The Hospital + Healthsystem Association of Pennsylvania

June 10, 2025

Honorable Mehmet Oz, M.D., MBA
Administrator, Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
7500 Security Boulevard
Baltimore, MD 21244-1850

RE: CMS-1833-P, Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Policy Changes and Fiscal Year 2026 Rates, Requirements for Quality Programs, and Other Policy Changes (Vol. 90, No. 82), April 30, 2025.

Dear Administrator Oz:

On behalf of The Hospital and Healthsystem Association of Pennsylvania (HAP), representing more than 230 hospitals and health systems statewide, we appreciate the opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS) hospital inpatient prospective payment system proposed rule for fiscal year (FY) 2025.

For FY 2026, CMS proposes a market basket increase of a net update of 2.4 percent. This is simply not enough. HAP has grave concerns about this inadequate update, especially when taken together with the underwhelming market basket increases from FYs 2022, 2023, 2024, and 2025. It does not capture either the unprecedented inflationary environment or the other persistent financial headwinds hospitals and health systems are experiencing. It also fails to account for the fact that labor composition and costs have remained extraordinarily high and that, as a result, the hospital field continues to face sustained financial pressures and workforce shortages.

Given all the above, HAP strongly urges CMS to find ways to account for these increased costs to ensure that beneficiaries continue to have access to quality inpatient care.

In addition, we incorporate additional comments provided in the American Hospital Association's response to the proposed rule by reference.

Thank you for your consideration of HAP's comments about this proposed rule regarding inpatient payment and other provisions related to hospitals and the patients they serve in Pennsylvania.

If you have any questions, contact **Brooke Bowers**, HAP's director, financial reimbursement and analysis.

Sincerely,

Jolene H. Calla

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Vice President, Finance and Legal Affairs

The Hospital + Healthsystem Association of Pennsylvania

HAP Comments—Inpatient Prospective Payment System
Proposed Rule for Fiscal Year 2026

INPATIENT PROSPECTIVE PAYMENT SYSTEM UPDATE

For fiscal year (FY) 2026, CMS proposes a market basket increase of a net update of 2.4 percent, including an extremely high proposed productivity cut of 0.8 percent. This is simply not enough as nearly 60 percent of Pennsylvania hospitals have a negative Medicare margin. HAP has grave concerns about this inadequate update, especially when taken together with the underwhelming market basket increases from FYs 2022, 2023, 2024, and 2025. It does not capture either the unprecedented inflationary environment or the other persistent financial headwinds hospitals and health systems are experiencing. It also fails to account for the fact that labor composition and costs have remained extraordinarily high and that, as a result, the hospital field continues to face sustained financial pressures and workforce shortages.

Market Basket Forecasts Continue to Underestimate Actual Market Basket Growth

During this period of significant cost growth, the market basket forecasts for inpatient hospitals consistently failed to accurately predict actual market basket growth. Specifically, since the COVID-19 public health emergency, IHS Global Inc. (IGI) has under-forecasted actual market basket growth each year, as shown below.

Table 1: Inpatient Prospective Payment System Market Basket Updates, FY 2021 through FY 2025

Year	FY 2021	FY 2022	FY 2023	FY 2024	FY 2025	Total (Compounded)
Market Basket Update in Final Rule	2.4%	2.7%	4.1%	3.3%	3.4%	16.9%
Actual/Updated Market Basket Forecast	3.0%	5.7%	4.8%	3.6%	3.4%	22.2%
Difference in Net Market Basket Update and Actual Increases	**-0.6%**	**-3.0%**	**-0.7%**	**-0.3%**	**-0.0%**	**-5.3%**

These missed forecasts have a significant and permanent impact on hospitals and health systems and the patients they care for. At current levels, this cumulative underpayment of 4.6 percentage points totals approximately $4.6 billion annually. Further, as CMS knows, future updates are based on current payment levels. Therefore, absent action from CMS, these missed

forecasts are permanently established in the standard payment rate for Inpatient Prospective Payment System (IPPS) and will continue to compound.

Indeed, these trends have continued and exacerbated Medicare's underpayments to the hospital field. The Medicare Payment Advisory Commission (MedPAC) projects that 2025 Medicare margins *will be less than negative 13 percent*, resulting in more than *20 straight years* of Medicare paying below costs.[1] Even among relatively efficient hospitals, the median Medicare margin will remain about *negative* 2 percent. The American Hospital Association's (AHA) analysis showed that Medicare underpayments reached $100 billion in 2023.[2] This cannot be sustained. 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.

AREA WAGE INDEX

Permanent Cap on Wage Index Decreases

In the FY 2024 rule, CMS finalized a policy to apply a 5 percent cap on all wage index decreases, regardless of the reason, in a budget-neutral manner; it proposes to continue this policy for FY 2026. **HAP 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 IPPS 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 their otherwise applicable wage index value and the 25th percentile wage index value across all hospitals for that year. While this policy had been originally scheduled to expire after FY 2023, CMS indicated that it had been unable to disentangle the effects of the COVID-19 pandemic and the low-wage index policy to determine whether the policy has 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.

[1] MedPAC March 2025 report to the Congress--Chapter 3: Hospital inpatient and outpatient services
[2] Costs of Caring | AHA

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 percent. However, the agency did not indicate if and how it would address the policy for FYs 2026 and beyond.

In this rule, CMS is proposing to discontinue the low-wage policy for FY 2026 and beyond. Additionally, the agency is proposing to implement a budget-neutral policy to help hospitals significantly impacted by the policy removal. For these hospitals, if the proposed FY 2026 wage index decreased by more than 9.75 percent compared to their FY 2024 wage index, the decrease would be capped at 9.75 percent in a budget-neutral manner. We believe that CMS is not bound by statute to make its proposed FY 2026 transition policy 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 2026 transition policy should also be implemented in a non-budget-neutral manner. Indeed, reducing the standardized amount for all Prospective Payment System hospitals intensifies historical Medicare underpayment. **As such, the HAP urges CMS to implement the FY 2026 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 2026. 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.

DISPROPORTIONATE SHARE HOSPITAL PAYMENT CHANGES

Under the disproportionate share hospital (DSH) program, hospitals receive 25 percent of the Medicare DSH funds they would have received under the former statutory formula (described as "empirically justified" DSH payments). The remaining 75 percent 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.

For FY 2026, CMS estimates an increase in DSH and uncompensated care payments of $1.5 billion as compared to FY 2025. **We support this proposal which is estimated to increase payments to Pennsylvania hospitals by $25 million.**

RURAL HOSPITAL PROGRAMS

Low-volume Adjustment Hospitals and Medicare-dependent Hospital Program

The Full-Year Continuing Appropriations and Extensions Act, 2025, extended the low-volume hospital qualifying criteria and payment adjustment (LVA) and Medicare-dependent Hospital (MDH) Program under the IPPS through September 30, 2025. However, as it currently stands, beginning on October 1, 2025, the LVA would revert to statutory requirements that were in effect prior to FY 2011. Similarly, beginning October 1, 2025, the MDH program would expire.

HAP supports Congressional action that would 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 the MDH payments, which would provide more flexibility for these hospitals to provide the best care possible for their patients and communities.

Pennsylvania hospitals will experience an estimated $20 million loss in reimbursement in FY 2026 and a total loss of $224.5 million through FY 2035 due to the expiration of these critical funding streams. We urge CMS to ensure that all hospitals currently eligible for LVH and MDH continue to receive this much needed funding to ensure continued access to high-quality health care in rural communities.

Finally, we urge CMS to expeditiously process claims and provide instructions to MACs during program extensions, especially in instances when extensions are made retroactively. Seamless transition of programmatic support is a crucial lifeline for rural providers.

TRANSFORMING EPISODE ACCOUNTABILITY MODEL

In the proposed rule, CMS makes several modifications to Transforming Episode Accountability Model (TEAM), a new mandatory alternative payment model introduced in FY 2025 IPPS.

TEAM requires all IPPS hospitals within selected Core-Based Statistical Areas (CBSA) (25 percent of the 803 eligible CBSAs) to participate in five surgical episode categories proposed for TEAM including: coronary artery bypass graft, lower extremity joint replacement, major bowel procedure, surgical hip/femur fracture treatment, and spinal fusion. In Pennsylvania, 13 CBSAs were selected, impacting 26 hospitals. The majority of impacted hospitals in the state are rural.

TEAM is expected to launch January 1, 2026, and continue for five years through the end of 2030. Episodes would begin with the hospital stay or anchor procedure and continue 30 days post-discharge and would include the surgical procedure, any inpatient stay, as well as all related care covered under Medicare Parts A and B.

Pennsylvania hospitals and health systems have been leaders in promoting accountable, coordinated care. Significant efforts continue to be made to increase the value and better serve patients across the commonwealth.

Specific proposals in this rule include:

- **Participation**
  - Deferment of participation for new hospitals established in a TEAM CBSA once the model is already underway for one year.
  - For calendar year 2026, Medicare Dependent Hospitals would be eligible for track 2 participation if the MDH program is active at the time the participation track selections are due to CMS.

- **Quality Measurement**
  - To ensure continued alignment between TEAM and Hospital Inpatient Quality Reporting (IQR) Program, CMS proposes to use the first mandatory reporting period of July 1, 2025, through June 30, 2026, as the TEAM performance year 1 performance period (the same as the first mandatory IQR reporting period).
  - CMS proposes adding the Information Transfer PRO-PM to the quality measure set, beginning with performance year 3. This measure would be available for lower-extremity joint replacement and spinal fusion procedures completed in the outpatient setting.
  - TEAM participants without quality measure performance data for certain measures would be assigned a scaled quality measure score of 50 (midpoint of the clinical quality score scale).

- **Target Pricing**
  - CMS proposes a three-step approach to remap and adjust episodes during the baseline period to account for ongoing coding changes.
  - Standardizing the Area Deprivation Index—CMS proposes to rename the social needs risk adjustment factor in TEAM to the beneficiary economic risk adjustment factor. Furthermore, CMS proposes to replace the use of Area Deprivation Index with the Community Deprivation Index in TEAM.
  - Hierarchical Condition Category risk adjustment—CMS proposes to conduct a 180-day look-back for each beneficiary beginning the day prior to the anchor hospitalization or anchor procedure.

- **Care Delivery**
  - Skilled Nursing Facility (SNF) Three-day waiver—CMS proposes to allow TEAM participants to use the TEAM SNF three-day waiver for TEAM beneficiaries discharged to hospitals and critical access hospitals providing post-acute care under swing bed arrangements. CMS clarifies that the minimum three-star rating requirement applies only if the provider furnishing SNF services is eligible for the CMS five-star quality rating system.
  - Health Data Reporting—CMS proposes the removal of the voluntary health equity plan and health-related social needs data. CMS proposes no changes to the TEAM elements related to the collection of demographic data.
  - Decarbonization and Resilience Initiative—CMS proposed to remove Designated Research Institution from TEAM

There are several areas of concern within the original TEAM proposal that persist even with the proposed modifications. Mandatory participation will likely be financially damaging to smaller hospitals with low volumes across these bundles or the inability to financially support the investments necessary to be successful in this type of model.

HAP appreciates many of the proposals that help streamline quality programs under Medicare as well as expanding the SNF three-day waiver.

We continue to strongly recommend that CMS make TEAM voluntary, and address the continuing problematic design elements, specifically, establishing a low-volume policy. As many mandated hospitals in Pennsylvania are in rural communities with lower volumes, there is significant risk to their financial viability in two-sided risk programs such as TEAM.

HOSPITAL QUALITY REPORTING AND VALUE PROGRAMS

While HAP appreciates CMS' continued commitment to high-quality care through hospital quality reporting and value-based programs, several proposals in the IQR Program, the Hospital Value-Based Purchasing (HVBP) Program, and the Hospital Readmissions Reduction Program (HRRP) warrant reconsideration. These proposed changes could introduce significant operational challenges and unintended consequences, particularly for hospitals serving complex patient populations.

Inpatient Quality Reporting Program

CMS proposes to remove four measures from the IQR Program starting in FY 2026:

1. COVID-19 vaccination coverage among health care personnel.
2. Structural measure for hospital commitment to health equity.
3. Screening for social drivers of health (SDOH).
4. SDOH screen-positive rate.

Hospitals will still be required to report on these measures in FY 2025 based on FY 2024 data.

HAP supports CMS' efforts to reduce regulatory burden by streamlining these measures, particularly the removal of the COVID-19 vaccination measure, which has become impractical to collect under current CDC guidelines. The ongoing administrative burden associated with the near-continuous monitoring and reporting outweighs the measure's utility after the conclusion of the public health emergency.

Likewise, while HAP supports the goal of advancing health equity, we recognize significant concerns surrounding the methodological soundness and feasibility of the SDOH measures. These measures have not been endorsed by a consensus-based entity, and stakeholders have raised issues related to their scoring reliability, duplicative reporting requirements, and unclear

implementation guidance. Given these shortcomings, HAP supports the proposed removal of these measures.

HAP supports CMS' proposal to remove the COVID-19 diagnosis exclusion from several claims-based IQR measures beginning in FY 2027, recognizing that the impact of COVID-19 on measure validity has significantly declined.

Regarding the proposed modifications to the stroke mortality and total hip/knee arthroplasty (THA/TKA) complication measures, **HAP supports the transition to individual ICD-10-CM codes for risk adjustment** and agrees that including Medicare Advantage (MA) patients could improve statistical reliability. However, we urge CMS to delay implementation until further evaluation is conducted on how MA inclusion might impact measure consistency and provider accountability, especially considering ongoing issues with MA plan behavior.

Hospital Value-Based Purchasing Program

CMS proposes to remove the health equity adjustment from the HVBP scoring methodology beginning in FY 2026. This adjustment had offered bonus points based on a hospital's quality performance and the proportion of dual-eligible patients served.

HAP shares CMS' commitment to equity but is concerned that the proposed removal of this adjustment overlooks the complex, community-level factors that impact patient outcomes. These include barriers such as poverty, limited access to primary or follow-up care, inadequate transportation, and challenges adhering to care plans. We urge CMS to explore alternative mechanisms, such as economic risk adjustment variables, to ensure hospitals serving disadvantaged populations are not unfairly penalized in value programs.

For FY 2027, CMS proposes to align the THA/TKA complication measure in HVBP with the IQR program and to reset the baseline year for health care-associated infection (HAI) measures to 2022. **HAP supports the harmonization of methodologies and the proposed HAI baseline adjustment.** However, we urge CMS not to proceed with the inclusion of MA patients in the HVBP complication measure calculation currently, echoing broader concerns about transparency, data reliability, and equity across hospital types.

Hospital Readmissions Reduction Program

CMS proposes to include MA patients in all six HRRP measures and shorten the performance period from three to two years beginning in FY 2027.
While HAP agrees that including MA patients could improve measure completeness in principle, we caution against this proposal in its current form. The inclusion of MA data introduces concerns around the fairness and validity of performance assessments. CMS' own data suggest increased penalties and reduced performance for hospitals with high MA patient volumes—often due to plan-level decisions beyond hospital control, such as delayed or denied post-acute care authorizations. These issues disproportionately affect safety net, teaching, and DSH hospitals.

Further, CMS has not provided sufficient data or transparency to allow hospitals to assess how these changes would affect their performance. The methodology for combining MA encounter data with hospital-submitted claims remains unclear, and the potential for distortion due to "information only" claims reporting is significant. Until CMS can ensure meaningful oversight of MA plans and greater transparency in its calculations, **HAP urges that CMS reconsider the inclusion of MA patients in HRRP penalty calculations as currently proposed.**

HAP supports other HRRP changes, including the removal of COVID-19 exclusions and the shift to ICD-10–based risk adjustment methodologies, which better reflect current clinical realities.

RFI: DEREGULATION

HAP is issuing a separate response letter to the recent CMS request for information (RFI) on deregulation of the Medicare program and emphasizes the need for regulatory reform in reference to the framework provided in the RFI.