AMERICA'S ESSENTIAL HOSPITALS

June 10, 2025

Mehmet Oz, MD
Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
Hubert H. Humphrey Building, Room 445-G
200 Independence Ave. SW
Washington, DC 20201

Ref: CMS-1833-P: Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Policy Changes and Fiscal Year 2026 Rates; Requirements for Quality Programs; and Other Policy Changes

Dear Administrator Oz:

Thank you for the opportunity to comment on the above-captioned proposed rule. America's Essential Hospitals appreciates and supports the Centers for Medicare & Medicaid Services' (CMS') efforts to improve health care quality and reduce regulatory burden for hospitals. However, we are concerned that some proposed changes could disproportionately harm essential hospitals at the forefront of efforts to make America healthy again. As CMS finalizes this rule, we ask the agency to consider these comments on ways to mitigate this disproportionate impact and more effectively support hospitals facing the greatest financial challenges.

America's Essential Hospitals is the leading association and champion for hospitals dedicated to high-quality care for all, including those who face social and financial barriers to care. Since 1981, America's Essential Hospitals has advanced policies and programs that promote health and access to health care. We support our more than 350 members with advocacy, policy development, research, education, and leadership development. Communities depend on essential hospitals for care across the continuum, health care workforce training, research, public health, and other services. Supported by Essential Hospitals Institute, the association's research and education arm, essential hospitals innovate and adapt to lead all of health care toward better outcomes and value.

The mission of essential hospitals aligns with President Trump's vision to make all Americans healthy. Essential hospitals are committed to serving people in all communities that need access to quality care. Although essential hospitals account for only 5% of acute-care hospitals nationwide, they provided 28% of the nation's charity care in 2022. About three-quarters of the

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patients our members serve are uninsured or enrolled in Medicare or Medicaid.[1] In addition, nearly two-thirds of essential hospitals provide services to rural patients and communities.[2] To meet the needs of these populations, members of America's Essential Hospitals constantly engage in robust quality improvement initiatives and have created programs that improve the quality of and access to care, including efforts to combat chronic conditions.

Unfortunately, **essential hospitals' ability to continue providing these services is threatened by payers that undervalue the care that they provide.** Essential hospitals take care of more Medicare and Medicaid patients than other hospitals, and, as Medicare and Medicaid payment rates are lower than those of other payers, essential hospitals have lower operating margins. In 2022, members of America's Essential Hospitals had an aggregate operating margin of -9.0%, which was far worse than the aggregate operating margins for all other hospitals (-2.8%).[3] Over time, this underinvestment has limited capital available to these hospitals to invest in the infrastructure needed to participate in delivery system reforms and take advantage of new technologies, such as artificial intelligence.

Given the limited federal funding available for Medicare, it is particularly important for policymakers to target available resources to the hospitals that need it most. To promote this improved efficiency, CMS should designate essential hospitals in federal regulation and use this designation to target enhanced funding and additional consideration in CMS quality programs. This letter highlights three priority areas for agency action:

- Establishing a federal designation for essential hospitals
- Ensuring adequate funding for essential hospitals
- Considering the unique needs of essential hospitals in the design of quality measurement programs

Establishing a Federal Designation for Essential Hospitals

CMS' annual updates to Medicare hospital payment policies provide an opportunity for the agency to reassess how effectively its payment policies support hospitals that need funding the most. Section 1886(d)(5)(I) of the Social Security Act (SSA) authorizes the Secretary to offer exceptions and adjustments to Medicare inpatient payments as the Secretary deems appropriate. This general authority can be used to designate classes of hospitals that deserve special consideration in Medicare payment policy. **CMS should use Section 1886(d)(5)(I) authority to designate essential health systems to ensure that Medicare payment policy appropriately considers the unique needs of these hospitals and the patients that they serve.**

More than two decades ago, the Institute of Medicine (IOM) reported that America's safety net is "intact but endangered" and recommended the creation of a federal definition of hospitals

[1] Miu R, Kelly K, Nelb R. *Essential Data 2024: Our Hospitals, Our Patients—Results of America's Essential Hospitals 2022 Annual Member Characteristics Survey*. America's Essential Hospitals. December 2024. essentialdata.info. Accessed May 13, 2025.
[2] America's Essential Hospitals. Policy Brief: Essential Hospitals Ensure Access to Care in Rural Areas. March 2025. https://essentialhospitals.org/wp-content/uploads/2025/03/2025-Access-to-Care-in-Rural-Areas-Brief.pdf. Accessed May 28, 2025.
[3] Miu R, Kelly K, Nelb R. *Essential Data 2024: Our Hospitals, Our Patients—Results of America's Essential Hospitals 2022 Annual Member Characteristics Survey*. America's Essential Hospitals. December 2024. https://essentialdata.info. Accessed May 13, 2025.

that serve a safety net role.[4] More recently, the Medicare Payment Advisory Commission (MedPAC) also recommended that CMS create a new metric to identify and invest in safety net providers.[5] Although we disagree with MedPAC's proposed metrics, **we strongly support the concept of establishing a federal designation of safety net providers and using the designation as a tool to target increased funding to providers that need it most**.

A federal definition of essential hospitals would help complement other existing Medicare hospital designations. For example, in 2022, 64% of essential hospitals provided access to care in rural areas but only 23% of essential hospitals qualified for existing Medicare designations based on rurality (i.e., critical access hospital, sole community hospital, or Medicare dependent hospital status).[6] A federal essential hospital definition would help recognize and support all hospitals that are providing access to low-income patients no matter where they are located.

The IOM's clarion call in 2000—to ensure safety net providers are "sustained and protected"—is even more relevant today than it was two and a half decades ago.[7] Hospital closures, physician shortages, and shuttered services in communities across the country have made the role of essential hospitals more important than ever. CMS must take steps to ensure essential hospitals are able to provide the care that their communities depend on. **By implementing an essential hospital designation, CMS would have a tested measure it could call upon to target resources more efficiently and effectively to hospitals that serve a safety net role.**

This letter reviews the association's proposed principles for identifying essential hospitals and ways that CMS could use this designation to more effectively target Medicare funding and other CMS policies.

1. CMS should establish a federal designation for essential hospitals using the practical and evidence-based measures essential hospital leaders have developed.

For decades, there has been a broad consensus that **safety net providers should be identified based on the share of all types of low-income patients they serve**. In 2000, the IOM convened a wide variety of stakeholders and experts to develop a consensus definition of safety net providers as those that serve a high share of uninsured, Medicaid, and other disadvantaged patients.[8] In 2022, when the Medicare Payment Advisory Commission

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[4] Institute of Medicine Committee on the Changing Market, Managed Care, and the Future Viability of Safety Net Providers. Lewin ME, Altman S, eds. *America's Health Care Safety Net: Intact but Endangered*. Washington, D.C.: The National Academies Press; 2000. https://nap.nationalacademies.org/catalog/9612/americas-health-care-safety-net-intact-but-endangered. Accessed May 13, 2025.

[5] Medicare Payment Advisory Commission. Report to the Congress. Medicare Payment Policy. March 2025. https://www.medpac.gov/wp-content/uploads/2025/03/Mar25_MedPAC_Report_To_Congress_SEC.pdf. Accessed May 20, 2025.

[6] America's Essential Hospitals. Policy Brief: Essential Hospitals Ensure Access to Care in Rural Areas. March 2025. https://essentialhospitals.org/wp-content/uploads/2025/03/2025-Access-to-Care-in-Rural-Areas-Brief.pdf. Accessed June 2, 2025.

[7] Institute of Medicine Committee on the Changing Market, Managed Care, and the Future Viability of Safety Net Providers. Lewin ME, Altman S, eds. *America's Health Care Safety Net: Intact but Endangered*. Washington, D.C.: The National Academies Press; 2000. https://nap.nationalacademies.org/catalog/9612/americas-health-care-safety-net-intact-but-endangered. Accessed May 13, 2025.

[8] Ibid.

(MedPAC) initially developed its framework for identifying safety net providers, it also acknowledged that Medicaid and uninsured patients should be considered when assessing whether a provider serves a safety net role.[9]

To further inform development of measures to identify essential hospitals, America's Essential Hospitals convened hospital leaders in 2022 to discuss practical considerations for the implementation of a new federal designation. In addition to reaffirming the importance of considering payer mix, these leaders also identified the importance of using available metrics, focusing on mission-driven institutions, and considering state variation.[10]

In the 119th Congress, a bipartisan group of lawmakers introduced the Reinforcing Essential Health Systems for Communities Act (H.R. 7397), which would create a comprehensive definition of essential health systems that is consistent with the principles outlined by essential hospital leaders and the IOM. **We urge CMS to consider this bipartisan approach to designating essential health systems that serve a safety net role.**

2. The safety net definition used for the Transforming Episode Accountability Model (TEAM) fails to identify hospitals that provide the most access to underserved patients.

In response to the fiscal year (FY) 2025 Inpatient Prospective Payment System (IPPS) proposed rule, and the calendar year (CY) 2025 Outpatient Prospective Payment System proposed rule, the association provided extensive analysis of why the essential hospital–proposed safety net definition was superior to the Medicare-only safety net definition that was proposed and ultimately finalized for use in TEAM at 42 CFR § 512.505.[11,12,13] **We remain concerned that measures based solely on the low-income Medicare population are too narrow and result in an inaccurate measure of safety net providers that excludes the hospitals that serve the most low-income patients.**

TEAM defines safety net hospitals as those that serve a high share of Medicare patients who are dually eligible for Medicaid or are eligible for the Medicare Part D Low-Income Subsidy (LIS). This definition ignores the care hospitals provide to Medicaid and uninsured patients. Therefore, **it is not a good measure of hospitals that are providing the most access to underserved patients and need additional federal support to participate in value-based care.**

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[9] Medicare Payment Advisory Commission. Report to the Congress: Medicare and the Health Care Delivery System, Chapter 3. June 2022. https://www.medpac.gov/wp-content/uploads/2022/06/Jun22_Ch3_MedPAC_Report_to_Congress_SEC.pdf. Accessed May 20, 2025.

[10] Dickson E, Purves S, Shields C. To Protect America's Safety-Net Hospitals, Establish A New Federal Designation. *Health Affairs Forefront*. Oct. 3, 2022. https://www.healthaffairs.org/content/forefront/protect-america-s-safety-net-hospitals-establish-new-federal-designation. Accessed Aug. 19, 2024.

[11] Siegel B. Letter to Chiquita Brooks-LaSure on June 10, 2024. https://essentialhospitals.org/wp-content/uploads/2024/06/AEH-FY2025-IPPS-Comment-letter.pdfAccessed May 20, 2025.

[12] Siegel B. Letter to Chiquita Brooks-LaSure on Sept. 9, 2024. https://essentialhospitals.org/wp-content/uploads/2024/09/AEH-FY2025-OPPS-Comments-20240906.pdf. Accessed May 20, 2025.

[13] Using 2022 Medicare cost report data, we found that the definition used in H.R. 7397 identifies a group of hospitals that serve twice as many low-income Medicare beneficiaries and provide twice as much uncompensated care as the safety net hospitals identified in the TEAM safety net definition.

Overall, we found CMS' proposed measure definition prioritizes smaller hospitals and misses several large essential hospitals that have long played a safety net role in their communities. Because CMS' proposed safety net definition at 42 CFR 512.505 only looks at the share of Medicare beneficiaries that are low-income, it inadvertently benefits hospitals that serve fewer Medicare beneficiaries. For example, if a hospital expands access to serve more Medicare beneficiaries overall, the hospital's share of LIS or dually eligible Medicare patients might decline, even though it is serving a larger number of patients. We found that although 37% of IPPS hospitals would qualify for CMS' proposed safety net definition, these hospitals only accounted for 29% of all discharges for low-income Medicare beneficiaries in 2022.[14] By omitting large safety net providers from special consideration in TEAM, CMS falls short of its goal to ensure more low-income Medicare beneficiaries benefit from Center for Medicare and Medicaid Innovation (CMMI) models.

Instead, CMS also should consider measures of the share of Medicaid and uninsured patients a hospital serves. These patients have historically been underserved because of low government payment rates. For example, Medicaid payment rates are well below commercial rates and 22% below Medicare rates.[15] In addition, the unpaid costs of care for uninsured individuals remain a substantial financial burden for hospitals and are not fully covered by disproportionate share hospital (DSH) payments or other funding. Safety net providers that serve a high share of Medicaid, Medicare, and uninsured patients also face added financial challenges because they serve few patients with private insurance and, thus, cannot make up for these losses with higher commercial payment rates.

Medicare payment models should consider a hospital's overall payer mix. This is a more reliable and useful measure for identifying facility-level characteristics that affect safety net providers' ability to fund the infrastructure and other necessary investments to succeed in value-based care arrangements. We share CMS' concern about improving care provided to the lowest-income Medicare beneficiaries. But to achieve this goal, it is more effective and efficient to focus resources on providers that serve the highest share of all low-income and uninsured patients, as defined by the practical and evidence-based measures that essential hospital leaders developed.

3. CMS should meaningfully engage with essential hospital leaders to develop an essential hospital designation.

Despite the evidence we provided about the benefits of our proposed measures in prior rulemaking, CMS has provided only a cursory response to our legitimate concerns. Nevertheless, we remain ready to engage with CMS on these important issues, and **we urge the agency to consult with essential hospitals, the nation's leading providers of safety net care, to develop a federal safety net designation**. In the end, policies intended to support safety net providers are made stronger by fully listening to the communities that policymakers are trying to help.

4. CMS should use a federal designation of essential health systems to efficiently target funding and other support across CMS programs.

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[14] Siegel B. Letter to Chiquita Brooks-LaSure on June 10, 2024. https://essentialhospitals.org/wp-content/uploads/2024/06/AEH-FY2025-IPPS-Comment-letter.pdfAccessed May 20, 2025.
[15] Mann C, Striar A. How Differences in Medicaid, Medicare, and Commercial Health Insurance Payment Rates Impact Access, Health Equity, and Cost. *The Commonwealth Fund*. Aug. 17, 2022. https://www.commonwealthfund.org/blog/2022/how-differences-medicaid-medicare-and-commercial-health-insurance-payment-rates-impact. Accessed May 13, 2025.

Once CMS defines essential hospitals, it should ensure Medicare payment policies appropriately support these providers and the communities they serve. In our comments below, we provide specific examples of how CMS could support essential hospitals through the Medicare IPPS rule. In addition, **the agency should consider ways other CMS policies can support essential hospitals and the safety net care they provide.** These include other Medicare payment systems (including fee-for-service (FFS) and Medicare Advantage), the Medicaid program, and demonstration projects under the purview of CMMI. For example, CMS should consider:

- Exempting provider-based departments of essential hospitals from site-neutral payment cuts to maintain access for underserved communities
- Ensuring essential hospitals are included in Medicare Advantage plan networks and that payment rates for essential hospitals are sufficient
- Limiting inappropriate denials in managed care for essential hospitals
- Developing CMMI models that recognize the financial challenges and unique needs of essential hospitals that have limited their participation

Ensuring Adequate Funding for Essential Hospitals

As noted above, essential hospitals face significant financial challenges because Medicare, Medicaid, and other government payers pay so much less than other payers. These financial challenges have been exacerbated in recent years by the disruptions of the COVID-19 pandemic. Federal programs—such as provider relief funds—bridged the gap for essential hospitals and helped them remain afloat during the pandemic, yet now essential hospitals are struggling to recover from rising uninsured rates, higher labor costs, and increased product costs. **In the face of these financial challenges, we urge CMS to use its authority to ensure that the annual IPPS payment update and DSH funding methodology for FY 2026 reflects current hospital costs.**

1. CMS should further increase its proposed annual hospital payment update to account for high and rising costs of hospital goods and services.

CMS' proposed payment update of 2.4% is wholly inadequate to account for hospitals' increasing costs. The low adjustment this year builds on prior inadequate adjustments, creating a compounding challenge for essential hospitals. We appreciate CMS' efforts to rebase the CMS market basket this year, as scheduled, but we are still concerned that CMS' analyses are not fully representative of the input costs for providing care.

A recent analysis found that year-to-date expenses have increased 7% year-over-year, and 14% when comparing 2025 to 2022.[16] While relative rates of inflation have slowed from the all-time highs of recent years, IPPS payment adjustments remain inadequate for the historic underinvestment in essential health care systems. **We urge CMS to adjust its methodology for calculating the annual payment update for FY 2026 to ensure it provides a sufficient payment update to adequately incorporate the effects of inflation and rising workforce costs on hospitals.**

[16] Kaufman Hall. National Hospital Flash Report. March 2025. https://www.kaufmanhall.com/sites/default/files/2025-05/KH-NHFR-Report_Mar_2025_Metrics.pdf. Accessed May 13. 2025

CMS calculated the proposed 2.4% net payment update based on a 3.2% market basket update minus a 0.8 percentage point productive adjustment, which is far lower than the updates that CMS has provided in other payment rules. For example, in its recent CY 2026 Rate Announcement for Medicare Advantage and Medicare Part D Prescription Drug Programs, CMS finalized a MA payment rate increase of 5.1%, more than double the proposed rate for hospitals.[17] **CMS should, at a minimum, match the 5.1% rate finalized for Medicare Advantage plans for IPPS acute care payments.**

Additionally, we are concerned about the downward adjustment of the labor-related share from 67.6 to 66% in FY 2026. Per-discharge labor costs have dramatically increased in recent years—according to one study, 37% from 2019 to 2022.[18] The proposed reduction disproportionately affects essential hospitals located in high-wage urban areas. While we understand that the rebasing of the market basket to a 2023 base year requires recalibrating cost weights, CMS is not required to reweigh the labor related share under 1886(d)(2)(H) as part of that rebasing.[19] **We urge CMS to maintain the current 67.6% labor-related share in light of rising labor costs borne by essential hospitals.**

2. CMS should use more current and accurate measures in the Medicare DSH methodology to support essential hospitals and their safety net role.

The Medicare DSH program provides crucial funding support for essential hospital services by helping to adjust Medicare inpatient payment rates for hospitals that have high uncompensated care costs, such as essential hospitals. Essential hospitals are the quintessential example of a disproportionate share hospital. For example, although essential hospitals accounted for about 5% of all U.S. hospitals in 2022, they provided more than a quarter of all charity care nationwide.[20]

Below we offer comments about how CMS can more accurately calculate each factor of the Medicare DSH formula to ensure that these critical payments are achieving their intended purpose.

a. CMS must ensure Factor 1 calculations accurately estimate pre–Affordable Care Act (ACA) DSH calculations and provide transparency on these calculations.

Statute provides CMS considerable flexibility to calculate Factor 1 of the Medicare DSH formula, which is an estimate of the amount of Medicare DSH payments hospitals would have received in the aggregate before reductions. This factor is important because it determines the starting point of the amount of uncompensated care (UC)–based DSH funding available to essential hospitals.

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[17] 90 Fed. Reg. 25,678 (April 15, 2025)
[18] Kaufman Hall. The Financial Effects of Hospital Workforce Dislocation. A Special Workforce Edition of the National Hospital Flash Report. May 2022. https://www.kaufmanhall.com/sites/default/files/2022-05/KH-NHFR-Special-Report-2.pdf. Accessed May 13, 2025.
[19] SSA Sec. 1886(d)(2)(H) declares "the Secretary shall adjust the proportion (as estimated by the secretary from time to time) of hospitals' costs which are attributable to wages and wage-related costs…"
[20] Miu R, Kelly K, Nelb R. *Essential Data 2024: Our Hospitals, Our Patients—Results of America's Essential Hospitals 2022 Annual Member Characteristics Survey*. America's Essential Hospitals. December 2024. essentialdata.info. Accessed May 13, 2025.

We are concerned that the overall methodology for calculating Factor 1 is not fully transparent and cannot be replicated by stakeholders. In the FY 2026 proposed rule, Factor 1 is based on FY 2023 DSH payment data trended forward using four components: the annual payment update; estimated changes in discharges; estimated changes in case mix; and an "other" category, which includes expected changes in Medicaid enrollment. CMS discusses some of the assumptions that are used for accounting for incomplete data with some of these components, but, unfortunately, the proposed rule only includes a one-sentence description of how the "other" component of factor 1 is calculated.

Because Medicaid enrollment has changed so much recently, it is particularly important for stakeholders to understand how Medicaid enrollment changes affect Medicare DSH payments. **CMS should provide transparent and detailed explanations of how it calculates Factor 1 so stakeholders can verify the calculation and ensure it is not inadvertently penalizing DSH recipients.**

b. CMS should use accurate and updated information on uninsurance rates to calculate Factor 2, reflective of changes in ACA Premium Tax Credits (PTCs), and other factors driving changes in insurance enrollment.

Factor 2 of the Medicare DSH formula adjusts Medicare uncompensated care payments based on the number of uninsured individuals. **We appreciate the proposed $1.5 billion increase in UC-based DSH amounts because of projected increases in the number of uninsured individuals, but we are concerned that CMS' projections do not fully account for all circumstances that could increase the number of uninsured individuals in FY 2026.**

CMS is required to use the "most recent period for which data is available" in calculating Factor 2 in the Medicare DSH formula.[21] In the proposed rule, CMS uses projections from the National Health Expenditure Accounts to estimate a modest increase in uninsurance rates to estimate a 3.5 million increase in the uninsured for FY 2026.

We agree with CMS' assessment that the number of uninsured individuals is expected to rise next year, but we are concerned that this assessment does not take into account all recent policy developments that will increase the number of uninsured individuals, such as the unwinding of the Medicaid continuous coverage protections, the expiration of the ACA's enhanced premium tax credits statutorily mandated by the Inflation Reduction Act, and recent rules to change eligibility requirements for federal health programs.[22]

Despite changes in federal policy that should affect the baseline calculation since the finalizing of the FY 2025 IPPS rule, CMS continues to reference the same 29.6 million uninsured figure for FY 2026.

Additionally, Congress has proposed several potential changes to Medicaid funding, which have the potential to dramatically change enrollment patterns in FY 2026 if enacted. For example, CBO estimates that the reconciliation recommendations considered by the House Energy and Commerce Committee would increase the number of uninsured individuals by 7.7 million by

[21] Section 1886 (r)(2)(B)(ii)(II) of the Social Security Act
[22] 26 CFR Sec. 1.36B-2

2034.[23] **CMS must be prepared for and respond to these changes should they be implemented before the FY 2026 IPPS rule is finalized.**

c. CMS should monitor changes in UC reported during the pandemic to ensure data accuracy and avoid improper redistributions of Medicare DSH funding away from essential hospitals.

Factor 3 of the Medicare DSH methodology ensures that Medicare uncompensated care payments are targeted to the DSH hospitals with the highest uncompensated care costs. As we have suggested in previous years, we urge CMS to continue to refine its methodology to capture these costs and to consider how best to account for changes in uncompensated care reported during the COVID-19 pandemic. **CMS should mitigate the effect of anomalies reported during the pandemic that will adversely impact UC-based DSH payments in FY 2026 and future years.**

i. CMS should review how disruptions in care during the COVID-19 pandemic affected Factor 3 calculations to ensure data accuracy.

Since the FY 2024 IPPS rule, CMS has used an average of uncompensated care delivered over a three-year period to determine a hospital's Factor 3 amount. **For FY 2026, the three-year average is calculated from UC provided between 2020–2022, a window entirely comprised of a time when hospitals experienced tremendous swings in utilization, occupancy, and patient care decisions. This data is not necessarily representative of the care hospitals provide today.**

During the COVID-19 pandemic, hospitals suspended their regular operations and experienced substantial, temporary changes in payer mix. At the prompting of federal guidance and state orders, hospitals postponed non-emergent and elective procedures. In addition, many patients were reluctant to seek care in emergency departments (EDs) or outpatient clinics, even for severe conditions, such as heart attack or stroke. One survey showed that nearly half of Americans put off seeking care because of the COVID-19 pandemic.[24]

Essential hospitals responded to the needs of their communities in ways that might have led to temporary changes in the types of patients they normally see. Some hospitals focused primarily on care for COVID-19 patients in the hospital, while other hospitals expanded their use of telehealth to provide care in alternative settings. Hospitals in cities with fewer COVID-19 cases might not have seen the same surge in COVID-19 patients but still were required to postpone their nonemergent cases to prepare for a possible surge.

Federal policy changes also affected hospitals' payer mix, including the Medicaid continuous coverage requirement discussed above and the fact that the Health Resources and Services Administration temporarily covered COVID-19-related care provided to uninsured individuals. Both provisions temporarily reduced the amount of uncompensated care hospitals reported on worksheet S-10 according to CMS guidance. Together, these changes dramatically changed how

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[23] Congressional Budget Office. CBO emails re: E&C reconciliation scores, May 11, 2025. U.S. House Committee on Energy & Commerce Democrats. https://democrats-energycommerce.house.gov/sites/evo-subsites/democrats-energycommerce.house.gov/files/evo-media-document/cbo-emails-re-e%26c-reconcilation-scores-may-11%2C-2025.pdf. Accessed May 20, 2025.

[24] Lawrence E. Nearly Half of Americans Delayed Medical Care Due To Pandemic. *Kaiser Health News*. May 27, 2020. https://khn.org/news/nearly-half-of-americans-delayed-medical-care-due-to-pandemic. Accessed May 13, 2025.

much and what uncompensated care hospitals provided. In 2020, hospitals nationwide provided $1.35 billion less uncompensated care than the year prior, and in 2022, they were still providing less uncompensated care than in 2019.[25]

These temporary reductions in UC during the pandemic may not reflect the amount of UC hospitals provided prior to 2020 and in later subsequent years. **As a result, we encourage CMS to more thoroughly review the effect of the pandemic on its UC estimates and consider steps to dampen the effect of any large downward swings in UC attributable to COVID-19 that will have a large, redistributive effect on UC-based payments.** One option to consider is for CMS to use its authority to ensure the inclusion of FY 2020, FY 2021, and FY 2022 data does not reduce Factor 3 for essential health systems as designated through the criteria discussed above.[26]

ii. CMS should include all patient care costs when using the S-10 to determine the UC costs and issue other clarifying guidance to improve the accuracy of these data.

As we have commented in previous years, we remain concerned that the amount of uncompensated care reported on Worksheet S-10 does not accurately reflect all the uncompensated care hospitals provide. As a result, we continue to urge CMS to make technical changes to capture the full costs of services essential hospitals provide. This way, Medicare DSH payments can be equitably targeted to the hospitals doing the most to provide access to underserved populations.

In general, we are concerned Worksheet S-10 does not currently account for all patient care costs when converting charges to costs. Most important, the current worksheet ignores substantial costs hospitals incur in training medical residents, supporting physician and professional services, and paying provider taxes associated with Medicaid revenue. As CMS continues using Worksheet S-10 as the data source for measuring UC costs, the agency should refine the worksheet to incorporate all patient care costs, including those for teaching, into the cost-to-charge ratio (CCR). In particular, CMS should:

- Use the total of worksheet A, column 3, lines 1 through 117, reduced by the amount on worksheet A-8, line 10, as the cost component
- Use worksheet C, column 8, line 200, as the charge component

The line items above are not limited to Medicare-allowable costs and include additional patient care costs, such as the cost of graduate medical education (GME). Because of this, the result would more accurately reflect the true cost of hospital services, compared with the CCR currently in Worksheet S-10.

CMS should include GME costs when calculating a hospital's CCR. Excluding these costs will disproportionately affect teaching hospitals by reducing their share of the UC pool relative to other hospitals. The costs associated with direct GME constitute a significant portion of overall costs at essential hospitals. Excluding these costs in the CCR understates teaching hospitals' UC costs when it converts those hospitals' UC costs to charges. Incorporating GME

[25] Analysis of FY-2020 Final Rule - FY 2026 IPPS Proposed Rule Medicare DSH Supplemental Data Files, CMS. Accessed May 19, 2025.
[26] Section 1886 (r)(2)(C)(i) of the Social Security Act allows the Secretary to select an appropriate time period for the collection of UC data and determine on a case-by-case basis whether alternative data would be a better proxy for uncompensated care costs.

costs into the CCR would reflect the full range of costs teaching hospitals incur. By excluding these costs, CMS' proposed CCR for determining UC costs will penalize teaching hospitals, such as academic medical centers, which tend to provide high levels of UC.

CMS also should include the cost of providing physician and other professional services when calculating UC. In addition to employing physicians and paying community specialists directly for patient care, many essential hospitals subsidize the cost of physician services to ensure vulnerable patients have access to necessary care. Because hospitals regularly incur these costs when providing charity care and other UC, CMS should recognize them when determining UC.

CMS should treat the unreimbursed portion of state or local indigent care programs as charity care. Many state or local indigent care programs are not formal insurance products but, rather, local coverage programs that help reduce hospitals' overall UC costs through de minimis reimbursement for services. These programs typically support the same populations that qualify for hospital charity care policies. Just as the unreimbursed costs for charity care patients are recognized in the S-10, the worksheet also should reflect the unreimbursed portion (i.e., the shortfall) of state or local indigent care programs.

Moreover, the agency should revise the S-10 so data on Medicaid shortfalls better resemble actual shortfalls incurred by hospitals. CMS to date has not used Medicaid shortfalls from the S-10 when calculating UC costs. We agree that Medicaid shortfalls, as currently reported on the S-10, should not be included in the calculation of UC. Nonetheless, all information produced on the S-10, including data not used in CMS' DSH calculations, should be an accurate representation of a hospital's UC and other costs. Data on Medicaid shortfalls is useful for informational purposes, as previously uninsured low-income individuals gain access to health coverage through Medicaid. Further, data on the unreimbursed costs of providing care to Medicaid patients (many of whom formerly were uninsured) will provide information on Medicaid underpayment and, thus, should be accurate.

Current data underestimate the amount of Medicaid shortfalls. First, GME-related costs are excluded, while GME-related reimbursements are included. Without the necessary revision to the CCR mentioned above, counting payments but not costs inaccurately measures shortfall. Second, the S-10 should consistently allow hospitals to reduce their Medicaid revenue by the amount of any contributions to funding the nonfederal share of the Medicaid program, whether through provider taxes, intergovernmental transfers (IGTs), or certified public expenditures (CPEs). Like provider taxes and assessments, provider-funded IGTs and CPEs are used to finance the nonfederal share of Medicaid and are critical to a state's ability to fund the program at adequate levels.

Allowing offsets for one such type of contribution—for example, provider taxes and assessments—and not others distorts shortfall amounts and might create inequities among hospitals. Because of this discrepancy in the instructions and the different types of permissible arrangements used by states, the S-10 in its current form provides an incomplete picture of Medicaid shortfalls and should be revised to allow hospitals to deduct IGTs, CPEs, and provider taxes from their Medicaid revenues.

CMS also should clarify the instructions on line 29 regarding non-Medicare bad debt for insured patients. CMS' revised cost report instructions and guidance dictate hospitals do not have to multiply non-reimbursed Medicare bad debt by the CCR, because coinsurance and deductibles are actual amounts expected from the patient (as opposed to

charges, which are not the actual amounts a patient is expected to pay). However, CMS' September 2017 transmittal states that hospitals still should multiply their non-Medicare bad debt by the CCR.

The different treatment of non-reimbursed Medicare bad debt and non-Medicare bad debt is inconsistent, and the agency provides no justification for the inconsistency. Coinsurance and deductible amounts for patients other than Medicare fee-for-service (FFS) patients, such as those with Medicare Advantage, are actual amounts the hospital expects patients to pay. Therefore, hospitals should list unpaid coinsurance and deductible amounts as bad debt in their entirety and CMS should not reduce those amounts by the CCR. Making this change would be consistent with the way CMS treats charity care amounts for insured patients. CMS has clarified that charity care amounts for insured patients—that is, coinsurance and deductible amounts patients do not have the ability to pay—do not have to be reduced by the CCR. **CMS should clarify the instructions for bad debt expenses to treat all coinsurance and deductibles for non-Medicare bad debt the same—not multiplying them by the hospital CCR.**

iii. CMS should provide clear guidelines on its audit protocols and ensure Worksheet S-10 reviews impose minimal burden and are fairly applied across all hospitals.

CMS has yet to make public its audit protocols; it is imperative the agency do so to be transparent with stakeholders about which factors it will use to determine the need to audit a hospital. **We urge the agency to disclose the criteria it uses to identify hospitals for audits. Given the relative and redistributive nature of DSH payments, it is important to ensure audits are conducted consistently and equitably.** Under the methodology of CMS' DSH calculation, a change in even one hospital's reported UC costs will alter its Factor 3 and, in turn, affect all other hospitals' Factor 3 values. Thus, any inaccurate audits or audits conducted selectively for some hospitals but not others will skew DSH payments across the board.

In addition, CMS must minimize the burden associated with audit documentation requests and conduct the audits well in advance of using the data for payment purposes, so hospitals can mitigate adverse findings. We are concerned the audits so far have been extremely burdensome. For example, some Medicare Administrative Contractors (MACs) have asked hospitals to compile and turn over large amounts of information not already available in their financial recordkeeping systems.

CMS can avoid these issues by providing more transparency for its audit protocols. Publishing audit protocols in advance will allow the hospital community more time and opportunity to respond to audits and address findings. CMS also should review audit findings to ensure MACs and subcontractors consistently apply audit protocols across hospitals nationwide. Finally, CMS should complete audits well in advance of its rulemaking for a given year to ensure the cost report data used are accurate and final. The accuracy and uniformity of audits across DSH hospitals are critical to ensure the data CMS uses to calculate UC-based payments are accurate and do not unfairly disadvantage audited hospitals at the expense of hospitals that were not audited.

Considering Essential Hospitals' Unique Needs in Other Aspects of Medicare Policy

In addition to payment rate increases, CMS can support essential hospitals through its workforce and quality improvement policies, as discussed below.

3. CMS should prioritize the distribution of new resident slots to essential hospitals.

As part of their commitment to training the next generation of health professionals, essential hospitals train more than three times as many physicians as other teaching hospitals, and on average train a number of physicians that is 30% higher than their GME cap. Because essential hospitals play such an outsized role in preparing health care professionals to care for all patients, prioritizing the distribution of residency slots to essential hospitals would help ensure all patients have access to needed medical care.

We appreciate CMS' continued implementation of the graduate medical education (GME) expansions authorized by the Consolidated Appropriations Act, 2021. In the FY 2026 proposed rule, CMS offers important clarifications for calculating full-time equivalent (FTE) counts during non-standard cost reporting periods. We appreciate the clarification and urge CMS to consult with stakeholders like America's Essential Hospitals—whose member teaching hospitals trained an average of 231 physicians in 2022—if any further modifications should be made. These technical adjustments are welcome and necessary to ensure the accuracy of Medicare GME payments and the fair allocation of limited residency training resources.

We recognize CMS' obligations under Section 5506 of the ACA to prioritize reallocation of GME slots from closed teaching hospitals and appreciate the opportunity for existing teaching hospitals to apply for these GME cap slots. However, with an essential hospital designation, CMS could prioritize allocation of slots under **Section 126 of the Consolidated Appropriations Act, 2021 to the hospitals that are most efficiently training new physicians** and have the capacity to train more.

4. CMS should consider essential hospitals' unique needs in TEAM.

America's Essential Hospitals remains concerned about the use of mandatory payment models like TEAM, particularly when applied to hospitals that care for high-need populations. Safety net providers operate under persistent resource constraints and serve communities with complex medical and social needs. Requiring their participation in a model that involves financial risk, without sufficient flexibility or support, could threaten access to care and worsen existing gaps in care.

Although we do not support the mandatory nature of TEAM, we appreciate the intent of the model to include adjustments for providers that serve a safety net role. **However, the proposed adjustments for safety net providers do not go far enough to ensure that essential hospitals can succeed in TEAM.**

Below we offer comments on how CMS can better support safety net providers participating in TEAM and on the programmatic changes to TEAM discussed in the proposed rule.

a. CMS should publish a list of safety net providers as soon as possible.

We are concerned that CMS has not yet published a list of hospitals that satisfy the definition of a safety net hospital in TEAM, as defined in 42 CFR 512.505. **CMS should publish its safety net provider list as soon as possible so affected hospitals can plan accordingly.**

b. CMS should provide upfront infrastructure payments or targeted technical assistance grants to TEAM participants that serve a safety net role to ensure they can make necessary investments to succeed under the model.

America's Essential Hospitals reiterates our strong recommendation that CMS provide up-front infrastructure payments to hospitals serving a safety net role that are required to participate in TEAM.[27] As CMS has acknowledged in previous rulemaking, safety net hospitals frequently operate with limited access to capital and narrower financial margins due to the high proportion of uninsured and publicly insured patients they serve. These resource constraints often impede the ability to invest in critical infrastructure required to succeed in a value-based care model with financial risk.

Due to significant start-up and implementation costs, many past CMMI models have increased costs for providers without resulting in substantial benefits for patients.[2]Thus, we strongly urge CMS to provide direct infrastructure payments or targeted technical assistance grants for TEAM participants that meet safety net criteria to ensure equitable model participation and success.

c. CMS should allow essential hospitals to remain in Track 1 throughout TEAM and adopt asymmetric risk for Track 2 to align incentives with their financial realities.

We continue to urge CMS to grant essential hospitals maximum flexibility in selecting their TEAM participation track. These hospitals should have the option to remain in Track 1 with no downside financial risk for the full duration of the model. A voluntary transition to downside risk should occur only when a hospital can demonstrate operational readiness and has received sufficient support.

For hospitals participating in Track 2, we recommend that CMS adopt an asymmetric risk structure: allowing the same upside potential as Track 3 hospitals (up to 20%) but limiting downside risk to 10%. This approach creates a more equitable pathway for transformation, appropriately balancing financial incentives and risks for safety net providers that operate under significant fiscal constraints.

d. CMS should maintain hospitals' safety net status for the entire five-year TEAM period to ensure financial predictability and promote long-term planning.

Long-term planning and budgeting require predictability, especially for safety net hospitals that make multiyear investments in facilities, personnel, and community-based services. We urge

[27] Siegel B, Bruce. Letter to Chiquita Brooks-LaSure on Comment Letter to CMS on FY 2025 IPPS Proposed Rule. June 10, 2024. https://essentialhospitals.org/wp-content/uploads/2024/06/AEH-FY2025-IPPS-Comment-letter.pdf. Accessed May 20, 2025.

CMS to finalize a policy that locks in a participant's safety net status for TEAM's full five-year duration.

Annual reassessments of safety net status could create disruptive financial uncertainty and hinder participants' ability to engage fully in model activities. Maintaining consistent status will allow safety net hospitals to plan and implement care transformation strategies effectively, while mitigating unnecessary administrative burdens and funding instability.

e. CMS should exclude the PRO-PM from the mandatory TEAM measure set and instead pursue a voluntary, phased implementation with tailored support for safety net providers.

America's Essential Hospitals supports the use of quality measures that reflect meaningful, patient-centered outcomes, including recovery and the resumption of daily activities following procedures such as lower extremity joint replacement and spinal fusion. While we recognize the value of patient-reported outcomes (PROs), we have significant concerns about the proposed mandatory inclusion of a Patient-Reported Outcome Performance Measure (PRO-PM) in TEAM.

Essential hospitals serve individuals with complex medical and social needs. They face structural challenges in PRO collection due to limited health literacy, language differences, and reduced access to patient portals and mobile health platforms among patients. These barriers affect response rates and the reliability of data—not because of poor care, but because of patients' limited ability to engage with collection tools. Additionally, essential hospitals often lack the staff and infrastructure required to implement robust PRO collection workflows.

Including the PRO-PM without addressing these limitations would create an uneven playing field and could unfairly penalize hospitals serving high-need populations. We strongly urge CMS to delay PRO-PM implementation and instead adopt a phased, voluntary approach. During this time, CMS should partner with safety net hospitals to explore alternative data collection strategies, tailored outreach approaches, and community-based engagement. CMS also should evaluate variation in PRO data collection by patient demographics and hospital characteristics and develop risk adjustment or stratification methods to ensure equitable comparisons. Finally, technical assistance and infrastructure support will be essential to help resource-limited hospitals build capacity to collect and report these measures effectively. Until these steps are taken, we recommend excluding the PRO-PM from TEAM's mandatory measure set to avoid unintended consequences for hospitals serving the most medically and socially complex patients.

f. CMS should extend Skilled Nursing Facility (SNF) 3-Day Rule Waiver eligibility to swing beds regardless of star rating and allow flexibility in star rating requirements to avoid limiting post-acute care access in underserved areas.

America's Essential Hospitals appreciates CMS' proposal to extend the SNF 3-Day Rule Waiver to TEAM participants and supports this effort to streamline post-acute care transitions for beneficiaries. **We are particularly supportive of CMS' consideration of hospital swing beds under this waiver, which are often access points for post-acute care, especially in rural and smaller hospitals.**

However, we are concerned about the proposed requirement that SNFs participating under the waiver must have a CMS star rating of three stars or higher. While this requirement aims to promote high-quality care, it could severely limit access in underserved regions, both rural and urban, where fewer SNFs meet that threshold. For essential hospitals, this restriction could result in delayed discharges, extended inpatient stays, and higher Medicare costs. It could also disrupt existing, trusted care coordination relationships that hospitals have with lower-rated but locally accessible SNFs and swing beds.

To ensure the waiver promotes equitable access and continuity of care, we recommend that CMS: (1) permit the use of swing beds under the waiver regardless of CMS star rating and (2) monitor the availability of eligible SNFs and swing beds in TEAM-participating regions to identify any gaps and adjust policy as needed. These changes will help ensure the waiver achieves its goal of improving patient-centered discharge planning without creating unintentional barriers for the vulnerable populations essential hospitals serve.

5. CMS should continue refining quality programs to contain only reliable, valid measures that accurately represent care quality.

CMS should continue to tailor the Hospital Inpatient Quality Reporting (IQR) Program, Hospital Value-Based Purchasing (VBP) Program, and Hospital Readmissions Reduction Program (HRRP) so they help hospitals improve care quality and benefits the public by accurately reflecting hospital care. America's Essential Hospitals support creating and implementing measures that lead to quality improvement.

In general, we appreciate CMS' consideration of the regulatory burden imposed by quality measures and its proposals to remove unnecessary measures. The association will submit separate public comments to CMS to elaborate on ways the agency can continue to reduce regulatory burden for hospitals.

We also appreciate CMS' interest in developing quality measures related to well-being and nutrition. Our member leaders in this space routinely invest in services that support patients' physical, emotional, and behavioral health alongside clinical care—79% of our members are addressing food insecurity, often through partnerships to operate food pantries, provide meal delivery, and increase access to nutritious food; 75% percent support healthy behaviors such as improved diet and physical activity; and 70% provide services that strengthen family and social support systems.[28]

For example, one member screened patients with uncontrolled diabetes for food insecurity and referred those in need to a healthy food center. Patients received weekly access to fresh produce and nutrition education, resulting in increased fruit and vegetable intake, improved self-reported health status, and better quality of life. A program survey showed a 33% increase in daily consumption of fruits and vegetables, an increase from 78% to 80% in patients reporting "good" or "very good" health, and a 27% improvement in patients who said they were never kept from daily activities due to poor physical or mental health.

Another member hosts one of the first hospital-based culinary medicine programs in the country. It offers over 300 classes annually to more than 2,000 patients and staff, with

[28] Miu R, Kelly K, Nelb R. *Essential Data 2024: Our Hospitals, Our Patients—Results of America's Essential Hospitals 2022 Annual Member Characteristics Survey*. America's Essential Hospitals. December 2024. essentialdata.info. Accessed June 3, 2025.

programming designed to improve dietary habits, support chronic condition management, and promote long-term health. Integrated into their clinical care, the teaching kitchen collaborates with departments such as cardiology, endocrinology, and pediatrics, and partners with community organizations and local higher education institutions to extend its reach and impact. Surveys indicate improved dietary patterns, increased culinary skills, and enhanced self-reported health among participants.

We encourage CMS to develop quality measures that recognize the diverse approaches hospitals use to support nutrition and well-being, including clinical interventions and community-based strategies such as food pharmacies, medically tailored meals, and culinary education programs. However, any future measures should allow flexibility in implementation and avoid penalizing hospitals that may not have the resources to offer these services. Measures should be designed to acknowledge and incentivize innovation without creating additional burden for hospitals serving high-need populations with limited funding.

6. CMS should not use MA data in the HRRP until it evaluates the effects of these changes on essential hospitals.

Given the rapid growth of MA enrollment, we understand the administration's interest in using MA data to better understand the quality of care provided to Medicare beneficiaries. However, we have significant concerns about how MA data could affect hospital performance and payment under the HRRP. **As a result, CMS should not use MA data in HRRP until it fully evaluates how these changes would affect essential hospitals.**

Below, we offer several technical issues that CMS should consider when assessing how MA affects quality measures for essential hospitals. However, to enable further analyses, CMS should also make the MA data that it collects available to stakeholders so they can replicate these analyses and consider other potential unintended effects of these policies.

a. Consider the reliability of MA encounter data.

We echo MedPAC's concerns about the accuracy and completeness of MA encounter data.[29]MA data remain less complete and less reliable than FFS Medicare claims data, which could undermine the integrity of performance comparisons. MedPAC has explicitly recommended that Congress take steps to improve the quality of MA encounter data to facilitate valid comparisons with FFS Medicare. Until CMS can ensure that MA encounter data are accurate, complete, and comparable, it would be premature to use these data in programs tied to financial penalties.

b. Consider the effects of regional MA penetration on hospital performance.

Because MA patients are generally healthier than patients covered in Medicare FFS, the inclusion of more MA patients in the HRRP quality measure may improve a hospital's performance on this measure. However, because HRRP penalties are assessed based on a hospital's performance relative to other hospitals, hospitals in markets with lower MA

[29] Medicare Payment Advisory Commission. Report to the Congress: Medicare and the Health Care Delivery System. 2019; Chapter 7. https://www.medpac.gov/wp-content/uploads/import_data/scrape_files/docs/default-source/reports/jun19_ch7_medpac_reporttocongress_sec.pdf. Accessed June 4, 2025.

penetration may unfairly hurt by this policy change. **Overall, CMS should ensure that MA measures used in hospital quality programs are appropriately adjusted so that hospitals are not penalized for factors outside of their control, such as the MA penetration in their local market.**

c. CMS should consider the effects of MA networks on DSH hospitals.

Some of our member hospitals have experienced challenges with being included in MA networks because MA plans do not want to pay the DSH and UC adjustments that are part of the Medicare payment rate. These adjustments are included in MA capitation rates, but because CMS does not regulate how MA plans pay providers, MA plans are not required to pass along these important adjustments to essential hospitals. As a result, some essential hospitals choose to be out-of-network for MA plans so that they are paid at least the FFS payment rate for out-of-network emergency care.

If an MA-enrolled patient has an out-of-network hospital stay, the hospital has less ability to provide care to the patient after their hospital stay, which could increase the likelihood of a hospital readmission. However, it does not appear the current CMS reporting collects information about whether an MA hospital stay is in-network or out-of-network. **CMS should collect and review MA network information and consider how the exclusion of essential hospitals harms quality and access to care for Medicare patients.**

d. CMS should appropriately risk-adjust readmission rates to avoid disproportionately harming essential hospitals

Overall, changes in a hospital's readmission rates from the inclusion of MA data could substantially affect hospital payments. To illustrate the potential magnitude of these changes, America's Essential Hospitals contracted with McDermott+ to examine how expected readmission ratios could change based on including unadjusted MA readmission rates. **Overall, we estimate that adding MA data without adjustment would increase HRRP penalties by as much as $427 million, which is much greater than the $41 million in cuts that CMS assumes in the proposed rule.** The percent increase in penalties for members of America's Essential Hospitals would be 9% higher than the percent increase in penalties for other hospitals under this scenario, showing a disproportionate impact for our member hospitals.

Appropriate risk adjustment can help mitigate the effects of these changes, so it is important that CMS fully examine that the risk adjustment is done properly. CMS's current risk adjustment methods are largely based on FFS data and so it is not clear that these methods will work the same for MA data because of coding differences in MA. **In particular, CMS should ensure that its risk adjustment methods do not disproportionately harm essential hospitals.**

7. CMS should avoid unintentional FFS penalties because of differences in MA utilization.

In addition to concerns about how readmission rates will change with the inclusion of MA data into HRRP, we also have concerns about how HRRP penalties will be applied to Medicare FFS payments. In particular, we are concerned that using MA data to determine the DRG ratio that is used to calculate HRRP penalties likely will increase the total penalty amount because of

differences in the share of patients who meet the qualifying criteria for HRRP, not because of differences in performance.

Our analysis found that **even if there was no change in readmission rates, hospitals would face $41 million in additional penalties because of differences in the characteristics of patients covered by MA.** The vast majority of these increased penalties ($40.6 million) are attributable to hospitals that would have larger penalties because of changes in their DRG ratio. An additional $0.4 million in penalties are for hospitals that would newly qualify for the penalties because they would meet the 25 case minimum thresholds with the inclusion of MA data.

Overall, if CMS moves forward with including MA data in the calculation of HRRP, it should ensure that the DRG ratios are only calculated based on FFS data to avoid unintentional FFS penalties for differences in MA utilization. Also, CMS should ensure that the minimum case threshold remains at a minimum of 25 FFS cases or 50 combined FFS and MA cases.

8. CMS should finalize the extraordinary circumstances exception (ECE) policy.

America's Essential Hospitals strongly supports CMS' proposal to codify and clarify the Extraordinary Circumstances Exception (ECE) policy within the Hospital IQR Program, HRRP, Hospital-Acquired Condition (HAC) Reduction Program, and Hospital VBP Program.

Our members are often located in communities vulnerable to natural disasters, public health crises, and infrastructure disruptions. The proposed rule provides critical flexibility by formally recognizing that events beyond a hospital's control can compromise data reporting, and that an extension of time may be a necessary and appropriate form of relief. We especially appreciate the clarification that CMS may proactively grant ECEs when widespread, systemic issues or regional emergencies affect hospitals' ability to report data, regardless of whether an individual hospital submitted a request.

Maintaining fairness and integrity in performance-based payment programs requires the ability to account for extraordinary circumstances. This policy ensures that hospitals are not penalized for issues unrelated to the quality of care provided, particularly those serving low-income populations.

We urge CMS to finalize this proposal and continue working with stakeholders to ensure that the ECE process is responsive, transparent, and equitable.

9. CMS should support essential hospitals with the transition to electronic clinical quality measures (eCQMs)

We appreciate the administration's interest in expanding the use of eCQMs to help reduce administrative burden for hospitals. The use of common standards, such as the Health Level 7 Fast Healthcare Interoperability Resources (FHIR) is an important step toward reducing many of the overly complex and duplicative processes in the current quality measurement landscape. Essential hospitals support efforts to reduce administrative burden but may need additional time and support to transition to new standards because they operate on thin operating margins and may not have the resources available to invest in new systems. **As a result, CMS should prioritize essential hospitals in its efforts to support hospitals making the transition to FHIR-based eCQM data.**

As CMS updates its standards for eCQMs, it also should use this opportunity to streamline and better align quality measures across programs, focusing on a targeted set of evidence-based measures that are clearly linked to improved health outcomes. Reducing the volume of overlapping or low-value measures will help hospitals more efficiently direct their resources toward clinical improvements and patient needs. We have provided additional comments on opportunities to streamline quality measures in response to CMS' request for information on areas to reduce regulatory burden in Medicare.

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America's Essential Hospitals appreciates the opportunity to submit these comments. If you have questions, please contact Director of Policy Robert Nelb, MPH, at 202-585-0127 or rnelb@essentialhospitals.org.

Sincerely,

Bruce Siegel, MD, MPH
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