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June 8, 2026

Dr. Mehmet Oz
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1849-P
7500 Security Boulevard
Baltimore, MD 21244-1850

Re: 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

Dear Administrator Oz,

The AAMC (the association) [1] welcomes this opportunity to comment on the proposed rule titled "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," 91 *Fed. Reg.* 19312 (April 14, 2026), issued by the Centers for Medicare & Medicaid Services (CMS or the agency).

The following summary reflects the AAMC's comments on CMS' proposals regarding graduate medical education payments, hospital payment, quality proposals, and requests for information (RFIs) in the FY 2027 IPPS Proposed Rule.

[1] The AAMC is a nonprofit association dedicated to improving the health of people everywhere through medical education, clinical care, biomedical research, and community collaborations. Its members are all 163 U.S. medical schools accredited by the **Liaison Committee on Medical Education**; 13 Canadian medical schools accredited by the **Committee on Accreditation of Canadian Medical Schools**; nearly 500 academic health systems and teaching hospitals, including Department of Veterans Affairs medical centers; and more than 70 academic societies. Through these institutions and organizations, the AAMC leads and serves America's medical schools, academic health systems and teaching hospitals, and the millions of individuals across academic medicine, including more than 210,000 full-time faculty members, 99,000 medical students, 162,000 resident physicians, and 60,000 graduate students and postdoctoral researchers in the biomedical sciences. Through the Alliance of Academic Health Centers International, AAMC membership reaches more than 60 international academic health centers throughout five regional offices across the globe.

- ***Graduate Medical Education***. Request not to finalize proposed regulatory changes to approved programs, support the adoption of policies to make determinations for a new program based on a letter of initial accreditation and clarifications for hospital merger calculations, and a request for information regarding CAA, 2021 Section 131 PRA and FTE resets.
- ***Market Basket Update***. CMS should increase the market basket update to incorporate expected growth in hospital input costs and reevaluate the accuracy of the total factor productivity adjustment.
- ***Disproportionate Share Hospital (DSH) and Uncompensated Care Payments***. CMS should increase transparency related to the calculation of the "other" factor in the Factor 1 calculation, account for the potential of higher rates of uninsured individuals in Factor 2, and include Medicaid Section 1115 waiver days related to state uncompensated care pools in the Medicare DSH calculation.
- ***Cost Allocation Principles Related to Organ Acquisitions***. CMS should withdraw the proposal to change cost reporting cost allocation principles, which results in transplant hospitals not being accurately reimbursed for their costs.
- ***Low Wage Index Policy*****:** CMS should identify factors and policies to support low wage index hospitals without impacting high wage index hospitals through budget neutrality**.**
- ***New Technology Add-on Payment (NTAP)*****:** CMS should collaborate with stakeholders to ensure beneficiaries have timely access to new technologies**.**
- ***Z-Code Severity Level Changes*****:** CMS must maintain accurate coding for patients requiring more resources to care for due to broader health needs.
- ***High-cost outlier payments.*** CMS should ensure the operating outlier threshold for high-cost cases uses inputs that accurately capture recent cost and charge trends.
- ***Provider-Based Criteria Changes.*** CMS should maintain the provider-based requirements in their current form to preserve patient access to inpatient services in rural and underserved areas and to avoid disruption to continuity of care
- ***Comprehensive Care for Joint Replacement Expanded (CJR-X) Model***: CMS should delay the model to a 2028 start, refine episode eligibility policies, establish a ramp up period to downside risk for hospitals, work with stakeholders to develop a sustainable target pricing methodology for the permanent model, ensure alignment of quality measurement policies with the IQR and OQR are appropriate for performance-based measurement, and refine data sharing policies.
- ***Transforming Episode Accountability Model (TEAM)***: CMS should establish a new opt-in period for hospitals to choose to participate in TEAM, ensure TEAM hospitals have sufficient data to identify patients ineligible for TEAM due to a current CJR-X episode, and ensure alignment of quality measurement policies with the IQR and OQR are appropriate for performance-based measurement.
- ***Readmissions Reduction Program***: CMS should modify and delay implementation of the proposed sepsis readmissions measure to ensure hospitals have appropriate notice for performance-based payment implications.

- ***Inpatient Quality Reporting (IQR) Program***: CMS should ensure (1) measures are appropriate for inpatient specification and measure that which is in the hospital's control prior to proposing adoption in the IQR; (2) that the electronic clinical quality measure (eCQM) portfolio is robust to support the hospital self-selected measure reporting framework; (3) that the majority of hospitals can meet reporting thresholds under the program – amending those thresholds in cases like the THA/TKA PRO-PM where evidence does not support the previously established threshold; and (4) that changes to hospital designations and ratings are thoroughly vetted and tested prior to proposed adoption to ensure they are well understood and meet the needs of patients, families, and communities evaluating their options for where to seek care.
- ***Promoting Interoperability Program***: CMS should continue capability-based approaches for assessing hospital's meaningful use of certified EHR technology until interoperability functionality, standards adoption, and external partner readiness are more uniformly established across the healthcare technology ecosystem.

GRADUATE MEDICAL EDUCATION PROVISIONS

Proposed Requirements to Prohibit Unlawful Discrimination in Approved Medical Residency Programs

Under existing regulations, an approved program is one that is accredited by a recognized GME accrediting body, including the Accreditation Council for Graduate Medical Education (ACGME), the Council on Podiatric Medical Education (CPME), the Commission on Dental Accreditation (CODA), and other accrediting entities identified in 42 C.F.R. §§ 413.75(b) and 412.152. Only approved medical residency training programs are eligible to receive Medicare Graduate Medical Education (GME) payments.[2] CMS now proposes to add a new requirement outside of the accrediting bodies to provide that an approved medical residency training program must not discriminate, or promote or encourage discrimination, on the basis of race, color, national origin, sex, age, disability, or religion, including through the use of those characteristics—or intentional proxies for those characteristics—as selection criteria for employment, program participation, resource allocation, or similar activities, opportunities, or benefits.[3]

To implement this policy, CMS proposes revisions to 42 C.F.R. §§ 412.105(f)(1)(i), 413.75(b), and 415.152 and would consolidate these provisions within a newly established regulation at 42 C.F.R. § 413.84. The proposed regulatory change would also apply to nursing and allied health education programs governed by 42 CFR 413.85, which would be subject to the same requirements for accreditors and programs. The new regulation would incorporate changes finalized in the CY 2026 Outpatient Prospective Payment System (OPPS) final rule regarding

[2] Social Security Act § 1886(h).
[3] 91 *Fed. Reg.* 19504.

accreditor requirements for approved medical residency and nursing and allied health programs, together with the additional requirements proposed here for approved programs themselves.[4] CMS proposes that these amendments become effective on October 1, 2026.

In comments submitted for the CY 2026 OPPS proposed rule, the AAMC emphasized that accrediting organizations for residency training programs have served as trusted, stewards of educational quality, program oversight, and patient safety for more than four decades. Throughout that period, CMS has appropriately afforded substantial deference to these accrediting bodies in the development, implementation, and enforcement of educational standards governing GME programs. The AAMC continues to disagree with the Agency's assertions that the changes finalized in the CY 2026 OPPS final rule and now reflected in the FY 2027 IPPS proposed rule are necessary to ensure that "even in the absence of discriminatory accreditation standards, individual programs do not implement policies that constitute unlawful discrimination under Federal law."[5]

Accreditation and program requirements encompass a wide range of educational, clinical, and patient-safety standards designed to account for differences in patient populations, training environments, and learner competencies. Regulatory changes that may affect educational requirements or the safe administration of residency programs should be undertaken only when supported by a clearly articulated need and a thorough assessment of their likely impact. CMS has not demonstrated that such a need exists here. Nor has the Agency explained how the proposed change would improve the administration of residency training programs, strengthen patient care, or advance any identifiable objective within the Medicare GME framework.

Moreover, unlawful discrimination is already prohibited under the Civil Rights Act, which provides avenues for redress under federal law.[6] Hospitals and programs are aware of these unlawful discrimination laws, and must comply accordingly. Given these existing protections, codifying additional nondiscrimination requirements within Medicare GME reimbursement regulations appears duplicative, ambiguous and unnecessary. The proposal risks creating additional compliance obligations for teaching hospitals and residency programs while introducing uncertainty regarding the administration of educational and accreditation standards.

For these reasons, the AAMC urges CMS **not to finalize the proposed revisions** to the definition of an approved medical residency training program. Instead, CMS should restore the regulatory text governing accreditors of approved programs to the longstanding framework that existed prior to the CY 2026 OPPS final rule and continue to rely on established accrediting bodies and existing federal civil rights laws to address concerns related to unlawful discrimination.

[4] 90 *Fed. Reg.* 33860-1.
[5] *Id*.
[6] Civil Rights Act of 1964, Pub. L. No. 88-352.

Proposed Modifications to the Criteria for New Residency Programs

The Balanced Budget Act of 1997 established, for the first time, full-time equivalent (FTE) resident caps for purposes of Medicare Graduate Medical Education (GME) reimbursement.[7] As a result, hospitals were limited to the number of Medicare-supported resident FTEs training at the institution as of December 31, 1996. Hospitals that had not established an FTE cap based on resident training occurring on that date, as well as hospitals that began operations after 1996, could not receive Medicare GME reimbursement until they established an FTE cap. Recognizing that new teaching hospitals would require a mechanism to participate in Medicare GME, Congress granted the Secretary authority to develop policies governing the establishment of FTE caps.[8] Under current law, rural hospitals and hospitals treated as rural under section 1886(d)(8)(E) of the Social Security Act are eligible to receive an FTE cap adjustment for each new residency program they establish.

CMS's longstanding policy for establishing Medicare GME FTE caps has, in part, focused on whether residents from a *new residency program* rotate at a hospital that has not previously trained residents or when rural hospitals start *new residency programs*. Pursuant to 42 CFR § 413.79(l), CMS defines a new residency program as a program that "receives initial accreditation by the appropriate accrediting body or begins training residents on or after January 1, 1995." In addition to this regulatory definition, CMS instituted a policy in the FY 2010 IPPS final rule that identified factors it would use to determine whether a residency program is genuinely "new."[9] These factors focused primarily on whether the program director, teaching faculty, and residents were "new," while also considering broader organizational relationships, such as common ownership arrangements, affiliations with the same medical school, and other teaching relationships among hospitals. Although CMS has an understandable interest in ensuring that hospitals do not inappropriately transfer existing programs, which would result in duplicating FTE cap, stakeholders have long expressed frustration with the ambiguity and subjectivity of the 2010 IPPS final rule framework. The AAMC therefore appreciates CMS's willingness to revisit its policy regarding program newness and to solicit stakeholder feedback as it develops a more transparent and administrable approach.

CMS most recently explored updates to new program criteria in the FY 2025 IPPS proposed rule and a second request for comment and request for information published in the FY 2025 IPPS final rule.[10] No change in policy was finalized at that time, and now CMS proposes revised criteria for determining when a residency program is "truly new." Under the current proposal, a program would be considered new if it receives initial accreditation and at least 90 percent of its

[7] Balanced Budget Act of 1997 Pub. L. 105-33.
[8] Balanced Budget Refinement Act of 1999 Pub. L. 106-113, 77 *Fed. Reg.* 53416. Since the BBA of 1997 established the FTE caps, both Congress and CMS have amended these policies, notably provisions enacted through the Balanced Budget Refinement Act of 1999, which allowed rural hospitals to establish and adjust FTE caps for each new residency program they create, and CMS's revisions in the FY 2013 IPPS final rule, which extended the cap-building period from three years to five years.
[9] 74 *Fed. Reg.* 43908.
[10] 89 *Fed. Reg.* 36221-4, 89 *Fed. Reg.* 69377-80.

residents have no prior training experience in that program specialty during the five-year cap-building period.[11] CMS also proposes several important exceptions when determining the 90 percent threshold. First, residents who matched into the program through the National Resident Matching Program (NRMP) or another formal matching process and who have prior experience in the same specialty would be excluded from the threshold calculation but would count toward establishment of the hospital's FTE cap. Second, displaced residents from closed hospitals or programs would be excluded both from the threshold calculation and from the determination of the FTE cap. Finally, programs accredited for 16 or fewer resident positions would be exempt from the 90 percent requirement altogether.

In comments submitted for the FY 2025 IPPS proposed rule, and the request for additional information published the FY 2025 IPPS final rule, the AAMC proposed that initial accreditation alone satisfies the regulatory requirements for demonstrating program newness and that alone should be sufficient evidence that a residency program has not simply been transferred from another institution. The AAMC continues to believe that initial accreditation is the most objective and appropriate benchmark for establishing program newness. Nevertheless, if CMS determines that additional safeguards are necessary, the proposed framework represents a substantial improvement over the factors-based approach adopted in the FY 2010 IPPS final rule. Compared with the current policy, the proposed standard is clearer, more objective, and significantly easier for residency programs, hospitals, and Medicare Administrative Contractors (MACs) to administer. The proposed exceptions appropriately recognize circumstances outside the hospital's control, particularly with respect to matched residents and displaced trainees. Likewise, exempting programs accredited for 16 or fewer residents from the 90 percent threshold provides important flexibility for smaller programs that may face unique challenges. The AAMC continues to urge CMS to consider an exception for residents with prior experience in the same specialty who replace residents that unexpectedly depart a program.

The AAMC also strongly supports CMS's proposal to eliminate restrictions related to the prior experience of program directors, faculty members, and administrative staff. New teaching hospitals and residency programs benefit greatly from the expertise of experienced leaders and administrators during the critical start-up phase of a training program. The current policy has often been misunderstood because it focuses on prior experience in the role, which is not intuitive. Allowing hospitals to recruit experienced program directors, faculty, and administrative personnel will strengthen new residency programs, support compliance with accreditation requirements, enhance the educational experience of residents, and ultimately improve patient care. Experienced leadership is essential to navigating the operational, educational, and regulatory complexities associated with establishing a new residency program, and CMS's proposed revision appropriately recognizes this reality.

Finally, the AAMC appreciates CMS's clarifications regarding the requests for information included in the FY 2025 IPPS final rule, specifically with respect to commingled residents and hospitals with more than one program in the same specialty.

[11] 91 *Fed. Reg.* 19505.

A significant concern CMS should consider in implementing changes to the program newness criteria is the confusion and uncertainty that would result from having two different "newness" policies operating simultaneously. CMS has historically evaluated program newness, and any associated FTE cap adjustments, at the conclusion of a program's fifth training year. Under the proposed rule, however, the revised policy would take effect on October 1, 2026, and apply only to programs that begin training residents on or after that date. As a result, programs that are still within their initial five-year cap-building period as of October 1, 2026, would continue to be evaluated under the existing criteria, despite CMS's recognition that those criteria warrant revision.

If CMS proceeds with this approach, many new teaching hospitals currently in the cap-building period could have their programs evaluated under markedly different standards based solely on when training began. This would create inequitable outcomes for similarly situated programs and impose unnecessary administrative complexity on MACs, which would be tasked with applying different newness standards to programs established during roughly the same timeframe.

Such an outcome is avoidable. Rather than maintaining parallel policies, CMS should apply the revised framework prospectively to all programs whose FTE caps are established on or after October 1, 2026, regardless of when resident training first began. Alternatively, CMS could adopt a hold-harmless provision for programs currently within the cap-building period, allowing programs to qualify under the revised criteria. Either approach would promote consistency, reduce administrative burden, and ensure that programs are evaluated under more uniform and equitable standards.

Calculation of Direct GME and IME Payments Following a Hospital Merger

CMS does not propose any changes to the policy for calculating merged teaching hospitals' reimbursement but rather clarifying the complex set of determinations that are required when a merger takes place. This year's discussion focusing on Direct Graduate Medical Education (DGME) and Indirect Medical Education (IME) payments following a hospital merger is welcome insight for stakeholders affected by a merger. Over the past several years, CMS has provided several clarifications regarding Medicare GME reimbursement calculations. The AAMC appreciates CMS's efforts to provide detailed explanations concerning the complex determinations associated with hospital mergers.

Conclusion of Section 131 Statutory Reset Window for PRAs and FTE Caps

Section 131 of the Consolidated Appropriations Act, 2021 (CAA) provided a critical opportunity for certain hospitals to reset artificially low or zero per resident amounts (PRAs) and resident full-time equivalent (FTE) caps when specified statutory criteria were met. Eligibility for resets was limited to a narrowly defined group of hospitals based on the timing and number of FTEs under which its PRA or FTE cap had originally been established. The five year statutory window

for obtaining these resets extended from the enactment of the CAA on December 27, 2020, through December 26, 2025.

The AAMC strongly supported both the enactment of Section 131 and CMS's implementation of the reset provisions. For many hospitals, low PRAs or FTE caps were established inadvertently, often as a result of a limited number of resident rotators. Once established, these low PRAs or FTE caps can significantly constrain a hospital's ability to expand residency training programs, with many effectively shut out of participating in Medicare-supported physician training altogether. Many hospitals that set artificially low PRAs or FTE caps could not support a GME program(s), hence, only hosting a small number of resident rotators. For hospitals that can now expand GME training capacity or stand-up full programs will continue to effectively be shut out of doing so, without reopening or rethinking the reset policy. These hospitals are in a unique position to help address the United State's anticipated workforce shortage of up to 86,000 physicians by 2036.[12]

Despite the importance of this relief, utilization of Section 131 resets appears to have been limited. Analysis conducted by the AAMC and the University of North Carolina's Cecil G. Sheps Center for Health Services Research found that, approximately three years after enactment, only 10.5 percent of eligible hospitals had initiated an FTE cap reset under Section 131.[13] This low participation rate suggests that many eligible institutions were unable to take advantage of the provision within the relatively brief statutory window, whether because of competing operational priorities, limited administrative capacity, resource constraints, or insufficient awareness of the opportunity.

With the closure of Section 131, program utilization information is needed to evaluate the impact of the policy and understand the extent to which eligible hospitals were able to benefit from the relief Congress intended to provide. The AAMC therefore requests that CMS publish data regarding the hospitals that successfully initiated PRA and FTE cap resets under Section 131, including aggregate information that would allow stakeholders to assess the provision's utilization and impact.

The AAMC also encourages CMS to support congressional efforts to reopen and extend the statutory window for PRA and FTE cap resets. Given the limited uptake observed during the original eligibility period, extending this opportunity for a longer window would allow additional hospitals to take advantage of the program. To the extent CMS possesses existing administrative authority to pursue policies that would achieve similar outcomes, the AAMC encourages the Agency to explore those options as well. Ensuring that hospitals are not permanently disadvantaged by historical PRA and FTE determinations remains an important step toward strengthening the nation's physician workforce, especially in rural and underserved communities.

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[12] GlobalData Plc. The Complexities of Physician Supply and Demand: Projections From 2021 to 2036. Washington, DC: AAMC; 2024.
[13] https://www.aamc.org/about-us/mission-areas/clinical-care/section-131

PAYMENT PROPOSALS

PROPOSED MARKET BASKET UPDATE

Increase the Market Basket Update for FY 2027 to Accurately Incorporate Expected Growth in Hospital Input Costs

CMS is proposing a net increase to the standardized amount of 2.4 percent, reflecting a market basket update of positive 3.2 percent and a total factor productivity adjustment of negative 0.8 percentage points for FY 2027.[14] We are concerned that the data used to calculate the FY 2027 market basket update are not representative of the significantly higher growth in labor, supply, and pharmaceutical costs hospitals continue to experience and which are expected to rise in FY 2027 due to the widespread effect of tariffs on the supply chain. The inadequate proposed FY 2027 update, market basket updates in preceding years that fell short of the actual pace of inflation, and policy changes that are resulting in payment reductions to hospitals, necessitate a course correction from CMS to ensure Medicare payments are accurately updated to reflect hospital input costs.

The data CMS used to calculate the market basket update do not accurately reflect the dramatic increase in labor and supply costs that hospitals and health systems continue to experience, particularly after FY 2022. Hospitals continue to experience substantial annual increases in their expenses, with year-over-year labor expense increases at 4 percent and 10 percent for non-labor expenses.[15] Drug costs in particular continue to put financial pressure on hospitals, seeing a year-over-year increase of 10 percent. In its March 2026 report, the Medicare Payment Advisory Commission (MedPAC) found Medicare fee-for-service hospital margins of negative 12.1 percent in 2023, only slightly changed from record-low negative 12.8 percent margins in 2022.[16] The financial outlook for academic health systems is even more grim—AAMC member hospital overall Medicare fee-for-service margins were negative 18.5 percent in fiscal year 2023.[17] We do not see these cost trends lessening in FY 2027 or the foreseeable future. On the contrary, in the face of continued economic and supply chain uncertainty stemming from tariffs, direct payment cuts resulting from the One Big Beautiful Bill Act (OBBBA),[18] and expected coverage losses from OBBBA and other coverage changes, we expect these conditions to substantially worsen in 2027.

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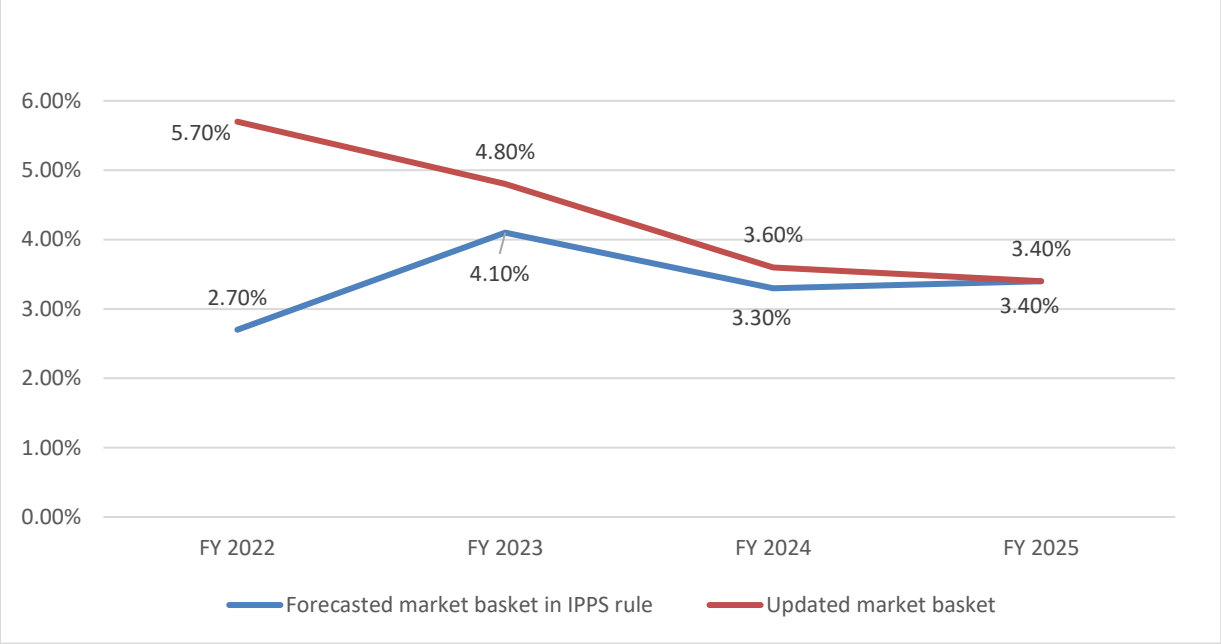
[14] Hospitals that successfully report quality measures and are meaningful users of electronic health records are eligible for the full payment update.
[15] Kaufman Hall March 2026 National Hospital Flash Report. May 18, 2026. https://www.kaufmanhall.com/sites/default/files/2025-05/KH-NHFR-Report_Mar_2025_Metrics.pdf.
[16] MedPAC March 2026 Report to Congress. Chapter 3.
[17] Note: AAMC margin data for 2024 are not yet available for comparison to MedPAC's 2024 all-IPPS hospital Medicare margins. Source: AAMC analysis of FY2023 Hospital Cost Reporting Information System (HCRIS), July 2025 release. AAMC membership data, September 2025.
[18] P.L. 119-21 (July 4, 2025).

The insufficiency of the FY 2027 proposed market basket update is compounded by historical underestimates by CMS of actual cost increases that began with and persisted after the COVID-19 pandemic. As shown below in Figure 1, in comparing forecast data CMS used at the time of the final rule with updated market basket data, it is clear that although the gap has begun to narrow, CMS has consistently underestimated market basket updates in recent years, with a staggering three percentage point underestimate in FY 2022.

Figure 1: Forecasted Regulation Market Basket Updates vs. Updated Market Basket Updates, FYs 2022-2025



Source: Forecasted market basket updates are from the respective fiscal year IPPS final rule. Updated market basket updates for FYs 2022-2024 are from CMS published 2024Q4 forecast with historical data through 2024Q3 and updated market basket update for FY 2025 is from CMS published 2025Q4 forecast with historical data through 2025Q3 (Summary Web Tables available at https://www.cms.gov/data-research/statistics-trends-and-reports/medicare-program-rates-statistics/market-basket-data).

The gap between forecasted and actual market data underscores that CMS continues to underestimate actual cost increases and thus does not accurately account for true increases in hospital input costs. For example, in FY 2022, hospitals experienced record high inflation and significant increases in the costs of labor, drugs, and equipment, yet CMS's market basket update was wholly inadequate in accounting for these costs. CMS calculates the market basket based on forecasts rather than actual labor and supply cost increases, thus failing to incorporate the challenging circumstances brought on by unprecedented labor, supply, and drug cost increases. Therefore, using the current methodology to calculate the payment update inaccurately estimates the financial strain hospitals have experienced and will continue to experience in FY 2027 and is insufficient to address these cost increases. Furthermore, the effect of underestimating the market

basket is amplified due to the compounding nature of payment updates, with each year's payment update building on the previous year. We recommend CMS look to alternative data sources that better reflect true labor and input cost increases in a more timely manner. At a minimum, CMS must provide additional publicly available data on the assumptions and inputs that go into developing a market basket update.

With tariffs still in effect and impacting the costs for many supplies and products purchased by hospitals, hospitals will inevitably experience significant price increases in FY 2027 on items such as pharmaceuticals, medical supplies, medical devices, and building materials used in capital projects.[19] Other common supplies and personal protective equipment, such as gowns, gloves, and masks, are also subject to tariffs and are routinely imported.[20] Last fall, the Department of Commerce launched a Section 232 investigation to determine whether to impose tariffs on personal protective equipment, medical consumables, and medical equipment, including medical devices.[21] Tariffs on these critical goods would raise the cost of patient care and research, worsen existing financial pressures, and increase the risk of shortages for essential clinical and laboratory supplies. The administration has also imposed tariffs on pharmaceuticals and pharmaceutical ingredients through this same authority.[22] CMS must ensure that in its final market basket update for FY 2027, it appropriately includes the cost increases attributable to tariffs.

In addition to the inadequate market basket update of 3.2 percent, CMS includes a higher-than usual total productivity (TFP) adjustment of negative 0.8 percentage points, which reduces the net payment update to 2.4 percent. The proposed productivity adjustment is the largest CMS has used since FY 2019 and is the second largest in the 15 years for which CMS has published data.

Productivity adjustments are based on a 10-year rolling average of data CMS acquires from the Bureau of Labor Statistics (BLS). Because the productivity adjustment has increased significantly, CMS should evaluate how the rolling average experienced such a significant increase when compared with the productivity adjustments of 0.5 percentage points or less in three of the last five years. Given the marked increase in the productivity adjustment, it is likely that one or two years of significantly high, outlier values contributed to the 10-year rolling average being 0.8 percentage points.

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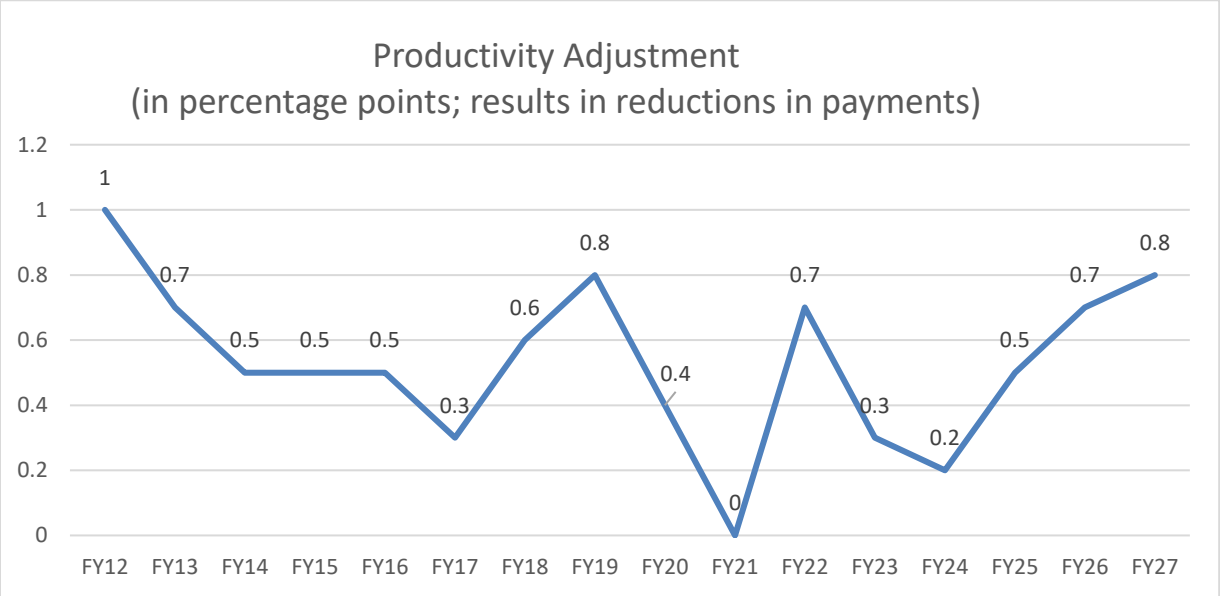
[19] Healthcare Dive. Tariffs send healthcare industry into 'unchartered waters'. April 4, 2025. https://www.healthcaredive.com/news/tariffs-aha-med-tech-brace-for-impact/744496/.
[20] Axios. Hospitals Begin to Grapple with Tariff Fallout. May 1, 2025. https://www.axios.com/2025/05/01/hospitals-struggle-tariff-impacts
[21] Department of Commerce. Notice of Request for Public Comments on Section 232 National Security Investigation of Imports of Personal Protective Equipment, Medical Consumables, and Medical Equipment, Including Devices. 90 FR 46383. Sept. 26, 2025.
[22] Notice of Request for Public Comments on Section 232 National Security Investigation of Imports of Pharmaceuticals and Pharmaceutical Ingredients. 90 FR 15951. April 16, 2025.

Figure 2: FYs 2012-2027 Productivity Adjustments



Source: CMS actual regulation market basket updates file. FY 2027 productivity adjustment is from proposed rule. Productivity adjustments are subtracted from the market basket update to yield the payment update—therefore, larger values in the graph indicate larger reductions.

We question the relevance of the TFP adjustment—which measures economy-wide, nonfarm private business gains in productivity—to the hospital payment update. The adjustment bears little relationship to the operational realities of hospitals, especially academic health systems that provide highly specialized, labor-intensive care while simultaneously fulfilling education and research missions. Applying this adjustment to hospitals fails to account for the fundamental differences between hospitals and other industries, where productivity gains might be more easily achieved. Providing labor-intensive clinical care to patients cannot be automated in the same way that businesses in other sectors, such as manufacturing, are able to realize productivity increases. This conclusion has been supported by the CMS chief actuary in the past, who has found that "hospital TFP growth [is] below BLS estimates of nonfarm business TFP growth" and that "other published estimates of hospital productivity also seem to indicate that hospitals are unable to achieve the productivity gains of the general economy over the long run."[23] Therefore, applying this economy-wide adjustment to the hospital payment update overcorrects for productivity and further suppresses the annual payment update. While we acknowledge that the TFP adjustment is mandated by statute, these disproportionately high downward adjustments to the market basket are further compounding the effect of the inadequate annual payment updates. CMS must account for this phenomenon when calculating its annual hospital payment update.

[23] Memo from CMS Chief Actuary. Hospital Multifactor Productivity: An Updated Presentation of Two Methodologies Using Data through 2019. June 2, 2022.

Given the low payment update proposed for FY 2027, coupled with persistent increases in hospitals costs that are expected to worsen as tariffs take effect, we call on CMS to explore other methodologies or data sources that more accurately reflect these costs for its annual market basket update.

MEDICARE DSH AND UNCOMPENSATED CARE PAYMENTS

Medicare DSH payments are a vital source of support for academic health systems and teaching hospitals, which provide nearly a third of all of uncompensated care (UC) compared with all hospitals nationally.[24] The DSH payments these hospitals receive enable them to continue to provide care to their low-income patients and offset their high levels of uncompensated care. The AAMC is concerned that CMS' methodology for calculating total Medicare DSH payments results in amounts that are not keeping pace with the millions of individuals expected to lose coverage, which will directly increase hospitals' UC costs.

Since the Affordable Care Act's (ACA's) revised DSH methodology went into effect in 2014, CMS makes DSH payments to hospitals in two forms: as empirically justified DSH payments and as UC-based DSH payments. A hospital's empirically justified DSH payment amount is 25 percent of the per discharge DSH add-on payment it would have received using the traditional DSH formula. The UC-based DSH payment is calculated as the product of three factors: Factor 1, which represents 75 percent of aggregate projected traditional DSH payments across all eligible hospitals; Factor 2, which is equal to one minus the change in the uninsured rate from 2013 (the year before the ACA's coverage expansions took effect) to the fiscal year in question; and Factor 3, which represents each DSH hospital's UC costs as a proportion of all DSH hospitals' UC costs. By multiplying factors 1 and 2, CMS arrives at the total pool of UC-based DSH payments. Multiplying this pool by each hospital's factor 3 results in the hospital's individual UC-based DSH payment. Each of these factors is dependent on the data sources and assumptions CMS uses to calculate them and can vary significantly if those sources or assumptions change.

For FY 2027, CMS estimates Factor 1 (the total pool of UC-based DSH funds before it is reduced to reflect the change in the uninsured rate) to be $11.477 billion (p.19483). CMS estimates that 9.1 percent of individuals will be uninsured in FY 2027, resulting in a Factor 2 of 0.65 (p. 19485). After Factor 2 is applied to reflect the changes in the uninsured rate, CMS calculates a total UC-based DSH pool of $7.46 billion. In comparison to the finalized FY 2026 UC-based payment pool, this marks a decrease of $250 million in UC-based payment funds available for distribution to DSH hospitals.[25] The UC-based payment amounts available each

[24] Source: AAMC analysis of a special tabulation using FY2024 American Hospital Association Annual Survey Database. AAMC membership data, December 2025

[25] However, we note that in many recent years, when CMS has updated its Factor 1 and Factor 2 calculations, the UC pool has decreased from the proposed to final rule.

year steadily decreased from FYs 2020 to 2025, with a dramatic decline between FY 2021 and FY 2022. This has raised concerns around the transparency of data used and the inability to validate the accuracy of CMS' overall DSH projections without having full visibility into the inputs that determine DSH payments. For example, various policy changes with significant effects on health care utilization and coverage will affect both the Factor 1 and Factor 2, but it is unclear how and to what extent they have been incorporated into CMS' calculation of these factors. These policy changes affect the number of inpatient discharges, hospital case mix, and Medicaid enrollment, such as in the case of recent legislative and regulatory changes that will result in Medicaid coverage losses.

These reductions in DSH payments have proved problematic for hospitals as they continue to incur significant amounts of uncompensated care, face unprecedented cost and workforce shortages, and brace for coverage losses and associated increases in uncompensated care resulting from regulatory and legislative changes. In particular, hospitals will face significant headwinds in 2027 onward due to policy changes that will cause individuals to lose or forgo health insurance, increase the uninsured rate, and thus increase hospital UC costs. These changes include:

- Medicaid, Children's Health Insurance Program, and ACA Marketplace changes in the OBBBA that will result in 5.2 million people losing insurance coverage by 2027 alone.[26]
- Reductions in ACA Marketplace enrollment, leading to five and a half million individuals losing ACA coverage in 2026 and an additional nearly four million losing coverage in 2027, per the Congressional Budget Office.[27]
- An additional 1.2 to 2 million ACA marketplace enrollees expected to lose coverage in 2027 as a result of the recently finalized Notice of Benefit and Payment Parameters rule.[28]
- Up to 1.8 million people losing coverage in 2026 due to CMS' Marketplace Integrity and Affordability final rule.[29]

Going forward, CMS must ensure robust, accurate, and transparent calculations of DSH payments so that they remain a sustainable source of funding for hospitals treating low-income patients and these hospitals are protected from large swings attributable to fluctuations in the uninsured rate or inaccuracies in CMS' projections.

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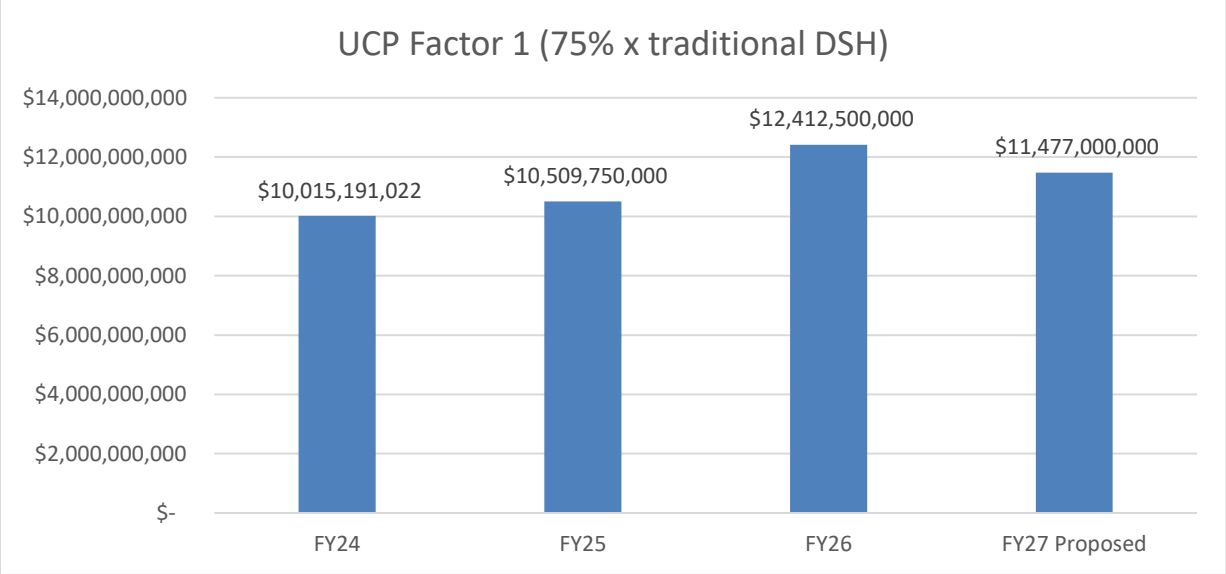
[26] New CBO Health Coverage Estimates of Budget Reconciliation Law. Georgetown Center for Families and Children. August 14, 2025.
[27] https://www.cbo.gov/system/files/2026-02/51298-2026-02-healthinsurance.pdf
[28] Patient Protection and Affordable Care Act, HHS Notice of Benefit and Payment Parameters for 2027; and Basic Health Program. 91 FR 29526. May 20, 2026.
[29] Patient Protection and Affordable Care Act; Marketplace Integrity and Affordability. 90 FR 27074. June 25, 2025.

Provide Greater Transparency Around Factor 1 Calculation, including "Other" Factors Used to Calculate Factor 1

CMS' projection of Factor 1 is nearly $1 billion lower than the FY 2026 IPPS final rule Factor 1 (see Figure 3 below). This almost 9 percent year-over-year decrease is a stark departure from recent trends, in which Factor 1 values increase annually. Although Factor 2 is understandably higher than in FY 2026 (due to the expected increase in the uninsurance rate), the lower Factor 1 results in a smaller UC-based payment pool for FY 2027. This suggests incongruence between the directionality of the Factor 1 and Factor 2 values that CMS must further examine, **as it ultimately results in fewer UC-based payments for DSH hospitals in a year where they are expected to have more UC costs.** Additionally, as we outline below, CMS continues to be opaque about the assumptions that go into its Factor 1 calculation, which renders it nearly impossible to validate its accuracy.

Figure 3: Factor 1 Values, FYs 2024-2027



Source: CMS IPPS final rules, FY 2024-2026; CMS IPPS proposed rule, FY 2027.

CMS utilized the Office of the Actuary's (OACT's) January 2026 Medicare DSH estimates that were based on the December 2025 Hospital Cost Report Information System (HCRIS) update and the FY 2026 IPPS/LTCH PPS final rule impact file to estimate Factor 1 (p.19483). CMS bases these estimates on OACT's Part A benefits projection model which begins with a FY 2023 baseline for Factor 1 then trends that number forward for each subsequent year, through FY 2027, updated using several additional factors including annual Medicare payment updates, discharges, case mix, and "other" factors (p.19483).

Notably, in the FY 2027 IPPS proposed rule, some of these factors have inexplicably decreased when compared with the same factors for the same years used in CMS' FY 2026 IPPS

calculation, ultimately resulting in a smaller Factor 1 projection for FY 2027. For example, in the FY 2026 IPPS final rule, CMS used a value of 1.0027 for FY 2026 in the "other" category, while this value for the same year has dropped to 0.9675 in the FY 2027 rule (see Figure 4 below). It is unclear what data or assumptions CMS would have changed to result in such a decrease in the "other" factor.

Figure 4: Factors Applied for FY2024 Through FY 2027 to Estimate Medicare DSH Expenditures Using FY 2023 Baseline

FY	IPPS Market Basket Update	Discharges	Case-Mix	Other (Value in 2026 Rule in Parentheses)	Total	Estimated DSH Payment (in billions)
2024	1.031	1.002	1.0000	1.0279 (1.0310)	1.0620	13.701
2025	1.029	1.022	1.0090	0.9937 (1.0029)	1.0546	14.449
2026	1.026	1.019	1.0075	0.9675 (1.0027)	1.0188	14.721
2027	1.024	1.009	1.0050	1.0015	1.0395	15.303

Source: FY 2027 IPPS Proposed Rule. Highlighted cells compare the "other" factor used in the FY 2027 rule with the "other" factor used in the FY 2026 final rule (values in parentheses), demonstrating underestimate of other factor in FY 2027 rule for the same underlying years.

Historically, it has been unclear what CMS includes in the "other" factor that goes into the Factor 1 calculation because CMS has not provided a detailed breakdown of its calculation of the "other" factor. In the rule, CMS provides a nebulous explanation of what it has incorporated into the other factor, saying it includes "the difference between the total inpatient hospital discharges and IPPS discharges and various adjustments to the payment rates that have been included over the years but are not reflected in the other columns" (p. 19484). In previous years, CMS has said that the other column factor incorporates the effect of estimated changes in Medicaid enrollment.[30] CMS does not reference changes in Medicaid enrollment being built into its Factor 1 estimate for FY 2027. CMS' explanations of what is in the other column change year after year, suggesting a lack of transparency and variability in what goes into a factor that is a major contributor to determining total UC-based DSH payments.

The AAMC does not believe that CMS is providing sufficient transparency around the data sources or calculations used in the application of these "other" factors. In other words, not all the factors considered as "other" are known or understood by stakeholders to appropriately replicate

[30] 90 FR 36536, 36887 (Aug. 4, 2025).

CMS' calculations. The lack of transparency in the calculations of Factor 1 is further underscored by the year-over-year variability in the "other" factor, which highlights the need for CMS to be transparent in its assumptions and calculations so that stakeholders can replicate CMS' Medicare DSH projections.

As mentioned in our FY 2022 IPPS comment letter, we continue to echo our concerns that the information being used in the "other" factor is not accurately accounting for the effects of the COVID-19 PHE.[31] Additionally, it is unclear how this "other" factor takes into account changes in Medicaid coverage resulting from Medicaid policy changes. **The AAMC strongly urges CMS to provide greater transparency on how OACT determines the "other" factor—including both the calculation and individual numbers included in the estimate—so that stakeholders can adequately understand and assess the appropriateness of the Factor 1 amount and the impact of external factors on the Factor 1 calculation in FY 2027.** One potential way of addressing this issue would be to disaggregate the "other" factor into the main variables that affect its value. CMS could show the impact of each of these named factors and its weight in the "other" factor with a residual for all other items that have less of an impact on the final value. With this information, stakeholders can determine whether CMS' methodology appropriately calculates Medicare DSH payments or whether revisions are needed to accurately estimate and trend forward historical Medicare DSH payment amounts.

Account for Expected Higher Rates of Uninsured Individuals Due to Policy Changes Leading to Coverage Losses in the Calculation of Factor 2

Factor 2 of the uncompensated care methodology is multiplied by Factor 1 to determine the total available UC-based payment pool. This is determined annually by a percentage amount that represents the percent change in the rate of uninsured individuals in FY 2013 and the estimated percent of uninsured in the most recent year where data is available. OACT determines Factor 2 based on data from the National Health Expenditures Accounts (NHEA). CMS is proposing to continue to use the same methodology to calculate Factor 2 as the agency has in previous years. To calculate the uninsured rate in FY 2027, CMS uses a weighted average of the projected uninsured rates in calendar years 2026 and 2027.

CMS uses the NHEA's uninsured rate projections, as certified by the Office of the Actuary.[32] These projections predated the passage of the OBBBA and other significant regulatory changes and therefore do not fully incorporate the most up-to-date data on the coverage losses that will occur because of the law. We do not feel that the current proposal for Factor 2 takes into account the magnitude of the dramatic increase in uninsured rates that will occur in FY 2027 due to various policy changes that will result in coverage losses. As we noted previously, coverage

[31] AAMC, Comments to CMS on the FY 2022 IPPS Proposed Rule (June 2021).
[32] Paul Spitalnic, Chief Actuary. Certification of Rates of Uninsured. February 27, 2026.

changes in the OBBBA, as well as CMS regulations related to the ACA Marketplace, will result in millions of people losing health insurance coverage. In previous years, CMS underestimated the impact of disenrollments, such as the effect of Medicaid redeterminations on the uninsured rate. With this in mind, we urge CMS to consider alternative data sources or calculations that more accurately account for the expected increase in the uninsured rate for FY 2027. We are concerned that the current data from the NHEA that CMS is proposing to utilize for Factor 2 is not up to date. **If CMS chooses to continue with its proposal of utilizing the NHEA data, which do not appear to be accurately accounting for coverage losses, then CMS must ensure that its estimates are accurate and up to date.**

Include Medicaid Section 1115 Waiver Days in Medicare DSH Calculation

In calculating empirically justified DSH payments, CMS uses each hospital's DSH adjustment percentage, which it multiplies by its geographic and case mix adjusted MS-DRG payment to determine the per-discharge DSH amount. The DSH adjustment percentage is derived from the disproportionate patient percentage (DPP), which is the sum of two fractions—the Medicaid fraction and the Medicare fraction. CMS previously finalized a policy, effective in FY 2024 (hereinafter "the 2024 policy", to exclude from the numerator of the Medicaid fraction of the DPP inpatient days of patients whose hospital costs are paid for with funds from an uncompensated or undercompensated care pool authorized by a Section 1115 demonstration.[33] When the previous administration proposed this policy, the AAMC submitted comments expressing its opposition to this proposal.[34] CMS' rationale in instituting this policy was that patients whose care is covered by payments from a UC pool are not receiving full Medicaid coverage and are therefore not Medicaid patients. CMS has previously estimated that this policy change costs the six affected states $349 to $438 million in lost DSH payments annually.[35] **As we outline below, we urge CMS to reverse this policy and to include Section 1115 waiver days related to UC pools in the Medicaid fraction as a matter of law and policy.**

First, Section 1115 waivers are tools that states leverage to provide coverage to their low-income populations. CMS should defer to states' choices on whether to expand Medicaid under the ACA or provide coverage for health care services through other avenues. Six states, primarily those that have not expanded Medicaid under the ACA, have chosen to provide coverage to their populations by funding a UC pool through a Section 1115 waiver. Excluding these patients from the numerator does not accurately capture the population of Medicaid eligible individuals who receive inpatient care. Individuals counted in uncompensated or undercompensated care pools are still receiving medical assistance under an 1115 waiver and therefore are Medicaid beneficiaries. By excluding these days from the Medicaid fraction, CMS is underrepresenting the

[33] FY 2024 IPPS Final Rule. 88 FR 58640. August 28, 2023.
[34] AAMC Letter to CMS. April 11, 2023.
[35] Medicare Disproportionate Share Hospital (DSH) Payments: Counting Certain Days Associated With Section 1115 Demonstrations in the Medicaid Fraction. 88 FR, 12623, 12636. February 28, 2023.

Medicaid days of the hospitals in these states, resulting in lower empirically justified DSH payments. Such a policy disproportionately penalizes non-expansion states, such as Florida, Tennessee, Kansas, and Texas, that rely on these uncompensated care pools to cover their uninsured populations.

Secondly, in addition to the most direct consequence of hospitals in these states having their DSH payments being reduced, there are other indirect consequences of this policy. For one, eligibility for various federal and state programs is linked to a hospital's DPP or DSH adjustment percentage, which means eligibility for these other benefits could be at stake, ultimately harming the patients that rely on these programs. Moreover, CMS' policy would affect not just hospitals in the six states with uncompensated care pools but hospitals nationally.[36] As described previously in this letter, CMS' Factor 1 that it uses in calculating UC-based Medicare DSH payments is based on its estimate of 75% of traditional DSH payments in a given year. If traditional DSH payments decrease by $400 million or more, this will result in a decrease in the Factor 1 as well, ultimately harming all hospitals that receive UC-based DSH payments.

Finally, if CMS were to reverse course and undo the 2024 policy, it would be acting consistently with multiple courts' interpretation of the Medicare statute. Multiple courts have previously held that once CMS approves a state's Section 1115 waiver, the days associated with that waiver must be included in the Medicaid fraction. For example, in *Forrest General Hospital v. Azar*, the U.S. Court of Appeals for the Fifth Circuit said, "If patients underlying a given day were Medicaid-eligible or 'receive[d] benefits under a demonstration project,' then that day goes into the numerator. Period."[37] Furthermore, the U.S. District Court for the Northern District of Texas found the 2024 policy to be unlawful and vacated it.[38] That case was subsequently reversed and remanded by the U.S. Court of Appeals strictly on jurisdictional grounds but not on the underlying merits of the argument.

COST ALLOCATION PRINCIPLES RELATED TO ORGAN ACQUISITIONS

CMS proposes to codify a change to hospital cost reporting practices specific to how hospitals report overhead costs related to organ acquisitions (p. 19744). **The AAMC supports CMS' broader goal of ensuring payment accuracy and reducing inappropriate Medicare spending. We have significant concerns that the overhead allocation proposal would not accurately reflect the reasonable costs of delivering highly complex transplantation services to Medicare beneficiaries.**

[36] CMS has previously stated that the policy affects hospitals in Florida, Kansas, Massachusetts, New Mexico, Tennessee, and Texas.
[37] Forrest General Hospital v. Azar. 926 F. 3d 221, 229-230 (5th Cir. 2019).
[38] Baylor All Saints Medical Center, et al. v. Becerra. No. 4:24-cv-00432-P. August 15, 2024.

AAMC member academic health systems and teaching hospitals provide a disproportionate amount of transplant care and are thus vital to the nation's organ acquisition and transplant systems. AAMC member hospitals comprise the majority of transplant-performing institutions nationwide. In 2024, they accounted for 68% of hospitals performing kidney transplants, 74% performing liver transplants, 78% performing heart transplants, and 85% performing lung transplants.[39] The investments AAMC member institutions make into their transplant programs allow them to perform some of the most advanced and cutting-edge procedures.
Examples of academic health systems having life-changing impact from complex and advanced procedures are numerous. In 2023, an AAMC member institution provided the first total-eye and partial-face transplant, and in 2025, two AAMC member institutions jointly performed the first human bladder transplant.[40] CMS' proposal would result in these types of hospitals, which provide highly specialized lifesaving services, not being adequately compensated for the overhead costs associated with procuring and transplanting organs. Ultimately, this proposal, coupled with other proposed changes to reimbursement for organ acquisition costs and reasonable cost reimbursement, would erode the financial stability of the providers offering these services and threaten access to these critical services for transplant recipients. **Therefore, for the reasons we outline below, we urge CMS to withdraw the proposed overhead cost allocation proposal.**

Under Medicare reimbursement methodologies, while most services costs incurred by IPPS hospitals are reimbursed through MS-DRG-based prospective payment, certain limited costs are reimbursed on a reasonable cost basis. These costs include organ acquisition costs and nursing and allied health professions education costs. A transplant hospital can perform organ acquisitions in the hospital or can purchase organs from an external organ procurement organization. In the latter case, the costs of purchasing the organ are included on the Medicare cost report and reimbursed on a reasonable cost basis. The costs that are used to determine reasonable cost reimbursement are based on the reported costs on the Medicare cost report and are separated into direct and indirect costs. CMS proposes to formally codify a change to its cost reporting guidance so that hospitals no longer report certain costs under their indirect costs as administrative and general (A&G) expenses. Specifically, CMS proposes to no longer allow hospitals to report the costs of purchased services, such as organs acquired from an organ procurement organization, or the cost of a CAR T-cell biologic, from the accumulated cost statistic, which is then used to allocate indirect costs across cost centers. CMS states that it believes when the cost of the organ purchase from the OPO is included in the direct cost category, it already includes the overhead costs incurred by the OPO and that including the cost

[39] AAMC analysis of FY2024 American Hospital Association Annual Survey Database. AAMC membership data, December 2025. Data reflect short-term, general, non-federal hospitals. Data for AAMC-member teaching hospitals reflect integrated and independent AAMC members.
[40] AAMC. The impact of federal actions on academic medicine and the U.S. health care system. June 11, 2025.

in the accumulated cost statistic could overpay the transplant hospital for overhead costs, i.e., A&G costs (p. 19745).

We disagree with this characterization, which does not account for the complexities of overhead at large academic health systems and would under reimburse transplant hospitals for the costs associated with procuring organs. CMS' assumption that transplant hospitals do not incur overhead costs because those costs are borne only by the OPO is inaccurate. On the contrary, transplant hospitals bear substantial administrative, financial, and operational costs to support organ acquisition and transplantation. Examples of these costs are program management, IT infrastructure supporting electronic records documentation and billing, transplant coordination, compliance infrastructure, financial oversight, regulatory oversight and management, donor and financial management, and other system-level functions that are captured through the accumulated cost statistic that is used to allocate indirect costs. Although an organ might be purchased externally, the transplant hospital still takes on administrative burden associated with procuring, managing, and utilizing that organ within a transplant program.

We are concerned that the proposed cost allocation change could result in Medicare Administrative Contractors disallowing legitimate patient care related costs, thereby reducing Medicare reimbursement for transplant hospitals in ways that do not reflect the actual cost of care at these institutions. **Therefore, the AAMC urges CMS to withdraw this proposal.**

MEDICARE WAGE INDEX - LOW WAGE INDEX POLICY

CMS has been interested in addressing disparities between high and low wage index hospitals in the current wage index calculation.[41] As part of this effort, CMS finalized a low wage index policy which directly raised the wage index of the lowest quartile wage index hospitals by half the difference between the 25th percentile wage index value and the hospital's individual wage index. The goal of this policy was to provide an opportunity for low wage index hospitals to increase employee compensation so it may then be permanently reflected in future wage index data. However, while this policy raised the wage index values of the bottom quartile hospitals, it did so at the expense of all hospitals nationwide due to a budget neutrality adjustment.
The low wage index policy was in place from FY 2020 until FY 2024. During this time, the low wage index policy and associated budget neutrality adjustment faced multiple legal challenges.[42,43] Prior to the release of the FY 2025 IPPS final rule, the U.S. Court of Appeals for the D.C. Circuit ruled that CMS did not have the authority to implement the low wage index policy or the associated budget neutrality adjustment.[44] Based on the court's July 23, 2024, decision in *Bridgeport Hospital v. Becerra*,[45] CMS reversed the continuation of the low wage

[41] 84 FR 42044
[42] Bridgeport Hosp. v. Becerra, 589 F. Supp. 3d 1 (D.D.C. 2022)
[43] Kaweah Delta Health Care Dist. v. Becerra, 1:21-cv-01422 AWI SKO (E.D. Cal. Sep. 22, 2021)
[44] Bridgeport Hosp. v. Becerra, No. 22-5249 (D.C. Cir. Jul. 23, 2024)
[45] *Id.*

index policy and associated budget neutrality adjustment for FY 2025 and then subsequently, discontinued the policy permanently in the FY 2026 IPPS final rule.[46] As a result, CMS has undertaken rulemaking to address the transition away from the low wage index policy to mitigate harm to low wage index hospitals.

Identify Factors and Policies to Support Low Wage Index Hospitals Without Impacting High Wage Index Hospitals Through Budget Neutrality

In this year's proposed rule, CMS is proposing to continue the transitional policy for hospitals significantly impacted by the removal of the low wage index policy in a budget neutral manner. (P.19476). The AAMC continues to support CMS' removal of the budget neutrality adjustment associated with the low wage index policy as we have historically been critical of implementing policies to support low wage index hospitals at the expense of higher wage hospitals.[47] Further, the AAMC continues to urge the agency to not include a budget neutrality adjustment in the transition policy as CMS did not include such an adjustment in the FY 2025 IPPS IFC.[48] Despite this, we support CMS' goal to address the difficulties faced by low wage index hospitals resulting in wage disparities and if the agency decides to consider alternative policies that improve the standing and ensure adequate reimbursement to low wage index hospitals, it should do so without negatively impacting payment to other hospitals. Further, we continue to encourage CMS to investigate the specific factors causing these wage disparities as a first step in the policy development process.[49] This will allow the agency to evaluate how the wage index was impacted following the original implementation of the low wage index policy, the disruptions from the COVID-19 public health emergency, and what other factors may be contributing to the disparities in wage index values. This understanding of outside factors will allow CMS to develop more precise and impactful wage index policies.

NEW TECHNOLOGY ADD-ON PAYMENT

Collaborate With Stakeholders to Ensure Beneficiaries Have Timely Access to New Technologies

CMS is proposing to continue the traditional new technology add-on payments (NTAP) for technologies that remain eligible in FY 2027. The NTAP is a supplemental payment to the IPPS MS-DRG payment designed to account for a hospital's use of new and innovative technologies in patient care. New technologies that are approved to receive this designation enable hospitals to receive an additional payment above the standard Medicare Severity Diagnosis-Related Group (MS-DRG) payment amount for that technology. This is a temporary payment to offset the high prices associated with new and innovative technologies. Applicants must meet a set of three criteria to be eligible for this payment, including a newness, a cost, and a substantial clinical

[46] 90 FR 36536
[47] AAMC, Comments to CMS on the FY 2025 IPPS IFC (Nov. 2024)
[48] AAMC, Comments to CMS on the FY 2026 IPPS Proposed Rule (June 2025)
[49] AAMC, Comments to CMS on the FY 2025 IPPS Proposed Rule (June 2024)

improvement criterion. CMS has also offered the option for device manufacturers to apply for the NTAP through an alternative pathway, which allows NTAP applications to use Food and Drug Administration (FDA) approval as a proxy for some of the criteria under the traditional pathway. However, CMS is now proposing to repeal this alternative pathway as well as a similar pathway under the Outpatient Prospective Payment System (OPPS) known as the device pass-through policy beginning with new applications in FY 2028. CMS is concerned that the pathway relies on a more limited evidentiary review and may not consistently ensure meaningful clinical benefit. (P.19397).

Further, CMS and FDA recently announced a new coverage pathway named RAPID (Regulatory Alignment for Predictable and Immediate Device), which would allow CMS and the FDA to work together with innovators, earlier in the technology development lifecycle so that evidence generated for FDA review can also support Medicare coverage decisions.[50] By aligning regulatory and coverage expectations in advance, the RAPID coverage pathway aims to reduce delays that have historically occurred between FDA market authorization and Medicare national coverage determinations. The AAMC supports CMS' effort to work with the FDA on aligning evidence needs between the agencies to ensure beneficiaries have timely access to new innovations and technologies that can improve patient care and overall health. However, CMS must ensure that changes to different coverage pathways do not have the unintended consequence of impacting Medicare beneficiaries' timely access to new or improved technologies and treatments. CMS should also be mindful that any policy changes to these coverage pathways may impact manufacturer business decisions and inadvertently limit advancements in the research and development of new technology and patient access. **We ask that CMS continue to work with relevant stakeholders on identifying best practices to streamline the approval process while maintaining sufficient review of clinical benefit.**

Z-Code Severity Level Changes

Maintain Accurate Coding for Patients Requiring More Resources to Care for Due to Broader Health Needs

In the FY 2024 and FY 2025 IPPS final rules, CMS finalized severity level changes for ten Z-codes used to describe homelessness, housing instability, and housing inadequacy. Specifically, CMS altered the severity level of these codes from non-complication or non-comorbidity (non-CC) to complication or comorbidity (CC) to account for the increased resources needed to care for patients experiencing housing challenges. In the current proposed rule, the agency is proposing to change the severity level for these codes from CC back to non-CC. (P.19370). CMS uses a standard mathematical process for establishing severity levels that evaluates each diagnosis code to determine the extent to which its presence as a secondary diagnosis results in

[50] https://www.fda.gov/news-events/press-announcements/cms-and-fda-announce-rapid-coverage-pathway-accelerate-patient-access-life-changing-medical-devices

increased hospital resource use. In CMS' original proposals, the agency found an increased use of resources for these patients.[51,52] CMS continues to find similar findings in its calculations within the current proposed rule, which suggests there is an increase in hospital resource use when these Z-codes are used as a secondary diagnosis code. However, CMS states that the severity level change should instead be based on resource use associated with the treatment of an underlying medical condition or illness rather than social circumstances. (P.19370). As an alternative CMS highlighted its belief that additional complexity added by social and economic circumstances should be addressed by separately coding those diagnoses that describe acute exacerbation or deterioration of an underlying medical condition or illness, rather than the social circumstance. (P. 19371).

Dropping the severity level for these Z-codes would fail to account for the additional complexity associated with caring for these patients and potentially result in lower reimbursement to providers who need to use additional resources to provide this care. **The AAMC asks that CMS not finalize this policy change as proposed.** Research studies have found increased spending and an additional need for resources to care for patients experiencing homelessness, unstable housing, and inadequate housing. Overall, homelessness has been found to be associated with $829 higher hospital cost of care per inpatient stay and 45 percent longer length of stay, which largely take place outside of intensive care. These costs can be even greater for certain subpopulations within this group.[53] This policy allows for the additional resources used by providers to care for these patients to be accurately reflected in coding as these patients are more expensive to treat, which CMS' calculations have confirmed. (P.19370). Should CMS decide to move forward by changing the severity level for these Z-codes, the agency should provide guidance to providers on evaluating and separately coding diagnoses that show acute exacerbation or deterioration of an underlying medical condition or illness due to additional complexity added by homelessness and housing instability or inadequacy.

Lastly, many of the factors influencing an individual's overall health and well-being take place outside the health care delivery system. The Make America Healthy Again initiative seeks to address and improve many of these factors to support American's health. Nonmedical upstream drivers of health, such as safe environments including safe housing, access to nutritious food, and physical activity, greatly impact well-being. To better understand and address patient needs to improve America's health, accurate coding and incentives to ensure accurate coding of these upstream drivers are needed. In prior comments, the AAMC has raised concerns that the cap on the number of diagnosis codes allowed to be included on Medicare inpatient claims may hamper Z-code reporting due to competing reporting priorities for both payment and quality measures. AAMC analysis revealed that 18.8 percent of inpatient claims reached the maximum limit of 25

[51] 88 FR 58640
[52] 89 FR 68986
[53] Onyango, R., Baker, M., & Hahn, E. (forthcoming June 2026). "Association between reported homelessness and inpatient resource use for Medicare beneficiaries." *Journal of Health Care for the Poor and Underserved*.

diagnoses that can be reported on the claim.[54] To ensure continued visibility and accuracy in coding upstream drivers to improve America's health, we urge CMS to explore ways to encourage and incentivize the use of Z-codes.

HIGH-COST OUTLIER PAYMENTS

Ensure the Operating Outlier Threshold for High-Cost Cases Uses Inputs That Accurately Capture Recent Cost and Charge Trends

The AAMC urges CMS to evaluate the factors affecting the calculation of the operating fixed-loss amount to ensure accuracy in operating outlier payments and that hospitals are adequately reimbursed for high-cost cases. For FY 2027, CMS proposes a fixed-loss amount (or outlier threshold) of $51,704 for operating cases, a 28 percent increase from the finalized FY 2026 threshold of $40,397. Outlier payments are intended to cover a portion of the expenses associated with extraordinarily high-cost cases. A hospital qualifies for an outlier payment for a given case if the costs of the case exceed the fixed-loss cost threshold, which is the sum of the hospital's Medicare IPPS payments (base DRG payments plus add-on payments) and the outlier threshold of $51,704. For FY 2027, CMS sets the fixed-loss cost threshold to target total outlier payments at 5.14 percent of total IPPS payments. An increase in the outlier threshold, as proposed for FY 2027, results in fewer IPPS cases being eligible for high-cost outlier payments.

To calculate the outlier threshold for a fiscal year, CMS uses charges from historical claims data (2025 data for the FY 2027 proposed rule) and updates the charges with a charge inflation factor. CMS converts these charges to costs using hospital-specific cost-to-charge ratios (CCRs), which are derived from 2025 data and adjusted for expected year-over-year changes in CCRs using a CCR adjustment factor. To calculate the charge inflation and the CCR adjustment factors that are used to trend the 2025 data forward, CMS analyzes the change in charges and CCRs from 2024 to 2025. CMS uses the increase in charges during this one-year period and then doubles it to trend forward 2025 charges to 2027. The agency uses a similar process for the CCR adjustment factor, looking at CCR changes during a one-year period (2024 to 2025), then doubling that adjustment and applying it to 2025 CCR data to derive estimated 2027 CCRs. Due to the two-year lag in the data being used and the fact that charges and costs can change significantly from year to year, these estimates are highly prone to fluctuation and variability. In addition, relying on the one-year rate of change in costs and CCRs to trend the baseline data forward might not fully capture broader, long-term trends related to costs and charges. This unpredictability and variability in the inputs (the CCRs and charges CMS uses to determine the outlier threshold) can ultimately have significant impacts on the outlier threshold.

Due to the anomalous increase in the outlier threshold, we urge CMS to evaluate the charge inflation and CCR adjustment factors to ensure they are accurately represented in the final

[54] Source: AAMC analysis of FY2024 Medicare Provider Analysis and Review (MedPAR) File. Beneficiaries enrolled in Medicare Advantage, those who discharge dead or leave against medical advice were excluded from the analysis.

rule. CMS should evaluate its methodology for calculating outlier payments to ensure they are driven by data representing actual year-over-year changes in CCRs and will be borne out as more recent data become available.

PROVIDER-BASED CRITERIA CHANGES APPLICABLE TO OFF-CAMPUS FACILITIES OR ORGANIZATIONS

To maintain patient access to inpatient services in rural and underserved areas and to avoid disruption to continuity of care, CMS must maintain the provider-based requirements in their current form. CMS proposes revising the provider-based regulations, specifically the location criteria applicable to off-campus facilities or organizations (p. 19670). Under the provider-based regulations,[55] an inpatient or outpatient facility or organization can qualify as provider-based to the main hospital if it demonstrates that it operates under the same license as the main provider, is clinically integrated with the main provider, is financially integrated with the main provider, and is held out to the public as part of the main hospital. These provider-based facilities can be an outpatient department, a remote location (e.g., another campus of the hospital under the same provider agreement), or a satellite facility.

Off-campus facilities (those more than 250 yards from the main hospital) must meet additional requirements, including a location requirement. One way to satisfy the location requirement is by satisfying the "same patient population test," which can be met by showing that over each 12-month period, the facility or organization meets one of two tests:

- Geographic test: At least 75 percent of the patients served by the facility or organization reside in the same zip code areas as at least 75 percent of the patients served by the main provider; or
- Referral-based test: At least 75 percent of the patients served by the facility or organization who required the type of care furnished by the main provider received that care from that provider.[56]

CMS proposes to apply the referral-based test to outpatient departments only, meaning that off-campus, inpatient remote locations and satellite facilities would no longer be able to use the referral-based test to meet the location requirement of the provider-based regulations. We oppose CMS' proposal, which would be a departure from longstanding precedent, potentially disrupting patient care if these locations would no longer be able to establish that they are provided-based.

CMS' provides multiple rationales for the proposed provider-based change, including that provider-based status does not confer benefits to a distant, remote inpatient location and that the agency believes the intent of the referral-based test was to apply to outpatient facilities only (p.

[55] 42 CFR 413.65.
[56] 42 CFR 413.65(e)(3)(iii).

19671). We disagree with both of these assertions. Provider-based status brings with it many benefits, because it allows the location to operate as an integral part of the hospital while expanding access to rural and underserved patients. In the case of remote inpatient locations, which provide inpatient care to patients of the main hospital closer to where they live, provider-based status allows hospitals to expand access to patients where there are a limited number of physicians available to treat patients. These off-campus locations are critical to enabling hospitals to improve access to care, especially for some of the sickest and most medically complex patients. CMS' proposal would disadvantage large health systems that leverage integrated, multi-campus hospitals to bring high-quality care to their patients.

Regarding the notion that the intent of the referral-based test was to apply strictly to outpatient facilities, we would remind CMS that the agency's policy has been in place since 2001. When it updated the provider-based regulations to include the referral-based test, CMS chose to apply it to both inpatient and outpatient provider-based facilities. And in responding to comments seeking to apply the same patient population test to outpatient facilities only, CMS stated that "We do not agree with the commenter's assumption that because the program memorandum and proposed rule were issued in response to situations primarily involving outpatient facilities, they can apply only to such facilities. On the contrary, we believe the policies are equally applicable to inpatient facilities…"[57]

Therefore, to continue to allow remote inpatient locations to operate and bring access into their communities that otherwise lack a reliable source of care, we urge CMS to withdraw its proposal and allow provider-based inpatient facilities to continue to satisfy the same patient population test using the referral-based test.

COMPREHENSIVE CARE FOR JOINT REPLACEMENTS – EXPANDED (CJR-X) MODEL

MODEL SCOPE

CMS proposes expanding the original Comprehensive Care for Joint Replacement Model to all eligible acute care hospitals nationwide, establishing the Comprehensive Care for Joint Replacement-Expanded (CJR-X). For Medicare patients receiving a hip, knee, or ankle replacement, hospitals would be held financially accountable for the entire episode of care, including the procedure and the 90 days following discharge. The AAMC's comments on the CJR-X model proposed policies follow.

[57] Office of Inspector General; Medicare Program; Prospective Payment System for Hospital Outpatient Services. 65 FR 18434, 18517. April 7, 2000.

Delay Model Start to January 2028 to Align Performance Periods with OPPS Cycle and TEAM Performance Years

CMS proposes that the CJR-X model begin October 1, 2027, consistent with the fiscal year (FY) IPPS payment cycle. (p. 19674) Instead, the AAMC encourages CMS to align the start of the model to the calendar year (CY) cycle for two reasons: (1) alignment with the OPPS is likely better suited to addressing any changes to outpatient billing codes as the shift of lower extremity joint replacements (LEJRs) continues from inpatient to outpatient settings and (2) alignment with the Transforming Episode Accountability Model (TEAM) CY performance periods will ease the transition for hospitals from TEAM to CJR-X when the TEAM model concludes. Analysis of AAMC member hospital data has shown a significant shift from inpatient to outpatient care for both total knee arthroplasty (TKA) and total hip arthroplasty (THA) since the removal of the services from the Inpatient Only List (effective 2018 and 2020, respectively). With this in mind, we believe a model performance alignment with the outpatient CY payment cycle reduces burden on the agency to address changes to outpatient billing codes that would otherwise impact CJR-X for three quarters of the FY-based performance period. Instead, like TEAM, CMS would need to identify and address changes to inpatient DRG codes, if any, from the FY inpatient cycle for only the fourth quarter of a CY-based performance period. Additionally, alignment with TEAM performance periods ensures hospitals currently in TEAM would have an immediate transition to CJR-X upon the conclusion of TEAM performance December 31, 2030, rather than a 9-month holding period to transition to CJR-X on October 1, 2031.

Establish Precedence for Overlapping LEJR Procedures

CMS does not address how it intends to treat secondary LEJR procedures, for example where a patient receives a total hip replacement on one side and then requires the procedure for the other side within the episode period. The AAMC suggests CMS follow previous models and establish a policy that the second LEJR procedure will take precedence over the initial LEJR to establish a single 90-day episode.

Amend Beneficiary Eligibility to Require Medicare Coverage 180 Days Prior to the Initiating LEJR Procedure

CMS proposes that for a patient's LEJR procedure to trigger an episode under CJR-X, a patient must have Medicare Parts A and B at the time of the initiating procedure. (p. 19675) CMS does not mention the period prior to the initiating procedure. Since risk adjustment is based on HCCs captured during the 180-days prior to the procedure (p. 19698), the AAMC recommends that CMS refine eligibility for concordance with the proposed risk adjustment policy so that patients must have Parts A and B for the entirety of the 180-days prior to the procedure.

PRICING METHODOLOGY

Establish a Ramp Up Period to Downside Risk for Hospitals with No Prior Medicare Episode-based Payment Experience

CMS proposes reduced stop loss/stop gain limits for certain hospitals (safety net hospitals, rural hospitals, Medicare-dependent hospitals, and sole community hospitals) to reduce their risk exposure under the model, but with immediate two-sided risk upon the model's start. (p. 19702) The AAMC appreciates recognition of safety-net hospitals and other hospitals that might be more vulnerable to downside risk, but we are concerned with immediate downside risk for all hospitals without prior experience in Medicare fee-for-service episode-based payments. Hospitals without prior experience will need ramp up time to redesign care, invest in that care redesign (including through hiring care coordination staff and clinical support teams), and implement the care redesign. Additionally, those without prior experience need time to get up to speed with CMS model data files and communications channels. With this in mind, we recommend that CMS establish a one-year stop gain only performance period for any hospital without prior experience in a CMS-administered episode-based payment model.

Revise the Definition of Safety Net Hospital to Better Reflect Safety Net Status in Risk Adjustment

CMS proposes to define safety net hospitals in CJR-X as hospitals in the top 25th percentile in their region for percentage of Medicare fee-for-service LEJR inpatient episodes provided to dually eligible patients during the applicable baseline period. CMS proposes to employ this definition in risk adjustment as a binary variable. (p. 19698) The AAMC appreciates the agency's inclusion of safety net status for purposes of risk adjustment in the model, but we recommend CMS adopt a more nuanced approach in recognition of the critical role safety net hospitals serve in our healthcare system. To this end, we encourage the agency to consider factors that account for Medicaid and low-income Medicare patients, uncompensated care costs, and state-level low-income care criteria.

Reduce or Eliminate the Discount Factor with a National Model

CMS proposes applying a two percent discount factor when establishing the target pricing for hospitals under CJR-X. (p. 19695) The AAMC urges CMS to reconsider the magnitude of the discount factor and either reduce it to one percent or eliminate it altogether. We believe establishing a national mandatory model, with nearly three times as many hospitals set to participate than under the original CJR model, should generate savings to CMS through scale and system-wide practice changes and reduce the dependency on a discount to guarantee savings to the Medicare program.

Share Target Price Update Factors with Hospitals Prior to Reconciliation

CMS proposes that ambulatory payment classification and MS-DRG payment rule changes will be applied to target prices upon reconciliation. (p. 19700). The AAMC urges CMS to share update factors with hospitals as soon as they are available during the performance year (following release of applicable rules) to provide participants with more timely information about their likely target prices.

Work With Stakeholders to Develop a Long-term, Sustainable Target Pricing Methodology to Protect Hospitals Against Ratcheting Effects

The CJR-X Model as proposed will be the first mandatory, permanent episode-based payment model in traditional Medicare. Without an end date, the proposed initial target pricing methodology, largely based on the agency's experience with CJR and absent a long-term plan to amend the methodology, will result in hospitals having to beat their own prior cost savings every year in perpetuity. This continuous rebasing on historical expenditure creates what is commonly referred to as a ratchet effect and could logically reach a point where hospitals have reduced spending in the 90-day post discharge period to zero to succeed in the model, leading to target prices ultimately requiring hospitals to assume a discount on the initiating trigger procedure's cost. The AAMC strongly urges CMS to develop a target pricing methodology that is not reliant on historical spending in the next year and engage stakeholders through a technical expert panel to advise CMS on refinements to any long-term pricing methodology in advance of such methodology's inclusion in notice and comment rulemaking.

Hospitals have made substantial investments in clinical transformation infrastructure under CJR, including care management staffing, data systems, preferred post-acute networks, patient navigation programs, and quality improvement initiatives. A pricing methodology that continually resets benchmarks downward based primarily on historical performance risks undermining the very innovations CMS seeks to encourage.
To ensure the long-term viability and success of CJR-X, CMS should engage stakeholders in developing a more stable and predictable benchmarking framework that balances accountability with incentives for innovation. Specifically, CMS should consider:

- Tracking regional trends and flagging when the trend stabilizes;
- Defining an administratively set floor based on a percentage discount of current regional averages;
- Limiting the extent of annual target price rebasing tied to prior participant savings;
- Incorporating longer pricing stability periods or glide paths;
- Providing pricing protections for historically efficient hospitals;
- Establishing transparent pricing methodologies that allow participants to forecast performance expectations; and

- Testing alternative pricing approaches through stakeholder engagement and model evaluation.

Importantly, hospitals need confidence that successful care redesign efforts will not simply result in continually lower future targets that eliminate opportunities for sustainable innovation. We encourage CMS to view CJR-X not solely as a cost containment mechanism, but as a long-term partnership with providers to improve patient outcomes, care coordination, and system efficiency. Achieving these goals requires a target pricing methodology that rewards sustained performance improvement while maintaining meaningful opportunities for hospitals to continue investing in innovation and transformation.

The AAMC urges CMS to work closely with stakeholders to develop a balanced and durable benchmarking approach that supports long-term participation, financial predictability, and continued advancement of high-value orthopedic care.

QUALITY MEASUREMENT

Align Measures and Measurement Performance Periods with the IQR and OQR

CMS proposes adopting five measures that hospitals currently must successfully report under the Hospital Inpatient Quality Reporting (IQR) and Outpatient Quality Reporting (OQR) Programs. (p. 19682) The AAMC supports and appreciates efforts to align quality measurement in value-based care models with broader quality measurement programs. However, the AAMC has concerns about performance-based use of the THA/TKA Patient-Reported Outcome Performance Measure (PRO-PM) as currently specified for the IQR. Our comments specific to the proposal to adopt that measure follow.

Make the Measure Voluntary Until Majority of Hospitals in IQR Demonstrate Ability to Hit 50 Percent Matching Threshold or Reduce the Survey Matching Threshold of THA/TKA PRO-PM

CMS proposes weighing the THA/TKA Patient-Reported Outcome Performance Measure (PRO-PM) more heavily in the Composite Quality Score than in CJR, where it remained a voluntary measure. (p. 19682) The AAMC supports efforts to increase the use of PROs and include patient perspective in outcomes-based quality measurement. However, we urge CMS to reconsider the proposed requirements, as established under the IQR for FY 2028 payment determinations, for the THA/TKA PRO-PM under the CJR-X model. Specifically, CMS should maintain the measure as voluntary for hospitals until hospitals demonstrate the ability to hit the 50 percent matching threshold in the IQR or reduce the required matched pre-operative/post-operative response rate threshold to 25 percent for performance-based use in CJR-X.

While we support the long-term goal of incorporating patient-reported outcomes into value-based care models, the operational realities associated with PRO-PM collection continue to present substantial barriers for hospitals and health systems. Experience under the original CJR model demonstrated that even highly engaged and clinically sophisticated organizations struggled to successfully report this measure, as discussed in our comments above on the measure in the IQR.

We recommend CMS maintain the THA/TKA PRO-PM as a voluntary measure within CJR-X until hospitals have sufficient time, technical support, and infrastructure to operationalize reliable and equitable longitudinal patient-reported outcome collection. Alternatively, we believe that reducing the matched response threshold to 25 percent could better balance the agency's interest in advancing patient-reported outcomes with the operational realities facing hospitals. We appreciate the commitment to improving patient-centered care and respectfully request that the agency adopt a more flexible approach to THA/TKA PRO-PM implementation in CJR-X.

DATA SHARING

Clarify Limits on Designated Data Custodians Under the Model's Data Sharing Agreement

CMS proposes that each hospital may designate "one or more data custodians" responsible for ensuring compliance with the privacy, security, and breach notification requirements set forth in the CJR-X data sharing agreement, as well as manually pulling data files from CMS. (p.19726) The AAMC is concerned that CMS is considering a potential limit on the data custodians a participating hospital may designate and recommends that CMS ensure the data sharing policies do not limit the number of data custodians a hospital may elect or at least specify an allowance of at least five designees per hospital.

Improve Data Delivery Options for Hospitals

CMS proposes to distribute claims data via flat files/binary portal delivery (like data sharing distribution under TEAM), which would require data custodians to manually download multiple files per CMS Certification Number (CCN) each month. (p. 19723) The AAMC suggests that CMS could reduce this administrative burden by utilizing data delivery methods featured in other CMS programs such as for accountable care organizations participating in the Medicare Shared Savings Program. CMS should pursue one or both of the following policy changes: (1) bulk multi-CCN retrieval allowing a single authenticated request to retrieve data for all affiliated CCNs; or (2) secure API access consistent with the Beneficiary Claims Data API, which uses the FHIR standard for other alternative payment model participants to receive Medicare claims data in a more timely manner.[58]

[58] CMS, "Improve Care Coordination with Medicare Claims Data" website.

TRANSFORMING EPISODE ACCOUNTABILITY MODEL (TEAM)

Establish A Voluntary Opt-in Period for Health Systems with Hospitals Currently in TEAM to Add Other System Hospitals to the Model

In conjunction with the proposal to adopt the new CJR-X mandatory model for all hospitals, the AAMC asks CMS to consider establishing a second voluntary opt-in period for TEAM to provide hospitals with a choice for participating in Medicare episode-based payment design for LEJR procedures. CMS could limit this opt-in choice to health systems with a hospital currently participating in TEAM to allow the entire health system to coordinate participation across the system in alignment with the TEAM policies and episodes (rather than managing care delivery redesign across two sets of model parameters for LEJR procedures).

Ensure TEAM Hospitals Have Data Available to Identify Patients Excluded Due to CJR-X

CMS proposes that if a patient is in a CJR-X model episode and receives a procedure at a TEAM hospital during the CJR-X 90-day post-discharge period, then the procedure at the TEAM hospital will not trigger a TEAM episode and the costs of that procedure at the TEAM hospital will be included in the CJR-X episode. (p. 19657) The AAMC supports this proposal to address CJR-X patients receiving care in TEAM hospitals during the CJR-X episode. We ask CMS to ensure that TEAM hospitals will have data available to them that will identify patients who are excluded from initiating TEAM episodes due to a current CJR-X episode to ensure that this policy can be best understood and implemented by hospitals.

Align the TEAM Quality Measure Performance Periods and Baseline Periods to the IQR and OQR

CMS proposes aligning TEAM quality measure performance periods and composite quality scoring baseline periods to the performance periods adopted for those measures under the Hospital Inpatient Quality Reporting (IQR) and Outpatient Quality Reporting (OQR) Programs. (p. 19659-60) The AAMC supports and appreciates efforts to align quality measurement in value-based care models with broader quality measurement programs. However, the AAMC has concerns about performance-based use of the THA/TKA Patient-Reported Outcome Performance Measure (PRO-PM) as currently specified for the IQR. Our comments specific to that measure follow.

Reduce the Survey Matching Threshold of THA/TKA PRO-PM or Make the Measure Voluntary Until Majority of Hospitals in IQR Demonstrate Ability to Hit 50 Percent Matching Threshold

The AAMC urges CMS to reconsider the proposed requirements, as established under the IQR for FY 2028 payment determinations, for the THA/TKA Patient-Reported Outcome Performance Measure (PRO-PM) under TEAM. Specifically, CMS should maintain the measure as voluntary for hospitals until hospitals demonstrate the ability to hit the 50 percent matching threshold in the IQR or reduce the required matched pre-operative/post-operative response rate threshold to 25 percent for performance-based use in CJR-X.

While we support the long-term goal of incorporating patient-reported outcomes into value-based care models, the operational realities associated with PRO-PM collection continue to present substantial barriers for hospitals and health systems. Experience under the original CJR model demonstrated that even highly engaged and clinically sophisticated organizations struggled to successfully report this measure, as discussed in our comments above on the measure in the IQR.

We recommend CMS maintain the THA/TKA PRO-PM as a voluntary measure within TEAM until hospitals have sufficient time, technical support, and infrastructure to operationalize reliable and equitable longitudinal patient-reported outcome collection. Alternatively, we believe that reducing the matched response threshold to 25 percent could better balance the agency's interest in advancing patient-reported outcomes with the operational realities facing hospitals. We appreciate the commitment to improving patient-centered care and respectfully request that the agency adopt a more flexible approach to THA/TKA PRO-PM implementation in TEAM.

HOSPITAL QUALITY PROGRAMS

HOSPITAL READMISSIONS REDUCTION PROGRAM (HRRP)

CMS Should Modify and Delay Implementation of the Proposed Sepsis Readmissions Measure to Ensure Hospitals Have Appropriate Notice for Performance-based Payment Implications

CMS proposes to adopt a new Sepsis Readmissions measure, first through an "early look" adoption for FY 2028 payment determinations, before pay-for-performance impacts beginning with FY 2029, based on the July 1, 2025 – June 30, 2027 measurement period. (p. 19528) The AAMC broadly supports the measure's inclusion in the Program, in recognition of the importance of improving sepsis care. We have two concerns with this measure, one related to the measure's specifications and the other to the proposed timing of adoption for performance-based payment that does not afford hospitals reasonable notice.

Exclude All Transfer Patients from Measurement

The measure would exclude patients from a hospital's performance if they were transferred to another hospital for their sepsis care. The AAMC believes the measure should also exclude transfer patients from the accepting hospital's evaluation. In these cases, transfer patients are transferred outside of their communities in part because they are too sick or too complex for the referring community hospital, which may delay timely and effective sepsis care. Additionally, the accepting hospital tends to be a hospital outside of the transferred patient's home area. AAMC analysis found that amongst sepsis inpatients that transfer across hospitals, only 19.7% are in the same county of their residence at the receiving hospital.[59] The accepting hospital and its physicians often can play only a very small role in readmission prevention, particularly more than 7-14 days following discharge, due to the lack of an ongoing care relationship with the transferred patient who returns to their home community post-discharge.

Delay Adoption for Performance-Based Accountability to FY 2031 to Provide Adequate Notice for Hospitals

We urge CMS to delay adoption of the proposed sepsis readmissions measure until FY 2031 to ensure hospitals have adequate notice and opportunity to prepare for performance-based accountability under the program. As proposed, CMS would adopt the measure beginning in FY 2029 using a performance period spanning July 1, 2025 through June 30, 2027. This approach would hold hospitals accountable for performance occurring well before CMS finalizes the policy and before hospitals have clear notice that the measure will be used for payment purposes. Applying accountability to performance periods that begin prior to finalizing the measure's adoption in the program undermines hospitals' ability to proactively respond to measure requirements and implement targeted improvement strategies. This concern is particularly significant for a complex condition like sepsis, where patient presentation, coding, care coordination, and post-discharge factors can substantially influence readmissions performance.

Delaying implementation of the measure for performance-based accountability until FY 2031 determinations would ensure that the entirety of the performance period occurs after hospitals receive final notice of the policy in the FY 2027 final rule. This approach would align with principles of transparency, fairness, and meaningful quality improvement by allowing hospitals an appropriate opportunity to understand the measure methodology, evaluate baseline

[59] Analysis based on 302,776 Medicare fee-for service claims from the 100% inpatient Standard Analytic Files, CY2024. The cohort was defined as those stays with an admitting sepsis diagnosis specified in Table 1 of QualityNet "Hospital 30-Day Sepsis Readmission Methodology," April 2026. Provider county is derived from CMS's Q3 2026 Provider of Services File. Excludes patients discharged dead, patients who left against medical advice, and patients paid under any method other than the prospective payment system.

performance, and implement evidence-based interventions before being held accountable under a federal quality performance program. program.

CROSSCUTTING QUALITY PROGRAM REQUESTS FOR COMMENT

RFI: Measuring Emergency Care Access and Timeliness in the Inpatient Quality Reporting (IQR) and Value-Based Purchasing (VBP) Programs

CMS seeks feedback on modifying and adopting the Emergency Care Access and Timeliness eCQM previously adopted in the Outpatient Quality Reporting (OQR) Program into inpatient reporting and performance programs. (p. 19574) While the AAMC agrees that timely access to emergency care and reducing ED boarding are important goals, we do not believe the Emergency Care Access and Timeliness measure is appropriate for use in inpatient quality reporting or value-based purchasing programs, considering the use of the measure in the OQR. Emergency department wait times, throughput and boarding are important operational indicators for hospitals and health systems, but they are also symptoms of broader systemic challenges that often extend far beyond the control of hospitals. Adoption of this measure into inpatient programs would inappropriately place accountability on hospitals for factors they frequently cannot meaningfully influence.

The measure's conceptual framework does not adequately reflect the complexity of emergency department operations or the broader continuum of inpatient and post-acute care. The specifications rely on fixed time thresholds that do not appear to be grounded in clear evidence linking those specific cut points to improved patient outcomes. In addition, the measure assumes that ED throughput is primarily driven by hospital operations, without sufficiently accounting for key external factors such as inpatient bed availability, workforce shortages, post-acute care capacity constraints, behavioral health infrastructure limitations, payer prior authorization requirements, lack of any insurance coverage, and broader community access issues. As a result, performance on the measure may reflect structural and market realities rather than differences in hospital quality.

In particular, hospitals increasingly face delays related to Medicare Advantage (MA) and commercial plan prior authorization requirements, as well as limited post-acute care network availability. These administrative barriers can delay admissions, transfers and discharges, despite clinically appropriate decision-making by providers. Consequently, hospitals serving higher proportions of MA patients could be disproportionately disadvantaged under this measure for reasons unrelated to the quality or timeliness of care they provide. Given significant geographic variation in MA penetration nationally, this raises important concerns regarding fairness and comparability in public reporting and pay-for-performance programs.

The measure also fails to adequately account for the persistent workforce and capacity shortages across the health care system. Shortages of primary care clinicians, behavioral health professionals, inpatient psychiatric beds, specialists, and post-acute care settings and resources all contribute significantly to ED crowding and boarding. In many communities, emergency departments increasingly function as the safety net for patients unable to access or afford timely outpatient or behavioral health services elsewhere. Evaluating ED throughput in isolation therefore risks measuring broader system inadequacies rather than hospital performance.

We are also concerned that the proposed timing thresholds are not sufficiently based on evidence. While prolonged ED stays may be associated with poorer outcomes in some studies, the literature does not clearly establish that narrowly defined thresholds — such as one hour to placement in a treatment room or four hours in the ED — reliably distinguish meaningful differences in quality or outcomes. It is unclear whether a hospital averaging 61 minutes to room placement should be considered materially worse than one averaging 60 minutes. Without stronger evidence linking these thresholds to clinically meaningful outcomes, the measure may create arbitrary distinctions in performance.

Further, use of the measure in accountability programs could create significant unintended consequences, including premature discharge decisions, inappropriate reductions in inpatient admissions, increased observation utilization, higher operational costs, worsening staff burnout, and exacerbation of disparities in care access. These risks are particularly concerning given limited evidence demonstrating specific interventions that consistently improve performance on the measure.

Although we appreciate that public reporting of the measure will stratify performance by age and mental health diagnosis, the measure still does not adequately address the unique challenges associated with patients presenting with substance use disorders, who often require behavioral health resources and care coordination. Additional refinement is necessary to ensure fair and clinically meaningful comparisons across hospitals.

Finally, the field has not yet established a clear set of evidence-based best practices that hospitals can implement to reliably improve performance on this measure. Many of the interventions cited in supporting documentation presented to the Pre-Rulemaking Measure Review in December 2025 require substantial system redesign, policy reform, workforce expansion, or investments outside the ED itself. Quality measures should support both meaningful quality improvement and informed patient decision-making. At present, this measure does not appear sufficiently mature to fulfill those goals if modified for use in either the IQR or the VBP. Instead, **CMS should continue to monitor hospital performance on the measure as adopted in the OQR and work collaboratively with hospitals, clinicians, policymakers and other stakeholders to address the broader systemic drivers of ED crowding and access challenges.**

RFI: Potential Future Use of the Adult Community-Onset Sepsis Standardized Mortality Ratio Measure in the IQR and VBP Programs

Currently, the sepsis bundle measure (SEP-1) is required by hospitals in the IQR since 2015 reporting and the VBP beginning with 2024 reporting.[60, 61] Hospitals have spent considerable effort — and achieved significant results — in mitigating the incidence and severity of sepsis, saving lives in the process. Unfortunately, research has demonstrated that the sepsis bundle measure has not led to better outcomes yet entails an enormous administrative burden as a chart-abstracted measure.[62] **The AAMC encourages CMS to work with clinical leaders to develop and adopt a valid, reliable, feasible outcomes measure to inform and improve effective and timely sepsis care.**

We support the agency's ongoing efforts to advance timely, evidence-based sepsis care and to use outcome measures to drive meaningful quality improvement. However, we have concerns regarding the appropriateness of the Community-Onset Sepsis Mortality measure for inclusion in the VBP, given the degree to which outcomes may be influenced by pre-hospital and community-based factors that are outside of a hospital's control.

Mortality among patients with community-onset sepsis is often affected by factors such as timing of symptom recognition, access to care, pre-hospital clinical decision-making, and recent healthcare encounters, including outpatient or emergency care prior to admission. These upstream factors may significantly influence patient condition at presentation and subsequent outcomes, regardless of the quality of inpatient sepsis care delivered.

Without adequate consideration of pre-hospital influences, there is concern that the measure may inappropriately attribute outcomes to hospital performance, potentially disadvantaging hospitals that serve populations with barriers to timely access to care and challenges with care adherence. Additionally, it disadvantages hospitals that operate in geographic areas with multiple healthcare systems, where limited interoperability and visibility across EHR platforms may constrain access to complete pre-hospital clinical information.

While continuing to support high-quality sepsis care and improvement efforts, we encourage CMS to consider whether the measure sufficiently accounts for recent healthcare utilization prior to hospitalization, such as evaluation by a primary care provider or another healthcare entity in the days or week preceding admission. Incorporating or acknowledging these contextual factors

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[60] 79 FR 50241 (August 22, 2014)
[61] 88 FR 59081 (August 28, 2023)
[62] C. Rhee, et al, Complex Sepsis Presentations, SEP-1 Bundle Compliance, and Outcomes, JAMA Network Open (March 19, 2025), finding that complex clinical presentations were more common among patients whose treatment was noncompliant with SEP-1, which may confound the association between SEP-1 compliance and mortality.

may improve risk adjustment, attribution, and fairness, particularly if the measure is used for performance-based payment determinations under the VBP.

INPATIENT QUALITY REPORTING (IQR) PROGRAM

IQR Reporting Requirements

Ensure a Meaningful Portfolio of Non-Hospital Harm eCQM Reporting Options in Advance of Mandating the Reporting of Hospital Harm Measures

CMS proposes to begin to mandate the reporting of any electronic clinical quality measures (eCQMs) designated as measures of hospital harm two years following their adoption into the IQR as a voluntary measure that hospitals may self-select to report. We are concerned that if CMS mandates reporting of all eCQMs designated as hospital harm measures, hospitals will be left with a very limited menu of non-hospital harm eCQMs available for meeting the self-selected measure reporting requirements. Specifically, by FY 2032 payment determinations, based on CY2030 reporting, hospitals would self-select three measures to report from a total of four such measures (down from self-selecting three from nine available measures), effectively making all eCQMs mandatory measures. This reduces flexibility for hospitals to report measures that are more meaningful, applicable, and representative of their specific patient populations, clinical services, and quality improvement priorities. We encourage CMS to maintain a broader portfolio of non-hospital harm eCQM options in advance of mandating the reporting of hospital harm measures or consider removing the self-selection concept altogether.

Reduce Response Rate for Reporting of the THA/TKA PRO-PM for FY 2028 and Beyond

CMS has previously adopted the THA/TKA PRO-PM measure as a voluntary measure for hospitals for two reporting cycles, before becoming mandatory for FY 2028 payment determinations. In adopting the measure for mandatory reporting, CMS set the patient survey response rate at 50% of eligible patients completing both the pre-operative and post-operative survey instrument in order to meet measure reporting requirements as part of the IQR and to be eligible for 25 percent of the annual payment update for that payment year.[63] The agency's rationale for the 50% response rate requirement in part referenced experience by hospitals in the Comprehensive Care for Joint Replacement (CJR) Model. [64] The agency acknowledged concerns with the 50% response rate, and committed to "evaluate our proposed approach during voluntary reporting and consider adjustments based on feedback *prior to mandatory reporting [emphasis*

[63] 87 FR 48780 (August 10, 2022), at 49246-49257.
[64] *Id*., stating "We selected the 50 percent reporting threshold after considering numerous factors and the experiences of CJR Model participants based on response rates for both pre-operative and post-operative surveys collected" suggesting CMS based it on the two component response rates, and not *matched* response rates.

added]." [65] In analysis of historical data, the AAMC observed that only 88 of 803 CJR hospitals participating in the second performance year (CY2017) of the model were able to meet the matched response rate necessary to receive the incentive for voluntary reporting. And this response rate does not appear to have improved over time with the model. Data refreshed through the CMS *Care Compare* public website in May 2026, showed that only 12 of 320 CJR hospitals successfully reported data on the measure for the July 2022 – June 2023 reporting period (PY7 of the model, requiring 85% response rate for credit). [66] Specific to the first voluntary reporting period under the IQR, a CMS contractor conducted analysis of voluntary reporting, finding that only 118 submitted any PRO data, 68 hospitals submitted both pre- and post-operative PRO data for eligible THA/TKA procedures, and only 42 hospitals submitted complete and matched PRO data (though no indicator that those hospitals also met the 50% response rate requirement).[67] To date, there does not appear to be any public data demonstrating that hospitals can reasonably meet the 50% response requirement. **CMS should reduce the THA/TKA PRO-PM match response rate to 20% for FY 2028 in the IQR and only increase the response rate threshold requirement upon evidence that an increase is reasonable based on publicly available data on hospital performance.**

RFI: Birthing-Friendly Hospital Designation

CMS seeks feedback on potential modifications to the Birthing-Friendly Hospital Designation for hospitals publicly reported on the *Care Compare* website. Such modifications would include incorporating hospital performance on the two maternal outcomes measures in the IQR: (1) the Cesarean Birth eCQM and (2) the Severe Obstetric Complications eCQM (p. 19598) **The AAMC supports efforts to improve transparency of hospital quality measurement information for patients and communities, but we urge CMS to ensure that the designation meaningfully represents information to patients and families on its own and within the context of other ratings.** For example, if CMS moves forward with a tiered designation concept based on outcomes, it should ensure that patients understand the tiers and how the designation does or does not relate to a hospital's Overall Hospital Quality Star Rating. It is unclear to the AAMC how patients and families will use a designation specific to maternity care separately from the Star Rating. Indeed, we are concerned that patients and families might be confused to see a Rating that might be interpreted as incongruent with the designation, for example, if a hospital receives the highest performing tier of the designation but receives an overall rating of one star. A lack of alignment of information might lead to broader distrust in CMS ratings and designations, and even with quality measurement information altogether.

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[65] *Id*.
[66] Analysis of data refreshed in the Provider Data Catalogue, May 2026.
[67] Yale New Haven Health Services Corporation – Center for Outcomes Research and Evaluation, 2025 Patient-Reported Outcomes (PROs) Following Elective Primary Total Hip Arthroplasty (THA) and/or Total Knee Arthroplasty (TKA) Hospital-Level Performance Measure Updates and Specifications Report – Version 2.0 (April 2025).

CMS must also be sure that a tiered designation based on performance does not further limit and exacerbate disparities in access to critical hospital care. It is unclear precisely how much choice pregnant patients have when it comes to which hospital they access to deliver their babies. Hospital choice can be limited by insurance coverage and networks. It can also be limited by physical accessibility barriers and other factors related to health-related social needs, such as transportation access. CMS should examine whether patients, families, and communities feel the designation is helpful to them in making choices about the hospital in which to seek care.

PROMOTING INTEROPERABILITY (PI) PROGRAM

Continue Capability-based Approaches for Assessing Hospital's Meaningful Use of Certified EHR Technology Until Interoperability Functionality, Standards Adoption, and External Partner Readiness are More Uniformly Established Across the Healthcare Technology Ecosystem

CMS seeks feedback on transitioning measures within the PI Program from attestation-based measures to performance-based measures. (p. 19629 and p. 19631) The AAMC recommends CMS not transition the Promoting Interoperability Program to performance-based measurement until the broader interoperability ecosystem has the operational and technical capabilities necessary to support fair and reliable performance assessment. While hospitals and clinicians play a critical role in advancing interoperability, many factors that directly influence interoperability performance remain outside the control of providers.

Successful exchange of health information depends on the readiness, responsiveness, and technical capabilities of numerous external stakeholders, including EHR vendors, health information exchanges, public health agencies, registries, payers, and community providers. Significant variability persists across these entities with respect to standards implementation, interface availability, data quality, response times, and overall interoperability maturity. In many cases, providers may fully meet their obligations to initiate data exchange yet remain unable to achieve successful performance outcomes due to limitations in external systems or infrastructure.

Additionally, public health reporting capacity and interoperability capabilities continue to vary substantially across jurisdictions, creating inconsistent opportunities for providers to meet performance thresholds. Holding hospitals accountable for outcomes that depend heavily on external entities risks creating inequitable scoring and may disproportionately disadvantage providers serving regions with less mature interoperability infrastructure.

We encourage CMS to continue emphasizing attestation-based or capability-based approaches until interoperability functionality, standards adoption, and external partner readiness are more uniformly established across the healthcare ecosystem. CMS should also consider shared

accountability models that more appropriately recognize the collective responsibility required to achieve nationwide interoperability.

Thank you for the opportunity to comment on this proposed rule. We would be happy to work with CMS on any of the issues discussed or other topics that involve the academic medicine community. If you have questions regarding our comments, please feel free to contact my colleagues – Shahid Zaman (szaman@aamc.org) and Katie Gaynor (kgaynor@aamc.org) on the payment proposals; Bradley Cunningham (bcunningham@aamc.org) on the GME proposals; Phoebe Ramsey (pramsey@aamc.org) on the quality programs and episode-based payment model proposals.

Sincerely,

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Chief Health Care Officer
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Cc: David J. Skorton, M.D., AAMC President and Chief Executive Officer