Proposed Rule for Fiscal Year 2027

Table of Contents

INPATIENT PPS PAYMENT UPDATE

The AHA remains concerned that CMS' proposed annual market basket update of 3.2% is not keeping pace with real-world cost growth. In recent years, CMS' market basket forecasts have consistently come in below broader inflation, let alone medical inflation, which has exceeded growth in the overall economy. Layered on top of that, the productivity adjustment, proposed to be 0.8 percentage points for FY 2027, further erodes the update, leaving Medicare payments increasingly out of sync with the cost of care. **We urge CMS to revisit both its market basket forecasts and the magnitude of the productivity adjustment, and to consider the combined effect on provider reimbursements. As such, we ask CMS to work with Congress to reduce the magnitude of the productivity adjustment**.

Rising Costs of Care Continue to Strain Healthcare Providers

Hospitals and health systems continue to face serious inflationary pressures. As detailed in our comments on the FY 2026 inpatient PPS proposed rule, unprecedented levels of inflation have raised labor, drug, supply and other costs. A recent AHA report found that total hospital expenses increased by 7.5% in 2025 alone.[1] Much of this increase reflects labor costs, which CMS notes account for more than half of the inpatient market basket. Indeed, an AHA analysis found that workforce costs rose by 5.6% in 2025.[2] Further, advertised salaries for registered nurses have averaged 5.5% growth over the last two years — more than double the rate of inflation.[3] Finally, the AHA has expressed concern that recent actions, such as changes to federal student loan limits that exclude nurses and other clinicians from enhanced borrowing limits, will exacerbate workforce shortages, which contribute to higher costs for labor.

Cost pressures, however, extend well beyond labor. Like other providers, hospitals are increasingly caring for sicker and more complex patients, requiring additional and more costly drugs and supplies, and these costs also continue to climb. An AHA analysis showed that in 2025, supply costs rose 9.9%, while drug costs rose a staggering 13.6%.[4] In fact, 19% of hospital cost growth is driven by the services to care for sicker and more complex patients, as hospitals devote more staff time, monitoring and specialized treatment to each case. Another 45% of hospital cost growth can be attributed to higher input costs per patient, such as rising wages and benefits for clinical and other staff, and higher prices for drugs, supplies and equipment. These cost challenges strain hospitals and health systems, which must be prepared to provide treatment for a wide range of conditions and comorbidities.

---

[1] AHA. (March 2026). The Cost of Caring: Challenges Facing America's Hospitals as They Care for Patients in 2026 (https://www.aha.org/costsofcaring).
[2] Id.
[3] Id.
[4] Id.

Providers also are absorbing escalating administrative costs that are not reflected in payment updates. In addition to direct costs of care, hospitals have also faced rising administrative costs. For example, the vast majority of Medicare Advantage (MA) plans require prior authorizations. As such, hospitals and health systems spend substantial amounts of time and resources navigating the prior authorization process. In 2025, hospitals spent nearly $18 billion on overturning claims denials alone.[5] All told, using data from the most recent annual survey, the AHA estimates that hospitals spent a staggering $43 billion in 2025 trying to collect payments insurers owe for care already delivered. In 2024, the average hospital employed about 64 administrative and billing staff dedicated to these functions — roughly 6.5% of total hospital employment — according to AHA analysis of annual survey data. Notably, many of these denials were ultimately overturned as noted above. In fact, a study by the Health and Human Services Office of Inspector General found that 75% of care denials were subsequently overturned.[6] Making matters worse, MA plans paid hospitals less than 90% of Medicare rates despite costing taxpayers substantially more than traditional Medicare in 2023.[7,8] Since plans do not reimburse these administrative expenses, providers must absorb them while caring for a growing share of MA patients.

Viewed collectively, these cost increases for staffing, drugs and other essential supplies and services are placing significant strain across the healthcare continuum. They also are forcing providers to redirect resources that otherwise could be used to support patient care, adopt new technologies and make other efficiency-enhancing investments. That reality makes CMS' insufficient market basket updates, which fall well below the levels of growth observed in labor, drugs, supplies and other costs, even more troubling. As discussed further below, these same pressures also amplify the negative impact of the productivity adjustment on providers' ability to fund the very investments that can drive operational efficiencies.

Severe Medicare Underpayments Cannot Be Sustained

During this period of significant cost growth, the market basket forecasts for inpatient hospitals consistently failed to accurately predict actual market basket growth. We have detailed these under-forecasts of the market basket and potential drivers of that under-forecast in our past comments. While forecasts will never be perfect, in the past, they have been more balanced. **AHA continues to stand ready to work with CMS to examine the**

[5] https://premierinc.com/newsroom/policy/claims-adjudication-costs-providers-257-billion-18-billion-is-potentially-unnecessary-expense
[6] DHHS OIG. (2023). High Rates of Prior Authorization Denials by Some Plans and Limited State Oversight Raise Concerns About Access to Care in Medicaid Managed Care. https://oig.hhs.gov/oei/reports/OEI-09-19-00350.pdf
[7] MedPAC (2021). MedPAC Report to Congress. https://www.medpac.gov/wp-content/uploads/import_data/scrape_files/docs/default-source/reports/mar21_medpac_report_to_the_congress_sec.pdf#page=401
[8] Ensemble Health Partners. (2023). The Real Cost of Medicare Advantage Plan Success. https://www.ensemblehp.com/blog/the-real-cost-of-medicare-advantage-plan-success/

market basket compensation indices and proxies to improve the accuracy of these measures.

Indeed, these trends have continued and exacerbated Medicare's underpayments to the hospital field. The Medicare Payment Advisory Commission projects that 2026 Medicare margins *will be negative 10%*, resulting in more than *20 straight years* of Medicare paying below costs.[9] The AHA's own analysis showed that Medicare underpayments reached $100 billion in 2024.[10] **This is unsustainable. Therefore, we urge CMS to focus on appropriately accounting for recent and future trends in inflationary pressures and cost increases in the hospital payment update, which is essential to ensure that Medicare payments for acute care services more accurately reflect the cost of providing hospital care.**

The Productivity Adjustment Exacerbates Insufficient Market Basket Updates

Under the Affordable Care Act (ACA), the inpatient PPS payment update is reduced each year by a productivity factor equal to the 10-year moving average of changes in the annual economy-wide, private nonfarm business total factor productivity (TFP). The private nonfarm business TFP is intended to reflect gains from new technologies, economies of scale, business acumen, managerial skill and changes in production. As such, it effectively assumes that the hospital field can achieve productivity gains comparable to those realized by private nonfarm businesses. However, as discussed in more detail below and in a report shared last year, the healthcare field cannot mirror these gains. As a result, it is not an appropriate or reliable proxy for healthcare productivity. **Therefore, we ask CMS to work with Congress to reduce the magnitude of the productivity adjustment.**

A core problem is that the productivity construct embedded in the private nonfarm business TFP is a poor fit for measuring healthcare productivity. TFP outputs are measured based on the total quantity and prices of goods and services produced in private nonfarm businesses. In industries that sell tangible products, outputs can often be measured in relatively straightforward and standardized ways. Healthcare outputs, however, do not operate in the same manner. For example, healthcare "quantity," such as volume of visits or procedures, is not necessarily an appropriate proxy for output; it may instead reflect the underlying disease burden in a community. More provider volume — i.e., more quantity — does not equate to higher productivity in the way it can for private nonfarm businesses.

Further, providers often cannot adjust prices per unit of service in response to changes in demand or quality in the way private nonfarm businesses can. Much of hospitals' and health systems' reimbursement is paid through fixed payment systems, such as the inpatient PPS, which limits providers' ability to alter prices. Similar constraints apply in the

[9] MedPAC. (2026). https://www.medpac.gov/wp-content/uploads/2026/03/Mar26_Ch3_MedPAC_Report_To_Congress_SEC.pdf
[10] AHA. (March 2026). The Cost of Caring: Challenges Facing America's Hospitals as They Care for Patients in 2026 (https://www.aha.org/costsofcaring).

commercial market: providers do not unilaterally set their rates, and prices for commercially insured patients are established through negotiations that frequently lock in rates for multiple years. Accordingly, applying a TFP output framework based on quantity and prices — as experienced in the private sector — to healthcare providers is problematic because that output function does not translate to the healthcare field.

In addition, the hospital field also differs from many private nonfarm industries because healthcare services are inherently labor-intensive. As discussed further in the report referenced above, economic literature has long recognized that sustained productivity gains are difficult to achieve in labor-intensive service industries because labor cannot be scaled or automated in the same way as in other sectors. In this respect, healthcare providers are more comparable to fields such as education and social assistance, which tend to experience lower total factor productivity rates. For example, Bureau of Labor Statistics data show rates ranging from -0.4 for educational services to -0.1 for social assistance, compared with 1.9 to 4.9 for industries such as mining, oil and gas, information, and professional services.

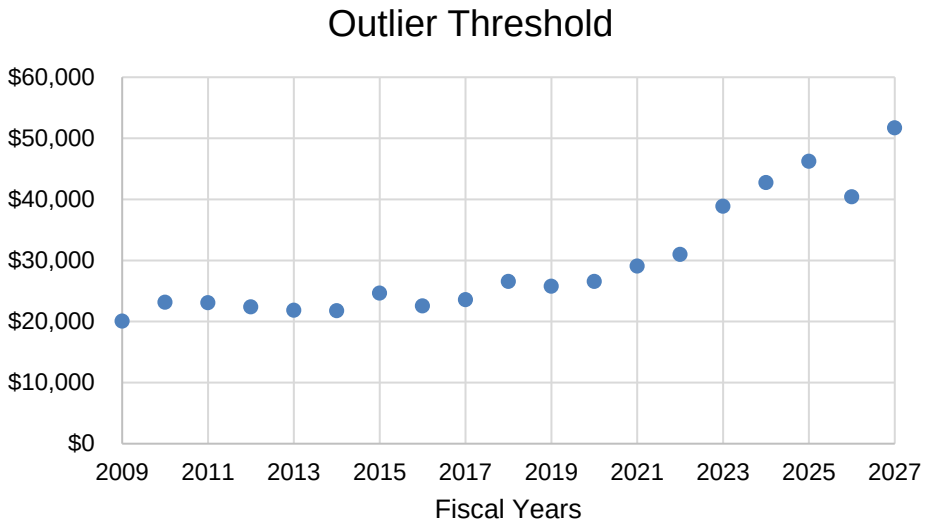
Finally, we continue to find it especially troubling that the productivity adjustment appears to be applied only when it *reduces* Medicare payments. For example, in FY 2021, the 10-year moving average growth of the productivity factor forecast was -0.1%. CMS acknowledged that subtracting a negative growth factor from the market basket would have *increased* it by 0.1 percentage point. However, the agency set the productivity factor at 0, stating that it is required to reduce — not increase — the market basket by changes in economy-wide productivity.[11] Put simply, the agency uses the productivity factor only when it lowers Medicare spending.

The cumulative, compounding effect of these annual reductions — coupled with the asymmetric treatment of periods of declining economy-wide productivity — has widened the gap between payments and the cost of providing services, leaving providers increasingly underfunded, as discussed above. In light of the above, the AHA continues to have serious concerns about the proposed productivity cut, particularly given the extraordinary pressures under which healthcare providers continue to operate.

INPATIENT PPS OUTLIER THRESHOLD

The AHA is concerned about the proposed increase in the high-cost outlier threshold. It represents a 28% increase from the FY 2026 threshold and, as such, would significantly decrease the number of cases that qualify for an outlier payment. We are further concerned that it is coming after CMS has already increased the threshold substantially in the past years. Indeed, the chart below details the increase in the outlier threshold over the past 19 years — a staggering 158% increase from FY 2009 through FY 2027 (as proposed).

[11] 85 Fed. Reg. 58797 (Sept. 18, 2020).



This large increase seems to be a result of the agency using the change in average charges from FY 2024 to FY 2025 to determine a charge inflation factor (CIF) and then using this factor to estimate the charge inflation for FY 2027. Indeed, the proposed charge inflation for FY 2027 is noticeably higher than FY 2026 — 15.154% compared to 11.313%. We ask that the agency examine its charge inflation methodology and the appropriateness of using two-year delayed data to estimate current year charge inflation. **We urge the agency to make additional, temporary changes to help mitigate the substantial increases occurring in the outlier threshold.**

MEDICARE DISPROPORTIONATE SHARE HOSPITAL PAYMENT

Under the DSH program, hospitals receive 25% of the Medicare DSH funds they would have received under the former statutory formula (described as “empirically justified” DSH payments). The remaining 75% flows into a separate funding pool for DSH hospitals. This pool is reduced as the percentage of uninsured declines and is distributed based on the proportion of total uncompensated care each Medicare DSH hospital provides.

Transparency Related to DSH Calculations

The AHA remains concerned about the lack of transparency on how CMS and the Office of the Actuary (OACT) calculate DSH payments. As we have previously commented, we urge the agency to disclose the OACT information outlined below in advance of publication of the final rule and permit further comment on it. Moreover, we urge the agency to disclose such information in its inpatient PPS proposed rule each year in the future.

Factor 1

Factor 1 is the estimate of what total DSH payments would have been under the former statutory formula. In estimating Factor 1, CMS used a variety of data inputs, which it included in a table detailing the factors applied for FYs 2024 through 2027.[12] In this table, the agency includes a "Discharges" column that shows changes in the number of Medicare fee-for-service (FFS) inpatient hospital discharges, with FY 2026 and FY 2027 figures based on historical experience and assumptions related to how many beneficiaries will be enrolled in MA plans. However, the agency provides no other details on how this historical experience or assumptions on MA enrollment are obtained to arrive at these estimates.

Additionally, the table also includes a "Case-mix" column that shows the estimated change in case-mix for inpatient PPS hospitals. CMS states that FY 2027 case-mix is based on assumptions from the 2012 "Review of Assumptions and Methods of the Medicare Trustees' Financial Projections" report by the 2010-2011 Medicare Technical Review Panel. This report utilizes data from the 1980s up until 2010.[13] The report itself states that "growth in the average complexity (or intensity) of healthcare services is an important element of Medicare expenditures … and that case-mix increases usually occur as a result of the development and diffusion of new medical technology." The report, at that time, had concluded "that a *short-range* (emphasis added) case-mix assumption […] would be more representative than the current assumption." Yet, CMS still chooses to utilize assumptions from this report that, at best, describe case-mix from 16 years ago. In other words, it takes the very action that the report effectively cautions against. As such, we question the continued use of assumptions from a report that used data that is, *at best,* 16 years out of date.

Finally, the table includes an "Other" column that the agency says "reflects the change in other factors that contribute to the Medicare DSH estimates," including the difference between total inpatient hospital discharges and inpatient PPS discharges, and various adjustments to the payment rates that have been included over the years but are not reflected in the other columns. In past years, CMS has described in more detail adjustments that contribute to these estimates. For example, in the FY 2026 proposed rule, CMS stated that this column "includes a factor for the estimated changes in Medicaid enrollment through FY 2023."[14] For this year's proposed rule, however, the agency has removed its prior-year descriptions and offers no details on the factors that contribute to this column, which makes it virtually impossible for stakeholders to comment on the estimated impacts of Medicaid changes during such a critical time.

Given the administration's interest in transparency, we urge the agency to detail its calculations. Specifically, we respectfully request that it publish a detailed methodology of its calculations that specifies how all the components contribute, as

[12] 91 Fed. Reg. 19484 (April 14, 2026).
[13] Page 19. https://www.cms.gov/research-statistics-data-and-systems/statistics-trends-and-reports/reportstrustfunds/downloads/technicalpanelreport2010-2011.pdf
[14] 90 Fed. Reg. 18257 (April 30, 2025).

well as their estimates from year to year, so that stakeholders can sufficiently comment on the issue.

Additionally, the AHA urges CMS to publish detailed calculations of the discharge estimates in the inpatient PPS proposed rule each year going forward, so there is sufficient information to evaluate the impact on FFS inpatient hospital payments and provide feedback to the agency on how growth in MA is affecting the development of FFS rates over time. The growth of MA has led to frustrations around, for example, prior authorization requirements placed by plans, which often negatively impact patients and providers alike.[15] As such, there are questions about the sustainability of MA growth and its impact on inpatient hospital payments, and in particular, on those hospitals that serve a disproportionate share of lower-income beneficiaries. The AHA welcomes the opportunity to work with CMS in examining the impacts of MA enrollment on FFS inpatient hospital payments.

Factor 2

CMS establishes Factor 2 in the calculation of uncompensated care DSH payments as one minus the percent change in the percent of uninsured individuals, determined by comparing the percent of the individuals who were uninsured in 2013 and the percent of individuals who were uninsured in the most recent period for which data is available. In the FY 2026 final rule, CMS used an uninsured rate of 8.7% for FY 2026. In this rule, CMS proposes to use an uninsured rate of 9.1% for FY 2027. **Given potential and realized Medicaid and enhanced ACA premium tax credit policy changes, we believe we will see a much larger increase in the number of uninsured than the agency proposes.**

To determine uninsured rates, OACT uses projections from the latest National Health Expenditure Accounts (NHEA) historical data, which account for expected changes in enrollment across several categories of insurance coverage, including Medicaid. OACT projects enrollment and spending trends for the coming 10-year period; the most recent projections are for 2024 through 2033 and use NHEA historical data through 2023. OACT utilizes NHEA projections, which estimate that in 2026, the uninsured growth rate will be 15.2%, but that in 2027 the rate will be 1.0%. Furthermore, NHEA projects that the Medicaid enrollment growth rate will be 2.1% for 2026 and 2027.[16] We question these estimates.

For example, recent estimates suggest that plan sign-ups for the ACA Marketplace fell by over a million people during the 2026 open enrollment period, the sharpest single-year

[15] https://www.nytimes.com/2024/03/24/opinion/prior-authorization-medical-care.html; https://www.nbcnews.com/health/rejecting-claims-medicare-advantage-rural-hospitals-rcna121012; https://www.npr.org/sections/health-shots/2023/10/17/1205941901/medicare-advantage-rural-hospitals; https://www.beckershospitalreview.com/finance/nearly-half-of-health-systems-are-considering-dropping-ma-plans.html

[16] "NHE Projections – Tables." https://www.cms.gov/data-research/statistics-trends-and-reports/national-health-expenditure-data/projected

drop since the ACA Marketplace launched.[17] Effectuated enrollment — the number of people who pay premiums and maintain effective coverage — is expected to fall substantially. Accounting for unpaid premiums, mid-year attrition and other factors, it is estimated that the average effectuated enrollment could decline by between 17% to 26% in 2026. Furthermore, a recent survey conducted in spring 2026 showed that 9% of 2025 Marketplace enrollees had become uninsured, 4% of returnees had not paid their first month's premiums, and 17% of returning enrollees were not confident they could pay premiums for the entire year. As the fallout of the expiration of the enhanced premium tax credits continues to play out for the remainder of 2026 and into 2027, it is clear that the uninsured rate will continue to rise substantially.

Similarly, the Congressional Budget Office's (CBO) estimate of the One Big Beautiful Bill Act projects that almost eight million people will become uninsured.[18] Specifically, one Medicaid provision alone — whereby on Dec. 31, 2026, states must start re-determining eligibility expansion enrollees every six months — would result in 11% of the expansion enrollees procedurally disenrolled.[19] Also under these estimates, average monthly Medicaid expansion enrollment would be reduced by 17%. CBO also estimates that the uninsured will increase by 1.3 million in 2026 and 5.2 million in 2027.[20] Given these estimates, we question the National Health Expenditure Data's (NHEA) conclusion that Medicaid enrollment will continue to grow in 2026 and 2027.

In such a climate of continued turbulent coverage losses, we urge CMS to carefully consider its reliance on current data sources and methodologies to estimate the uninsured rate. Data and projections that worked when coverage levels were more stable may no longer be adequate.

Finally, CMS also does not publish its Factor 2 methodology, which severely limits the AHA's ability to sufficiently comment on this issue. Specifically, the agency has not published the details of its methodology and how it incorporates NHEA projections, despite stakeholders, including the AHA, consistently voicing their concerns. As such, we urge CMS to not only publish a detailed methodology on the Factor 2 calculation and how it uses and incorporates NHEA projections, but also to use real-world data from key stakeholders and researchers to arrive at a more appropriate uninsured estimate.

Use of Worksheet S-10 Data

CMS proposes to use three years of audited data to determine uncompensated care payments in FY 2027. Specifically, the agency proposes to use the three-year average of uncompensated care from the three most recent FYs for which audited data are available.

---

[17] https://www.kff.org/affordable-care-act/what-we-know-so-far-about-2026-aca-marketplace-enrollment-premiums-and-deductibles/
[18] https://www.cbo.gov/system/files/2025-06/Arrington-Guthrie-Letter-Medicaid.pdf
[19] https://www.urban.org/research/publication/obbbas-six-month-redetermination-could-reduce-medicaid-expansion-enrollment-20
[20] https://www.cbo.gov/system/files/2025-08/61367-Uninsured-Data.xlsx

The AHA has a longstanding position supporting the use of audited S-10 data to promote accuracy and consistency. We continue to believe that audited data and, by extension, ongoing refinements to the audit process, result in data that are most appropriate for use in Medicare DSH payments. In addition, three-year averages help to reduce year-to-year fluctuations, providing more predictability and stability for hospitals. **We, therefore, support CMS' proposal to use the three most recent FYs of S-10 data to determine each Medicare DSH hospital's share of uncompensated care in FY 2027.**

We also support the following DSH proposals:

- Newly Merged Hospitals. CMS proposes to continue its policy to treat hospitals that merge after the development of the final rule as new hospitals. Specifically, the newly merged hospital's (i.e., the surviving hospital's) current cost report would be used to determine the hospital's DSH payment. CMS also proposes to continue its policy that interim uncompensated care payments for the newly merged hospital would be based only on the data for the surviving hospital's CMS Certification Number available at the time of the development of the final rule. CMS would then determine the final DSH payment for the newly merged hospital during the FY 2026 cost report settlement.
- New Hospitals. CMS proposes to continue its policy for new hospitals. Specifically, for newly established hospitals, the hospital's Medicare Administrative Contractor (MAC) would make a final determination concerning whether the hospital is eligible to receive Medicare DSH payments at the cost report settlement.

Section 1115 Waiver Days

In 2023, the Biden administration implemented a policy that penalizes non-expansion states, rewriting long-standing policy without congressional authorization and putting safety-net hospitals at risk in the process. Specifically, CMS will not allow hospitals to include CMS-approved Section 1115 waiver days associated with uncompensated care pools in the Medicare DSH calculation.

AHA has consistently emphasized that this policy is inconsistent with the plain language of the Medicare statute and decades of policy and practice.[21,22,23] The statute directs that the Medicaid fraction capture patient days for individuals "eligible for medical assistance under a State plan approved under title XIX," and longstanding policy recognized that individuals served through Section 1115 demonstrations, including uncompensated care pools, fall within this framework. CMS' reinterpretation improperly narrows the statute by imposing additional criteria that are not supported by the law.

[21] https://www.aha.org/lettercomment/2021-06-28-aha-comments-inpatient-pps-proposed-rule-fy-2022
[22] https://www.aha.org/lettercomment/2022-06-17-comments-cms-its-fy-2023-proposed-inpatient-prospective-payment-system
[23] https://www.aha.org/lettercomment/2023-05-01-aha-letter-cms-medicare-disproportionate-share-hospital-payments-section-1115

In addition, AHA has underscored that CMS' repeated attempts to exclude these days, described in agency rulemaking as efforts to limit the counting of uncompensated care pool days, would materially reduce the number of Medicaid days included in the DPP calculation.

This policy, in turn, will have significant adverse consequences for hospitals that serve a disproportionate share of low-income and vulnerable patients. By reducing DSH payments, the policy would undermine a critical source of financial support hospitals depend on to furnish essential services in underserved communities. AHA has expressed concern that these reductions could jeopardize access to care for low-income populations and exacerbate existing health disparities, particularly in states that have not expanded Medicaid and rely heavily on Section 1115 demonstrations to finance care for uninsured and underinsured individuals.

Finally, AHA has noted that the policy would introduce unnecessary complexity and administrative burden by requiring hospitals to distinguish among categories of Section 1115 enrollees and verify detailed coverage criteria, while disregarding the practical realities of how states structure Medicaid coverage through demonstrations. These changes would disrupt settled expectations, create operational challenges and inject further instability into the DSH payment methodology.

For these reasons, AHA is asking CMS to consider restoring the historical treatment of inpatient days associated with CMS-approved Section 1115 demonstrations, including uncompensated care pool days, as days for patients "regarded as eligible for medical assistance under a State plan approved under title XIX for purposes of the Medicaid fraction of the Medicare DSH calculation." And in making this change, we ask CMS to consider allowing hospitals to include these patient days in the Medicaid fraction numerator.

GRADUATE MEDICAL EDUCATION PAYMENTS

Medicare direct GME and indirect medical education (IME) funding are critical to educating the physician workforce and sustaining access to care. Yet, currently insufficient funding levels and limits on the number of residents for whom each teaching hospital is eligible to receive GME reimbursement are major barriers to reducing the nation's significant physician shortage. CMS proposes several modifications that would affect Medicare GME payments to teaching hospitals.

CMS establishes the rules for applying direct GME and IME caps for new medical residency training programs — those established on or after Jan. 1, 1995. The agency previously defined a "new" residency program and adopted criteria to determine whether a residency program qualifies as "new" for purposes of determining whether a hospital can receive additional direct GME and/or IME slots for that program. Specifically, to be considered a "new" program, a previously non-teaching hospital would have to ensure that

the program meets three primary criteria: 1) the residents are new; 2) the program director is new; and 3) the teaching staff are new.

We appreciate that CMS has carefully considered stakeholder comments on its initial set of proposals regarding the newness of a residency program and a related request for information from the field. Specifically, we thank CMS for proposing that it will no longer consider the previous employment of the faculty or program director in determining whether the program director is new for cap building purposes. As we stated in our FY 2025 comment letter, we agree that it is important to have experienced faculty and program directors to stand up new residency programs, where they have the expertise and knowledge of accreditation requirements and how to properly train the next generation of physicians. To combat the current physician workforce shortage and ensure that the field continues to train high-quality physicians, *experience* is a necessary factor.

After considering stakeholder comments, CMS is proposing that for programs starting on or after Oct. 1, 2026, at least 90% of the individual resident trainees (not full-time equivalents) must not have previous training in the same specialty as the new program. The agency also proposes several exceptions to this rule. Specifically, we had previously expressed our concern that programs may have every intent to meet the threshold of 90% individual trainees being new, but through the binding residency matching program, find themselves unable to meet the threshold. Therefore, we thank CMS for proposing to exclude trainees with previous experience training in another program in the same specialty who enter the new program as first-year residents, recognizing that hospitals should not be penalized for results of the binding matching program and fulfilling the 90% requirement. CMS would also create an exception to the 90% requirement for small residency programs, defined as one accredited for 16 or fewer positions, regardless of whether the program is located in an urban or rural area. **We support these proposals.**

NURSING ALLIED HEALTH EDUCATION PAYMENTS

Medicare makes payment for its share of a hospital's reasonable cost for approved nursing and allied health education (NAHE) programs operated by the hospital. These payments play a critical part in training the next generation of health providers.

In last year's rule, CMS issued a proposal to address a court ruling related to the net costs of NAHE that hospitals are allowed to claim for pass-through payment. The AHA urged CMS to reconsider its proposal. We stated at the time that the proposal could result in circumstances where revenue from or on behalf of students reduces direct NAHE costs to zero, and there would be no indirect costs to allocate. As such, providers could no longer receive NAHE payments, without which they may be forced to close such programs. **We appreciate that CMS considered stakeholder comments and modified its proposal in this year's rule to ensure that the deduction of revenue does not inappropriately reduce the allocation of indirect costs to the NAHE cost center.**

However, the AHA remains concerned that portions of the proposed discussion regarding related organizations and indirect costs may not fully reflect the realities of how many NAHE programs operate. Many NAHE programs depend on the centralized administrative resources operated by their hospital to improve efficiency, reduce duplication and better coordinate NAHE programs across all affiliated hospitals. These centralized functions include payroll processing, accounting systems, human resources support, benefits administration and other operational infrastructure. They do not alter the fact that the provider hospitals themselves continue to *directly operate and control* their NAHE programs, including direct control over curriculum, administration, faculty, and classroom and clinical instruction. **We urge CMS to consider that a NAHE program's use of centralized or shared administrative infrastructure does not, by itself, invalidate hospital-operated status or otherwise preclude allowable NAHE pass-through reimbursement as long as the hospital continues to satisfy the substantive operational control requirements established under the regulation.**

AREA WAGE INDEX

Permanent Cap on Wage Index Decreases

In the FY 2024 rule, CMS finalized a policy to apply a 5% cap on all wage index decreases, regardless of the reason, in a budget-neutral manner. For FY 2027, CMS estimates that the cap on reductions will require a budget neutrality adjustment of -0.80%. **The AHA appreciates CMS' recognition that significant year-to-year changes in the wage index can occur due to external factors beyond a hospital's control. While we support this policy that would increase the predictability of inpatient PPS payments, we continue to urge CMS to apply this policy in a non-budget-neutral manner.**

Low-wage Hospital Policy

Beginning in FY 2020, CMS finalized a policy to increase wage index values for low-wage hospitals. This was done in a budget-neutral manner through an adjustment applied to the standardized amounts for all hospitals. Specifically, the agency increased the wage index for hospitals with a wage index value below the 25th percentile by half the difference between its otherwise applicable wage index value and the 25th percentile wage index value across all hospitals for that year. While this policy was originally scheduled to expire after FY 2023, CMS indicated it had been unable to disentangle the effects of the COVID-19 pandemic and the low-wage index policy to determine whether the policy had successfully resulted in hospitals raising wages to get a higher wage index. Therefore, in the FY 2025 proposed rule, the agency proposed to extend the policy and related budget neutrality adjustment for at least three more years.

However, in the FY 2025 final rule, CMS noted that the policy had become the subject of litigation. Specifically, on July 23, 2024, the Court of Appeals for the D.C. Circuit held that the secretary lacked authority to adopt the policy and that it, and its related budget neutrality adjustments, must be vacated. As a result of this court decision, the agency

discontinued the low-wage index policy and its related budget neutrality factor for FY 2025. It also implemented a non-budget-neutral transition policy for hospitals impacted by the discontinuation, which capped wage index decreases at 5%.

In the FY 2026 rule, CMS finalized that it would discontinue the low-wage policy for FY 2026 and beyond. Additionally, the agency implemented a budget-neutral policy to help hospitals significantly impacted by the policy removal, capping decreases at 5%. CMS is proposing the same transitional policy done in a budget-neutral way for FY 2027. However, we believe that CMS is not bound by statute to make its proposal budget-neutral. We appreciate that the agency's FY 2025 transition policy was implemented in a non-budget-neutral manner, and we maintain that the FY 2027 transition policy should also be implemented in a non-budget-neutral manner. Indeed, reducing the standardized amount for all PPS hospitals intensifies historical Medicare underpayment. **As such, the AHA urges CMS to implement the FY 2027 low-wage hospital transition policy in a non-budget-neutral manner.**

Imputed Rural Floor Calculation

As required by law, CMS proposes to continue the minimum area wage index for hospitals in all-urban states, known as an "imputed rural floor," for FY 2027. This policy applies to states that have no rural hospitals or no rural areas to set a rural floor wage index for those states. Also, as required by law, CMS proposes to apply this policy in a non-budget-neutral manner. **We support this proposal.**

RURAL HOSPITAL PROVISIONS

Low-volume Adjustment and Medicare-dependent Hospital Program

The Consolidated Appropriations Act, 2026, extended the low-volume hospital qualifying criteria and payment adjustment (LVA) and the Medicare-dependent Hospital (MDH) Program under the inpatient PPS through Dec. 31, 2026. However, as it currently stands, beginning on Jan. 1, 2027, the LVA would revert to statutory requirements that were in effect prior to FY 2011. Similarly, beginning Jan. 1, 2027, the MDH program would expire. **The AHA supports congressional action to make permanent the enhanced LVA so that hospitals can continue to qualify for and be paid under the current enhanced method. We also support congressional action to make permanent the MDH program, with an additional base year available to calculate MDH payments, which would provide more flexibility for these hospitals to provide the best care possible for their patients and communities.**

Additionally, we also urge CMS to expeditiously process claims and provide instructions to MACs during program extensions, especially in instances when extensions are made retroactively. Although FFS Medicare makes retrospective payments for program extensions that occur retrospectively, many MA plans do not. That is, until CMS issues instructions to the MACs and updates its databases identifying MDH and LVA hospitals,

these hospitals do not receive enhanced Medicare reimbursements from MA plans. These rural hospitals, which are already in vulnerable financial states, are owed tens of millions of Medicare payments as a result of cumbersome administrative processes. Seamless transition of programmatic support is a crucial lifeline for rural providers.

Hospitals Applying for Rural Referral Center Status

One way in which a hospital can qualify for rural referral status is based on a combination of discharge volume and case-mix criteria, in comparison to other providers in the hospital's region. CMS proposes to use FY 2025 data to calculate case-mix criteria and FY 2024 cost report data to calculate discharge volume. **We support the use of this data.**

PROPOSED CHANGES TO SPECIFIC MS-DRG CLASSIFICATIONS

Overall, the AHA supports CMS' proposed changes within the Medicare Severity Diagnosis-Related Group (MS-DRG) Classifications section. We agree with most proposals based on the data analysis presented in this proposed rule. However, we request that CMS consider the exceptions detailed below.

First, the AHA thanks CMS for continuing to provide test versions of files and software applications needed to assess proposed MS-DRG classification changes. Specifically, we thank CMS for providing the draft MS-DRG test GROUPER and Medicare Code Editor (MCE) ICD-10 software Version 44 (V44).

We also value CMS making available the supplemental mapping files in Tables 6P.1a (mapped V44 FY 2027 ICD-10-CM codes and deleted Version (V43) FY 2026 ICD-10-CM codes) and 6P.1b (mapped V44 FY 2027 ICD-10-PCS codes and deleted V43 FY 2026 ICD-10-PCS codes). These mapping files support hospitals' efforts to use the test GROUPER alongside their own claims data to develop claims-based scenarios to evaluate the impact of the proposed changes included in the FY 2027 inpatient and LTCH PPS proposed rule.

As previously expressed, the absence of a batch test GROUPER significantly limits hospitals' ability to efficiently evaluate the impact of proposed MS-DRG changes. While the availability of updated test software is appreciated, requiring users to enter test cases individually is time-intensive and inherently restricts hospitals' ability to conduct comprehensive testing across larger, more representative datasets.

In addition to the broader operational limitations described above, several recurring technical issues noted in this proposed rule further underscore the need for batch GROUPER functionality and enhanced transparency to support meaningful evaluation of the proposed changes.

These technical issues include the following:

- Proposed revisions involving the elimination of cluster logic materially alter MS-DRG assignment pathways and limit stakeholders' ability to accurately model impacts using existing tools.
- Absent recalibration through a batch GROUPER that reflects the proposed logic changes, stakeholders' ability to conduct reliable analysis is materially limited. This limitation is evident across MDCs in this proposed rule.
- Several proposed GROUPER changes rely on procedure codes that were not included in the FY 2025 claims data used for CMS's analysis, as these codes became effective in FY 2026. As a result, CMS relied on mapping methodologies to approximate these procedures. However, procedure code mapping inherently introduces limitations, as it requires the use of broader, less specific legacy codes, thereby reducing the precision and reliability of impact estimates. This issue is particularly relevant within Major Diagnostic Categories (MDCs) 05, 08 and 10.
- The absence of clear and consistent "from/to" MS-DRG mappings limits stakeholders' ability to validate and replicate CMS' analyses. This limitation is further compounded by observed discrepancies between narrative descriptions of expected MS-DRG shifts and the corresponding data presented in the After Outliers Removed (AOR) file included with the proposed rule materials, which in some instances reflect conflicting directional impacts. This issue is also observed within MDCs 05, 08, and 10.

We appreciate CMS' acknowledgment and stated future consideration of providing a batch test GROUPER, as noted in its response to comments in the FY 2026 inpatient and LTCH PPS final rule. Given this prior recognition and the technical issues outlined above, we urge CMS to prioritize and provide a batch GROUPER option in conjunction with future rulemaking. Doing so would materially reduce administrative burden, enhance the quality and depth of stakeholder feedback, and support more informed and effective policy development.

FY 2027 MS-DRG Updates

For the FY 2027 IPPS proposed rule, we acknowledge that CMS's MS-DRG analysis is based on ICD-10 claims data from the September 2025 update of the FY 2025 MedPAR file, which includes hospital bills received from October 1, 2024, through September 30, 2025.

We recognize the level of detail and the significant time and effort CMS dedicates to developing the analysis and supporting materials included in the inpatient and LTCH PPS proposed and final rules related to MS-DRG classification. However, consistent with concerns raised in our comments on the FY 2026 MS-DRG classification proposals, we again note challenges related to transparency, specifically with respect to MS-DRG volume shifts when comparing GROUPER V43 to V44 in the AOR file accompanying this proposed rule.

MDC 05 (Disease and Disorders of the Circulatory System) WiSE®Cardiac Resynchronization Therapy (CRT System)

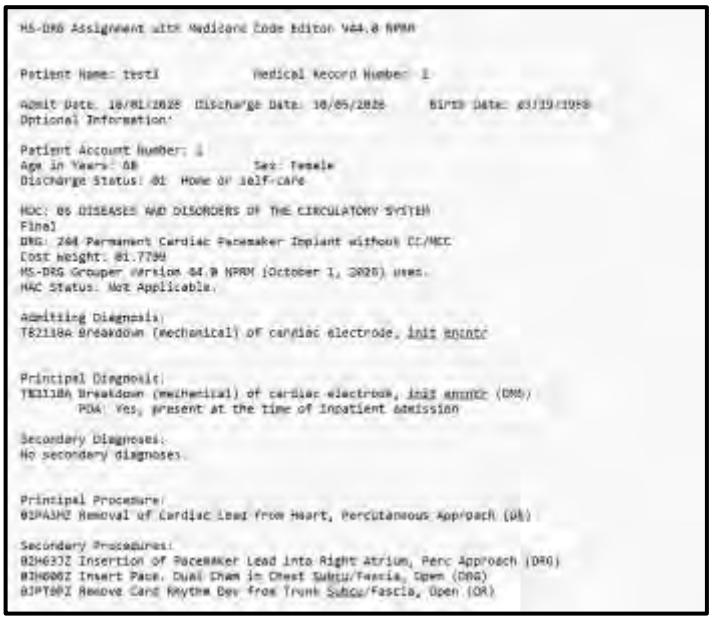
We appreciate CMS' efforts to modernize MS-DRG classifications within MDC 05. Including the proposed deletion of cardiac pacemaker replacement and revision MS-DRGs (258-262) to consolidate pacemaker replacement and revisions into two new MS-DRGs (210 and 211), as well as the deletion of MS-DRG 264 and the creation of two new MS-DRGs with a two-level severity hierarchy (361 and 362) for other circulatory system O.R. procedures. We also recognize CMS' intent to refine classification for emerging technologies, including the WiSE® CRT system, through the removal of cluster logic and reassignment of newly established ICD-10-PCS procedure codes.

While we support CMS' goal of improving MS-DRG clarity and alignment with evolving procedural approaches, we have identified potential inconsistencies between the proposed MS-DRG logic, the ICD-10-PCS procedure code assignments, and the draft V44 GROUPER outcomes. Specifically, CMS proposes that ICD-10-PCS procedure codes associated with the WiSE® CRT system, X2HN37B, would be assigned to MS-DRGs 228 and 229, and XHH80HB would be reassigned to the proposed new MS-DRGs 210 and 211 as standalone procedures, respectively, with the removal of cluster logic.

However, using draft test GROUPER V44 indicates that cases involving pacemaker revision with replacement scenarios (e.g., replacement of generator and leads due to device malfunction or end-of-life) are not consistently grouped to MS-DRGs 210 and 211 as expected. Instead, these cases are assigned to MS-DRGs 242-244 (pacemaker insertion), which appear inconsistent with both the clinical scenario and the intended MS-DRG definitions.

This outcome appears to be driven in part by surgical hierarchy logic, whereby insertion procedures supersede revision with replacement procedures within the grouping algorithm. However, in clinically typical scenarios, pacemaker replacement requires both removal and insertion procedures (e.g., removal of malfunctioning leads and generator with insertion of new components). In these instances, reliance on surgical hierarchy may not appropriately reflect the clinical intent of the procedure (replacement versus initial insertion), resulting in MS-DRG assignments that do not appear to be the intent.

We also identified challenges in replicating CMS's analysis based on the information provided. Although Table 6P.2a lists the ICD-10-PCS codes proposed for assignment to MS-DRGs 210 and 211, the relationship between those codes and actual V44 GROUPER results cannot be fully validated without additional detail on the logic interactions, including surgical hierarchy rules and the effects of removing cluster requirements. The screenshot below illustrates a pacemaker revision case that groups to pacemaker insertion, even though the procedure codes appear in Table 6P.2a for assignment to MS-DRGs 210 or 211.



```
MS-DRG Assignment with Medicare Code Editor V44.0 NPRM

Patient Name: test1              Medical Record Number: 1

Admit Date: 10/01/2025  Discharge Date: 10/05/2025      Birth Date: 03/19/1958
Optional Information:

Patient Account Number: 1
Age in Years: 68                 Sex: Female
Discharge Status: 01  Home or Self-Care

MDC: 05 DISEASES AND DISORDERS OF THE CIRCULATORY SYSTEM
Final
DRG: 244 Permanent Cardiac Pacemaker Implant without CC/MCC
Cost Weight: 01.7799
MS-DRG Grouper Version 44.0 NPRM (October 1, 2025) used.
HAC Status: Not Applicable.

Admitting Diagnosis:
T82110A Breakdown (mechanical) of cardiac electrode, init encntr

Principal Diagnosis:
T82110A Breakdown (mechanical) of cardiac electrode, init encntr (DX6)
        POA: Yes, present at the time of inpatient admission

Secondary Diagnoses:
No secondary diagnoses

Principal Procedure:
02PA3MZ Removal of Cardiac Lead from Heart, Percutaneous Approach (OR)

Secondary Procedures:
02H633Z Insertion of Pacemaker Lead into Right Atrium, Perc Approach (OR6)
0JH606Z Insert Pace. Dual Chamb in Chest Subcu/Fascia, Open (OR6)
0JPT80Z Remove Card Rhythm Dev from Trunk Subcu/Fascia, Open (OR)
```

Additionally, analysis of the AOR file for MDC 05 demonstrates substantial MS-DRG shifts under the proposed policy, including movements that appear attributable both to severity-level changes (Complication (CC) or Comorbidity/Major Complication (MCC) or Comorbidity CC/MCC refinements) and to structural changes such as the removal of cluster logic. The magnitude and distribution of these shifts make it difficult for hospitals to reliably model financial and operational impacts using standard tools and the case-by-case test GROUPER. (Reference the following excerpt from the AOR file).

CMS indicated in its discussion that cases involving WiSE® CRT procedures would shift into MS-DRGs 228 and 229. However, our review comparing V43 and draft V44 from the AOR file suggests a decline in case volumes within MS-DRGs 228 and 229, as well as in certain pacemaker-related MS-DRGs such as 242 and 243, which appears inconsistent with CMS' intended expectations. (Reference AOR file excerpts to follow).

V43 DR	V43 Cases	V43 MSDRG Weight	V44 DR	V44 Cases	V44 MSDRG Title	V44 MSDRG Weight	Case Variance (V44 - V43)
228	6025	4.9474	228	6018	OTHER CARDIOTHORACIC PROCEDURES WITH MCC	4.9942	-7
229	7480	3.1495	229	7479	OTHER CARDIOTHORACIC PROCEDURES WITHOUT MCC	3.4824	-1
242	12614	3.1928	242	12611	PERMANENT CARDIAC PACEMAKER IMPLANT WITH MCC	3.145	-3
243	18264	2.1309	243	18254	PERMANENT CARDIAC PACEMAKER IMPLANT WITH CC	3.1257	-10
244	8453	1.8075	244	8461	PERMANENT CARDIAC PACEMAKER IMPLANT WITHOUT CC/MCC	1.7799	8
			161	5649	OTHER CIRCULATORY SYSTEM O.R. PROCEDURES WITH MCC	3.7384	5649
			162	2711	OTHER CIRCULATORY SYSTEM O.R. PROCEDURES WITHOUT MCC	2.1981	2711
264	8359	3.3406			Deleted MSDRG FY2027		-8359

V43 DR	V43 Cases	V43 MSDRG Title	V43 MSDRG Weight	V44 DR	V44 Cases	V44 MSDRG Title	V44 MSDRG Weight	Case Variance (V44 - V43)
		New MSDRG FY2027		210	2938	CARDIAC PACEMAKER REVISION OR DEVICE REPLACEMENT WITH MCC	3.2705	2938
		New MSDRG FY2027		211	3938	CARDIAC PACEMAKER REVISION OR DEVICE REPLACEMENT WITHOUT MCC	1.8236	3938
258	34	CARDIAC PACEMAKER DEVICE REPLACEMENT WITH MCC	3.1421			Deleted MSDRG FY2027		-34
259	67	CARDIAC PACEMAKER DEVICE REPLACEMENT WITHOUT MCC	2.0221			Deleted MSDRG FY2027		-67
262	848	CARDIAC PACEMAKER REVISION EXCEPT DEVICE REPLACEMENT WITHOUT CC/MCC	1.6299			Deleted MSDRG FY2027		-848
260	2908	CARDIAC PACEMAKER REVISION EXCEPT DEVICE REPLACEMENT WITH MCC	3.2528			Deleted MSDRG FY2027		-2908
261	3020	CARDIAC PACEMAKER REVISION EXCEPT DEVICE REPLACEMENT WITH CC	1.8905			Deleted MSDRG FY2027		-3020

These observations raise questions regarding:

- The interaction between reassigned procedure codes and broader MS-DRG logic.
- The role of hierarchy in overriding proposed classification intent.
- Whether additional codes or combinations are driving cases into alternative MS-DRGs not identified in CMS' narrative.

Absent additional technical detail, it is difficult to reconcile CMS' projected directional impacts with observed GROUPER and AOR file results.

To ensure clinical coherence, analytic validity and stakeholder confidence in these proposed changes, we respectfully request that CMS:

- Provide detailed technical specifications regarding how ICD-10-PCS procedure codes associated with WiSE® CRT and pacemaker revision/replacement interact with the surgical hierarchy, particularly in cases involving both removal and insertion procedures.
- Assess whether the current surgical hierarchy accurately reflects the clinical intent of device replacement cases, and refine it as needed to avoid classifying replacements as initial insertions.
- Provide additional analytic resources, including:
    - A "from/to" MS-DRG crosswalk reflecting proposed logic.
    - More detailed AOR file identifying drivers of MS-DRG shifts.

MDC 08 (Diseases and Disorders of the Musculoskeletal System and Connective Tissue) Spinal Fusion and Pelvic Fixation Procedures

We appreciate CMS' ongoing efforts to refine the MS-DRG classification system to ensure that inpatient cases are grouped in clinically coherent categories that appropriately reflect

resource use. However, we wish to highlight a key analytic concern specific to MS-DRG 426 when evaluating trends across FY 2025 and FY 2026.

In the FY 2025 inpatient PPS final rule, CMS finalized a major restructuring of spinal fusion MS-DRGs, including the creation of MS-DRGs 426-428 to describe multi-level non-cervical combined anterior/posterior spinal fusion cases, along with other new fusion groupings. This redesign effectively established a new cohort definition beginning in FY 2025, rather than a continuation of an existing, stable classification population.

For FY 2026, CMS implemented annual updates to the MS-DRG GROUPER and Medicare Code Editor (MCE), including the FY 2026 GROUPER and associated classification updates for discharges on or after Oct. 1, 2025. Even when an MS-DRG title remains unchanged, GROUPER version changes can affect case assignment through updated code logic, edits and classification pathways.

Because FY 2025 established a new MS-DRG cohort and FY 2026 proceeded under a new GROUPER version, observed shifts in MS-DRG 426 relative weight and case volume across these two years may reflect classification dynamics rather than true changes in patient acuity or resource use. These dynamics include:

- Stabilization effects following the FY 2025 restructure.
- Evolving coding and documentation patterns under the new fusion constructs.
- GROUPER version changes that affect case routing and logic application.

Accordingly, hospitals attempting to assess payment adequacy, budget neutrality or operational impacts for MS-DRG 426 across FY 2025 and FY 2026 may reach misleading conclusions if these years are treated as directly comparable.

These considerations are particularly important in the context of CMS' proposed FY 2027 MS-DRG weight for MS-DRG 426, which reflects a notable decrease from prior years. Given the structural and methodological changes described above, we are concerned that this proposed reduction may not fully reflect a stable or mature representation of the underlying case mix and resource use associated with this MS-DRG.

To support transparent, reproducible analysis by hospitals and stakeholders, we respectfully request that CMS:

- Acknowledge the non-comparability of spinal fusion MS-DRGs across FY 2025, FY 2026 and FY 2027 through a major spinal fusion restructure.
- Provide explicit documentation of any FY 2026 refinements that affect case assignment to MS-DRG 426, including logic sequencing or edit-driven pathways that could shift cases among related spinal fusion MS-DRGs.
- Publish supplemental, stakeholder-usable crosswalks and testing support to enable hospitals to evaluate impacts using their own claims under the applicable

GROUPER logic (e.g., clarifying which code/logic changes materially alter routing into or out of MS-DRGs).

- Where feasible, provide comparative impact metrics (e.g., “case movement” summaries between related spinal fusion MS-DRGs) so stakeholders can distinguish between true acuity/resource shifts and classification-driven redistribution.
- Re-evaluate the proposed FY 2027 MS-DRG weight (9.2898) for MS-DRG 426 and exercise caution in relying on FY 2025-FY 2026 data trends as a stable basis for recalibration. Specifically, we urge CMS to consider whether the observed downward weight trend proposed for FY 2027 (FY 2025: 10.4754; FY 2026: 11.0212; FY 2027 proposed: 9.2898) reflects transitional classification effects rather than sustained changes in resource utilization, and to consider maintaining or recalibrating the weight accordingly.

MDC 08 (Diseases and Disorders of the Musculoskeletal System and Connective Tissue) Hip or Knee Procedures with Periprosthetic Joint Infection

As background, in the FY 2026 inpatient and LTCH PPS proposed rule, CMS proposed creating MS-DRGs 403 and 404 to better capture the complexity of periprosthetic joint infection (PJI) cases involving hip and knee procedures. CMS’ initial analysis found that these cases were not adequately represented in existing MS-DRGs and supported a two-level severity split.

However, during the FY 2026 rulemaking cycle, stakeholders identified concerns related to inconsistencies in the GROUPER logic. Specifically, commenters noted overlapping procedure code logic between the proposed PJI MS-DRGs and existing MDC 08 MS-DRGs for revision hip and knee procedures. CMS subsequently confirmed that certain ICD-10-PCS procedure code cluster restrictions were limiting case assignment and interfering with intended clinical groupings.

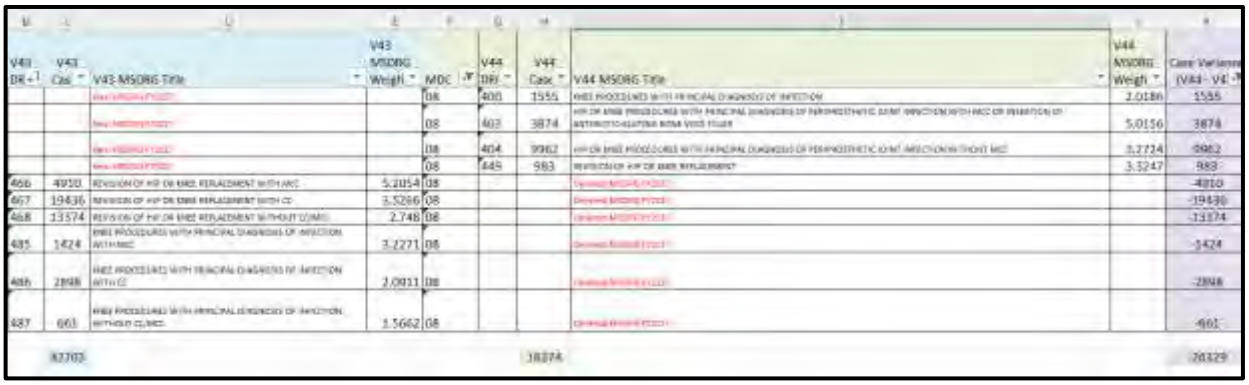
After removing these restrictions and conducting additional analysis, CMS observed significant redistribution of cases across multiple MS-DRGs, which reduced case volumes and affected the integrity of existing severity splits. CMS determined that addressing these issues would require more extensive restructuring of MDC 08 and therefore did not finalize the proposal for FY 2026 due, in part, to the lack of updated test GROUPER results available for stakeholder evaluation.

For FY 2027, CMS again proposes to establish MS-DRGs 403 and 404 for PJI cases and indicates that it has addressed prior concerns through technical refinements. We appreciate CMS’ continued efforts to improve the clinical coherence and payment accuracy of MS-DRG classifications for cases involving hip or knee procedures complicated by PJI. We support CMS’ goal of better aligning MS-DRG assignments with patient complexity, resource use and severity of illness.

At the same time, we have significant concerns regarding both 1) the transparency and replicability of the proposed methodology and 2) the resulting clinical coherence of MS-DRG groupings following these changes, particularly as they relate to the redistribution of cases across existing MS-DRG families.

CMS indicates that the proposed reassignment of cases is driven in part by the removal of MDC 08 "cluster restriction" logic within MS-DRGs 466-468 and 485-487, which alters how procedure code attributes are evaluated and affects assignment through the surgical hierarchy. These same MS-DRGs are proposed for deletion after the removal of the cluster logic, and new MS-DRGs 400, 403, 404 and 449 are proposed.

Our review of the AOR file demonstrates that MS-DRGs 466, 467, 468, 485, 486 and 487 for V43 of the GROUPER total 42,703 cases; however, the case total for the new MS-DRGs only totals 16,374. The proposal does not indicate the existing MS-DRGs to which the remaining 26,329 cases will shift.



V43 DRG	V43 Cas	V43 MSDRG Title	V43 MSDRG Weigh	MDC	V44 DRG	V44 Case	V44 MSDRG Title	V44 MSDRG Weigh	Case Variance (V43 - V44)
				08	400	1555		2.0186	1555
				08	403	3874		5.0156	3874
				08	404	9962		3.2724	9962
				08	449	983		3.3247	983
466	4910		5.2054	08					-4910
467	19436		3.5266	08					-19436
468	13374		2.748	08					-13374
485	1424		3.2271	08					-1424
486	2848		2.0911	08					-2848
487	661		1.5662	08					-661
	42703					16374			26329

The AOR file also provides some information regarding the shifts and demonstrates shifts within multiple MS-DRGs within MDC 08.

Our review of the AOR file indicates substantial shifts in case volume across MS-DRG families, including:

- A significant increase in case volume for MS-DRGs 463-465 (Wound Debridement or Skin Graft).
- A substantial decrease in case volume for MS-DRGs 489, 488 and 481 (knee procedures without a principal diagnosis of infection and hip/femur procedures, except major joint).

However, while CMS describes the mechanism at a high level, the proposal context does not provide sufficient detail for stakeholders to fully understand, replicate or validate the resulting case movements across MS-DRGs.

While these aggregate changes are observable, stakeholders cannot independently determine:

- Which specific cases are shifting?
- Which procedure codes and code clusters are driving the reassignment?
- How do surgical hierarchy and cluster attribute changes interact to produce the observed outcome?

In addition to transparency issues, we question the clinical coherence of the resulting MS-DRG assignments, particularly the significant redistribution of cases into MS-DRGs 463-465 (Wound Debridement or Skin Graft Except Hand). The substantial increase in volume within these existing debridement MS-DRGs will negatively affect data comparability over time.

Analysis of the AOR file comparing debridement MS-DRGs between V43 and V44 reflects an increase of 29,560 cases under the proposed GROUPER. It is unclear why new MS-DRGs were not considered to account for this shift. Under the proposal, these MS-DRGs would absorb a materially different case mix, including hip and knee procedures, which were not represented in prior versions of these DRGs. (Reference the AOR file excerpt to follow).

V43 DR	V43 Cas	V43 MSDRG Weigh	MDC	V44 DRI	V44 Case	V44 MSDRG Title	V44 MSDRG Weigh	Case Variance (V44 - V4
464	6361	3.1147	08	464	20130	WOUND DEBRIDEMENT OR SKIN GRAFT EXCEPT HAND FOR MUSCULOSKELETAL AND CONNECTIVE TISSUE DISORDERS WITH CC	3.2039	**13769**
465	1499	1.8237	08	465	15100	WOUND DEBRIDEMENT OR SKIN GRAFT EXCEPT HAND FOR MUSCULOSKELETAL AND CONNECTIVE TISSUE DISORDERS WITHOUT CC/MCC	2.5108	**13601**
463	4504	5.6995	08	463	6694	WOUND DEBRIDEMENT OR SKIN GRAFT EXCEPT HAND FOR MUSCULOSKELETAL AND CONNECTIVE TISSUE DISORDERS WITH MCC OR INSERTION OF ANTIBIOTIC-ELUTING BONE VOID FILLER	5.0224	**2190**
501	4205	1.7481	08	501	4585	SOFT TISSUE PROCEDURES WITH CC	1.8672	**380**
498	5811	3.0168	08	498	6118	LOCAL EXCISION AND REMOVAL OF INTERNAL FIXATION DEVICES OF HIP AND FEMUR WITH CC/MCC	3.199	**307**
500	1738	3.1648	08	500	1902	SOFT TISSUE PROCEDURES WITH MCC	3.3566	164
502	1594	1.3459	08	502	1697	SOFT TISSUE PROCEDURES WITHOUT CC/MCC	1.4311	103
499	1005	2.0148	08	499	1053	LOCAL EXCISION AND REMOVAL OF INTERNAL FIXATION DEVICES OF HIP AND FEMUR WITHOUT CC/MCC	2.1865	48
482	14132	1.631	08	482	14171	HIP AND FEMUR PROCEDURES EXCEPT MAJOR JOINT WITHOUT CC/MCC	1.6472	39
492	6210	3.6716	08	492	6216	LOWER EXTREMITY AND NUMERUS PROCEDURES EXCEPT HIP, FOOT AND FEMUR WITH MCC OR INSERTION OF ANTIBIOTIC-ELUTING BONE VOID FILLER	3.6876	6
470	50924	1.9289	08	470	50922	MAJOR HIP AND KNEE JOINT REPLACEMENT OR REATTACHMENT OF LOWER EXTREMITY WITHOUT MCC	1.97	-2
483	13601	2.7719	08	483	13594	MAJOR JOINT OR LIMB REATTACHMENT PROCEDURES OF UPPER EXTREMITIES	2.9225	-7
476	355	1.1802	08	476	336	AMPUTATION FOR MUSCULOSKELETAL SYSTEM AND CONNECTIVE TISSUE DISORDERS WITHOUT CC/MCC	1.1287	-19
479	952	1.8589	08	479	932	BIOPSIES OF MUSCULOSKELETAL SYSTEM AND CONNECTIVE TISSUE WITHOUT CC/MCC	1.8606	-20
494	7682	2.0065	08	494	7659	LOWER EXTREMITY AND NUMERUS PROCEDURES EXCEPT HIP, FOOT AND FEMUR WITHOUT CC/MCC	2.0372	-23
477	3354	3.4546	08	477	3328	BIOPSIES OF MUSCULOSKELETAL SYSTEM AND CONNECTIVE TISSUE WITH MCC OR INSERTION OF ANTIBIOTIC-ELUTING BONE VOID FILLER	3.4078	-26
469	4192	3.0332	08	469	4131	MAJOR HIP AND KNEE JOINT REPLACEMENT OR REATTACHMENT OF LOWER EXTREMITY WITH MCC OR TOTAL ANKLE REPLACEMENT	3.1294	-61
480	26724	2.9123	08	480	26592	HIP AND FEMUR PROCEDURES EXCEPT MAJOR JOINT WITH MCC OR INSERTION OF ANTIBIOTIC-ELUTING BONE VOID FILLER	2.9253	-132
474	2534	4.2929	08	474	2396	AMPUTATION FOR MUSCULOSKELETAL SYSTEM AND CONNECTIVE TISSUE DISORDERS WITH MCC OR INSERTION OF ANTIBIOTIC ELUTING BONE VOID FILLER	4.161	-138
478	5705	2.4592	08	478	5539	BIOPSIES OF MUSCULOSKELETAL SYSTEM AND CONNECTIVE TISSUE WITH CC	2.4367	-166
475	2966	2.2757	08	475	2687	AMPUTATION FOR MUSCULOSKELETAL SYSTEM AND CONNECTIVE TISSUE DISORDERS WITH CC	2.2247	-279
493	18342	2.5361	08	493	18010	LOWER EXTREMITY AND HUMERUS PROCEDURES EXCEPT HIP, FOOT AND FEMUR WITH CC	2.5616	**-332**
481	65186	2.0945	08	481	64829	HIP AND FEMUR PROCEDURES EXCEPT MAJOR JOINT WITH CC	2.1335	**-357**
488	1411	1.5236	08	488	934	KNEE PROCEDURES WITHOUT PRINCIPAL DIAGNOSIS OF INFECTION WITH CC/MCC	2.2072	**-477**
489	1935	1.1168	08	489	283	KNEE PROCEDURES WITHOUT PRINCIPAL DIAGNOSIS OF INFECTION WITHOUT CC/MCC	1.3123	**-1652**
	252922				279838			26916

Given that these changes rely on upstream GROUPER mechanics, specifically the interaction between procedure code clusters, MDC restrictions, and hierarchy precedence, this lack of transparency significantly limits the ability of hospitals to conduct reliable,

apples-to-apples impact analyses, evaluate payment implications or validate CMS' conclusions.

To support meaningful stakeholder evaluation, we respectfully request that CMS provide:

- Consider whether new or refined MS-DRGs are warranted to distinguish differences with debridement MS-DRGs 463, 464 and 465 that reflect the new MS-DRG shifts.
- Consider whether the proposed redistribution into MS-DRGs 463-465 appropriately reflects clinical similarity and resource use, or whether further refinement of logic lists or hierarchy is needed.
- Provide a comprehensive "from/to" crosswalk showing case counts moving from each MS-DRG under the current GROUPER V43 to each MS-DRG under the proposed GROUPER V44, with specific alignment to the populations defined in Table 6P.3b.

Lastly, for MDC 08, we note that CMS acknowledges the proposed implementation of a new ICD-10-PCS procedure code (XW0V0BC) effective October 1, 2026, to describe the administration of CERAMENT® V, an antibiotic-eluting bone void filler containing vancomycin, in contrast to the existing code XW0V0P7, which describes CERAMENT® G (gentamicin).

In the proposed rule, CMS recognizes that cases involving the use of antibiotic-eluting bone void fillers are associated with higher resource utilization. Accordingly, we request that CMS apply a consistent policy approach, designating this new code as non-O.R., impacting MS-DRG so that it groups with the MS-DRGs that recognize the antibiotic-eluting bone void filler (e.g., 463, 474, 477, 480, 492, 616, 628).

Proposed Changes to Severity Levels

With respect to Table 6A (New Diagnosis Codes), CMS identifies the proposed severity levels for new diagnosis codes. We support the proposed severity designations for new diagnosis codes for FY 2027 as listed.

We also support the proposed additions in Table 6I.1 (Proposed Additions to the MCC List) and the additions in Table 6J.1 (Proposed Additions to the CC List). Regarding Table 6J.2 (Proposed Deletions to the CC List), we support the deletions from the CC list except as discussed below.

CMS' proposal to revise the severity designations for certain social determinants of health (SDOH) Z-codes merits careful reconsideration, given the agency's longstanding data-driven methodology and prior conclusions supporting CC status for these conditions.

CMS established (84 FR 19158) and consistently relies on a mathematical analysis of resource use (C1, C2, C3 metrics) derived from MedPAR claims data to determine

whether secondary diagnoses meaningfully increase hospital resource utilization. As described in prior rulemaking and supporting files, this methodology requires:

- Sufficient case volume.
- Demonstrated increases in resource use across severity strata (C1, C2, C3 groupings).
- Alignment with clinical expectations and operational burden.

This framework formed the basis for elevating homelessness and housing-related SDOH codes to CC status, reflecting objective, reproducible evidence, not anecdotal interpretation.

In the FY 2024 (88 FR 26658 and 88 FR 5860) inpatient and LTCH PPS rulemaking, CMS explicitly determined that homelessness-related Z-codes met criteria for CC designation:

- C1 values near ~2.0 demonstrated alignment with CC-level resource use.
- C2 values similarly supported CC classification across scenarios with additional comorbidities.
- CMS concluded that these conditions “support increasing the severity level from a Non-CC to a CC” based on consistent findings across multiple MedPAR years.

ICD-10-CM Code	Description	Total Count	Cnt1	C1	Cnt2	C2	Cnt3	C3
Z59.00	Homelessness, unspecified	27,148	3,485	1.75	12,608	2.19	11,055	3.10
Z59.01	Sheltered homelessness	6,862	821	2.00	3,027	2.24	3,014	3.08
Z59.02	Unsheltered homelessness	4,394	453	2.12	1,948	2.35	1,993	3.10

Importantly, CMS acknowledged:

- Results were evaluated across multiple years of data (FY 2019-FY 2022).
- Variability during the public health emergency was explicitly considered and not used as a basis to reverse conclusions.
- The agency applied nine guiding principles, integrating both quantitative and clinical factors.

CMS has repeatedly articulated that SDOH conditions, particularly homelessness and housing instability, drive increased hospital resource use, including:

- Extended length of stay due to discharge barriers.
- Higher care coordination and social service needs.
- Increased nursing intensity and monitoring.
- Medication access and adherence challenges.
- Greater clinical severity at presentation due to delayed care access.

This rationale was reaffirmed and expanded in FY 2025, where CMS applied identical logic to additional housing instability codes (Z59.1x, Z59.81x), again concluding these conditions warrant CC designation based on both data and clinical reality (89 FR 35934 and 89 FR 68986).

ICD-10-CM Code[a]	Description[b]	Total Count[c]	Cnt1[d]	C1[e]	Cnt2[f]	C2[g]	Cnt3[h]	C3[i]
Z59.10	Inadequate housing, unspecified	227	21	2.63	85	1.38	121	2.81
Z59.11	Inadequate housing environmental temperature	74	4	0.51	33	1.02	37	2.64
Z59.12	Inadequate housing utilities	162	12	0.99	80	1.65	70	2.39
Z59.19	Other inadequate housing	987	93	1.85	431	2.82	463	3.07
Z59.811	Housing instability, housed, with risk of homelessness	165	21	1.97	79	2.51	65	3.18
Z59.812	Housing instability, housed, homelessness in past 12 months	141	15	0.76	65	1.77	61	2.33
Z59.819	Housing instability, housed unspecified	1,237	96	0.92	619	2.25	522	2.88

CMS acknowledged in the FY 2025 inpatient and LTCH PPS proposed and final rules that diagnosis codes Z59.10 (Inadequate housing, unspecified), Z59.11 (Inadequate housing environmental temperature), Z59.12 (Inadequate housing utilities) and Z59.19 (Other inadequate housing) became effective on April 1, 2023 (FY 2023). CMS further noted that, when examining the predecessor code Z59.1 (Inadequate housing), historical impact on resource use data demonstrated C1 values of 2.09, 1.73, 2.04, and 2.69 using FY 2019 through FY 2022 MedPAR claims data. These values consistently aligned with, or exceeded, thresholds associated with CC-level resource use.

Importantly, CMS recognized that the comparatively lower C1 values observed for certain newly established codes, specifically Z59.11 (Inadequate housing environmental temperature) and Z59.12 (Inadequate housing utilities) in FY 2023 data, may reflect limited uptake, evolving coding practices and lack of familiarity with the expanded code set, rather than a true reduction in associated resource utilization. CMS noted that the available data may not yet fully capture the extent of resource use for patients experiencing these circumstances.

Based on CMS' own established approach, removal or downgrading of CC status for SDOH Z-codes would represent a departure from prior policy without a clearly articulated methodological justification, particularly if:

- The agency relies on limited or short-term data fluctuations, rather than multi-year trends.
- There is insufficient evidence that C1/C2 values now fall below thresholds previously used to justify CC status.

ICD-10-CM Code[a]	Description[b]	Total Count[c]	Cnt1[d]	C1[e]	Cnt2[f]	C2[g]	Cnt3[h]	C3[i]
Z59.00	Homelessness unspecified	30,603	3,308	1.67	13,544	2.24	13,751	3.24
Z59.01	Sheltered homelessness	14,271	1,538	1.81	6,236	2.28	6,497	3.23
Z59.02	Unsheltered homelessness	8,023	712	2.03	3,528	2.35	3,783	3.32
Z59.10	Inadequate housing, unspecified	2,019	74	1.97	853	2.16	1,092	3.03
Z59.11	Inadequate housing environmental temperature	753	32	1.96	281	1.76	440	3.10
Z59.12	Inadequate housing utilities	3,541	196	1.61	1,497	2.20	1,848	3.07
Z59.19	Other inadequate housing	2,277	145	1.62	904	2.63	1,228	3.27
Z59.811	Housing instability, housed, with risk of homelessness	14,069	720	1.02	5,215	2.13	8,134	3.07
Z59.812	Housing instability, housed, homelessness in past 12 months	593	37	1.83	268	2.42	288	3.04
Z59.819	Housing instability, housed unspecified	10,565	643	1.35	4,295	2.08	5,627	3.09

Reversing or narrowing CC status for SDOH codes would:

- Undermine accurate representation of patient complexity.
- Reduce payment alignment with actual hospital resource utilization.

CMS' FY 2027 analysis acknowledges that these SDOH Z codes are associated with increased hospital resources and that C1 values close to 2.0 indicate a CC-like pattern; accordingly, any proposed policy shift away from CC recognition should be reconciled with CMS' established CC/MCC analytic framework, including the nine guiding principles that expressly account for higher levels of care and impediments to patient management, features that are characteristic of homelessness and housing instability in the inpatient setting.

We respectfully request CMS to maintain the CC designation for SDOH Z-codes currently assigned such status and provide transparent reconciliation with prior rulemaking conclusions and guiding principles.

Alternative Pathway for Breakthrough Devices — Ceribell Delirium Monitor System

CMS notes that a new technology add-on payment (NTAP) application has been submitted for the Ceribell Delirium Monitor System for FY 2027. At the same time, the NTAP for the Ceribell Status Epilepticus Monitor is scheduled to expire at the end of FY 2026.

In response, CMS proposes to exclude cases reporting ICD-10-CM diagnosis codes that it believes identify patients with status epilepticus when submitted in combination with the relevant procedure code (Table 10.2).

The AHA supports the NTAP pathway for innovative technologies, including consideration of the Ceribell Delirium Monitor System. However, we have concerns with CMS' proposed reliance on diagnosis code-based exclusions as the mechanism for distinguishing between the use of the monitor for status epilepticus versus delirium. For example, the monitor may

be utilized based on presenting symptoms without a definitive diagnosis of either status epilepticus or delirium established. We request that CMS reconsider the proposal to exclude cases that report diagnosis codes to identify patients with status epilepticus.

NEW TECHNOLOGY ADD-ON PAYMENTS

The inpatient PPS provides additional payments, known as the new technology add-on payments (NTAPs), for cases with relatively high costs involving eligible new medical services or technologies. For certain transformative new devices and certain antimicrobial products, CMS designated alternative pathways for NTAP approval, and thus, these products do not have to meet the three criteria specified under regulations. In this rule, however, CMS proposes to remove these alternative pathways and require that all applications meet the three criteria specified in the regulation. **We urge CMS to not finalize this proposal**.

CMS' proposed repeal of the alternative pathways would weaken a pathway that it specifically designed to bridge the gap between innovation and standard inpatient payment rates. For example, many technologies enter the market with strong safety and efficacy data but without long-term outcomes or large comparative studies. Requiring proof of substantial clinical improvement, as is required under the three criteria, disadvantages breakthrough technologies that are clinically promising but still accumulating real-world evidence. In addition, beneficiaries' access to these breakthrough technologies may be limited if hospitals cannot recoup a portion of the incremental costs during the adoption period. While CMS, in collaboration with the FDA, has announced plans to implement the proposed Regulatory Alignment for Predictable and Immediate Device Coverage Pathway to expedite access to certain breakthrough devices for Medicare beneficiaries, removing existing alternative pathways seems counter to the goal of helping beneficiaries access new and life-changing health technology faster.

PROMOTING INTEROPERABILITY PROGRAM FOR HOSPITALS

ONC Health IT Certification Program Proposed Updates

CMS proposes to revise the definition of certified electronic health record (EHR) technology for the Medicare Promoting Interoperability Program in accordance with the proposed changes the Office of the National Coordinator of Health IT (ONC) released as part of the Health Data, Technology, and Interoperability (HTI)-5 proposed rule. In HTI-5, ONC proposed the removal of 34 certification criteria and the revision of seven criteria.

The AHA recognizes CMS' desire to align its definition of certified EHR technology with the most recent version of its HTI rules. At the same time, the HTI-5 rule has not yet been finalized, and we have urged CMS to make several modifications to the HTI-5 proposals that we reiterate here.[24] We appreciate CMS and ONC's focus on ensuring modernized certification criteria that remove undue regulatory barriers. However, we recommended that ONC retain current HTI criteria around privacy, security, transitions of care and decision support interventions because the risks of their removal outweighed

[24] https://www.aha.org/lettercomment/2026-02-27-aha-comments-astponc-health-care-technology-interoperability-proposed-rule

potential benefits. We recognize that many of the certification criteria included in the HTI-5 rule are also part of the promoting interoperability program measures or included in the definition of certified EHR, which is why we are underscoring our comments in response to the HTI-5 proposed rule.

We also continue to urge CMS and ONC to work in a coordinated fashion to provide hospitals with sufficient time to implement changes affecting EHR certification criteria. In HTI-5, ONC proposed that all 41 removals or modifications to certification criteria be effective either as of the date of the final rule or no later than Jan. 1, 2027. Similarly, in the inpatient PPS proposed rule, CMS proposes that changes to the certified EHR definition be effective Jan. 1, 2027, for the Promoting Interoperability Program. We assert that this timeline is not tenable as it does not provide sufficient runway for workflow redesign, testing and implementation. At a minimum, we recommend that both CMS and ONC provide 24 months for transitioning certification criteria after updates are made to both certification criteria and corresponding CMS programs through final rules.

Proposal to Remove ONC Direct Review and ONC-ACB Surveillance Attestations

CMS proposes to remove attestations related to ONC Direct Review and ONC-Authorized Certification Body (ONC-ACB) Surveillance beginning in the CY 2026 EHR reporting period. **We concur that this would reduce the burden on hospitals and support the removal of these attestations.** We also agree that surveillance activities remain important and, as such, would urge the agency to encourage voluntary cooperation with ONC and ONC-ACB.

Proposal to Remove the Support Electronic Referral Loops Measures

The agency proposes to remove the “Support Electronic Referral Loops by Sending Health Information” and the “Support Electronic Referral Loops by Receiving and Reconciling Health Information” measures from the Health Information Exchange objective beginning with the CY 2028 reporting period. The agency proposed the removal of these measures to reduce the complexity of multiple measure reporting options for the Health Information Exchange objective and to focus program performance on measures that assess the adoption of newer health information technologies.

While we recognize that network-based exchange frameworks are less dependent on these workflows, many rural and critical access hospitals are still dependent on these and other Consolidated Clinical Data Architecture (C-CDA) based workflows. If these measures are removed, the only measures left in the Health Information Exchange objective would be Health Information Exchange Bi-Directional Exchange and Enabling Exchange Under TEFCA, which may pose limitations for certain hospitals. The Support Electronic Referral Loops Measures are also still meaningful backup measures in instances where network capability is unavailable or when a hospital is migrating to a new network exchange environment. **We would encourage the development of exceptions for the Health**

Information Exchange objective in these sorts of instances before the "Support Electronic Referral Loops" measures are removed.

Proposed Updates to Electronic Prior Authorization Measure

CMS proposes to modify the Electronic Prior Authorization (ePA) measure. Specifically, the agency proposes to modify the measure definition, change to an optional bonus measure for the CY 2027 performance period and make the measure mandatory for the CY 2028 performance period. Below are our comments on the ePA proposals.

Proposed Changes to Electronic Prior Authorization Measure Definition. In the FY 2027 inpatient PPS, CMS proposes to change the definition for the ePA measure as part of the Promoting Interoperability Program. The current definition of the measure is: "For at least one hospital discharge and medical item or service (excluding drugs) ordered during the EHR reporting period, the prior authorization is requested electronically via a Prior Authorization API using data from CEHRT."

The agency proposes to change the definition to: "For at least one medical item or service (excluding drugs) ordered during a hospital encounter that occurs within the EHR reporting period, the prior authorization is requested electronically through a Prior Authorization API using CEHRT."

We support the proposed modification to the ePA definition to include "hospital encounter" versus "hospital discharge." Broadening the definition to include the variety of hospital encounters addresses some of the confusion in the current measure terminology and more accurately captures the breadth of encounters relevant to ePA processes.

However, we oppose the proposed modifications to the measure definition that would change from "using data from CEHRT" to "using CEHRT." Hospitals and health systems may use different EHR platforms, revenue cycle systems, payer portals and clearinghouses in ePA processes. The proposed modifications to the definition could unintentionally limit the types of tools that could be used for prior authorization workflows and impose undue burden on hospitals. We urge CMS to retain the current language of "using data from CEHRT."

Proposal to Make Optional Bonus Measure

The agency also proposes to make the ePA measure optional and eligible for 10 bonus points for hospitals and critical access hospitals that attest "Yes" to the measure for the EHR reporting period in CY 2027. **We support CMS' approach to making the ePA measure optional and eligible for bonus points. We encourage the agency to continue this through CY 2028 and delay mandatory reporting until CY 2029 or later to allow for adequate time for configuration, testing and training.** We also appreciate that CMS has retained the measure structure as an attestation measure. We encourage

CMS to focus on medical services first and not expand the measure to include other categories, such as drugs.

Proposal to Adopt a Unique Device Identifier for Implantable Medical Device Measure

CMS proposes to adopt a Unique Device Identifier (UDI) for Implantable Medical Devices attestation measure within the Public Health and Clinical Data Exchange objective beginning with the CY 2027 reporting period.

The AHA appreciates that CMS is evaluating ways to increase capture of UDIs. We agree with CMS that UDI capture can support patient safety by supporting device traceability for safety events and recall efforts. However, integrating a new UDI measure in the CY 2027 reporting period is too rapid a timeline to move from measure development to testing to implementation. We have consistently supported reasonable timelines for measure development to support workflow redesign, training and coordination with stakeholders (like manufacturers, supply chain partners and developers, in this case). We would urge CMS not to finalize the UDI measure as a required measure under the Public Health and Clinical Data Exchange objective for the CY 2027 reporting period and instead would encourage CMS to explore developing an optional bonus measure.

HOSPITAL INPATIENT QUALITY REPORTING PROGRAM

The inpatient quality reporting (IQR) program is CMS' pay-for-reporting program in which hospitals must submit measures and meet other administrative requirements to avoid a payment reduction equal to one quarter of the annual market basket update. CMS proposes to adopt eight measures into the IQR program, remove three measures and modify three measures already in the program. CMS also proposes changes regarding reporting of electronic clinical quality measures (eCQMs) and requests feedback on future measures for the program, as well as the expansion of the Birthing Friendly designation.

Measure Adoptions

Advance Care Planning (ACP) eCQM. Beginning with the CY 2028 reporting period (FY 2030 payment determination), CMS proposes to adopt this measure that calculates the proportion of adult patients with at least one inpatient hospitalization during the measurement period who have an ACP document or documentation of an ACP discussion resulting in a documented decision in the patient's EHR by the time of hospital discharge. To report the data, hospitals would use their certified health IT platform to aggregate patient-level data and then submit it to CMS.

The AHA recognizes that ACP is an important part of ensuring that the care patients receive aligns with its goals and values, and the discussions and decisions involved in ACP are relevant during inpatient care. However, we urge CMS to take significant steps to improve the measure's feasibility before adopting it in the IQR.

When this measure was reviewed by the Hospital Workgroup of the Pre-Rulemaking Measure Review (PRMR) process, the committee raised multiple concerns about the measure's feasibility. These issues include a lack of structured fields to capture the ACP information in some EHRs; codes for ACP discussions inconsistently documented; and some items (such as goals, preferences and priorities) do not exist as standalone items in a structured field. In the proposed rule, CMS notes that "[t]he eCQM underwent extensive analysis and measure specifications development required for the endorsement process. Test results indicated high measure reliability and validity (including agreement between data exported from the EHR and manual review of the patient chart)." However, the measure has not gone through the endorsement process yet, and it appears from the measure developer's feasibility analysis that the measure was only tested on two EHRs: three Epic and one Cerner systems. Absent additional analysis, it is not clear whether the feasibility concerns raised during the PRMR have been addressed.

While we recognize that CMS is not required to use measures endorsed by a consensus-based entity (CBE), the CBE process may provide clarity on the issues raised above and would be critical to ensuring that measure reporting does not result in duplicative or discordant data collection, with multiple versions of ACPs existing across multiple different entities and providers. Thus, **we urge CMS not to adopt this measure until it has gone through the CBE endorsement process and can provide insight into whether this measure can be feasibly and reliably reported outside of Epic and Cerner EHR systems.**

Hospital Harm–Postoperative Venous Thromboembolism (VTE) eCQM. Beginning with the CY 2028 reporting period (FY 2030 payment determination), CMS proposes to adopt this measure that assesses the risk-adjusted proportion of inpatient hospitalizations for adult patients who suffer a postoperative VTE during hospitalization or within 30 days after a surgical procedure. **While the AHA appreciates CMS' focus on measures that assess important safety outcomes, like postoperative blood clots, we have serious logistical and conceptual concerns with this measure and urge CMS to not adopt it into the IQR at this time.**

Logistically, we are concerned that measure performance may be unduly influenced by surveillance bias stemming from whether a hospital uses a multi-facility enterprise-wide EHR. As an eCQM, the measure is informed by an extensive list of data elements to identify cases or indicators of postoperative VTE; EHRs that span across multiple hospitals and facilities (i.e., an enterprise-based EHR used in a health system) may be more extensively able to detect evidence of a postoperative VTE than a hospital that uses an isolated (i.e., not integrated across multiple sites) EHR. As a result, a hospital that is part of a system may have postoperative VTE cases attributed to it that would have gone undetected if its EHR were not tied to an enterprise-wide system. These concerns were raised during the PRMR process, especially as the measure was only tested in two hospitals on two EHR systems (Epic and Meditech). Participants suggested that the

measure should undergo additional testing to ensure the measure is appropriately assessing performance and not just surveillance.

The PRMR discussion raised several conceptual concerns with the measure as well. The measure overlaps with a measure currently included in the patient safety composite measure, PSI-12 (Perioperative Pulmonary Embolism or DVT Rate). We appreciate CMS noting that the proposed measure may serve as a replacement, but it does not present a clear strategy and explicit proposal to avoid overlap between the two measures. Retaining both would result in a duplicative and inconsistent approach to measuring and preventing hospital-onset VTE.

Similarly, we are concerned that the measure's inclusion in the IQR may lead to unintended consequences. Anticoagulant drugs are one of the most effective DVT prevention approaches; however, such therapy also carries the risk of major bleeding events. CMS has indicated its intent for the proposed postoperative VTE measure to be implemented in tandem with a measure on anticoagulant overuse, which was reviewed during a previous PRMR cycle. Yet, the PRMR did not reach consensus on the anticoagulant overuse measure, and it was not proposed for adoption into the IQR. Deploying these individual measures in the IQR without an overarching measurement strategy (i.e., implementing balancing measures simultaneously) raises questions about whether the CMS proposal would improve postoperative patient safety.

Lastly, we note that because of these logistical and conceptual questions, the PRMR work group did not come to a consensus on recommending the measure for inclusion in the IQR. Indeed, 65% of workgroup participants did not support the measure for inclusion. **Until CMS can address these outstanding concerns, this measure should not be adopted into the IQR.**

Excess Days in Acute Care (EDAC) After Hospitalization for Diabetes Measure. Beginning with the July 1, 2025, through June 30, 2027, performance period (FY 2029 payment determination), CMS proposes to adopt this claims-based measure that assesses the number of days a patient aged 65 or older spends in acute care within 30 days of discharge for a diagnosis of diabetes mellitus with complications. Days in acute care are defined as time spent in the emergency department (ED) without an associated admission, observation stays and unplanned readmissions.

This measure is specified nearly identically to the EDAC measures on other conditions included in the IQR related to acute myocardial infarction (AMI), heart failure and pneumonia. As proposed for the existing EDAC measures and commented upon below, CMS proposes that the patient population for EDAC Diabetes would include Medicare Advantage (MA) beneficiaries in addition to Medicare Fee-for-Service (FFS) beneficiaries. On its surface, this proposal makes sense due to the increasing proportion of all Medicare enrollees who are covered by MA plans. We also appreciate that including MA beneficiaries improves the statistical reliability of the measure by including a larger "denominator." This allows CMS to use a shorter two-year performance period (instead of

the three years it has used in prior versions of the EDAC measure) and improves the timeliness of the data for hospitals and the public.

However, as we noted when CMS made similar proposals in its FY 2026 inpatient PPS proposed rule, we are concerned that CMS has not demonstrated that inclusion of these beneficiaries will not unfairly skew hospital performance on the measure. MA enrollees differ from FFS enrollees in that they are more likely to be dually eligible for Medicare and Medicaid, have incomes below $20,000, and self-report fair or poor health.[25] In addition, and more significantly, commercial MA plans often use aggressive care management practices to control costs, leading to MA beneficiaries being less likely to use specialty and post-acute care.[26] This matters greatly in the context of a performance measure that encompasses post-hospital discharge outcomes, where utilization of post-discharge services that can prevent hospital revisits may not be fully within their control. As a result, hospital performance on the measure may be driven more by the behaviors of the commercial health plans in the market in which hospitals provide services rather than by true differences in quality of care.

These issues were raised during the PRMR meeting. In response, CMS noted that "EDAC measures are risk-standardized for patient demographics and comorbidities, which helps account for varying health complexities." However, the only demographic variable in the risk adjustment is age. The risk adjustment methodology does not account for other variables that distinguish MA beneficiaries from FFS beneficiaries. CMS explains that it tested the measure using dual-eligible status as a proxy for sociodemographic status and found minimal impact on hospital scores, but it is not clear whether the agency tested this measure with and without the inclusion of MA beneficiaries in the measure cohort to determine how hospital performance may differ, and whether further refinement of the risk adjustment methodology is merited.

The measure is also currently undergoing CBE endorsement review, with final decisions on endorsement status due to be announced in September. **We encourage CMS to delay adoption of the measure into the IQR until the review is completed**, in hopes that the process yields additional insight into the influence of the inclusion of MA beneficiaries on measure performance.

Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate Measures. Beginning with the FY 2028 payment determination, CMS proposes to adopt modified versions of five condition- or procedure-specific claims-based mortality measures that were removed from the IQR in previous rulemaking. These measures assess death from any cause within 30 days of the start of the index admission for a principal diagnosis of AMI, heart failure, pneumonia, chronic obstructive pulmonary disease or coronary artery bypass graft (CABG) procedure for patients aged 65 and older. Similar versions of these measures were previously included in the IQR, later to be adopted into the Hospital Value-based

[25] https://www.kff.org/medicare/a-snapshot-of-sources-of-coverage-among-medicare-beneficiaries/
[26] https://www.kff.org/medicare/beneficiary-experience-affordability-utilization-and-quality-in-medicare-advantage-and-traditional-medicare-a-review-of-the-literature/

Purchasing (VBP) program. In the FY 2019 inpatient PPS final rule, CMS removed, or "de-duplicated," the measures from the IQR while maintaining them in the VBP program. Since then, CMS has made two modifications to the measures proposed for readoption. First, the denominator would include MA beneficiaries in addition to FFS beneficiaries; second, CMS would reduce the performance period from three to two years. The agency states that its analysis shows sufficient reliability for the modified measures and that mortality rates did not vary significantly between MA and FFS-only beneficiaries. CMS also proposes to adopt the modifications to the measures in the VBP program.

CMS proposes to "re-adopt" these measures into the IQR for them to have been publicly reported in the program for at least one year in accordance with statutory and regulatory requirements prior to deploying them in the VBP program, which the agency proposes in this same rule to do beginning with the FY 2032 program year. We comment on this proposal separately below and refer the agency to our comments in the previous section about the challenges of adding MA beneficiaries to performance calculations. **However, we request that CMS include plans to subsequently remove — or "de-duplicate" — these measures from the IQR after they have been adopted into the VBP program as it did in the FY 2019 final rule.**

Measure Removals

Beginning with the CY 2028 reporting period (FY 2030 payment determination), CMS proposes to remove the VTE Prophylaxis (VTE-1) and Intensive Care Unit VTE Prophylaxis (VTE-2) measures contingent upon the adoption of the newly proposed Hospital Harm–Postoperative VTE eCQM. The agency reasons that the eCQM better assesses the desired patient outcomes than the VTE-1 and 2 process measures. **The AHA supports the removal of these measures, regardless of whether the Hospital Harm–Postoperative VTE eCQM is finalized for adoption.**

In addition, CMS also proposes to remove the Discharged on Antithrombotic Therapy eCQM (STK-02) beginning with the CY 2028 reporting period (FY 2030 payment determination). CMS has found that measure performance among hospitals is so high and unvarying that meaningful distinctions and improvements in performance can no longer be made. **We appreciate that CMS has identified this "topped out" measure for removal as part of the agency's goal to streamline its quality reporting programs and support the removal of certain measures.**

Measure Modifications

Expanding Patient Population of Existing EDAC Measures to Include MA Beneficiaries. In addition to the EDAC After Hospitalization for Diabetes measure proposed for adoption, the IQR includes other EDAC measures for patients admitted for pneumonia, AMI or heart failure, which use similar definitions and exclusion criteria. Beginning with the July 1, 2024, through June 30, 2026, performance period (FY 2028 payment determination), CMS proposes to modify these measures to include both MA and

FFS patients and to shorten the performance periods from three to two years. This would align the specifications for all EDAC measures in the IQR.

The AHA has the same concerns regarding the effects on measure performance based on the proportion of a hospital's patient population enrolled in MA as described for the EDAC Diabetes measure. The CBE Endorsement and Maintenance Committee that reviewed the EDAC After Hospitalization for AMI measure during the spring 2025 cycle raised similar issues, with multiple committee members recommending the measure not receive endorsement. Ultimately, the measure was endorsed with conditions; specifically, "When the measure returns in 5 years for maintenance endorsement, the developer would have empirically explored the differences with outpatient visits and post-hospitalizations for MA patients compared to fee-for-service patients." The EDAC After Hospitalization for Heart Failure and Pneumonia measures are due to undergo maintenance endorsement review in the fall of 2027, and — considering that the measures are specified very similarly and are undergoing the same modifications as the AMI measure — are likely to receive similar feedback.

The frequency with which misgivings regarding the effects of including MA beneficiaries in the measure cohort are raised suggests to us that CMS should do additional investigation into the issue prior to adopting these modifications.

eCQM Data Submission

Mandatory Reporting of Hospital Harm eCQMs. Currently, there are seven Hospital Harm eCQMs; for CY 2026, five of them are on the "menu" of measures from which hospitals may self-select (Opioid-Related Adverse Events; Pressure Injury; Acute Kidney Injury; Falls with Injury; and Postoperative Respiratory Failure). CMS proposes to implement a stepwise approach beginning with the CY 2028 reporting period (FY 2030 payment determination) in which Hospital Harm eCQMs not already finalized for mandatory reporting would become mandatory in their third year of use in the program.

The AHA appreciates CMS' proposal to focus mandatory measurement on topics related to patient safety as it transitions to a fully digital measure set, and we think the proposed cadence will allow hospitals time to familiarize themselves with the measures before they become mandatory. We note that, due to the design of the eCQM reporting requirements, hospitals choose measures from the "menu" to report not solely based on which measures will demonstrate their best performance; indeed, for many hospitals — particularly smaller or rural hospitals — they may not have sufficient volume to report certain measures, and thus are unable to select them from the "menu" regardless of their performance. We encourage CMS to provide adequate guidance on minimum volumes for reporting, as well as clear language to interpret performance when minimum volumes cannot be met when the measures are publicly reported.

CMS suggests that the Hospital Harm eCQMs "could serve as potential replacements for claims-based measures, such as those reported within the Patient Safety and Adverse

Events Composite (PSI-90).” **We support the idea of replacing PSI-90 with these eCQMs, and encourage CMS to formally adopt a strategy to do so in the near future.** As the AHA has repeatedly noted, PSI-90 is an unreliable indicator of hospital performance on patient safety measures because it uses claims data rather than clinical records, which leads to significant time lags and flawed conclusions based on administrative information. It is insufficiently risk-adjusted, and the composite nature of the measure makes overall performance susceptible to arbitrary shifts in individual measure weights. The eCQMs present an opportunity for measurement that may address these issues.

Requests for Information

Emergency Care Access and Timeliness (ECAT) Measure. In the FY 2026 outpatient PPS final rule, CMS adopted the ECAT measure in the Outpatient Quality Reporting and Rural Emergency Hospital Quality Reporting Programs. Recognizing that strategies to address ED throughput are not specific to one setting (that is, either inpatient or outpatient) but that CMS’ quality reporting programs are specified by setting, the agency seeks feedback on how it could incorporate the ECAT measure into the IQR in future rulemaking and whether the agency should consider including the measure in the hospital VBP program.

The AHA agrees that tracking information related to wait times and length of stay in the ED is important for hospital and health system planning purposes. We also agree that ED boarding is a significant issue that affects patients’ experience of care and that can make it more challenging to deliver the best patient outcomes. At the same time, ED wait times, throughput and boarding are also broader systemic issues whose drivers are often well beyond the control of hospitals and health systems. By considering this measure for adoption into the IQR and hospital VBP programs, we are concerned that CMS would be asking hospitals to shoulder the accountability for addressing this issue alone, but with often limited ability to make improvements in measure performance. Furthermore, we are concerned by several other technical and conceptual shortcomings of this measure and believe further work is necessary for the measure to be ready for use in any national measurement program. For these reasons, the AHA would not recommend the adoption of this measure into the IQR and VBP programs.

Conceptually, the measure’s specifications do not sufficiently capture the complexity of ED operations and the hospital care continuum. The measure relies on time windows without a clear base in evidence to determine appropriate access, assumes that ED throughput is solely a factor of ED and hospital operations, and inadequately accounts for differences in patient case mix and volumes. The field currently lacks evidence-based guidelines on improving performance on the measure. However, we believe that a more proactive approach to addressing these issues would involve CMS working with the AHA, its members, policymakers and other stakeholders to investigate and implement effective solutions rather than using a generalized accountability measure.

The measure concept focuses on ED operations; the idea of "throughput" relies on the conclusion that other parts of the hospital can accommodate any ED volume at any time and thus inadequate ED operations are the lone driver of delays. The reasons for variations in wait times in the ED are many, and several, if not most, of these drivers are outside of the control of the ED and the hospital as a whole. Admission times rely partly on the availability of staffed inpatient beds; patient turnover decisions elsewhere in the hospital, such as in the ICU, are made based on patient clinical needs. While initial triage in the ED is based on medical priority, delays in admission can occur after the initial evaluation as providers wait for insurance authorization.

As has been well documented by providers as well as by the Department of Health and Human Services Office of Inspector General and congressional investigations, the prior authorization process used by MA and large commercial health plans places a significant administrative burden on hospitals and other providers. Perhaps more importantly, it is directly harmful to Medicare beneficiaries — at best delaying their care and at worst outright denying medically necessary treatment. Despite important steps taken by CMS in recent years to strengthen the oversight of MA plans' use of prior authorizations, providers have seen little meaningful change in MA plan behavior and no increased access for beneficiaries. Additionally, post-acute care providers still face challenges with MA plans listing them within their networks. These issues would be exacerbated in pay-for-performance programs where providers who serve a high proportion of MA patients would face disadvantages.

For these reasons, we are concerned that hospitals that care for larger proportions of MA patients could perform worse on this measure because of decisions by MA plans to delay needed care and narrow their networks, and not because of the quality of care hospitals deliver. This situation could be especially problematic given that there remains variation in MA participation nationally. While it is true that in 2024 MA covered approximately 50% of Medicare beneficiaries, 21 states and the District of Columbia had MA rates under 50%, and 14 states had enrollment rates under 40%. For public reporting and pay-for-performance programs like the IQR and VBP to work in a fair manner, hospitals must be assured that measure performance is truly their own, and not disproportionately influenced by factors beyond their control.

The ECAT measure also does not account for other factors that are not solely within hospitals' control but could greatly impact ED throughput and boarding and, therefore, measure performance. Certain diagnoses may require specialist consultations, which can be difficult to obtain in health professional shortage areas. A severe shortage of primary care in many communities means that conditions that could have been caught before they became emergent become serious and lead to larger volumes of ED visits. In addition, for medical issues that require prompt but not emergent attention, long wait times for primary care mean that patients have few choices other than an ED to receive care. In addition, our nation continues to face critical shortages of behavioral healthcare professionals, inpatient psychiatric beds and other supportive care for those who need behavioral health services. These structural shortages all influence the ability of hospital EDs to move

patients to the next level of care and, therefore, how long a patient may spend in the ED. By assessing ED operations in a vacuum, the measure would not provide insight into predominant drivers of long ED waits that are influenced by hospitals.

We are also concerned that the measure assesses performance based on timing that is not well supported by evidence as impacting patient outcomes. The measure calculates the proportion of all ED encounters during a 12-month period where the patient experiences a wait or stay in the ED longer than a specified length of time (e.g., one hour after arrival to be placed in a treatment room for evaluation). However, it is unclear whether there exists evidence that these particular time windows — one hour, four hours, etc. — have any marginal influence on patient outcomes. Studies cited in the measure's documentation demonstrate that longer wait times are sometimes associated with poorer outcomes, but the various studies use definitions of ED length of stay ranging from two to 24 hours. We are unsure if it would be accurate to determine that a hospital averaging 61 minutes to place a patient in a room for evaluation is "worse" than a hospital that averages 60 minutes to do the same thing.

Another concern relates to the potential unintended consequences that the use of this measure may impose, such as premature discharge from the ED, inappropriate reductions in inpatient admissions, increases in staff burnout, worsening disparities of care, and increased costs due to increases in observation volume.

We appreciate that the measure has been updated since its earlier assessment in the PRMR process to stratify rates by age and mental health diagnosis. However, we are concerned that the latter stratification approach does not include patients with primary diagnoses of substance use disorder (SUD). Clinical and federal guidelines generally include SUD alongside mental illness in the category of behavioral health due to their frequently overlapping patient presentation. In other words, separating ED throughput rates acknowledges the unique considerations for treating patients with diagnoses of mental illness; patients with SUD diagnoses require those same considerations.

Finally, the field is continuing to explore best practices to improve performance on this measure. Several examples of changes in care for improvement provided in the measure's supporting documentation are related to transformations of the care environment outside of the ED, such as use of "hospital home" care models. Others are suggestions that would require significant investments, clinical research and policy change, such as "changes to diagnostic testing/imaging processes" or "Triage interventions, including predictive models, use of clinicians, and others." Quality measures serve multiple purposes: informing patient decision-making, tracking progress on quality improvement, and, in the case of the hospital VBP program, tying performance to payment. Even when hospitals can implement these interventions, the effects of the external environment described above make it uncertain whether hospitals can influence measure performance. For these reasons, we believe the ECAT measure would not align well with the IQR or hospital VBP programs.

Adult Community-Onset Sepsis Standardized Mortality Ratio Measure. CMS has worked with the Centers for Disease Control and Prevention (CDC) to develop a digital quality measure of sepsis mortality. The measure uses the Fast Healthcare Interoperability Resource (FHIR) standard to pull patient-level, risk-adjusted surveillance data from a facility's EHR, combining those data with claims to calculate a risk-adjusted mortality ratio. CMS invites public input on the potential use of this measure in future IQR programs and other CMS programs.

The AHA thanks CMS and CDC for their work thus far to develop this measure and believes it holds considerable promise for future CMS measurement programs. As a general matter, the AHA believes that any measures used in CMS' programs should focus on high-priority quality and safety issues with known and effective strategies for delivering better outcomes. Sepsis affects millions of patients and may contribute to as many as 350,000 deaths each year. Hospitals and health systems share CMS' goal of reducing sepsis mortality and improving outcomes for patients with sepsis and have worked relentlessly to improve sepsis care, saving lives in the process. A well-designed sepsis mortality measure could serve to further advance these efforts. As CMS and CDC continue this important work, we offer several suggestions for ensuring the measure fulfills its promise.

First, to ensure a focused, consistent and sustainable approach to measuring sepsis care, we recommend that CMS phase out the sepsis bundle measure (SEP-1) currently included in the hospital VBP and IQR programs. Researchers, clinicians and hospital staff have been working tirelessly for decades to improve care and prevent sepsis and septic shock. We are heartened to see this work reflected in the rapidly evolving sepsis management landscape. However, this accelerated learning has also meant that the underlying evidence around which interventions are most effective and appropriate for reducing sepsis mortality for given types of patients has changed continually. These shifts matter greatly for a process of care measure like SEP-1 that prescribes the use of specific time-based steps in sepsis care management that are supposed to be derived from evidence.

Unfortunately, the SEP-1 measure has not always kept up with shifting evidence, and emerging studies suggest that the implementation of the measure also carries potential significant unintended consequences. For several years, multiple specialty societies (including the American College of Emergency Physicians, Infections Diseases Society of America, the Society for Healthcare Epidemiology in America and the Association for Professionals in Infection Control and Epidemiology) have highlighted peer-reviewed research showing no meaningful association between implementation of the SEP-1 measure and improved sepsis outcomes. Furthermore, SEP-1's focus on immediate administration of antibiotics has the potential to lead to excessive antibiotic use. The overuse of antibiotics is an especially important risk to consider given that the CDC has repeatedly highlighted antimicrobial resistance as a global public health threat. We also note that hospitals have continually expressed frustration about continual shifts and a lack

of clarity in the measure specifications. We are concerned this has led to inconsistent interpretations and implementation of the measure across facilities.

The AHA also notes that the level of administrative effort to collect SEP-1 measure data is very high, with a complex abstraction algorithm that currently includes 74 steps, each of which has sometimes multiple sub-parts. Given that the sepsis outcome measure will also entail significant effort to collect and report, it is critical that hospitals can focus their resources on the measure most likely to drive better care. Given the shortcomings with SEP-1 described above, we believe the outcome measure is much more likely to do so.

The AHA also recommends that CMS allow sufficient time for pilot testing in hospitals before placing the measure into its programs. We believe that pilot testing in as many facilities as possible across multiple different EHR systems for at least one year — with additional time post-reporting to review results and make adjustments — would be the minimum CMS would need to ensure the measure is implemented successfully. We appreciate that one of CMS and CDC's goals in implementing a digital outcome measure is ultimately to reduce administrative burden on hospitals by drawing on electronic sources and requiring less manual chart abstraction to report measure data. Indeed, the AHA strongly shares the administration's goal of reducing burden and agrees that a digital measurement approach likely would entail far less burden than a chart-abstracted version of the measure. At the same time, the front-end transition to digital measures will be complex for hospitals, necessitating the reconfiguration of electronic systems to enable the reporting of accurate and complete data. Among other activities, our members would need to continue building their expertise in the FHIR-based API standards, examine workflows within their EHRs to assess whether data are being fully captured in structured fields and assess the readiness of their systems to enable data to flow securely through FHIR-based APIs. The creation of this infrastructure would be essential for supporting FHIR-based reporting of any measure, including the digital sepsis outcome measure.

In addition, the measure specifications themselves are highly complex. While a degree of complexity is necessary to ensure the measure accounts for the wide range of factors that can influence sepsis outcomes, hospitals will still need time to validate that the measure is working as intended. For example, the measure's definition of sepsis rests on a combination of clinical findings, suspected infection and organ dysfunction. The clinical findings include four separate vitals or lab findings, and the organ dysfunction definition includes seven parameters. Each of these pieces of information likely exists in each hospital's EHR, but our members would need time to ensure their systems are configured to report them in a standardized way. They would also welcome the chance to ensure that the risk adjustment approach appropriately accounts for differences across hospital patient populations.

Lastly, we highly encourage CMS and CDC to pursue CBE endorsement of the measure as soon as is feasible, and before the measure is placed into the program. The CBE process would help provide an unbiased review of the measure's scientific properties and ensure it is reliable, accurate and feasible to collect.

Birthing-friendly Hospital Designation. CMS seeks public input on potential modifications to this designation, which was adopted in the FY 2023 inpatient PPS final rule. Currently, the designation is awarded based solely on positive attestation to the Maternal Morbidity Structure Measure. It has limited utility in distinguishing high-quality perinatal care, as 96% of eligible hospitals have received the label. Thus, we agree with CMS that expanding the designation to include additional indicators of quality care for mothers and babies would improve the usefulness of this distinction. At the same time, we have concerns about the suitability of the two other perinatal care measures that CMS could include to inform a "birthing-friendly" designation. We also would discourage CMS from considering a scoring methodology for the birthing-friendly designation that aligns with hospital star ratings.

First, the Cesarean Birth measure assesses the rate of nulliparous, term, singleton, vertex live-born deliveries via C-section at greater than 37 weeks gestation (i.e., low-risk deliveries). While AHA has long supported efforts to reduce early elective C-section deliveries, this measure does not adequately distinguish between medically necessary and unnecessary procedures.

In fact, CMS' justification of the measure in the rule seems to inadvertently frame C-section births as inherently harmful. To be clear, C-sections are procedures that can save the lives of the mother and the infant. Nevertheless, CMS states that this measure addresses the Meaningful Measures quality priority of "make care safer by reducing harm caused in delivery of care" through the measure area of "preventable healthcare harm." Furthermore, CMS suggests that rising rates of C-section nationwide are an indication of poor hospital performance. Yet, CMS provides no evidence suggesting that these rates are rising solely because of hospital practice rather than changes in the underlying patient population, such as advancing maternal age. A measure that reports on the incidence of the procedure alone — even for low-risk deliveries — should not be viewed reflexively as an indicator of hospital safety. Indeed, in its review of the measure in 2018, the NQF Scientific Methods panel found no strong or convincing case that the measure addresses a real quality problem.

Consistent with other surgical procedures, C-sections are associated with higher morbidity and mortality than are vaginal deliveries; however, as noted in the rule, existing literature largely does not distinguish whether these outcomes derive from cause (higher-risk patients undergo C-section) or effect (the poorer outcomes were due to the procedure). We certainly agree that it is reasonable to avoid a C-section birth if possible. Yet, CMS believes that adoption of this measure "may ultimately reduce the occurrence of non-medically indicated C-sections," even though the measure does not differentiate between medically and non-medically indicated procedures. In addition, U.S. practice guidelines have not indicated an optimal rate of Cesarean birth or an appropriate variance rate. As a result, it is unclear how a hospital or the public would judge "good" or "poor" performance.

Further, CMS notes that it "encourage[s] hospitals whose measure rates are higher than rates at other hospitals to explore and evaluate differences in the clinical management of women in labor." Without any context, risk adjustment or benchmark rate of C-sections, this gross rate provides little useful information. If CMS is attempting to encourage hospitals to adopt clinical practices in line with evidence-based guidelines, it has already adopted a measure asking whether hospitals are participating in collaboratives that support the implementation of these practices. If CMS is attempting to improve surveillance of poor outcomes that occur in the course of delivery, the proposed severe obstetric complication eCQM CMS has proposed in this same rule would likely achieve this goal far more effectively.

In addition to the conceptual weaknesses of this measure, it carries logistical disadvantages as well. The measure only excludes patients with abnormal presentations or placenta previa; it includes no other risk adjustment. Without accounting for patient-level factors like comorbidities (including eclampsia or pre-eclampsia, for whom Cesarean birth may be indicated but would still be included in the measure cohort) or social determinants of health, use of performance data is likely to lead to inappropriate comparisons between referral centers for more complex patients and hospitals that serve a higher proportion of patients with fewer comorbidities that increase the likelihood of C-section.

The other measure CMS suggests it could include in this designation, Severe Obstetric Complications, is a more conceptually compelling indicator of quality and potentially better suited for inclusion in a designation. However, it, too, has notable disadvantages. First, the measure's numerator is so broad that it could put hospitals caring for more complex patients at a disadvantage. The risk adjustment methodology must be robust to account for differences in case mix. Furthermore, while instances of severe complications are a valuable outcome to track for both providers and parents, they are still very rare. In the methodology report, the measure developers note that the low rate of occurrences may necessitate a substantial sample size. This sample size may rule out many hospitals with lower volumes. According to the measure developer's testing across 60,000 delivery encounters, the severe obstetric complications rate, excluding blood transfusion-only cases, was 0.5% (50 per 10,000 delivery hospitalizations). In the context of a designation program, it means that many hospitals would still have their designation based on only one measure (i.e., the structural measure currently included in the designation).

Further, upstream drivers of health often play a major role in how patients fare, especially mothers; we want to ensure that those drivers are not ignored or explained away, but the designation should be informed by issues that are within the control of the provider. Because the measure is still relatively novel, it is not yet clear whether codes indicating important upstream drivers of health are consistently and reliably recorded so that this eCQM is truly informed by precise clinical and patient-level data.

CMS also requests feedback on potential scoring methodologies for the designation that would be similar to those used in the Overall Star Ratings program. As we have expressed

to CMS in past comments, we remain concerned with an overall quality rating system's ability to accurately reflect meaningful differences in quality of care. Because of the shortcomings of such an approach, including the disproportionate weight that differing volumes play in calculating ratings (which could be even more disproportionate given the wide ranges of volumes of live births across hospitals in the nation), we recommend that CMS decline to develop a scoring or tiering system at this time.

HOSPITAL VALUE-BASED PURCHASING PROGRAM

Beginning with the FY 2032 program year, CMS proposes to modify the five existing Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate measures proposed for readoption into the IQR, as described above. Specifically, CMS would expand the denominators of these measures to include MA beneficiaries in addition to FFS beneficiaries, and would reduce the performance period from three to two years.

While the AHA appreciates the intent of this proposal, we believe additional work is necessary before CMS adopts the expanded measure cohorts for mortality measures into the hospital VBP program. We appreciate that including MA beneficiaries in the denominator would double the size of the patient cohort and thus allow CMS to shorten the performance period, resulting in more timely assessments of performance. In concept, the larger denominator also should improve these measures' reliability. However, as we noted earlier in our comments on CMS' inclusion of MA data into its EDAC measures in the IQR, we remain concerned that hospital performance on this measure may be influenced by the adverse practices of MA plans to delay and deny access to post-acute care.

Access to post-acute care is often a key determinant of post-discharge outcomes like mortality. Yet, as has been well documented by providers as well as by the Department of Health and Human Services Office of Inspector General and congressional investigations, MA plans often place restrictions on post-acute care. The prior authorization process used by MA plans places a significant administrative burden on both acute-care hospitals and post-acute care providers. Perhaps more importantly, it is directly harmful to Medicare beneficiaries — at best delaying their care and at worst outright denying medically necessary treatment.

Furthermore, whenever CMS adds or makes substantial changes to measures in its pay-for-performance programs, we believe it is critical for the agency to be transparent about the impacts of the changes to both hospital performance and payment adjustments. Unfortunately, the proposed rule lacks any detail on how CMS has modeled payment adjustments' effect based on changes in individual hospital patient cohorts.

We believe such analysis is especially important for expanding the measure cohort to include MA beneficiaries because while MA beneficiaries are increasing as a proportion of total Medicare enrollees nationally, MA market penetration and specifics of enrollee makeup still vary widely. Hospital VBP payment adjustments are calculated based on the

distribution of all participating hospitals' performance on measures within the program. As a result, the inclusion of MA beneficiaries in this calculation could mean significant changes in the distribution of scores and payments hospitals experience under the hospital VBP program. We urge CMS to conduct these analyses and make them publicly available before using the measure in the program.

HOSPITAL READMISSIONS REDUCTION PROGRAM

Beginning with the FY 2029 program year, CMS proposes to adopt the Hospital 30-Day, All-Cause, Risk-Standardized Readmission Rate Following Sepsis Hospitalization measure for the Hospital Readmissions Reduction Program (HRRP). Consistent with the updates made in previous rulemaking to the other readmission measures, the Sepsis Readmission measure includes both MA and Medicare FFS beneficiaries aged 65 and older. The assessment methodology is the same as that used for the current measures in the HRRP.

Historically, CMS has implemented measures in the IQR program before adopting them into the HRRP for hospitals to become familiar with the measures, understand their performance and prepare for potential impacts to their payment adjustments. However, CMS states that "given the significant morbidity and mortality linked to sepsis and the high case volume and cost of hospital readmissions," they propose to instead adopt the Sepsis Readmission measure directly into the HRRP to inform FY 2029 payment adjustment.

The AHA urges CMS to adopt the sepsis measure into the IQR and monitor its performance in a pay-for-reporting environment before deploying the measure in the HRRP. During the PRMR process, consensus was not reached on whether this measure was appropriate to adopt into the HRRP; while the AHA and other participants on the Hospital Workgroup appreciated CMS' focus on the critical issue of sepsis, this measure raised several conceptual questions that suggested it may be inappropriate for use in the HRRP.

Participants in the workgroup noted that readmission rates are influenced by many factors outside of the hospital's control. For example, adherence to medication and access to post-acute care are two factors that reduce readmissions in general; however, the influence of these factors may depend on patient-level characteristics, including payer mix (e.g., MA beneficiaries are significantly less likely to use post-acute care). Thus, while it is reasonable to specify the measure based on a broad cohort, hospital performance on the measure — and thus payment penalties under the HRRP — may be skewed by these external factors. If the measure were incorporated into the IQR prior to use in the HRRP, CMS would be better able to model the potential impacts on payment adjustments.

The agency would offer confidential "early look" reports for FY 2028, which would calculate performance on the Sepsis Readmission measure for the July 1, 2024, through June 30, 2026, reporting period, as well as what payment adjustment would look like if the measure were included in the HRRP that program year. While we appreciate that CMS recognizes

the value in seeing the potential impacts of the measure on payment adjustments, this "early look" period would overlap with the first actual performance period (July 1, 2025, through June 30, 2027), negating its usefulness. In other words, hospitals would not see how their payments might be impacted until after their performance had already been impacted. Considering that CMS estimates that including the Sepsis Readmission measure in the HRRP would increase total Medicare savings in the form of payment reductions of $169,652,338 and increase the number of hospitals receiving a payment penalty by nearly 100, the impact may be substantial. Thus, instead of the proposed "early look" reports, we recommend that CMS adopt the measure into the IQR or perform additional testing and analysis of the measure before using it in the HRRP.

CMMI TRANSFORMING EPISODE ACCOUNTABILITY MODEL

TEAM is a mandatory bundled payment model that began on Jan. 1, 2026. The five-year model requires acute care hospitals in selected geographic areas to participate in five surgical episode categories. TEAM holds participant hospitals accountable for the quality and cost of items and services furnished during an episode of care, from the date of inpatient admission or outpatient procedure through 30 days post-discharge. Similar to other bundled payment models, CMS reconciles performance year (PY) spending on episodes against a target price to determine if a participant hospital is eligible for a reconciliation payment or repayment.

Spinal Fusion Episode Category

CMS proposes changes to certain MS-DRGs that would affect the spinal fusion episode category in TEAM. Specifically, the agency proposes to move discharges for certain spinal fusion procedures from existing MS-DRGs to three new proposed MS-DRGs (523, 524 and 525) because it would better classify beneficiary acuity and resource utilization. If these new MS-DRGs are finalized, CMS proposes to add them as episode initiators in the spinal fusion episode category in TEAM.

Our analysis shows that this proposal would add a significant number of spinal fusion episodes to TEAM. Specifically, our analysis of discharges that would move to new MS-DRGs 523, 524 and 525 indicates that 37% would come from MS-DRGs that are not currently included as spinal fusion anchor hospitalization initiators in TEAM (see Table 1).

Table 1. Medicare Discharges Moving to MS-DRG 523, 524 and 525

MS-DRG		Medicare Discharges Under Current FY 2026 DRG Grouper	Medicare Discharges Under Proposed FY 2027 DRG Grouper	Medicare Discharges Moving to MS-DRG 523, 524 and 525	Percent of Discharges Moving
MS-DRGs Included in TEAM					

402	SINGLE LEVEL COMBINED ANTERIOR AND POSTERIOR SPINAL FUSION EXCEPT CERVICAL	15,344	15,248	96	
426	MULTIPLE LEVEL COMBINED ANTERIOR AND POSTERIOR SPINAL FUSION EXCEPT CERVICAL WITH MCC OR CUSTOM-MADE ANATOMICALLY DESIGNED INTERBODY FUSION DEVICE	3,123	2,044	1,079	
427	MULTIPLE LEVEL COMBINED ANTERIOR AND POSTERIOR SPINAL FUSION EXCEPT CERVICAL WITH CC	13,359	11,359	2,000	
428	MULTIPLE LEVEL COMBINED ANTERIOR AND POSTERIOR SPINAL FUSION EXCEPT CERVICAL WITHOUT CC/MCC	7,847	7,498	349	
447	MULTIPLE LEVEL SPINAL FUSION EXCEPT CERVICAL WITH MCC OR CUSTOM-MADE ANATOMICALLY DESIGNED INTERBODY FUSION DEVICE	2,428	2,362	66	
448	MULTIPLE LEVEL SPINAL FUSION EXCEPT CERVICAL WITHOUT MCC	13,835	13,577	258	
450	SINGLE LEVEL SPINAL FUSION EXCEPT CERVICAL WITH MCC OR CUSTOM-MADE ANATOMICALLY DESIGNED INTERBODY FUSION DEVICE	1,141	1,101	40	
451	SINGLE LEVEL SPINAL FUSION EXCEPT CERVICAL WITHOUT MCC	12,475	12,419	56	
Total		**69,552**	**65,608**	**3,944**	**63%**
MS-DRGs Not Included in TEAM					
28	SPINAL PROCEDURES WITH MCC	2,067	2,063	4	
29	SPINAL PROCEDURES WITH CC OR SPINAL NEUROSTIMULATORS	3,070	3,066	4	
30	SPINAL PROCEDURES WITHOUT CC/MCC	861	861	-	
456	SPINAL FUSION EXCEPT CERVICAL WITH SPINAL CURVATURE, MALIGNANCY, INFECTION OR EXTENSIVE FUSIONS WITH MCC	1,571	900	671	
457	SPINAL FUSION EXCEPT CERVICAL WITH SPINAL CURVATURE, MALIGNANCY, INFECTION OR EXTENSIVE FUSIONS WITH CC	3,706	2,187	1,519	
458	SPINAL FUSION EXCEPT CERVICAL WITH SPINAL CURVATURE, MALIGNANCY, INFECTION OR EXTENSIVE FUSIONS WITHOUT CC/MCC	1,265	1,097	168	

Total		**12,540**	**10,174**	**2,366**	**37%**

CMS did not include MS-DRGs 28, 29, 30, 456, 457 and 458 as spinal fusion anchor hospitalization initiators when it established TEAM. Yet, cases from these MS-DRGs would become anchor hospitalizations under the agency's proposal. CMS does not explain why it believes this is appropriate, and we are unable to determine a clear reason. **CMS should not add MS-DRGs 523, 524 and 525 to TEAM without first explaining its rationale for including these previously excluded discharges and providing a meaningful opportunity for comment.**

Pricing Methodology

Ambulatory Payment Classification (APC) and MS-DRG Update Factors. CMS proposes to apply APC and MS-DRG update factors in final target price calculations for TEAM beginning in PY 1. This ensures the final target price and reconciliation amounts align with payment rates and weights that are applied during each PY. Specifically, the agency proposes to add an APC update factor to the calculation of the prospective and retrospective trend factors. The APC update factor would be calculated as the ratio of the benchmark prices calculated with APC weights corresponding to the CY of the PY (CY 2026 for PY 1) to the preliminary benchmark prices calculated with the APC weights corresponding to the CY prior to the PY (CY 2025 for PY 1).

CMS further proposes to add an MS-DRG update factor to the calculation of the prospective trend factor for episodes with anchor end dates in the fourth quarter of the PY. The MS-DRG update factor would be calculated as the ratio of benchmark prices calculated with the second FY inputs (FY 2027 MS-DRG definitions and weights for PY 1) to preliminary benchmark prices calculated with the first FY inputs (FY 2026 MS-DRG definitions and weights for PY 1).

We support incorporating APC and MS-DRG update factors in target price calculations for TEAM. Our analysis indicates that including these update factors would help to improve the accuracy of target prices and reconciliation amounts by accounting for annual changes in the APC and MS-DRG payment rates and weights. **However, any changes in target prices for PY 1 (CY 2026) resulting from the application of these update factors should be to participant hospitals' benefit only.** Through these proposals, CMS would be making a substantive change to the model's payment methodology for PY 1 after it has already begun. Because of this, hospital participants should be held harmless from any negative financial consequences associated with this retroactive rule change.

Prospective Normalization Factor Construction. Starting with PY 2, CMS proposes to calculate the prospective normalization factor based on the applicable episodes in the full baseline period instead of only the most recent baseline year. The agency states this would improve predictive accuracy and better represent all episodes used in benchmark

price construction. Additionally, in the calculation of the risk-adjustment multiplier, CMS proposes to apply the risk-adjustment coefficients to all applicable baseline year episodes, rather than restricting application to the most recent baseline year episodes. The agency asserts this would improve the accuracy of the multiplier and help to smooth short-term fluctuations.

We support using the full three-year baseline period in the prospective normalization factor construction and risk-adjustment multiplier as proposed. Our analysis indicates that these proposed changes would lead to more accurate target prices for episodes than the current methodology using only the most recent baseline year.

Requests for Information

Ambulatory Surgical Center (ASC) Episodes. CMS states that it is exploring ASC participation in TEAM beginning as early as CY 2028. The agency states that more procedures, including ones that initiate episodes in TEAM, are being performed more regularly in the ASC setting. CMS requests information on the parameters under which ASCs could be incorporated into TEAM, including whether their addition would necessitate a separate model test.

We support the concept of a voluntary bundled payment model that includes procedures performed in the ASC setting. With advancements in surgical interventions and new developments in technology, it seems likely more procedures will continue to be performed safely and effectively in an ASC setting. This increase in ASC procedures could create opportunities for care redesign and efficiency gains that could be tested through an episode-based payment approach, applying lessons learned from TEAM and other previous bundled payment models.

However, we would have significant concerns with adding ASC episodes to TEAM itself, given the significant differences in patient populations and payment policies between ASC and hospital settings. For example, a recent KNG Health Consulting study found that from 2019 to 2021, Medicare beneficiaries who received care in HOPDs had higher needs than beneficiaries treated in independent physician offices (IPOs) and ASCs.[27] In addition, HOPD beneficiaries were of lower socioeconomic status and were more likely to be non-white compared to ASC and IPO patients. Further, the percent of beneficiaries enrolled in Medicare due to end-stage renal disease and/or disability was higher for the HOPD setting. Finally, HOPD patients were more likely to have at least one complication or comorbidity and more likely to have had a prior hospital stay and ED visit within the past 90 days compared to ASC and IPO patients.

The vastly different and less complex patient population receiving care in ASCs, combined with lower ASC payment rates, would make it impossible for hospitals to succeed in TEAM

[27] https://www.aha.org/system/files/media/file/2023/03/Comparison-of-Medicare-Beneficiary-Characteristics-Between-Hospital-Outpatient-Departments-and-Other-Ambulatory-Care-Settings.pdf

if ASC episodes were included. **As such, if CMS were to create an ASC bundled payment model, it should be entirely separate from TEAM, with its own construction and design elements, including benchmark prices and risk adjustment factors.** Hospitals cannot be expected to achieve savings when target prices are constructed based on payment rates that do not apply to them and patient populations with substantially lower clinical and socioeconomic complexity. **Moreover, we question whether including ASC episodes in TEAM would constitute an expansion of the model without first having met the statutory criteria for expansion in section 1115A(c) of the Social Security Act.**

Additionally, the agency should analyze whether meaningful savings could be achieved in the post-anchor procedure period of the ASC episode. For example, lower-acuity ASC patients almost certainly have less need for post-procedure care, particularly during a 30-day episode. CMS should examine whether specific interventions could be implemented around ASC procedures to reduce spending and improve quality.

Physician-owned Hospitals (POHs). CMS states that current law restrictions on POH participation in Medicare avoid the underlying concerns of the Physician Self-Referral Law, including overutilization, patient steering and cherry-picking the most profitable patients. However, it asserts that some evidence suggests POHs may help control costs, maintain or improve patient outcomes, and prevent hospital consolidation. Therefore, CMS requests information on whether it should initiate a voluntary opt-in period to allow POHs located in core-based statistical areas not selected for TEAM to participate in the model. It further states that approximately 15 POHs are currently required to participate in TEAM.

We oppose a voluntary opt-in period for POHs. In 2010, Congress acted to protect Medicare integrity and patient access by banning new POHs from participating in Medicare and restricting the expansion of existing ones. The decision was based on evidence that POHs:

- Encouraged self-referral, creating financial conflicts of interest.
- Overutilized services, driving up costs.
- Cherry-picked healthier, better-insured patients, leaving community hospitals with more complex and costly cases.
- Avoided the provision of emergency services, undermining comprehensive care delivery.

Sixteen years later, these concerns still apply. A 2023 study by Dobson | DaVanzo found that POHs treat younger, less complex, and wealthier patients; are five times more likely to receive CMS' maximum readmission penalty; provide fewer emergency services and rely on community hospitals for critical care.[28] The study also found that POHs report on fewer

[28] https://www.aha.org/system/files/media/file/2023/03/2023-Fact-Sheet-20230323-with-Appendix-and-Charts-POH-vs-Non-POH-Only.pdf

Medicare quality measures, raising concerns about transparency and accountability.[29] Additionally, POHs pose a particular threat to patient care in rural communities. Specifically, a further Dobson | DaVanzo study from last year found that if a new POH opens in the same market as a full-service rural hospital, the full-service hospital's margins decrease significantly as the POH siphons off healthier and commercially insured patients, risking access to 24/7 care and community jobs.[30]

Community hospitals are held to standards that require them to provide emergency services, treat all patients and invest in community health. **Because POHs tend to focus on profitable service lines and avoid the financial risks associated with comprehensive care, allowing them to opt in voluntarily to TEAM would destabilize the model, especially in rural and underserved areas.** It would also undermine fair competition by allowing POHs to selectively serve profitable patients and threaten access to emergency and complex care for vulnerable populations.

Indeed, our past analysis has confirmed that this trend applies to TEAM. It found that for TEAM episodes of care, POHs cherry-pick the healthiest and most profitable patients, and subsequently treat fewer dual-eligible (DE) and low-income subsidy (LIS) patients than full-service acute care hospitals.[31] For example, for CABG episodes, we found that non-POH hospitals' episode losses (i.e., the difference between their regional target price and spending per episode) were almost 2.5 times as much as POH hospitals' episode gains (see Table 2).

Table 2. CABG Episode Spending for POHs compared to Non-POHs

	Number of Hospitals	Avg. Number of Episodes	Avg. Episode Spending	Avg. Target Price	Difference Between Target and Spending (before CQS and stop loss/gain)	Percent Difference between Target and Spending
POH Hospitals	26	159.6	$48,000	$48,667	$667	1.4%
Non-POH Hospitals	1,047	102.6	$52,592	$50,939	-$1,652	-3.2%
All Hospitals	1,073	104.0	$52,421	$50,855	-$1,566	-3.1%

[29] https://www.aha.org/system/files/media/file/2023/08/Analysis-of-Selected-Medicare-Quality-Measure-Reporting-Data-by-Hospital-Ownership.pdf
[30] https://www.aha.org/system/files/media/file/2025/10/Introduction-of-Physician-Owned-Hospitals-Could-Lead-to-Reduced-Overall-and-Medicare-Margins-for-Existing-Rural-Comm.pdf
[31] https://www.aha.org/system/files/media/file/2024/06/aha-comments-on-cms-proposed-transforming-episode-accountability-model-team-letter-6-10-24.pdf

Our analysis also found that POH hospitals had a lower proportion of patients admitted through the ED or for trauma and treated a lower proportion of DE and LIS patients (see Table 3).

Table 3. Descriptive Hospital Characteristics for POH and non-POH Hospitals for CABG Episodes

	Number of Hospitals	Avg. Number of Episodes	Percent Difference between Target and Spending	Percent of episodes with patients admitted through ED or trauma	Percent of patients who are DE	Percent of patients who are LIS eligible
POH Hospitals	26	159.6	1.4%	10.6%	6.4%	7.7%
Non-POH Hospitals	1,047	102.6	-3.2%	24.7%	9.4%	10.6%
All Hospitals	1,073	104.0	-3.1%	24.2%	9.3%	10.5%

These disparities between POHs and full-service hospitals would be exacerbated even further through a voluntary opt-in period for POHs. Due to self-selection bias, only those POHs who expected to be successful under the model would choose to opt in. This would destabilize target prices and threaten access to care for the most vulnerable TEAM beneficiaries, particularly in rural areas. **Moreover, creating a voluntary opt-in period only for POHs while full-service hospitals are not also offered this flexibility would be an arbitrary policy that favors one type of hospital over another without a reasonable basis.**

PROPOSED CHANGES TO THE OFF-CAMPUS PROVIDER-BASED LOCATION RULES

CMS proposes a change to the Medicare provider-based regulations that describe how an inpatient facility located more than 35 miles away from the main hospital may become provider-based for payment, billing and certification purposes. Currently, the regulations allow distant off-campus HOPDs or off-campus inpatient facilities to obtain provider-based status via one of two location criteria. These criteria are intended to show overlap in where the main campus and distant off-campus patients live (via overlapping ZIP codes) or receive follow-up care (via referrals). In other words, the provider-based rules require distant off-campus facilities to demonstrate that they serve the ‘‘same patient population’’ as the main provider in one of two ways. These include submitting records showing that one of these is true:

- At least 75% of the patients served by the off-campus facility or organization reside in the same ZIP code areas as at least 75% of the patients served by the main provider (referred to as the “ZIP code overlap exception”).

- At least 75% of the patients served by the off-campus facility or organization who required the type of care furnished by the main provider received that care from that provider (referred to as the "referral-based exception").

In the proposed rule, CMS raises concerns that the referral-based exception for off-campus *inpatient facilities* seeking provider-based status could allow certain specialty and PPS-excluded hospitals to obtain significant payment advantages for inpatient services provided at considerable distances from the main provider. Therefore, it proposes a targeted change to the referral-based exception. Specifically, CMS proposes to limit the referral-based 75% test to allow only distant *outpatient* departments to become provider-based. Under the proposal, distant inpatient facilities seeking provider-based status could only qualify as provider-based using the ZIP code criteria.

The AHA does not support CMS' proposed narrowing of this pathway to provider-based status. It is important to preserve this option for those circumstances where patients requiring specialized care may need to be seen by a distant provider for inpatient follow-up services but have a condition(s) that requires the type of specialty care provided by a main provider. In such circumstances, the patient would benefit tremendously from the substantial level of integration that a provider-based relationship offers. For example, in the case of severe burns, a patient in a rural area may need to receive follow-up inpatient treatment involving infection management and rehabilitation at their local rural hospital, but would also need to receive more specialized services, such as skin grafts and critical care, at the main hospital with a burn center. Another example is complex psychiatric disorders. Such a patient may primarily receive care in the inpatient units of their local hospital to handle stabilization, but would need to receive more intensive, long-term or specialized care for co-occurring disorders at a specialized psychiatric hospital that is the main provider. In such circumstances, the AHA does not believe that hospitals are seeking out "unwarranted payment advantages" but rather are intending to provide the best possible care to their patients and communities.

ORGAN ACQUISITION COST ALLOCATION PRINCIPLES

In the rule, CMS clarifies how to properly allocate indirect costs to various cost centers. Under generally accepted accounting rules, providers' general service costs (that is, overhead costs) must be properly allocated to all centers that they serve, regardless of whether these centers produce revenue, to ensure that Medicare beneficiaries' costs are correctly calculated. However, the generally accepted account rules also state that for a general services cost center to be allocated to an individual department, there must be a causal relationship, such that the department receiving a portion of overhead costs receives a direct benefit from being serviced by that cost center.

CMS is proposing to add regulation §413.24(d)(8) to specify that providers must not include costs that do not relate to the allocation of administrative overhead expenses when it causes an improper distribution of indirect costs. For example, when a hospital performs organ transplants, it may purchase organs (kidneys, hearts or livers) from outside sources

such as organ procurement organizations (OPOs). CMS states that these purchased organs carry a very high dollar value but have no causal relationship to administrative overhead compared to other hospital services. CMS asserts that these purchased organs include all of the OPO's overhead in the purchased price of the organ. For this reason, CMS indicates that these purchased services should not be receiving any allocated overhead.

Hospitals acquire organs from OPOs, include those costs on the Medicare cost report, and are reimbursed for organ acquisition on a reasonable cost basis. Transplant programs operate within a highly complex, multidisciplinary infrastructure that extends well beyond direct clinical services. Yet, CMS fails to consider that essential administrative and operational functions are integral to safe and effective organ transplantation. These activities include organ procurement coordination, regulatory compliance, accreditation readiness, ethics review, transportation logistics, IT systems, finance, legal oversight and human resources. They are not ancillary; they are foundational to meeting the safety, timeliness and quality standards required for life-saving transplant care. They also, therefore, serve different functions from OPO overhead — they are not duplicative of it. OPO overhead relates to organ procurement activities, while, as noted, hospital administrative and general costs support the hospital's transplant program and broader institutional operations. As such, the suggestion that including acquired organ costs in the allocation base results in improper overhead allocation is not supported by the underlying cost structures and does not reflect operational reality. **The proposed changes risk materially underestimating the true resource intensity of transplant programs and could unintentionally destabilize the infrastructure that supports optimal outcomes. Therefore, we urge CMS to withdraw its proposal to add 413.24(d)(8) to the regulatory text.**