



The Hospital + Healthsystem
Association of Pennsylvania

June 9, 2026

The Honorable Mehmet Oz, MD
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1849-P
P.O. Box 8013
Baltimore, MD 21244-8013

RE: CMS-1849-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 2027 Rates; Requirements for Quality Programs; and Other Policy Changes, April 14, 2026.

Dear Administrator Oz:

On behalf of The Hospital and Healthsystem Association of Pennsylvania (HAP), representing more than 235 hospitals and health systems statewide, we appreciate the opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS) hospital inpatient prospective payment system (IPPS) proposed rule for fiscal year (FY) 2027.

Pennsylvania's hospitals and health systems are the backbone of the health care 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. Over the past decade, 25 hospitals have closed in Pennsylvania, and another 12–14 hospitals are at risk of closure by 2030 if reimbursement continues to fall below the cost of providing care.

For FY 2027, 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, 2025, and 2026. It does not capture either the unprecedented inflationary environment, nor 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.

As such, HAP strongly urges CMS to strengthen the FY 2027 IPPS payment update by revisiting the market basket forecast and working with Congress to reduce the magnitude of the productivity adjustment. Current market basket increases, especially when reduced by the productivity adjustment, do not reflect hospitals' rising labor, drug, supply, and administrative costs. CMS must find ways to account for these increased costs to ensure that beneficiaries continue to have access to quality inpatient care.



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In addition, we incorporated 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, Esq.
Vice President, Finance & Legal Affairs

Attachment



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MARKET BASKET UPDATE

CMS proposes to increase payments by a net 2.4 percent in fiscal year (FY) 2027 compared to FY 2026. This payment includes a 3.2 percent market basket update, minus a 0.8 percentage point productivity cut as required by the Affordable Care Act.

The Medicare Payment Advisory Commission (MedPAC) projects that 2026 Medicare margins will be less than negative 10 percent¹, resulting in more than 20 straight years of Medicare paying below costs. The American Hospital Association's (AHA) analysis showed that Medicare underpayments reached \$100 billion in 2024.² This cannot be sustained.

HAP has grave concerns that CMS' proposed annual market basket update of 3.2 percent 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. **This is simply not enough as nearly 63 percent of Pennsylvania hospitals have a negative Medicare margin on inpatient services. We urge CMS to revisit both its market basket forecasts and the magnitude of the productivity adjustment, and to consider their combined effect on provider reimbursements.**

Hospitals continue to face sustained inflationary pressures. Inflation has continuously pushed up labor, drug, supply, and other core operating costs. A recent AHA report found that total hospital expenses increased by 7.5 percent in 2025 alone. Much of this increase reflects labor costs, which rose by 5.6 percent in 2025. Further, advertised salaries for registered nurses have averaged 5.5 percent growth over the last two years—more than double the rate of inflation.³

Cost pressures, however, extend well beyond labor. Hospitals are increasingly caring for sicker and more complex patients, requiring additional and more costly drugs and supplies, and these costs continue to climb. An AHA analysis showed that in 2025 supply costs rose 9.9 percent while drug costs rose a staggering 13.6 percent.⁴ In addition, a report from the Department of Health and Human Services found that list prices for nearly 2,000 drugs increased by an average of 15.2 percent from 2017 through 2023—outpacing general inflation.⁵ These cost

¹ March 2026 Report to the Congress: Medicare Payment Policy

² Costs of Caring | AHA

³ Costs of Caring | AHA

⁴ Costs of Caring | AHA

⁵ Changes in the List Prices of Prescription Drugs, 2017-2023 | ASPE



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challenges strain hospitals who must be prepared to provide treatment for a wide range of conditions and comorbidities.

The proposed increase 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. CMS must 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 2027. **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

Under the low-wage index policy, for hospitals with a wage index value below the 25th percentile, CMS increased the hospital's wage index by half the difference between the otherwise applicable wage index value for that hospital and the 25th percentile wage index value for all hospitals. However, the policy was subject to litigation, and on July 23, 2024, the United States Court of Appeals for the District of Columbia Circuit held that it was unlawful. In FY 2025, the agency issued an interim final rule to discontinue the low-wage policy for FY 2025. Subsequently, in the FY 2026 rule, CMS discontinued the policy.

Additionally, in the FY 2026 rule, the agency implemented 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. CMS is proposing to extend the transitional policy in FY 2027 for hospitals, if the proposed FY 2027 wage index decreased by more than 14.2625 percent compared to their FY 2024 wage index. This would again be applied in a budget neutral manner.

We believe that CMS is not bound by statute to make its proposed FY 2027 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 2027 transition policy should also be implemented in a non-budget-neutral manner. Indeed, reducing the standardized amount for all



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prospective payment system hospitals intensifies historical Medicare underpayment. **As such, HAP 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.**

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 2027, CMS estimates a \$564 billion decrease in DSH and uncompensated care payments as compared to FY 2026. **We oppose the proposed decrease to the DSH and uncompensated care pool.**

RURAL HOSPITAL PROGRAMS

Low-volume Adjustment Hospitals and Medicare-dependent Hospital Program

The Consolidated Appropriations Act, 2026, extended the low-volume hospital qualifying criteria and payment adjustment (LVA) and Medicare-dependent Hospital (MDH) Program under the IPPS through December 31, 2026. However, as it currently stands, beginning on January 1, 2027, the LVA would revert to statutory requirements that were in effect prior to FY 2011. Similarly, beginning December 31, 2026, 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 \$15.9 million loss in reimbursement in FY 2027 and a total loss of \$175.8 million through FY 2036 due to the expiration of these critical funding streams. We urge CMS to ensure that all



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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.

VALUE-BASED PROVISIONS

The rule proposes several modifications to the CMMI Transforming Episode Accountability Model (TEAM), a five-year mandatory model that began on January 1, 2026. The model reimburses participating hospitals under a bundled payment approach for five surgical episodes.

The rule also proposes to expand the Comprehensive Care for Joint Replacement (CJR) Model, renaming it CJR-X, to include mandatory participation, nationwide. The model is slated to begin October 1, 2027, and would hold hospital participants responsible for the quality and costs of Medicare Parts A and B items and services furnished during a lower extremity joint replacement (LEJR) episode of care, from the date of inpatient admission or outpatient procedure through 90 days post-discharge. It includes a discount factor of up to 2 percent as Medicare's share of episode savings.

Hospitals and health systems are eager to advance value-based payment arrangements that improve quality, enhance patient outcomes, and make health care more affordable. HAP and its members support continued innovation in Medicare payment models that align incentives, promote coordinated care, and reward prevention and wellness.

While we appreciate CMS' efforts to expand the reach of value-based models, **we believe that mandatory participation in any current or future model would present significant challenges, particularly for hospitals that lack the scale or financial capacity to make the necessary investments in care redesign. A phased or voluntary approach would better support success, allowing organizations to build the infrastructure and partnerships needed to achieve savings and improved outcomes.**

OFF-CAMPUS PROVIDER-BASED LOCATION RULES

HAP opposes CMS' proposal to limit the application of the referral-based 75 percent test to outpatient departments only. Narrowing eligibility for provider-based status for facilities more than 35 miles away from the main provider stands to disproportionately impact rural hospitals and health care networks that are already struggling to provide their communities with a comprehensive set of health care services. The proposed change stands to disrupt referral patterns for coordinated specialized care in these areas.

If CMS chooses to move forward with this proposal, HAP would request that CMS grandfather existing provider-based departments and limit the application of this policy change to new determinations.



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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 Medicare Advantage (MA) and Medicare fee-for-service (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 Hospital Inpatient Quality Reporting (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,” it proposes to instead adopt the Sepsis Readmission measure directly into the HRRP to inform FY 2029 payment adjustment.

HAP 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 Pre-Rulemaking Measure Review (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 payor 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 was 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 could 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 was 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 impacted their payments.



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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.