



# AMERICA'S ESSENTIAL HOSPITALS

June 9, 2026

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-1849-P: Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals (IPPS) and the Long-Term Care Hospital Prospective Payment System and Policy Changes and Fiscal Year (FY) 2027 Rates; Requirements for Quality Programs; and Other Policy Changes**

Dear Administrator Oz:

Thank you for the opportunity to comment on the 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.** As CMS finalizes this rule, we ask the agency to consider these comments on ways to 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 400 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 accounted for only 6% of acute-care hospitals nationwide, they provided 29% of the nation's charity care in 2023.**<sup>1</sup> More than three-quarters of the patients essential hospitals serve are uninsured or covered by

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<sup>1</sup> Miu R, Kelly K, Nelb R. *Essential Data 2025: Our Hospitals, Our Patients—Results of America's Essential Hospitals 2023 Annual Member Characteristics Survey*. America's Essential Hospitals. November 2025. [essentialdata.info](https://essentialdata.info). Accessed May 7, 2026.

Medicare and Medicaid.<sup>2</sup> In addition, nearly two-thirds of essential hospitals provided services to rural patients and communities in 2022.<sup>3</sup> 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 essential hospitals provide. Essential hospitals take care of more Medicare and Medicaid patients than other hospitals. Since payment rates for those programs are lower than those of other payers, essential hospitals have lower operating margins. **In 2023, members of America’s Essential Hospitals had an aggregate operating margin of -7.1%, which was far worse than the aggregate operating margins for all other hospitals (-2%).**<sup>4</sup> Over time, this underinvestment has limited the ability 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 the following priority areas for agency action:

- Eliminating mandatory participation in the comprehensive care for joint replacement expanded (CJR-X) model and addressing known harms to essential hospitals
- Establishing a federal designation for essential hospitals
- Ensuring adequate funding for essential hospitals
- Supporting essential hospitals’ role in developing the health care workforce
- Considering the unique needs of essential hospitals in the design of quality measurement programs

## Eliminating Mandatory Participation in the CJR-X Model and Addressing the Model’s Known Harms to Essential Hospitals

1. CMS should not mandate participation in the CJR-X model.

We have long been opposed to mandatory payment models because of the added up-front costs required to implement these models and the uncertain benefits for providers and their patients. However, **we are particularly opposed to mandatory participation in CJR-X because of the harm the initial comprehensive care for joint replacement (CJR) model caused to safety net providers.**

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<sup>2</sup> Ibid.

<sup>3</sup> 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-inRural-Areas-Brief.pdf>. Accessed May 11, 2026.

<sup>4</sup> Miu R, Kelly K, Nelb R. *Essential Data 2025: Our Hospitals, Our Patients—Results of America’s Essential Hospitals 2023 Annual Member Characteristics Survey*. America’s Essential Hospitals. November 2025. [essentialdata.info](https://essentialdata.info). Accessed May 7, 2026.

The evidence from CMS' own evaluation consistently demonstrated that safety net hospitals tended to have lower financial performance, challenges adapting to CJR, and concerns that CJR did not represent their patient populations.<sup>5</sup> **Proceeding with a mandatory expansion without first addressing these documented failures would repeat a harm CMS has already identified.**

Selection bias highly influences bundled payment models for joint replacement. In general, hospitals that were able to select healthier patients performed better in CJR because their patients had fewer care needs. However, essential hospitals that have a mission to serve all patients regardless of their health status generally performed worse in CJR because their patients had more complex care needs for which the model did not account. The CMS evaluation of CJR confirmed that safety net hospitals performed fewer outpatient and more inpatient elective joint replacements than other hospitals because patients' home environments were not safe enough for them to return home the same day. The evaluation also found that the low-income Medicare patients that safety net hospitals serve had added challenges accessing post-acute care, thus limiting essential hospitals' ability to effectively manage post-discharge care costs.<sup>6</sup>

In performance years 6 and 7, CMS introduced risk adjustment to target safety net hospital disadvantages in CJR. However, the agency's own evaluation of this change found that those adjustments had no clear impact on performance and were insufficient to offset rising internal costs. In performance year 7, safety net hospitals accounted for more than half of all hospitals with the highest per-episode repayments to Medicare, despite comprising only about one quarter of all CJR participants.<sup>7</sup>

Independent research further corroborates what CMS' own evaluation found. A study by Carey and Lin examining safety net hospital performance across the first five years of CJR found that safety net hospitals showed a performance trajectory of -\$1,011 compared with +\$1,382 for non-safety net hospitals. Thus, while other hospitals improved their financial position under CJR, safety net hospitals moved in the wrong direction.<sup>8</sup> By performance year 5, safety net hospitals received average penalties of \$1,055 per episode, while non-safety net hospitals received average rewards of \$2,096, a nearly \$3,200 per-episode gap that widened as CJR matured. The shift to fully regional target pricing, which CMS designed as a mechanism for alignment, hit safety net hospital target prices 24 to 28% harder than non-safety net hospitals, which absorbed reductions of only 12 to 14%. Critically, these authors concluded that CMS' methodology for establishing spending targets may not be sufficient to address the persistent financial performance disparities safety net hospitals face under mandatory bundled payment.<sup>9</sup> **CMS should not expand a mandatory model when both its own evaluation findings and external research indicate that the model was not appropriately designed to address safety net hospitals' needs.**

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<sup>5</sup> Markovitz A, Bijelic E, Hopewell C, et al. Evaluation of the CMS Comprehensive Care for Joint Replacement (CJR) Model. *Centers for Medicare & Medicaid Services*. December 2025. <https://www.cms.gov/priorities/innovation/data-and-reports/2025/cjr-safety-net-hospital-exp-rpt>. Accessed May 26, 2026.

<sup>6</sup> Ibid.

<sup>7</sup> Ibid.

<sup>8</sup> Carey K, Lin MY. Safety-net hospital performance under Comprehensive Care for Joint Replacement. *Health Services Research*. 2023;58(1):101–1106. <https://pubmed.ncbi.nlm.nih.gov/35904218/>. Accessed May 27, 2026.

<sup>9</sup> Ibid.

2. CMS should add more protections for safety net providers to address the unintended consequences of this model.

America's Essential Hospitals appreciates CMS' acknowledgement of the need for additional adjustments to support safety net hospital participation in CJR-X, **but the proposed remedies fall short of mitigating the challenges raised in CMS' prior CJR model.** Below, we offer suggestions for additional protections CMS could add to help level the playing field for essential hospitals. If CJR-X moves forward, CMS also should conduct a formal evaluation to reassess how the model is affecting safety net hospitals and pause the model if it continues to find evidence of disproportionate harm to essential hospitals.

- a. **CMS should provide up-front support for safety net hospitals participating in CJR-X.**

CMS' evaluation of safety net hospitals' experience in CJR-X found that more resources were needed to provide high-quality whole-person care to patients with substantial medical and nonmedical needs. CMS should provide essential hospitals with up-front investments to help implement the CJR model, such as funding to hire a nurse navigator and prepare for successful implementation. 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 their ability to invest in critical infrastructure required to succeed in a value-based care model with financial risk.

- b. **CMS should incorporate tiered participation tracks, including an option for safety net providers to participate without downside risk.**

We appreciate that CMS recognized the need for lower stop-loss protection for safety net hospitals, but we remain concerned that the proposed protections do not go far enough to protect essential hospitals and enable their successful participation in the model. To better meet essential hospitals' needs, CMS should consider creating tiered participation tracks that include an option for upside risk only. For example, in the Transforming Episode Accountability Model (TEAM), CMS recognized that participant readiness and institutional capacity vary and designed the model with three distinct tracks: Track 1 provides upside risk only, with no downside financial exposure and a positive reconciliation cap of 10%, and safety net hospitals may remain in this track for up to three years; Track 2 introduces moderate risk with stop-gain and stop-loss limits both set at 5%; and Track 3 represents full risk participation with stop-gain and stop-loss limits of 20% and the highest potential reward. This structure allows hospitals to build operational competency and financial resilience before assuming greater exposure. Given the shared goals of TEAM and CJR-X, CMS should ensure protections for safety net providers in both programs.

- c. **CMS should exclude the PRO-PM from the mandatory CJR-X measure set.**

Essential hospitals face structural, population-driven barriers to equitable PRO-PM data collection that CMS' proposed rule does not adequately address. The patients essential hospitals serve face significant obstacles engaging with PRO collection tools that have nothing to do with the quality of care they received. These barriers systematically suppress response rates at essential hospitals, producing data that reflects a patient's limited ability to engage with collection infrastructure, not a hospital's clinical performance. Tying financial reconciliation

outcomes to a measure that essential hospitals cannot collect equitably penalizes these hospitals for their mission. America's Essential Hospitals urges CMS to maintain the voluntary nature of PRO-PM participation in CJR-X, consistent with the approach finalized under the original CJR. In this model, hospitals received bonus quality points for participation and improvement rather than financial penalties for structural collection gaps.

If CMS proceeds with mandatory PRO-PM inclusion, we urge CMS to better tailor the measure to account for the needs of essential hospitals. First, CMS should restore improvement-based quality scoring. This method allows hospitals to demonstrate meaningful progress in PRO-PM collection and performance over time rather than measuring them solely against static benchmarks they are structurally less equipped to meet. Second, CMS should implement social risk adjustment methodologies for PRO-PM performance before tying these measures directly to financial reconciliation outcomes. Adjustment must account for the population-level factors that drive collection gaps at essential hospitals independent of care quality. Without both protections in place, mandatory PRO-PM participation will function as a financial penalty on essential hospitals for serving the populations that need them most.

**d. CMS should include more accountability and monitoring to help address the post-acute care challenges essential hospitals face.**

During CMS' evaluation of the original CJR, safety net hospital interviewees consistently identified post-acute care access as a critical and unresolved challenge.<sup>10</sup> Essential hospitals serve patient populations with limited access to skilled nursing facilities and inpatient rehabilitation facilities. These access gaps directly affect episode costs and discharge timelines. CMS' report recommended developing systems of shared accountability to encourage post-acute care providers to participate. In addition, CMS also should consider ways to better monitor post-acute care access barriers and provide technical assistance or modify the model if necessary.

## Establishing a Federal Designation for Essential Hospitals

Within the U.S. health care system, a small share of hospitals provides a disproportionate share of care to low-income patients. Policymakers long have recognized the need to identify these hospitals because of their role in making health care affordable for patients. **However, existing federal hospital designations fail to identify the hospitals that are the most committed to the mission of providing access to essential care in their communities.**

CMS' annual updates to Medicare hospital payment policies are a key opportunity for the agency to reassess the effectiveness of its payment policies for hospitals that federal programs support. CMS has specific authority under Section 1886(d)(5)(I) of the Social Security Act that authorizes the Secretary of Health and Human Services to offer "other exceptions and adjustments to such payment amounts under this subsection as the Secretary deems appropriate."<sup>11</sup> CMS can use this authority to designate a class of hospitals that merit special consideration in Medicare payment policy. **Using Section 1886(d)(5)(I) authority, CMS**

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<sup>10</sup> Markovitz A, Bijelic E, Hopewell C, et al. Evaluation of the CMS Comprehensive Care for Joint Replacement (CJR) Model. *Centers for Medicare & Medicaid Services*. December 2025. <https://www.cms.gov/priorities/innovation/data-and-reports/2025/cjr-safety-net-hospital-exp-rpt>. Accessed May 26, 2026.

<sup>11</sup> 42 U.S.C. § 1886(d)(5)(I) (2012).

**should create a special designation for essential health systems. This designation would give CMS a tool to appropriately consider the unique needs of essential health systems and the patients essential hospitals serve.**

We appreciate that the proposed rule modifies CJR-X for hospitals that serve a safety net role and that CMS has added a safety net provider track to TEAM. However, using different measures of safety net providers for these programs limits CMS' ability to provide consistent support for essential hospitals and evaluate how these policies affect access to essential services overall. Moreover, CMS' narrow focus on Medicare-only metrics limits CMS' ability to identify the hospitals who need the most support. **Rather than propose a new definition of safety net provider for each innovation model, we encourage CMS to develop a consistent, comprehensive, all-payer measure to use across programs.**

3. CMS should establish a federal designation for essential hospitals using practice- and evidence-based measures developed by essential hospitals.

**More than 25 years ago, the Institute of Medicine (IOM) reported that America's safety net is "intact but endangered" and recommended the creation of a federal designation for hospitals that serve a safety net role.**<sup>12</sup> Building on prior recommendations from the IOM and feedback from essential hospital leaders, America's Essential Hospitals recommends that an essential health system designation consider the following four factors:

- Payer mix that includes all low-income patients
- State variation in health coverage
- Availability and reliability of data metrics
- Mandate or mission to provide access to low-income patients<sup>13</sup>

**To help identify which providers serve key roles in supporting uninsured, Medicare, Medicaid, and dually enrolled patients, we urge CMS to consider the measures proposed in the Reinforcing Essential Health Systems for Communities Act (H.R. 7145).** America's Essential Hospitals convened safety-net leaders in 2022 to guide development of a federal designation. They affirmed the importance of payer mix and stressed using metrics already available to policymakers, focusing on mission-driven institutions, and accounting for state-level variation.<sup>14</sup>

Critically, the Reinforcing Essential Health Systems for Communities Act uses three measures to identify essential hospitals:

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<sup>12</sup> 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 7, 2026.

<sup>13</sup> 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 May 20, 2026.

<sup>14</sup> Ibid.

- **Disproportionate patient percentage (DPP)** captures a hospital’s portion of Medicaid and low-income Medicare patients. This measure long has been used in the Medicare program.
- **Medicare uncompensated care payment factor (UCPF)** measures a hospital’s share of UC costs relative to all hospitals’ UC costs and can help identify the costs of care delivered to uninsured individuals. This measure also is currently used to distribute UC-based Medicare disproportionate share hospital (DSH) payments. *To qualify via this measure, a hospital must meet a minimum UCPF of 0.0005.*
- **State-adjusted low-income care criteria** measures a hospital’s DPP and UCPF relative to other hospitals in the state to account for differences in state Medicaid coverage policies. This measure is similar to the deemed DSH standard used in the Medicaid DSH program.

The bill also uses these measures to build an essential health system index, giving CMS another way to target support to the hospitals most in need.

#### 4. CMS should use all-payer metrics to identify essential hospitals.

**Over the past several years, we have raised concerns that CMS’ use of Medicare-only metrics to identify safety net providers does not accurately identify the hospitals that need the most support.** Essential hospitals treat many patients dually eligible for Medicare and Medicaid, as well as large shares of Medicaid and uninsured patients—groups not reflected in CMS’ proposed CJR-X, TEAM, and related metrics. **As a result, these metrics fail to identify the hospitals caring for the lowest-income patients and most in need of support.**

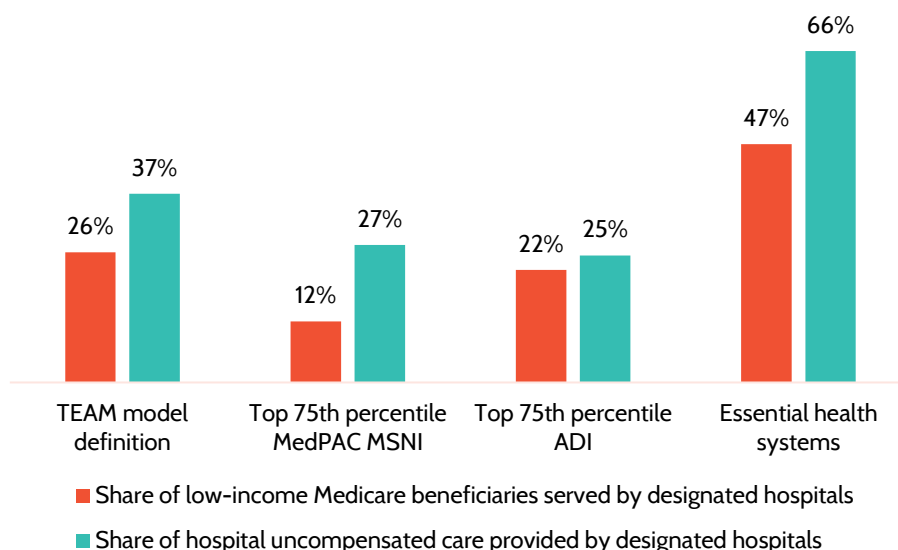
For example, in our comments on past safety net definitions, we raised concerns with the Medicare Safety-Net Index (MSNI) proposed by the Medicare Payment Advisory Commission (MedPAC), which relies on Medicare-only metrics. Thus, hospitals in the top 75th percentile of the MSNI provide half as much uncompensated care as essential health systems that meet the criteria of H.R. 7145, which uses metrics that account for Medicaid, Medicare, and uninsured patients (Figure 1).<sup>15,16</sup>

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<sup>15</sup> Siegel B. Letter to Chiquita Brooks-LaSure on Sept. 9, 2024. <https://essentialhospitals.org/wp-content/uploads/2024/09/AEHFY2025-OPPS-Comments-20240906.pdf>. Accessed May 19, 2026.

<sup>16</sup> For the purposes of analyzing CMS’ proposed TEAM safety net definition for the FY 2025 IPPS proposed rule, America’s Essential Hospitals conducted a detailed analysis that compared the TEAM safety net definition to the MedPAC MSNI measure, an area deprivation index (ADI) and for the measures included in the Reinforcing Essential Health Services for Communities Act. According to our analysis of FY 2025 data, 1,083 hospitals qualified for the proposed TEAM model definition, 651 were in the top 75th percentile of the MedPAC MSNI, 982 were in the top 75th percentile of the ADI measure, and 998 were eligible for the essential health system designation proposed in the Reinforcing Essential Health Systems for Communities Act (H.R. 7397). Analysis was limited to short-term acute care hospitals included in the Medicare inpatient prospective payment system (IPPS) and excluded Maryland and Indian Health Service hospitals.

**FIGURE 1. Essential Health Systems Provide More Uncompensated Care and Serve More Low-Income Medicare Beneficiaries than Hospitals Identified through Other Definitions**



**Notes:** TEAM is Transforming Episode Accountability Model. MedPAC is Medicare Payment Advisory Commission. MSNI is Medicare Safety Net Index. ADI is area deprivation index, and the ADI measure used in this analysis is the share of discharges in core-based statistical areas with an ADI greater than the 85th percentile nationally. Low-income Medicare beneficiaries are defined by eligibility for the low-income subsidy (LIS) or dual eligibility in Medicare or Medicaid. Analysis is based on inpatient discharges, and 75th percentile thresholds were determined using a discharge-weighted method.

**Source:** Dobson and Davanzo, 2024, analysis for America’s Essential Hospitals of 2021-2023 FFS Research Identifiable Files, 2022 Medicare cost reports, and the FY 2025 IPPS proposed rule impact file.

Measures that include Medicaid and uninsured payer mix are crucial, especially as recent Medicaid cuts will sharply increase uncompensated care. Essential hospitals face unprecedented challenges as statutory changes in the Medicaid program are expected to reduce Medicaid payments by \$279.4 billion between 2025 and 2034.<sup>17</sup> These changes will disproportionately affect essential hospitals. **By 2034, we estimate that uncompensated care costs at essential hospitals will more than double to \$44.3 billion, which would lower essential hospitals’ aggregate operating margins to -16.6% without policy action to offset these costs.**<sup>18</sup>

As CMS pursues policies to ensure beneficiaries have access to reasonable and necessary care, we urge CMS to use reliable and comprehensive measures to protect providers of essential health services.

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

<sup>17</sup> America’s Essential Hospitals. Additional Hospital Uncompensated Care Costs Projected Under Proposed Senate Revisions to H.R. 1. June 2025. <https://essentialhospitals.org/wp-content/uploads/2025/06/Additional-Hospital-Uncompensated-Care-Costs-Projected-Under-Proposed-Senate-Revisions-to-H.R.-1.pdf>. Accessed May 21, 2026.

<sup>18</sup> Ibid.

With a ready category of essential health systems, CMS then could ensure Medicare payment policies appropriately support these critical providers and the communities they serve. In this comment letter, we provide specific examples of how CMS could support essential hospitals through the Medicare IPPS rule, such as providing more protection for essential hospitals in CJR-X or exempting them from mandatory participation in this model that has proven to disproportionately harm safety net providers.

CMS also should consider other ways policies can support essential hospitals and the safety net care they provide. These include other Medicare payment systems, including fee-for-service (FFS), outpatient care, and Medicare Advantage (MA); the Medicaid program; and demonstration projects under the purview of the Center for Medicare and Medicaid Innovation (CMMI). For example, CMS should consider:

- Exempting essential hospital provider-based departments from site-neutral payment cuts to ensure access is maintained for medically underserved communities
- Updating network adequacy requirements for MA plan networks
- Limiting inappropriate denials in managed care for essential hospitals
- Developing CMMI models that recognize essential hospitals' financial challenges and unique needs, which have previously limited their ability to participate

America's Essential Hospitals appreciates CMS' interest in protecting safety net providers and looks forward to working with the agency to ensure policies preserve access to care for Medicare beneficiaries, including by finalizing and implementing an essential health system designation.

## Ensuring Adequate Funding for Essential Hospitals

Essential hospitals face significant financial challenges because Medicare and other government payers reimburse far less than commercial payers. CMS has an obligation to preserve access to care for beneficiaries these providers serve through payment adjustments that support essential hospitals. While we appreciate that CMS continues to provide routine updates to payment amounts for inpatient care, **essential hospitals continue to struggle in the face of rising uninsurance rates, increasing labor costs, and medical product inflation rates that outpace inflation in other settings.**

These financial challenges show few signs of abating. One recent study found that bad debt and charity care have increased 38% per calendar day when comparing year-to-date data in December 2022 to December 2025.<sup>19</sup> **In the face of these financial challenges, we urge CMS to use its authority to ensure annual IPPS payment updates and DSH funding methodology in FY 2027 accurately reflect current hospital costs and protect access to care for all beneficiaries.**

6. CMS should increase its proposed payment update to accurately account for rising costs of hospital goods and services.

**CMS' proposed net payment update of 2.4% is inadequate in the face of hospitals' increasing costs in FY 2027.** Unfortunately, Medicare payment rates have failed to keep up

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<sup>19</sup> KaufmanHall. December 2025 Metrics National Hospital Flash Report. February 2026.

[https://www.kaufmanhall.com/sites/default/files/2026-02/KH-NHFR\\_Report\\_December2025\\_Metrics.pdf](https://www.kaufmanhall.com/sites/default/files/2026-02/KH-NHFR_Report_December2025_Metrics.pdf). Accessed May 21, 2026.

with inflation in recent years as hospitals incur unprecedented costs and high uncompensated care rates. In its March 2026 report to Congress, MedPAC determined “FFS Medicare payments for inpatient and outpatient services continued to be well below hospitals’ costs in aggregate” for FY 2024 and that hospitals’ FFS Medicare margin was -12.1%.<sup>20</sup> As CMS updates inpatient payment amounts, we urge the agency to consider this underlying reality.

The 2.4% proposed increase will compound the challenges essential hospitals face after years of inadequate updates. **Accounting for the proposed FY 2027 rate increase, CMS will have provided a total adjustment increase of merely 8.1% since FY 2025. This increase is less than one-third the rate of increase in supply expenses (27%) and approximately half the rate of increase in labor expenses (15%) over the same period.**<sup>21</sup> IPPS payment updates remain inadequate given the historic underinvestment in essential health care systems. We urge CMS to revise its FY 2026 update methodology so it fully reflects inflation’s effect on hospital costs.

## 7. CMS must ensure Medicare payment benchmarks adequately support beneficiary access across programs.

The Social Security Act requires CMS to recalibrate diagnosis-related group (DRG) “classifications and weighting factors” “at least annually” to reflect changes in hospital resource use. It also authorizes the Secretary to implement necessary additional payment adjustments to account for factors not adequately captured in the IPPS methodology.<sup>22</sup>

Medicare rates now serve as benchmarks across many federal programs, so CMS must ensure IPPS payments fully support beneficiary access, including payments for services Medicare patients use less often. **To meet its statutory obligations, CMS should account for how Medicare rates ripple across other programs through benchmarking.**

The Working Families Tax Cut legislation (WFTCL) established new ties between the Medicare and Medicaid programs that cause Medicare payment rates to serve as a benchmark for state Medicaid programs. Considering the WFTCL’s policy changes, we are particularly concerned that low Medicare payment rates—especially for services like labor and delivery—will reduce service availability for beneficiaries that fall short of the reasonable and necessary standard.

Medicaid cuts risk significant service-capacity losses that extend beyond Medicaid patients. Essential hospitals—only 6% of acute-care hospitals—provide a disproportionate share of critical services, including 16% of neonatal intensive care unit beds, 21% of psychiatric beds, 31% of level I trauma centers, and 43% of burn beds. Inadequate Medicare benchmarks threaten their ability to sustain these high-loss services.

One study found all-payer margins for these key services are uniformly negative: -25.5% for behavioral health, -19.1% for burn and wound care, -8.4% for trauma, and -8.1% for

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<sup>20</sup> Medicare Payment Advisory Commission (MedPAC). March 2026 Report to Congress. March 2026. [https://www.medpac.gov/wp-content/uploads/2026/03/Mar26\\_MedPAC\\_Report\\_To\\_Congress\\_SEC.pdf](https://www.medpac.gov/wp-content/uploads/2026/03/Mar26_MedPAC_Report_To_Congress_SEC.pdf). Accessed May 21, 2026.

<sup>21</sup> KaufmanHall. February 2026 Metrics National Hospital Flash Report. April 2026. [https://www.kaufmanhall.com/sites/default/files/2026-04/KH-NHFR\\_Report-February-2026-Metrics.pdf](https://www.kaufmanhall.com/sites/default/files/2026-04/KH-NHFR_Report-February-2026-Metrics.pdf). Accessed May 21, 2026.

<sup>22</sup> 42 U.S.C. § 1886(d)(4)(C) (2012)

obstetrics.<sup>23</sup> **CMS must ensure Medicare payment benchmarks are sufficient to maintain access to essential services across programs.**

The WFTCL makes Medicare payment rates the de facto benchmark for Medicaid, reinforcing Medicare's role as a lead payer. Beginning in FY 2027, Medicare rates will set Medicaid FFS payments, leading to reduced reimbursement that will particularly impact essential hospitals. Lower Medicaid funding can limit Medicare beneficiaries' access to care, especially at hospitals with high Medicaid shares. **CMS should assess how this alignment affects access and increase Medicare rates where needed to preserve services.**

8. CMS should increase DSH pools to align with the reality of uncompensated care amounts in 2027.

We are gravely concerned that CMS proposes to cut Medicare DSH payments for FY 2027. Medicare DSH provides crucial funding support for essential hospitals' services by adjusting the Medicare inpatient payment rates for hospitals that provide more uncompensated care. **The notion that DSH payments should decrease in the face of anticipated increases in uninsured patients is inconsistent with both the purpose and intent of the DSH statute.** The Affordable Care Act (ACA) restructured Medicare DSH payments to operate as a countercyclical adjustment, reducing DSH funding when coverage expansions lowered uncompensated care and increasing support when uninsured population rises.

In the current environment, however, CMS' DSH methodology has become increasingly divorced from that intent. Rather than responding dynamically to coverage and uncompensated care changes, the agency relies on lagged data, static assumptions, and systemwide proxies that fail to capture real-time increases in uninsured patients and shifts in care delivery. **CMS should recalibrate its methodology to restore the countercyclical function of DSH payments and ensure funding levels respond appropriately to current and projected increases in uncompensated care.**

Below, we offer suggestions for how CMS can more accurately calculate each factor of the Medicare DSH formula to ensure these payments achieve their desired purposes.

- a. **CMS must ensure Factor 1 calculations accurately estimate pre-ACA DSH calculations and provide transparency on how CMS makes these calculations.**

Essential hospitals rely on the Medicare DSH program to offset underpayment from federal payers and for uncompensated care, and CMS' proposed Factor 1 amount of \$11.477 billion is deeply troubling in multiple respects. First, we are gravely concerned that the proposed FY 2027 Factor 1 amount is significantly lower than the \$12.412 billion finalized for FY 2026.<sup>24</sup> Secondly, we find CMS' continued failure to provide adequate insight into its calculations deeply flawed. Due to the agency's repeated refusal to provide any meaningful insight into their calculations, we have been forced to file a freedom of information act (FOIA) request to gain clarity on how the agency estimates this vitally important figure.

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<sup>23</sup> American Hospital Association. Costs of Caring: Challenges Facing America's Hospitals as They Care for Patients in 2026. March 2026. <https://www.aha.org/costsofcaring>. Accessed May 21, 2026.

<sup>24</sup> 90 Fed. Reg. 36,536, 36,886. (Aug. 4, 2025).

To determine the amount of DSH funding available to qualifying hospitals, CMS must estimate the amount of DSH payments that would have been made under pre-ACA law. **The statute affords CMS meaningful discretion in how it develops this estimate, and it is critical that the agency ensures its methodology accurately reflects how DSH hospitals will deliver care in the upcoming fiscal year.** These estimates are critical, as they determine both the empirically justified DSH payments and the total uncompensated care (UC) pool.

President Trump and Administrator Oz have rightly prioritized transparency within the health care system; the continued use of non-descriptive multiplying factors in the Factor 1 methodology is inconsistent with these principles. In the FY 2027 proposed rule, CMS constructs Factor 1 by trending forward a historical DSH baseline using four components:

- The annual payment update
- Estimated changes in discharges
- Estimated changes in case mix
- An “other” factor that includes expected changes in Medicaid enrollment.

While CMS provides limited discussion of certain assumptions—particularly where data are incomplete—the proposed rule offers only minimal explanation of how the agency develops the “other” factor.

**Given the magnitude of recent changes in Medicaid enrollment, it is especially important that stakeholders understand how these dynamics affect Medicare DSH estimates.** CMS should provide a more detailed and transparent explanation of its Factor 1 methodology so stakeholders can evaluate the assumptions used and ensure the resulting estimates do not inadvertently disadvantage DSH hospitals. CMS’ previous response to similar concerns—directing stakeholders to the Medicare Trustees report without meaningfully identifying any principles the agency uses for its own modeling—is insufficient.

We urge CMS to consider the following in its Factor 1 calculations and ensure its estimate accurately reflects uncompensated care provided in FY 2027.

- i. To ensure stakeholders can evaluate policy impact, CMS should clarify how it uses MA data to inform Factor 1.*

CMS only briefly notes the discharge figures for FY 2026 and FY 2027 “are assumptions based on recent historical experience and assumptions related to how many beneficiaries will be enrolled in MA plans.” However, MA penetration varies massively by state, community, and provider. DSH status also meaningfully affects hospital relationships with MA plans. We have consistently heard from members of America’s Essential Hospitals that MA plans frequently exclude essential hospitals with higher DSH adjustments from their networks.

In recent years, many health care services have transitioned from inpatient settings to outpatient and physician-based settings. CMS has codified this further in regulation by eliminating the inpatient-only list and expanding outpatient payment policies. As a result, inpatient care, particularly at essential hospitals, is increasingly reserved for more complex, resource-intensive patients.

This trend is reflected in projections by CMS actuaries that Medicare Part A per capita spending will grow at an average annual rate of 4.5% between 2020 and 2030, even as CMS proposes a

decline in the proposed case-mix index from 1.0075 in FY 2026 to 1.0050 in FY 2027.<sup>25</sup> **We urge CMS to update its proposed case mix index to accurately reflect the increasing intensity of inpatient encounters.**

**b. CMS should use current, accurate uninsurance data to calculate Factor 2 and fully capture Medicaid disenrollments from work requirements.**

Factor 2 of the Medicare DSH formula adjusts Medicare uncompensated care (UC) payments based on the number of uninsured individuals. While we appreciate that CMS acknowledges the uninsured population is expected to increase in FY 2027, **we are concerned that CMS' projections do not fully account for all causes of the increase and that CMS data was modeled prior to the passage of the WFTCL.**

CMS is required by the Social Security Act to use the “most recent period for which data is available” in calculating Factor 2 in the Medicare DSH formula.<sup>26</sup> In the proposed rule, CMS uses National Health Expenditure Accounts (NHEA) projections to estimate a FY 2027 uninsurance rate of 9.1%, which is 65% of the value of the 2013 uninsurance rate of 14%. **However, this data was most recently updated in June 2025, prior to the passage of the WFTCL** This legislation is projected to cut federal Medicaid funding by more than \$1 trillion over 10 years and increase the number of uninsured individuals by 10 million in 2034.<sup>27</sup>

NHEA data are limited to 2023, and forward projections for calendar year 2027 suppose only modest growth in uninsured rates. That conclusion is understandable when one considers “The figures in the table above are based on the latest publicly available projections of the NHEA produced by the CMS Office of the Actuary and published on June 25, 2025.”<sup>28</sup> These estimates precede passage of the WFTCL and seemingly do not account for the millions of Americans who will lose access to health insurance in FY 2027. The most conservative estimates, from federal agencies like the Congressional Budget Office (CBO), indicate work requirements will “increase the number of people without health insurance by 4.8 million in 2034,” and that the cumulative impact of the WFTCL will reach 10 million by 2034.<sup>29</sup> Other nonpartisan estimates of uninsured patients are higher, with one ranging from 9.9 million to 14.9 million becoming uninsured from work requirements alone.<sup>30</sup>

Additionally, while CMS' baseline data from 2025 accounts for the anticipated sunset of enhanced premium tax credits (EPTCs) for plans purchased on the ACA marketplace, recent analysis suggests prior modeling might have underestimated the rate of disenrollment from

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<sup>25</sup> Cubanski J, Neuman T. What to Know about Medicare Spending and Financing. *KFF*. Jan 19, 2023. <https://www.kff.org/medicare/what-to-know-about-medicare-spending-and-financing/>. Accessed May 21, 2026.

<sup>26</sup> 42 U.S.C. § 1886 (r)(2)(B)(ii)(II). (2012)

<sup>27</sup> Congressional Budget Office. *Estimate of Annual Changes in the Number of People Without Health Insurance Under Title VII, P.L. 119-21*. Aug. 11, 2025. <https://www.cbo.gov/publication/61367>. Accessed May 27, 2026.

<sup>28</sup> *2026 Certification of Rates of Uninsured*. CMS Office of the Actuary. <https://www.cms.gov/files/document/certification-rates-uninsured-fy-2027-proposed-rule.pdf>. Accessed May 21, 2026.

<sup>29</sup> Swagel P. Letter to Ron Wyden, Frank Pallone Jr., and Richard Neal on June 4, 2025. [https://www.cbo.gov/system/files/2025-06/Wyden-Pallone-Neal\\_Letter\\_6-4-25.pdf](https://www.cbo.gov/system/files/2025-06/Wyden-Pallone-Neal_Letter_6-4-25.pdf). Accessed May 21, 2026. [https://www.cbo.gov/system/files/2025-06/Wyden-Pallone-Neal\\_Letter\\_6-4-25.pdf](https://www.cbo.gov/system/files/2025-06/Wyden-Pallone-Neal_Letter_6-4-25.pdf)

<sup>30</sup> Zhang E, Lukens G. Medicaid Work Requirements Will Take Away Coverage From Millions: State and Congressional District Estimates. *Center on Budget and Policy Priorities*. July 22, 2025. <https://www.cbpp.org/research/health/medicaid-work-requirements-will-take-away-coverage-from-millions-state-and>. Accessed May 21, 2026.

insurance plans. One recent report estimates that coverage in the marketplaces will drop by as much as 26% total over FY 2026 and FY 2027, which would represent a coverage decline in excess of 6 million from 2025 enrollment amounts.<sup>31</sup> These figures even exceed estimates from the CBO on the long-term impact of EPTC expiration, where the CBO estimated 5.1 million more uninsured over a 10 year policy window.<sup>32</sup>

**CMS must use up-to-date estimates that include the impact of changes to premium tax credits, work requirements, and other policies included in the WFTCL that will reduce Medicaid enrollment in 2027 and beyond.**

**c. CMS should ensure data accuracy in calculations of total uncompensated care provided by essential hospitals.**

Factor 3 of CMS' DSH formula determines hospitals' individual share of uncompensated care-based DSH amounts. We remain concerned that this methodology lacks the nuance to measure how much uncompensated care essential hospitals provide.

- i. *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 noted in previous years, we remain concerned that the amount of uncompensated care reported on Worksheet S-10 does not accurately reflect the full scope of uncompensated care hospitals provide. Accordingly, we continue to urge CMS to make technical changes to capture the full costs of services essential hospitals furnish. Doing so will ensure Medicare DSH payments are more equitably targeted to the hospitals doing the most to provide access to underserved populations.

More broadly, Worksheet S-10 does not account for all patient care costs when converting charges to costs. Most notably, the current worksheet excludes substantial costs hospitals incur in training medical residents, supporting physician and professional services, and paying provider taxes associated with Medicaid revenue. As CMS continues to rely on Worksheet S-10 as the primary data source for measuring UC costs, the agency should refine the worksheet to incorporate all patient care costs—including those related to teaching—into the cost-to-charge ratio (CCR). Specifically, 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 actual cost of hospital services, compared with the CCR currently in Worksheet S-10.

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<sup>31</sup> Anderson M, Chin CY, Cohen M. Who Paid, and Who Stayed? Early 2026 Enrollment Trends in the Individual Market. *Wakely Consulting Group*. April 2026. <https://www.wakely.com/blog/who-paid-and-who-stayed-early-2026enrollment-trends-in-the-individual-market/>. Accessed May 21, 2026.

<sup>32</sup> Swagel P. Letter to Ron Wyden, Frank Pallone Jr., and Richard Neal on June 4, 2025. [https://www.cbo.gov/system/files/2025-06/Wyden-Pallone-Neal\\_Letter\\_6-4-25.pdf](https://www.cbo.gov/system/files/2025-06/Wyden-Pallone-Neal_Letter_6-4-25.pdf). Accessed May 21, 2026.

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 sizable 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 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. In calculating Factor 3, CMS should recognize the full costs regularly incurred when hospitals provide charity care and other services. 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 of these 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 S-10 recognizes unreimbursed costs for charity care patients, 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 UC calculation. 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 were previously uninsured) will provide information on Medicaid underpayment and 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 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 that 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 outside of Medicare FFS patients, such as those with MA, 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.

- ii. *CMS should provide clear guidelines on its audit protocols and ensure Worksheet S-10 reviews impose minimal burden and are applied fairly 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 constitute 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 provide substantial 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. Accurate and uniform audits across DSH hospitals are critical to ensure CMS uses reliable data to calculate UC-based payments and does not unfairly disadvantage audited hospitals at the expense of those not audited.

9. CMS should withdraw the proposed adjustments to organ procurement related to administrative & general (A&G) cost allocation.

**America's Essential Hospitals appreciates and supports CMS' goals of reducing inappropriate Medicare spending, including for organ procurement organizations. However, we are concerned that the proposed revisions to A&G cost allocation for purchased organs and other purchased services may exclude legitimate costs incurred by transplant hospitals in furnishing highly specialized services.**

CMS proposes to exclude purchased organ costs from the allocation of certain A&G expenses on the basis that these costs do not have a sufficient causal relationship to hospital overhead. However, transplant hospitals incur substantial administrative and infrastructure costs associated with organ transplantation, including program administration, regulatory compliance, quality oversight, care coordination, financial administration, and other hospital-wide functions that are essential to maintaining transplant programs. Excluding these costs from organ acquisition activities may understate the actual resources required to furnish transplant services.

Moreover, CMS has not adequately evaluated the potential impact of the proposal on transplant hospitals, particularly those serving large numbers of Medicare beneficiaries and other medically complex patients. By limiting the allocation of legitimate overhead costs, the proposal may reduce reimbursement for services that are already resource-intensive and financially challenging to provide. **We urge CMS to withdraw the proposed changes to A&G cost allocation to help ensure continued Medicare beneficiary access to transplant services.**

## Supporting Essential Hospitals' Role in Developing the Health Care Workforce

10. CMS should finalize its proposal to cease consideration of prior employment conditions when evaluating new teaching programs.

**America's Essential Hospitals supports CMS' proposal to eliminate consideration of the prior employment of faculty and program directors when considering whether a teaching program is "new."** We appreciate CMS' recognition through this policy change that residency programs require experienced leadership to ensure optimal training. Medicare support is vital to ensure universities and hospitals can establish new residency programs to serve the nation's current workforce needs. We agree with CMS that hiring faculty and program directors with experience in the relevant specialty should not preclude necessary Medicare support for new programs.

11. CMS should retain its longstanding definition of an "approved medical residency training program."

America's Essential Hospitals is deeply concerned, however, with CMS' proposal to add provisions into the definition of an "approved medical residency training program" that do not offer hospitals an opportunity for due process in the event there is a potential antidiscrimination claim. America's Essential Hospitals values equal access and treatment for all, and its members support and comply with federal antidiscrimination provisions. However, resident training at essential hospitals could be substantially disrupted if CMS were allowed to withhold funding for unsubstantiated antidiscrimination claims. CMS should not be permitted to disqualify residency programs from otherwise available Medicare support while this due process occurs. **CMS should retain the current definition of an "approved medical residency training program."**

## 12. 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 was 37% higher than their GME cap in 2023.<sup>33</sup> 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 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 nonstandard cost reporting periods. We appreciate the clarification and urge CMS to consult with stakeholders like America's Essential Hospitals—which represents teaching hospitals that trained an average of 193 physicians in 2023—on future changes.<sup>34</sup> 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.**

## Considering the Unique Needs of Essential Hospitals in Quality Improvement Programs

In addition to ensuring that payment updates accurately reflect the economic and structural realities of FY 2027, CMS can support essential hospitals through improvements to CMS' proposed quality and value-based care adjustments. In general, we appreciate CMS' consideration of the regulatory burden imposed by quality measures and its proposals to

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<sup>33</sup> Miu R, Kelly K, Nelb R. *Essential Data 2025: Our Hospitals, Our Patients—Results of America's Essential Hospitals 2023 Annual Member Characteristics Survey*. America's Essential Hospitals. November 2025. [essentialdata.info](https://essentialdata.info). Accessed May 7, 2026.

<sup>34</sup> Ibid.

remove unnecessary measures. However, we are concerned about the addition of new measures that are not fully tested.

### 13. CMS should finalize proposals to eliminate unnecessary and redundant eCQMs.

We welcome and appreciate CMS' efforts to streamline the eCQM program in the FY 2027 IPPS proposed rule by eliminating the VTE-1 and VTE-2 eCQMs and the Antithrombotic Therapy eCQM for CY 2028. We urge CMS to build on this efficiency and continue to eliminate other resource-intensive and non-actionable measures.

We urge CMS 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. **CMS should remove structural measures from hospital quality programs and instead focus on outcome measurement.** Examples of these structural measures include the Patient Safety structural measure, Age-Friendly Hospital measure, and Maternal Morbidity structural measure. While these measures focus on extremely critical issues, they are burdensome and resource-intensive, and they frequently do not provide actionable insights into care quality or patient outcomes.

### 14. CMS should not add the Sepsis Readmission Measure to the Hospital Readmissions Reduction Program (HRRP).

Reducing preventable readmissions is of paramount concern to America's Essential Hospitals and its members. We believe that any program directed at reducing readmissions must target readmissions that are preventable and include appropriate risk-adjustment methodology. Unfortunately, CMS' proposed new measure for FY 2027, the Hospital 30-Day, All-Cause, Risk-Standardized Readmission Rate Following Sepsis Hospitalization measure (the Sepsis Readmission measure), fails this test because it disproportionately harms essential hospitals, as described further below.

#### a. **The proposed Sepsis Readmission measure is not appropriately risk-adjusted.**

CMS' own analysis of the proposed sepsis measure found that it disproportionately harms hospitals that serve a high share of low-income patients, as measured by the DSH DPP. For example, CMS estimates that hospitals with a DPP that exceeds 65% will face a 0.89% penalty, compared with a 0.77% penalty for hospitals with a DPP between 0 and 24%.<sup>35</sup>

This finding is consistent with past analysis showing that HRRP continues to disproportionately penalize hospitals serving a disproportionate share of medically and socially complex patients. Essential hospitals care for a disproportionate share of patients experiencing homelessness, behavioral health conditions, substance use disorder, and other risk factors that correlate with readmission risk. Despite recent CMS action to mitigate these risks, **the HRRP program still does not adequately account for the full range of factors outside hospitals' control that influence readmissions.**

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<sup>35</sup> 91 Fed. Reg. 19,312, 19,536 (April 14, 2026).

We are particularly concerned about proposals to expand or refine readmission measures without sufficient consideration of patients' unique clinical complexity. Readmissions are a function of broader failures, including the lack of capacity in post-acute placement options and for outpatient follow-up, rather than deficiencies with the care provided by the inpatient setting. Essential hospitals often serve communities with limited access to primary care and patients who will receive follow-up care from other hospitals. As a result, hospitals serving the highest-need populations have disadvantages under HRRP, even when providing clinically appropriate and high-quality care.

**b. CMS should not include MA data in the Sepsis Readmission measure until it is more closely studied.**

Given the rapid growth of MA enrollment, we understand CMS' interest in using MA data to better understand the quality of care provided to Medicare beneficiaries. However, we remain concerned that **using MA data in HRRP could lead to irregular outcomes.** We urge CMS to reject the proposed Sepsis Readmission measure. Because MA patients are generally healthier than patients covered through Medicare FFS, the inclusion of more MA patients in the HRRP quality measure could improve a hospital's measure performance. However, because HRRP penalties are assessed based on a hospital's performance relative to other hospitals, hospitals in markets with lower MA penetration might be unfairly hurt by this policy change. Overall, CMS should appropriately adjust MA measures used in hospital quality programs so that hospitals are not penalized for factors outside of their control, such as the MA penetration rate in their local market.

For example, while reviewing the proposed addition of MA data in the FY 2026 IPPS proposed rule, **we analyzed readmission rates for MA beneficiaries and found that CMS' estimates likely undercounted readmission penalties by a factor of 10.**<sup>36</sup> Considering the potential impact of MA data inclusion, we urge CMS to use consistent data collection processes across HRRP.

In addition,, we are concerned about how CMS will apply HRRP penalties to Medicare FFS payments. Using MA data to determine the DRG ratio 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 readmission rates remained constant, hospitals would face additional penalties because of differences in the characteristics of MA patients. These increased penalties largely are attributable to changes in DRG ratios that increased penalties for some hospitals. For additional feedback on how MA data inclusion in the HRRP program would potentially harm essential hospitals, we refer CMS to our submitted comments on the FY 2026 IPPS proposed rule.<sup>37</sup>

**c. Hospitals need more experience reporting Sepsis Readmission measures before they are used as a basis for payment.**

We agree with the concerns voiced during the Pre-Rulemaking Measure Review process, particularly that hospitals would benefit from understanding their performance on the Sepsis

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<sup>36</sup> Siegel, B. Letter to Mehmet Oz on June 10, 2025. <https://essentialhospitals.org/wp-content/uploads/2025/06/FY-2026-IPPS-Comment-Letter.pdf>. Accessed May 21, 2026.

<sup>37</sup> Ibid.

Readmission measure prior to using the measure for payment adjustments.<sup>38</sup> **If CMS finalizes a policy to monitor sepsis readmissions, it should do so in the Hospital Inpatient Quality Reporting Program, where performance is not tied to payment.**

15. A Birthing-Friendly Hospital Designation should recognize the unique role of essential hospitals.

We appreciate CMS' interest in updating the Birthing-Friendly Hospital Designation to ensure the measure provides meaningful information to expectant parents. We support CMS' efforts to create a "consumer-friendly, publicly reported display signaling a hospital's commitment to improving maternal health." However, it is critical that any adjustments to the measure—and potential policies eventually associated with the designation—do not inadvertently penalize the essential hospitals that anchor the maternal safety net.

- a. **CMS should incorporate social risk adjustment in the Severe Obstetric Complications measure.**

As CMS moves toward an outcome-based designation, the methodology must ensure that "Severe Obstetric Complications" (eSOC) scores reflect the quality of clinical intervention rather than the baseline health complexity of the patient. Patients treated at essential hospitals often present with significant preexisting clinical complications and a lack of prior clinical management. **Without adjusting for the baseline health status and clinical complexity of these patients, the eSOC measure will produce skewed data that suggests poor hospital performance when the hospital is managing a much higher-risk caseload.**

Failing to account for these baseline health indicators will result in misleading public data, which could steer patients away from the high-acuity centers best equipped to handle their care. Furthermore, if these metrics are eventually tied to performance evaluations, the resulting financial pressure could force hospitals to scale back obstetric services, directly reducing patient access in the communities that need it most. To ensure the designation truly measures outcomes and not just patient mix, CMS must implement a risk-adjustment model that accounts for the high-acuity baseline of the safety net population.

- b. **CMS should risk-adjust for patient acuity and hospital service levels, rather than volume of deliveries.**

We appreciate that CMS acknowledges the importance of peer grouping hospitals based on key characteristics. **However, we are gravely concerned that volume alone lacks sufficient detail to identify which providers are committed to serving high-risk pregnancies.** Many essential hospitals operate in geographic proximity to other facilities with comparable bed volume. What makes essential hospitals unique is their commitment to serving all patients, even the most complex ones, regardless of their ability to pay. Peer grouping hospitals solely by delivery volume and further clustering within those groups risks identifying facilities that serve healthier patients rather than those best equipped to manage complex pregnancies. **Before applying k-means clustering, CMS should adjust for risk scores, inclusive of social risk, to ensure the measure is adequately outcome-adjusted.**

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<sup>38</sup> 91 Fed. Reg. 19,312, 19,533 (April 14, 2026).

Further, we encourage CMS to use absolute rather than relative qualities for Birthing-Friendly Hospital Designation criteria. Any hospital that can meet a highest-performing “cluster 3” standard should be eligible; achieving the designation should not be predicated on surpassing other hospitals’ performance.

**c. CMS should not use the Birthing-Friendly Hospital Designation to adjust payments.**

Before publicly designating Birthing-Friendly Hospitals, CMS should provide a pilot period with anonymized data to allow policymakers to identify and mitigate any methodological issues. Hospitals participating in the pilot should have access to their results to identify deficiencies before CMS applies clustering publicly.

As CMS continues to evaluate and promote alternative payment models and pursue two-sided risk solutions, **the agency should not seek to use a Birthing-Friendly Hospital Designation to adjust Medicare payments.** All-payer margins on obstetric care are already meaningfully negative, with one study finding obstetric margins exceed -8%.<sup>39</sup> This reality has significantly contributed to declines in obstetric care availability, the creation of obstetric care deserts, and new challenges for expectant parents. Using the Birthing-Friendly Hospital Designation to penalize lower-performing hospitals likely will reduce access to obstetric care overall, not improve obstetric care outcomes.

**16. CMS should engage providers in developing meaningful solutions, not more burdensome reporting requirements, to improve timely access to emergency care.**

We appreciate CMS’ interest in efforts to reduce emergency department (ED) boarding, crowding and improve ED outcomes, but we do not support CMS’ new Inpatient ED Boarding measure. This proposed measure duplicates existing aspects of the Outpatient Quality Reporting program measures, specifically OP-18: Median Time from ED Arrival to ED Departure for Discharged ED patients, and OP-22: Patient Left Without Being Seen. **President Trump and Administrator Oz have rightfully focused on reducing administrative burden. Rather than create new systems to measure data already captured by existing protocols, CMS should focus on more functional ways to improve patient outcomes.**

Instead of adding more provider reporting, CMS should engage with providers to understand the specific challenges that are contributing to ED boarding and overcrowding. Clinical leaders at essential hospitals long have been engaged on efforts to address these issues and recently offered several recommendations for policymakers on how best to address the underlying challenges.<sup>40</sup> We look forward to continuing to work with CMS to develop strategies to realign incentives across the delivery system to minimize ED boarding and promote access to appropriate care in the most appropriate settings.

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<sup>39</sup> American Hospital Association. Costs of Caring: Challenges Facing America’s Hospitals as They Care for Patients in 2026. *American Hospital Association*. March 2026. <https://www.aha.org/costsofcaring>. Accessed May 21, 2026.

<sup>40</sup> Yun B, Singh M, Reznick M, et al. Strengthening essential emergency departments: Transforming the safety net. *Health Affairs Scholar*. 2025;3(3). <https://academic.oup.com/healthaffairsscholar/article/3/3/qxaf044/8047338>. Accessed June 1, 2026.

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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](mailto:rnelb@essentialhospitals.org).

Sincerely,

Jennifer DeCubellis  
President and CEO