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June 9, 2026

Submitted electronically via: https://www.regulations.gov/

The Honorable Dr. Mehmet Oz
Administrator
Centers for Medicare & Medicaid Services
7500 Security Blvd
Baltimore, MD 21244

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

Dear Administrator Oz,

Vizient, Inc. appreciates the opportunity to comment on the Centers for Medicare & Medicaid Services (CMS) proposed rule regarding the fiscal year (FY) 2027 Hospital Inpatient Prospective Payment System (IPPS) for Acute Care Hospitals and Fiscal Year 2027 Rates and Requirements for Quality Programs (CMS-1849-P) (hereinafter, "Proposed Rule"). Many of the policies in the Proposed Rule have a significant impact on our provider clients and the patients they serve. Given the range of financial challenges hospitals endure, Vizient is concerned that inadequate Medicare payment rates and mandatory payment models will make care delivery more challenging. In response, Vizient offers various recommendations to CMS, including several that align with the agency's interest in reducing waste and easing administrative burdens.

Background

Vizient, Inc., the nation's largest provider-driven healthcare performance improvement company, provides solutions and services to more than two-thirds of the nation's acute care providers and more than one-third of ambulatory providers. Vizient offers proprietary data and analytics to deliver unique clinical and operational insights and a contract portfolio representing $156 billion in annual purchasing volume enabling the delivery of cost-effective care. With its acquisition of Kaufman Hall in 2024, Vizient expanded its advisory services to help providers achieve financial, clinical and operational excellence. Headquartered in Irving, Texas, Vizient has offices throughout the United States. Learn more at www.vizientinc.com.

Recommendations

In our comments, Vizient responds to various issues, proposals and requests for information (RFIs) provided in the Proposed Rule. We thank CMS for the opportunity to share recommendations related to payment policy and quality programs, among other topics, and urge CMS to ensure payment rates and policies are sufficient to support ongoing access to care. In addition, we strongly encourage CMS to make participation in the proposed Comprehensive Care for Joint Replacement Expanded (CJR-X) Model voluntary.

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Proposed IPPS Payment Rate Updates for FY 2027

CMS proposes to increase IPPS operating payment rates by 2.4% in FY 2027 for hospitals that successfully participate in the Hospital Inpatient Quality Reporting (IQR) Program and are meaningful electronic health record (EHR) users. In determining this increase, CMS uses a third party to estimate the 3.2% market basket update and the productivity adjustment, which will reduce the market basket by 0.8 percentage points. However, there is limited information available in the Proposed Rule regarding how the market basket and productivity adjustment were reached, including the underlying assumptions. Vizient encourages CMS to provide additional detail and resources regarding the assumptions used to develop the market basket update and productivity adjustment.

Market Basket

In the Proposed Rule, CMS provides a 3.2% market basket update for FY 2027, which is 0.1% less than the FY 2026 IPPS market basket.[1] Vizient notes that hospital expenses for supplies, labor, purchased services and drugs are projected to be higher in 2026 compared with 2025.[2] For example, Kaufman Hall's March 2026 Hospital Flash Report indicates that hospitals' supply expense per calendar day is 11% greater in 2026 versus 2025. A recent American Hospital Association report found that hospital spending on equipment and supplies used in most patient encounters increased 9.9% and pharmaceutical expenditures increased 13.6% in 2025.[3] Also, Vizient's Spend Management Outlook Winter 2026 projects that indirect spend and purchased services are expected to increase 3.85% from July 2026 to June 2027.[4] Considering this information, which highlights the significant and ongoing increases in costs to provide care, Vizient believes the proposed market basket is inadequate. Vizient encourages CMS to consider using its special exceptions and adjustments authority to provide a more substantial increase to the market basket in the IPPS Final Rule for FY 2027.

In addition, it is unclear whether the forecast that CMS relies on to update the market basket has accounted for known or potential tariff-related changes. For example, a Section 232 investigation was initiated in September 2025 to determine the effects on national security of imports of personal protective equipment (PPE), medical consumables and medical equipment - including devices. This investigation could lead to future tariffs being imposed.[5] In addition, in April 2026, a 100% tariff was announced for certain patented pharmaceuticals and pharmaceutical ingredients; these tariffs are scheduled to begin on July 31, 2026 for certain large manufacturers and September 29, 2026 for others.[6,7] Tariffs have also been applied to

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[1] https://www.federalregister.gov/documents/2025/08/04/2025-14681/medicare-program-hospital-inpatient-prospective-payment-systems-for-acute-care-hospitals-ipps-and

[2] The Kaufman Hall March 2026 Hospital Flash Report shows a year over year change from 2025 to 2026 for total expenses per calendar day (7%), labor expenses (4%), non-labor expenses (10%), supply expenses (11%), drug expenses (10%), and purchased services (8%). https://www.kaufmanhall.com/sites/default/files/2026-05/KH-NHFR_Report-March_2026-Metrics_0.pdf

[3] American Hospital Association March 2026 Cost of Caring Report, https://www.aha.org/costsofcaring

[4] https://www.vizientinc.com/insights/reports/spend-management-outlook/winter-2026-from-cost-pressure-to-strategic-resilience

[5] https://www.federalregister.gov/documents/2025/09/26/2025-18729/notice-of-request-for-public-comments-on-section-232-national-security-investigation-of-imports-of

[6] https://www.federalregister.gov/documents/2025/04/16/2025-06587/notice-of-request-for-public-comments-on-section-232-national-security-investigation-of-imports-of

[7] https://www.whitehouse.gov/fact-sheets/2026/04/fact-sheet-president-donald-j-trump-bolsters-national-security-and-strengthens-u-s-supply-chains-by-imposing-tariffs-on-patented-pharmaceutical-products/#:~:text=BOLSTERING%20NATIONAL%20SECURITY:%20Today%2C%20President,deals%20with%20the%20U.S.%20Government.

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other products (e.g., steel, aluminum).[8] Although the future impact of these tariffs on hospitals is not clear, Vizient believes it is imperative that CMS clarify how it is accounting for tariffs in payment policy, particularly the market basket update, for FY 2027.

Proposed Revision to Provider-Based Location Criteria Regulations Applicable to Off-Campus Facilities or Organizations

To address the agency's concerns that the referral-based test,[9] which is used by certain sites to satisfy the location-based criteria for a provider-based department (PBD), is not being used as originally intended to help certain off-campus outpatient facilities qualify as a PBD, CMS proposes revisions to the PBD regulations. Specifically, CMS proposes to limit use of the referral-based test to outpatient facilities or organizations only, thereby barring inpatient facilities from using the referral-based test. In the Proposed Rule, CMS does not provide evidence demonstrating a clear, systemic problem that would warrant changing long-standing regulatory practice. Further, changing these regulations without such careful analysis risks destabilizing care delivery, particularly in rural and underserved communities that rely on distant inpatient sites. Vizient recommends CMS withdraw the proposed revisions and retain the current PBD regulations, allowing inpatient provider-based facilities to continue using the referral-based test to meet the location-based criteria and preserve access to care in the communities they serve.

Chimeric Antigen Receptor (CAR) T-Cell and Other Immunotherapies

For FY 2027, CMS proposes to use previously finalized policy to establish reimbursement for CAR T-cell and other immunotherapies (MS-DRG 018). According to a Vizient report based on responses from 61 hospitals and health system leaders from across the country, organizations are strongly committed to expanding cell and gene therapy programs but face persistent financial, operational and contracting challenges that threaten scalability.[10] Additionally, health system respondents reported that Medicare and Medicaid payments, especially for inpatient care, often do not cover full treatment costs, putting sustained pressure on hospital margins. Based on these challenges, which can have downstream consequences for patient access, Vizient encourages CMS to implement more comprehensive actions to support providers, such as expedited reimbursement and additional financial support.

Proposed Payment Adjustment for Medicare Disproportionate Share Hospitals (DSH) for FY 2027

Factor 1 Recommendations

To estimate Factor 1, CMS includes a table in the Proposed Rule that delineates the components CMS applied for FYs 2024 through 2027 to estimate Factor 1. This table contains an "Other" column that reflects the additional factors (e.g., certain other payment rate adjustments, certain discharge data) that contribute to the Medicare DSH estimates. However, in the Proposed Rule, CMS provides only a high-level description of the "Other" column and does not provide enough detail for stakeholders to independently validate the component

[8] https://www.bis.gov/about-bis/bis-leadership-and-offices/SIES/section-232-investigations/section-232-steel-aluminum
[9] Facilities submit 12 months of data showing at least 75% of the patients served by the facility or organization who required the type of care furnished by the main provider received that care from that provider (for example, at least 75% of the patients of a Rural Health Clinic (RHC) seeking provider-based status received inpatient hospital services from the hospital that is the main provider).
[10] Cell and gene therapy report: How leading health systems are operationalizing the next era of medicine

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assumptions or year-to-year changes. Also, in the FY 2026 IPPS Final Rule, CMS counted Medicaid enrollment as an additional factor in the "Other" column, but this was not included for the "Other" column in the FY 2027 Proposed Rule.[11] This lack of transparency makes it difficult to determine how each additional factor contributes to the "Other" column. Vizient recommends CMS consistently publish more detailed information for the "Other" column, including information related to all contributing components, how the data is applied to calculate DSH payments, and the year-to-year estimates utilized.

Factor 2 Recommendations

To calculate Factor 2 of the uncompensated care payment (UCP), CMS relies on annual estimates and projections from the Office of the Actuary, which models enrollment and health spending trends over a 10-year period. OACT's most recent projections, published in June 2025, estimate the uninsured rate will be 9% in calendar year (CY) 2026 and 9.1% in CY 2027.[12] For FY 2027, CMS proposes to continue using the same methodology to calculate Factor 2 that has been applied in rulemaking from FY 2018 through FY 2026.

Vizient is concerned that CMS may be underestimating the number of uninsured used in the calculation of Factor 2, as current estimates do not account for coverage losses from recent changes that impact Marketplace enrollment under the Affordable Care Act (ACA) and Medicaid enrollment that could substantially increase the uninsured population. For example, on December 31, 2025, the enhanced premium tax credits that further reduced the cost of health insurance premiums for people who obtain insurance through Health Insurance Marketplaces expired. In addition, the passage of the *One Big Beautiful Bill Act (OBBBA)*[13] spurred numerous changes that are expected to drastically increase the number of uninsured individuals through 2034.[14]

In the latest Open Enrollment Period (OEP) report released in March 2026, CMS found that approximately 1.2 million fewer consumers reenrolled in Marketplace coverage during the 2026 OEP compared to the 2025 OEP, representing a 5% decline.[15] The report also showed the number of new consumers selecting Marketplace coverage during the 2026 OEP declined 13% to 3.6 million, compared to 4.1 million in the 2025 OEP. The results from these recent policy changes suggest OACT's estimate of the uninsured rate in the Proposed Rule is inaccurate because it only reflects law and finalized administrative actions as of March 25, 2025.[16] Given the ongoing coverage losses from recent policy changes, we urge CMS to utilize more recent data sources and methodologies when estimating the uninsured rate.

Application of the Rural Floor, Application of the Imputed Floor, Application of the State Frontier Floor, Continuation of the Low Wage Index Hospital Policy, and Proposed Budget Neutrality Adjustment

[11] https://www.govinfo.gov/content/pkg/FR-2025-08-04/pdf/2025-14681.pdf
[12] In the Proposed Rule, CMS says to calculate Factor 2 for FY 2027, CMS needs projected U.S. uninsurance rates for calendar years 2026 and 2027, which come from the Office of the Actuary's (OACT's) annual 10-year National Health Expenditure Accounts (NHEA) enrollment and spending projections. The most recent projections (published June 25, 2025) cover 2024–2033 and were built using NHEA historical data available through 2023, with methods that incorporate expected enrollment shifts across all insurance coverage categories.
[13] https://www.congress.gov/bill/119th-congress/house-bill/1/text#
[14] https://www.cbo.gov/publication/61570
[15] https://www.cms.gov/files/document/health-insurance-exchanges-2026-open-enrollment-report.pdf
[16] https://www.cms.gov/files/document/certification-rates-uninsured-fy2026-fr.pdf

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Continued Transition for the Discontinuation of the Low Wage Index Hospital Policy

For FY 2027, CMS proposes to continue the FY 2026 transitional payment exception for low wage hospitals, in a budget-neutral manner, to protect hospitals that would otherwise face large wage-index declines after the low wage-index policy ended.[17] Following the *Bridgeport Hospital v. Becerra* decision, CMS issued an interim final rule (IFR) revising the FY 2025 wage index and also established a transitional payment exception for low wage hospitals significantly impacted by those revisions in a non-budget-neutral manner.[18] While the transitional exception provided in the Proposed Rule is similar to policy provided in the IFR, CMS's FY 2027 proposal differs in that it would apply the policy in a budget-neutral manner. Consistent with prior comments, Vizient remains concerned that offsetting increases for low-wage hospitals by reducing payments to others only worsens continuing Medicare under-reimbursement to hospitals. While Vizient supports the proposal to extend the transitional policy, to align with the IFR and minimize financial disruption, Vizient urges CMS to implement the transitional exception for FY 2027 IPPS payments in a non-budget neutral manner.

Expiration of Low-Volume Hospital Adjustment and Medicare-Dependent Hospital (MDH) Program

Federal law provides an additional, non–budget-neutral IPPS payment adjustment for qualifying low-volume hospitals based on total per-discharge payments.[19] Congress extended the temporary criteria through FY 2026 and the first quarter of FY 2027, ending December 31, 2026. CMS proposes conforming regulatory updates while noting the policy would revert to the original criteria on January 1, 2027 absent further legislation.[20] Similarly, under current law, additional payments for Medicare-dependent hospitals (MDHs) will also expire on December 31, 2026, after which hospitals that previously qualified for MDH status would be paid at the federal rate beginning January 1, 2027. Vizient requests that CMS work with Congress to secure timely extensions for low-volume hospitals and MDHs to avoid abrupt payment reversion and to preserve access and financial stability for these rural and low-volume providers.

Proposed Alternative Pathway Repeal for New Technology Add-on Payment (NTAP) and Outpatient Prospective Payment System (OPPS) Device Pass-Through

In the Proposed Rule, CMS proposes repealing the alternative pathway for certain transformative new devices and antimicrobial products so that all NTAP[21] and OPPS device

[17] In *Bridgeport Hosp. v. Becerra,* the D.C. Circuit court ruled that the Department of Health and Human Services (HHS) lacked authority to implement the low wage index hospital policy and that both the policy and the related budget neutrality adjustment must be vacated. https://cases.justia.com/federal/appellate-courts/cadc/22-5249/22-5249-2024-07-23.pdf?ts=1721746878

[18] https://www.federalregister.gov/documents/2024/10/03/2024-22765/medicare-program-changes-to-the-fiscal-year-2025-hospital-inpatient-prospective-payment-system-ipps

[19] Social Security Act §1886

[20] Under this policy that was in place from 2005-2010, a hospital must be more than 25 road miles from another IPPS hospital and have fewer than 200 total discharges to qualify. Although the statute allows hospitals with under 800 discharges to be considered, CMS's analysis found that only hospitals with under 200 discharges show meaningful incremental costs, so only those hospitals receive the 25% adjustment. Hospitals with 200–799 discharges receive no adjustment. Eligibility continues to be based on total discharges from the most recent cost report and the 25-mile distance requirement.

[21] CMS created an alternative NTAP pathway for certain high-priority technologies, specifically Food and Drug Administration (FDA) Breakthrough Devices, Qualified Infectious Disease Products (QIDPs), and drugs approved under the Limited Population Pathway for Antibacterial and Antifungal Drugs (LPAD) in the FY 2020 IPPS Final Rule to speed up Medicare beneficiary access to these products.

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pass-through[22] applications, regardless of FDA designation, will need to meet certain criteria (e.g., NTAP criteria or OPPS pass-through criteria).[23] CMS proposes ending the OPPS alternative pathway starting with applications submitted on or after October 1, 2026, and repealing the NTAP alternative pathway starting with FY 2028 applications. Removing the alternative pathway would mean fewer devices and therapies may qualify for temporary add-on payments, making early adoption significantly more financially risky for providers and limiting patient access. Further, these temporary payments help hospitals provide new therapies, while increasing the data needed to determine clinical improvement. For these reasons, we discourage CMS from repealing the alternative pathways for NTAPs and OPPS device pass-through payments.

Cross-Program Quality Proposals

Adoption of the Advance Care Planning (ACP) Electronic Clinical Quality Measure (eCQM) in the Hospital Inpatient Quality Reporting (IQR), and the Medicare Promoting Interoperability (PI) Programs

CMS proposes adopting the Advance Care Planning electronic clinical quality measure (eCQM) beginning with the CY 2028 reporting period/FY 2030 payment determination for the IQR and Medicare PI Programs.[24] Placing primary responsibility for initiating and documenting ACP on hospitals during an acute care visit is problematic because ACP is most appropriately initiated and sustained through a longitudinal clinician-patient relationship, such as with a primary care clinician. Expecting a patient to reach a well-considered decision during an acute care hospitalization risks rushing patient decision making during a vulnerable time. Further, requiring a decision at discharge may prevent patients from having adequate time to discuss preferences with family or their primary care clinician. Therefore, while Vizient agrees with CMS that the hospital is a critical touchpoint, we continue to question the benefit of this measure.

In addition, the measure's requirements include that an ACP document is available in the hospital electronic health record (EHR) during the inpatient stay or when an inpatient-dated ACP discussion results in a documented decision. Although CMS notes that certain EHR codes may capture instances where a patient does not name a surrogate or provide an advance care plan, the measure has no numerator or denominator exclusions, and Vizient remains concerned that hospitals may not receive appropriate credit when ACP efforts are clinically appropriate but do not result in a completed ACP document or documented decision.

While eCQMs can help reduce burden associated with reporting, such measures must be tested and validated to ensure they can be consistently reported. Currently, hospitals' EHR systems may lack a standardized, structured data field that reliably captures both an ACP

[22] CMS established a parallel alternative pathway under the Outpatient Prospective Payment System (OPPS) for Breakthrough Devices in the FY 2020 Final Rule.
[23] Under the IPPS, a service or technology may be considered for a new technology add-on payment (NTAP) if: (1) the medical service or technology is new ("newness" criterion); (2) the medical service or technology is so costly such that the DRG rate otherwise applicable to discharges involving the medical service or technology is determined to be inadequate ("cost" criterion); and (3) the service or technology demonstrates a substantial clinical improvement over existing services or technologies ("substantial clinical improvement" criterion). https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-412/subpart-F/subject-group-ECFR5703923263fedba/section-412.87?utm_source=copilot.com
[24] This measure calculates the proportion of adult patients with one or more inpatient hospitalizations during the measurement period who, by the time of hospital discharge for at least one encounter, have an advance care planning document or documentation of an advance care planning discussion resulting in a documented decision in the patient's electronic health record (EHR). https://ecqi.healthit.gov/ecqm/hosp-inpt/2028/cms1317v1

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discussion and the patient's resulting decision in a way that can be extracted for electronic measurement. Building that capability requires EHR configuration or vendor development, which could create variability in feasibility across organizations. This challenge is consistent with concerns raised by a CMS Technical Expert Panel (TEP), where feedback included the need for additional outreach to sites with different EHR vendors to evaluate this measure's feasibility.[25] Although additional analysis from the Partnership for Quality Measures indicates testing on two EHR vendors was performed, there is limited information available regarding these results.[26] To ensure adoption of the measure is feasible across providers and does not impose additional burden, Vizient encourages CMS to provide additional information regarding feasibility testing before finalizing the proposed policy.

Cross Program Proposals for Mandatory Reporting of the Hospital Harm eCQMs in IQR and Medicare PI Programs

CMS proposes that beginning with the CY 2028 reporting period/FY 2030 payment determination, the Hospital Harm—Falls with Injury and Hospital Harm—Postoperative Respiratory Failure eCQMs would become mandatory. In addition, the Hospital Harm—Postoperative VTE eCQM would become mandatory beginning with the CY 2030 reporting period/FY 2032 payment determination, after being available for two years of optional self-selected reporting.

Building from these changes, in subsequent years, CMS proposes that newly adopted Hospital Harm eCQMs would become mandatory eCQMs for reporting after two years of self-selected reporting in the Hospital IQR Program and the Medicare PI Program. Under this proposal, as more Hospital Harm eCQMs are adopted, hospitals would have less flexibility regarding which measures to self-select. Further, the proposal improperly presumes that the proposed and existing eCQMs are appropriate for mandatory reporting. For example, the Hospital Harm—Postoperative VTE eCQM has not previously been used in a CMS quality program; additional validation, improved risk adjustment and careful review of denominator exclusions to ensure clinical and statistical validity are needed. While Vizient supports CMS's proposal that the measure be available for two years of optional self-selected reporting, we urge CMS to ensure that eCQMs undergo thorough vetting and testing before mandating reporting.

Proposed Refinements to Mortality Measures in the IQR and VBP Programs

Addition of Medicare Advantage Beneficiary Data

CMS proposes expanding the criteria of the mortality measures[27] to include Medicare Advantage (MA) patients, beginning with the FY 2028 payment determination for the IQR Program and beginning with the FY 2032 program year (PY) for the VBP Program. MA beneficiaries can vary significantly across plans and may be selectively healthier. Without careful and appropriate risk adjustment, these differences could unintentionally bias performance results. CMS's analysis in the Proposed Rule indicates no meaningful differences in the mortality rates between fee-for-service (FFS) and MA cohorts, and that the

[25] https://mmshub.cms.gov/sites/default/files/CORE-ACP-TEP3SummaryReport-092625.pdf
[26] https://www.p4qm.org/prmr-measures/muc2025-020
[27] CMS proposes expanding the criteria for five of the six mortality measures. In prior rulemaking, CMS finalized adding MA data and shortening the performance period for the mortality measure focused on stroke. If finalized, all six measures would include MA beneficiary data.

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modified measures demonstrated acceptable reliability. Vizient appreciates the agency's analysis, and consistent with our prior comments, recommends CMS continue to monitor for differences between MA and FFS populations to ensure that hospitals serving different patient mixes are not disadvantaged in performance rankings. In addition, to enhance transparency and help stakeholders assess the practical effects of adding MA data, Vizient recommends CMS publish an interim report evaluating the impact across hospitals and commit to annual testing and analysis to monitor changes and recalibrate risk adjustment as needed.

Technical Update to the Performance Period

CMS proposes, beginning with the FY 2028 payment determination for the IQR Program and beginning with the FY 2032 PY for the VBP Program, to reduce the measurement period for the modified mortality measures from three years to two years. Vizient supports this change. Based on Vizient's experience, relying on more recent data better reflects the rapid pace of change in clinical practice. For example, Vizient conducts annual performance rankings using a one-year measurement window, comparing results to the prior year. The risk adjustment models are updated annually and are based on two years of data, ensuring sufficient statistical robustness while maintaining relevance to current practice. Therefore, the agency's proposal to reduce the measurement period to two years would better capture recent changes in hospital quality. As such, Vizient encourages CMS to finalize the proposal for a two-year applicable performance period.

Technical Update to International Classification of Diseases (ICD)-10 Codes

In the Proposed Rule, CMS proposes replacing Hierarchical Condition Categories (HCCs) with ICD–10 codes to improve risk adjustment for five modified mortality measures[28] beginning with the FY 2028 payment determination for the IQR Program and beginning with the FY 2032 PY for the VBP Program. While its effectiveness will ultimately depend on implementation, using ICD-10 codes allows for more actionable and clinically relevant analysis. Vizient supports the proposed modification to use individual ICD-10 codes in the risk adjustment model, as this approach is more granular, actionable and clinically meaningful.

Request for Information (RFI) on Possible Adoption of the Emergency Care Access and Timeliness eCQM in the IQR and VBP Programs

In the Proposed Rule, CMS requests feedback on the possible adoption of the Measuring Emergency Care Access and Timeliness (ECAT) eCQM in the IQR and VBP Programs. CMS previously adopted the measure for the Hospital Outpatient Quality Reporting (OQR) Program for CY 2026 and is currently evaluating its use for future IQR and VBP adoption to measure care access and timeliness. Since the measure has only been recently adopted in the OQR Program, hospitals have had limited experience in utilizing the measure for quality improvement. In addition, the Equity of Emergency Care Capacity and Quality eCQM TEP raised persistent implementation concerns around accurately capturing time to place a patient in a private

[28] These measures include: 1) Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate Following Acute Myocardial Infarction Hospitalization (MORT–30–AMI) measure; 2) Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate Following Heart Failure Hospitalization (MORT–30–HF) measure; 3) Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate Following Pneumonia Hospitalization (MORT–30–PN) measure; 4) Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate Following Chronic Obstructive Pulmonary Disease (COPD) Hospitalization (MORT–30–COPD) measure; and 5) Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate Following Coronary Artery Bypass Graft (CABG) Surgery (MORT–30–CABG) measure.

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treatment space.[29] As a result of these implementation concerns, Vizient discourages CMS from pursuing policy that would broaden application of the measure.

In addition, related to actionability, Vizient anticipates that the outcomes from the measure will have limited clinical utility. For example, the measure only captures wait times and does not account for patient acuity, severity or other clinical factors that meaningfully influence emergency department operations and patient outcomes. Without careful attention to stratification for acuity or severity, the measure risks drawing misleading comparisons between hospitals that treat fundamentally different patient populations. High-acuity emergency departments may appear to perform worse simply because they care for sicker, more complex patients who require longer evaluation and stabilization times. These issues can also limit quality improvement opportunities, benchmarking and meaningful identification of variation in emergency care delivery.

Vizient is also concerned that the ECAT eCQM measure could create confusion, as key definitions included in this measure such as “dedicated treatment area” and “boarding” could be interpreted differently. Clear and consistent definitions are essential to ensure hospitals interpret and report these elements uniformly. Without precise definitions, hospitals may classify treatment areas or boarding status differently, undermining the validity of the measure and limiting its usefulness for quality improvement. Standardization is also necessary to ensure that data collected across diverse emergency departments can be reliably used to assess capacity constraints and identify opportunities to improve patient flow and emergency care delivery. Given these concerns, Vizient recommends that CMS work closely with stakeholders to better understand stakeholder experiences for those voluntarily reporting this measure under the OQR Program before including the measure in the IQR or VBP Programs.

Hospital Readmissions Reduction Program (HRRP)

CMS proposes adopting the Hospital 30-Day, All-Cause, Risk-Standardized Readmission Rate Following Sepsis Hospitalization measure (Sepsis Readmission measure) in the HRRP beginning with “early look” reports for FY 2028.[30] In addition, CMS proposes that the Sepsis Readmission measure would be used for payment adjustment beginning with the FY 2029 program year (PY). Vizient welcomes the provision of “early look” reports that include baseline and performance-period results before payment adjustments begin but suggests CMS defer finalizing policy related to payment adjustments until experiences based on the “early look” reports are understood. Further, should CMS pursue using the measure for payment adjustments, we emphasize that FY 2029 would be too early, as hospital would need sufficient time to prepare for the measure. Such preparation would not be possible if adjustments would go into effect for the FY 2029 PY. Therefore, if CMS finalizes policy beyond the “early look” period, such policy should be delayed until at least FY 2031 to give hospitals sufficient time to prepare.

While Vizient supports efforts to improve sepsis care, the Sepsis Readmission measure, which includes patients with a sepsis diagnosis, may be duplicative. For example, the Sepsis Readmission measure appears to overlap with existing measures that hospitals already report, such as the Severe Sepsis and Septic Shock: Management Bundle (SEP-1). Vizient is

[29] https://mmshub.cms.gov/sites/default/files/ECCQ-TEP-2-Summary-Report.pdf
[30] The applicable period is from July 1, 2024, to June 30, 2026. Data used in this early look period would not be publicly reported or used for payment adjustment.

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concerned that introducing a new sepsis-related measure, especially if existing measures are retained, risks increasing burden without clear evidence regarding which measurement approach, if any, will be most beneficial in the context of patient care. In addition, adopting additional sepsis-related measures appears to counter the administration's goal of reducing burden. Given the overlap with SEP-1 and the significant burden associated with SEP-1, consistent with our prior comments, Vizient suggests retiring SEP-1 and replacing it with significantly fewer measures.

Hospital IQR Program

Excess Days in Acute Care (EDAC) After Hospitalization for Diabetes Measure[31]

CMS proposes adoption of the EDAC After Hospitalization for Diabetes measure in the IQR Program beginning with the July 1, 2025 - June 30, 2027, performance period (FY 2029 payment determination). Currently, there is limited information regarding how this measure aligns with existing diabetes-related quality initiatives and whether it has been evaluated for overlap or redundancy with existing measures. Understanding how this measure fits within the broader diabetes care landscape is essential to avoiding unnecessary burden and ensuring that new measures add meaningful value. Vizient encourages CMS to provide additional information regarding the measure in the context of other diabetes-related quality measures and initiatives before finalizing the proposal.

In addition, Vizient recognizes the value of identifying opportunities to reduce avoidable acute care utilization for patients with diabetes. However, as this is a newly developed measure, additional testing, validation and stakeholder review are needed before the measure is considered for use in the IQR program. In 2024, a TEP released a summary of its meetings on the development of a similar 30-day risk-standardized EDAC After Hospitalization for Diabetes measure, where its members raised concerns regarding the reliability of diagnosis coding for diabetes, the complexity of risk adjustment and the feasibility of accurately capturing the full range of acute care encounters for patients with diabetes, among other concerns.[32] The TEP suggested additional refinement and indicated additional testing would be necessary to ensure the measure's validity and reliability. Considering the concerns raised by the TEP and the limited testing information currently available, Vizient recommends that CMS continue to refine and evaluate the EDAC After Hospitalization for Diabetes measure before it is included in the Hospital IQR program.

Malnutrition Care Score eCQM[33]

CMS proposes to require reporting of the Malnutrition Care Score eCQM in the IQR Program beginning with the CY 2028 reporting period/FY 2030 payment determination. This measure includes malnutrition risk screening and, for patients identified as at risk or malnourished, nutrition assessment and care planning involving a Registered Dietitian (RD) or Registered Dietitian Nutritionist (RDN). These staffing requirements could impose substantial operational burden on rural and medically underserved hospitals that might not be able to provide full-time

[31] This is an outcome measure that assesses the number of days a patient spends in acute care within 30 days of discharge from an inpatient hospitalization for a diagnosis of diabetes mellitus with complications. https://p4qm.org/prmr-measures/muc2025-053?utm_source=copilot.com
[32] TEP Meetings Summary Report for 30-Day Risk-Standardized Excess Days in Acute Care (EDAC) following Hospitalization for Diabetes
[33] https://ecqi.healthit.gov/ecqm/hosp-inpt/2026/cms0986v5

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RD or RDN staffing. Vizient recommends that CMS evaluate whether hospitals can realistically provide this level of staffing, so facilities are not unfairly penalized due to the mandatory reporting of this measure.

Proposed Refinements to EDAC Measures

CMS proposes technical updates including the addition of MA data, shortening the performance year and use of ICD-10 codes to the following EDAC measures in the IQR Program: (1) Excess Days in Acute Care after Hospitalization for Acute Myocardial Infarction;[34] (2) Excess Days in Acute Care after Hospitalization for Heart Failure;[35] and (3) Excess Days in Acute Care after Hospitalization for Pneumonia as outlined below.[36]

Addition of Medicare Advantage Beneficiary Data

CMS proposes expanding the criteria of the EDAC measures to include MA data in the IQR Program beginning with the July 1, 2024 - June 30, 2026 performance period, associated with the FY 2028 payment determination. As outlined above, additional steps are needed to ensure that MA data can be used alongside FFS data and it is unclear if this type of analysis has been completed for the EDAC measures. For example, there may be differences in how FFS claims and MA encounter data are recorded. Vizient recommends CMS analyze the data to ensure encounter data is accurate and comparable between FFS and MA before including MA beneficiaries in these measures.

Technical Update to the Performance Period

CMS proposes reducing the performance period from three years to two years beginning with the July 1, 2024 - June 30, 2026 performance period for the IQR Program. As previously mentioned above, Vizient supports shortening the performance period from three to two years so that measures rely on more recent data and better capture the rapid change of clinical practice.

Technical Update to International Classification of Diseases (ICD)-10 Codes

In the Proposed Rule, CMS proposes replacing HCCs with ICD–10 codes to improve risk adjustment for these EDAC measures beginning with the July 1, 2024 - June 30, 2026 performance period, associated with the FY 2028 payment determination. Vizient endorses using individual ICD-10 codes in the risk-adjustment model to produce more actionable risk estimates and improve the validity of performance comparisons.

Proposed Measure Removals

CMS proposes removing the following eCQMs from the IQR Program beginning with the CY 2028 reporting period/FY 2030 payment determination: (1) Venous Thromboembolism Prophylaxis (VTE-1);[37] (2) Intensive Care Unit Venous Thromboembolism Prophylaxis (VTE-

[34] https://www.cms.gov/priorities/innovation/files/fact-sheet/bpciadvanced-fs-nqf2881.pdf
[35] https://p4qm.org/measures/2880
[36] https://p4qm.org/measures/2882
[37] https://ecqi.healthit.gov/ecqm/hosp-inpt/2024/cms0108v12

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2);[38] and (3) Discharged on Antithrombotic Therapy.[39] CMS notes that removal of the VTE-1 and VTE-2 eCQMs is contingent on finalizing the proposed Hospital Harm—Postoperative VTE eCQM. Vizient supports reducing reporting burden but recommends additional validation and field testing before broadly implementing the Hospital Harm—Postoperative VTE eCQM.

Future Adoption of the Adult Community-Onset Sepsis Standardized Mortality Ratio Measure

CMS seeks feedback on the potential use of the Adult Community-Onset Sepsis Standardized Mortality Ratio (SMR) measure in the IQR Program as a digital quality measure (dQM).[40] This measure largely overlaps with existing sepsis reporting (notably SEP-1) and has not been sufficiently vetted in CMS programs or real-world hospital settings. Introducing a new sepsis-related measure, especially if existing measures are retained, risks increasing burden without clear evidence regarding which measurement approach, if any, will be most beneficial in the context of patient care. CMS should allow sufficient time for testing any new sepsis-related dQM to allow validation across multiple EHR systems and review and refinement of results before the agency proposes the measure for adoption. Therefore, Vizient discourages future adoption of the Adult Community-Onset Sepsis SMR measure. Instead, Vizient recommends CMS retire SEP-1 and pursue a smaller, well-tested set of sepsis measures developed through rigorous expert review, including Consensus-Based Entity (CBE) endorsement, and field testing, to confirm fewer measures can achieve the same or better outcomes.

Proposed Changes to the Medicare Promoting Interoperability (PI) Program

Proposed Updates to the Definition of Certified Electronic Health Record (EHR) Technology (CEHRT)

CMS proposes updating the definition of CEHRT to align with certain proposals from the Office of the National Coordinator for Health Information Technology's (ONC) Deregulatory Actions to Unleash Prosperity (HTI-5) Proposed Rule, including removal of several ONC certification criteria.[41] Specifically, CMS proposes deleting references to four criteria, including, "family health history", "patient health information capture," "automated numerator recording" and "automated measure calculation," from the CEHRT definition, effective January 1, 2027.[42] While the functionality reflected in these criteria is already embedded in EHRs and widely available and used by eligible hospitals, it is unclear if CMS intends for the functional, clinically useful data elements to be retained or removed. Before finalizing this proposal, Vizient recommends CMS publish a detailed list of the data elements collected for these criteria and indicate whether

[38] https://ecqi.healthit.gov/ecqm/hosp-inpt/2025/cms0190v13
[39] https://ecqi.healthit.gov/ecqm/hosp-inpt/2025/cms0104v13
[40] This measure is currently being developed as a digital quality measure (dQM) to enable real-time, automated reporting through Centers for Disease Control's (CDC) National Healthcare Safety Network's (NHSNLink) application programming interface (API).
[41] The HTI-5 proposed rule would change which ONC certification criteria count toward the CEHRT definition used in the Medicare Promoting Interoperability Program by removing or revising several requirements. ONC proposes eliminating multiple criteria within the Base EHR definition—such as implantable device lists and certain transport protocol functions—which would mean hospitals and CAHs would no longer need CEHRT that includes those capabilities. ONC also proposes removing four criteria explicitly referenced in the CEHRT definition, including family health history and automated measure calculation. Additional criteria that support specific Promoting Interoperability measures, such as those tied to providing patients electronic access to their health information, would be revised or removed, narrowing the required functionality for reporting. Some public health–related criteria would be removed or updated, shifting toward more flexible, functional requirements rather than specific standards. https://healthit.gov/regulations/hti-rules/hti-5-proposed-rule/
[42] If finalized, hospitals and critical access hospitals (CAHs) would no longer be required to use EHR technology certified to these functions to meet CEHRT requirements.

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each is captured elsewhere in the EHR so stakeholders can determine if removing the certification would create clinical gaps or merely eliminate duplication. Providing this level of detail will allow stakeholders to assess operational and clinical impacts of the proposal updates.

Proposal to Make the Electronic Prior Authorization Measure[43] a Bonus Measure for the EHR Reporting Period in CY 2027

For CY 2027, CMS proposes delaying mandatory reporting of the Electronic Prior Authorization (PA) measure to CY 2028 and making it a bonus measure worth 10 bonus points in CY 2027.[44] Vizient supports the agency's proposal to delay mandatory reporting of the electronic PA measure, as this will help ease provider burden.

Request for Comment on Additional Expansion of the Electronic PA Measure

In the Proposed Rule, CMS requests stakeholder feedback on expanding the Electronic PA measure, as the agency is considering allowing hospitals to satisfy the Electronic PA measure by using CEHRT to check whether PA is required, even if hospitals do not submit a request. If hospitals can implement these CEHRT capabilities directly in the EHR, it could reduce operational burden by helping clinicians identify when PA is needed, assemble required documentation within the same workflow and submit and track requests more efficiently. This could give hospitals needed flexibility to improve performance on this measure; however, feasibility will vary across hospitals because implementation and workflow configurations can differ significantly, even within the same EHR platform. If this proposal is finalized, Vizient recommends that CMS pair this flexibility with clear technical definitions, reasonable documentation expectations and a phased implementation approach that accounts for variability in EHR configurations and dependence on vendor and payer technical readiness.

Proposed Expansion of the Comprehensive Joint Replacement (CJR) Model

In the Proposed Rule, CMS proposes to expand the previously tested CJR Model, which ended December 31, 2024. The new model would be the Comprehensive Care for Joint Replacement Expanded Model (CJR-X), a nationwide, mandatory episode of care model with no specified end date. CMS proposes that episodes in CJR-X would include lower extremity joint replacement (LEJR) procedures including inpatient hip, knee and ankle replacement procedures paid through the IPPS under select MS-DRGs and hospital outpatient hip and knee replacement procedures billed under select Healthcare Common Procedure Coding System (HCPCS) codes through the OPPS.[45,46] Consistent with Vizient's prior comments, we oppose mandatory payment models, as such models have been disruptive and burdensome to providers, among other concerns. While Vizient also has concerns regarding the structure

[43] This was adopted in the 2024 CMS Interoperability and Prior Authorization Final Rule added a new Electronic Prior Authorization measure for eligible clinicians under the Merit-based Incentive Payment System (MIPS) Promoting Interoperability performance category and eligible hospitals and critical access hospitals (CAHs) in the Medicare Promoting Interoperability Program to report their use of payers' Prior Authorization APIs to submit an electronic prior authorization request. https://www.govinfo.gov/content/pkg/FR-2024-02-08/pdf/2024-00895.pdf

[44] If this proposal is finalized, hospitals that attest "Yes" in CY 2027 would earn 10 bonus points, while hospitals attesting "No" would not be penalized and would still be considered meaningful EHR users.

[45] MS-DRG 469 (Major Hip and Knee Joint Replacement or Reattachment of Lower Extremity with Major Complications or Comorbidities (MCC) or Total Ankle Replacement), 470 (Major Hip and Knee Joint Replacement or Reattachment of Lower Extremity without MCC), 521 (Hip Replacement with Principal Diagnosis of Hip Fracture with Major Complication or Comorbidity (MCC)), or 522 (Medical Back Problems Without MCC) would trigger LEJR episodes in CJR-X.

[46] HCPCS codes 27130 (primary total hip arthroplasty (THA) or 27447 (total knee arthroplasty (TKA), involving the replacement of both the medial and lateral knee compartments, with or without patella resurfacing), would trigger LEJR episodes in CJR-X.

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of CJR-X, we believe that shifting to a voluntary model is the most important change that CMS should make to the proposed CJR-X Model, if finalized.

Mandatory Participation

CMS proposes to require mandatory participation of CJR-X participants, defined in the Proposed Rule as all eligible acute care hospitals nationwide located in all 50 states (excluding Maryland), the District of Columbia or a U.S. territory that initiate LEJR episodes and are paid under both IPPS and OPPS.

Mandatory payment models can be extremely disruptive to healthcare providers, as alternative payment models generally require significant planning and coordination for success. As drafted, the proposed mandatory nationwide model would impose a significant shift in reimbursement and care delivery on hospitals that more generally have opted not to participate in alternative payment models. In addition, many hospitals have not previously participated in CJR or other episode-based models and therefore lack the operational infrastructure and experience needed to implement these requirements effectively. Hospitals should be able to determine whether participation in a model of this type, or inclusion of specific clinical episodes within the model, is appropriate and feasible for their patient populations and community needs. As a result, Vizient is concerned that hospitals required to participate across the nation could be at greater financial risk since they may lack the resources and experience needed to succeed in CJR-X.

Also, while model evaluation is important, the agency should provide additional consideration of the potential harm that such a mandatory model could have on hospitals and the beneficiaries they serve. Participating hospitals could be discouraged from providing care if that care is not financially sustainable. Vizient suggests CMS better ensure that beneficiary access to care would not be negatively impacted by a mandatory model. Vizient urges CMS to withdraw the proposal that CJR-X be mandatory.

However, if this proposal is finalized, at a minimum, Vizient recommends CMS adopt a phased-in participation approach for CJR-X. A phased implementation approach could allow participants without prior model experience to build capacity before being held to full financial risk.[47] In addition, a phased in implementation approach may be particularly beneficial as the CJR Model ended October 1, 2024, so hospitals may need more time to prepare for the new CJR-X Model than if there was continuity between the models.

Scope of Episode

In the Proposed Rule, CMS notes that outpatient total ankle arthroplasty (TAA) procedures are not included in the initial CJR-X model, as adding outpatient TAAs would be too big a change from the CJR Model.[48] Instead, CMS is testing and assessing performance of outpatient TAAs in TEAM before considering broader inclusion in CJR-X. Vizient agrees that CMS should not add outpatient TAA procedures to CJR-X at this time for the reason CMS states.

[47] https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-425/subpart-G/section-425.600?utm_source=chatgpt.com
[48] CPT Code 27702 represents a total ankle arthroplasty (total ankle replacement) with an implant.

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In addition, inpatient TAA volume is relatively low, and the inpatient cases that do occur tend to be more complex and have higher risk. Expanding a low-volume, higher-acuity procedure into a nationwide mandatory episode model without adequate data could introduce instability in benchmarking and increase financial volatility for participating hospitals. CMS should rely on publicly available volume data to assess whether the procedure has sufficient case counts to support a stable episode design before advancing any expansion.

CJR-X Participant Exceptions

CMS proposes that TEAM participant hospitals would be exempt from CJR-X, but this exclusion would end when TEAM concludes or when a hospital no longer meets the TEAM participant definition, at which point any hospital meeting the CJR-X participant definition would have to participate in CJR-X. Given Vizient's previously stated concerns with mandatory model participation, we recommend CMS allow TEAM hospitals to voluntarily elect whether to participate in CJR-X, rather than being required to transition automatically. Further, for hospitals transitioning to CJR-X, it is unclear whether CMS has considered the operational and financial strain that could result if hospitals are not provided with adequate time to transition between models. TEAM's first performance year was intentionally designed as a ramp-up period, and hospitals had lead time before implementation; therefore, a comparable transition period is needed to move from TEAM to CJR-X. If this proposal is finalized, Vizient recommends that CMS consider a voluntary or phased transition approach that accounts for variation in hospital readiness and patient populations to allow hospitals to close out TEAM requirements and prepare for CJR-X obligations.

Data Sharing

CMS proposes to provide CJR-X participant hospitals with beneficiary-identifiable Medicare claims data limited to the services within a CJR-X episode for patients whose episodes are attributed to the hospital, including a three-year baseline set of episode claims and monthly claims reports during the performance year. Model participants need timely access to beneficiary-identifiable claims data before episodes begin but historically, lack of transparent, real-time data has created confusion on trigger events and eligibility for episodes and program participation. While not addressed in the Proposed Rule, Vizient urges CMS to make beneficiary claims data, historical baseline data and regional aggregate data available to participants at least 60 days before the start of the relevant performance period.

Transforming Episode Accountability Model (TEAM)

Mandatory Participation

In prior rulemaking, CMS finalized policy to require hospitals located in selected geographic areas that meet the proposed TEAM participant definition to participate in TEAM. Vizient continues to believe that mandatory payment models are disruptive to healthcare providers, as alternative payment models generally require significant planning and coordination for success. These steps may not be feasible for all types of providers, particularly given that resource constraints may prevent certain providers from taking these actions to improve their participation outcomes. Vizient urges CMS to change the model from mandatory to voluntary.

Proposed Changes to Spinal Fusion Episode Category

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CMS proposes, starting on October 1, 2026, adding MS-DRGs 523, 524 and 525 to the spinal fusion episode category that would initiate a spinal fusion anchor hospitalization.[49] Many procedures within the proposed MS-DRGs are not currently included as episode initiators in TEAM, and the Proposed Rule does not give a clear rationale for an expansion of TEAM. Implementing new MS-DRGs in the middle of a performance year raises concerns about additional burden for hospitals, including how this change will affect measurement for the 2026 performance period. Vizient urges CMS to withdraw this proposal and maintain the current list of episode-initiating procedures in TEAM.

Proposed Changes for Episode Attribution

In the Proposed Rule, CMS proposes that if a beneficiary in a CJR-X episode has a procedure performed at a TEAM hospital that would initiate a TEAM episode during the CJR-X 90-day post-discharge period, then that procedure would not initiate a TEAM episode or be attributed to the TEAM participant. Vizient supports this proposal, as it helps avoid double attribution and aligns accountability with the hospital responsible for the initial episode. If finalized, Vizient recommends CMS closely monitor implementation to confirm the policy consistently prevents episode overlap that might negatively affect a hospital's outcomes. Further, Vizient recommends that CMS clarify how TEAM hospitals should identify beneficiaries in a CJR-X episode to prevent duplication.

Proposed Measurement Performance Periods for Certain Quality Measures

CMS proposes to set the measurement performance periods for three TEAM quality measures to align with the Hospital IQR Program's calendar year reporting requirements.[50] Specifically, CMS proposes a one-year measurement performance period for the Hospital Harm—Falls with Injury[51] and Hospital Harm—Postoperative Respiratory Failure[52] measures and a two-year rolling measurement performance period for the Thirty-Day Risk-Standardized Death Rate among Surgical Inpatients with Complications (ISCMR) measure.[53] Vizient is concerned that changes to measurement windows during a performance year will make it difficult to reconcile current performance with expectations for the following year. Hospitals need clear, annual measurement calendars that specify which measures apply to each performance year and shifting measurement windows makes it difficult for hospitals to identify stable targets and plan improvement efforts when the measurement performance periods keep changing. Vizient recommends that CMS publish a specific annual measurement calendar with relevant benchmarking updates to avoid mid-year changes so hospitals can reliably align quality improvement efforts.

Proposed Updates to Pricing Methodology

CMS proposes applying new Ambulatory Payment Classification (APC) and MS-DRG update factors to final TEAM target price calculations beginning in performance year (PY) 1 to ensure

[49] MS-DRG 523, 524, and 525 represents Extensive or Complex Spinal Fusion Procedures Except Cervical with MCC, with CC and without CC/MCC. The agency explains that adding these new MS-DRGs to TEAM will help hospitals maintain enough spinal-fusion episode volume to achieve care-delivery efficiencies, distribute financial risk, and expand beneficiaries' access to value-based care
[50] CMS notes that TEAM aims to align with existing reporting requirements so as not to introduce additional burden to participants.
[51] Hospital Harm - Falls with Injury | eCQI Resource Center
[52] Hospital Harm - Postoperative Respiratory Failure | eCQI Resource Center
[53] https://p4qm.org/measures/4125

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that target prices reflect the coding and weight changes that occur during each PY.[54] Vizient supports applying APC and MS-DRG update factors to TEAM target prices because it ensures target prices reflect current coding and weight changes and reduces the risk of under- or over-targeting the estimated expected cost or resource use for each episode.

Requests for Information (RFIs)

Ambulatory Surgical Center (ASC) Episode RFI

In the Proposed Rule, CMS explains the agency is exploring adding ASCs to TEAM beginning as early as CY 2028 (PY 3). CMS recognizes that a larger number of procedures, including certain procedures that initiate episodes in TEAM, are being performed more regularly in the ASC setting and asks for feedback on how ASCs could be incorporated into TEAM.[55] As CMS is aware, hospitals and ASCs serve different case mixes and patient acuity levels. Therefore, CMS should ensure that any ASC participation in TEAM is structured as a separate track or model construct with ASC-specific target prices and methodology, rather than blending ASC episodes into hospital benchmarks.

Incorporating ASC utilization and population mix into hospital target prices could inappropriately lower targets and obscure setting-specific cost structures and resource use. If CMS proceeds with adding ASCs to TEAM, target pricing and attribution should be calibrated separately for ASCs and hospitals so that they do not affect target pricing for hospitals, which must be specific and calibrated to reflect each care setting's distinct cost structure and resource use. Vizient also recommends that, where appropriate, CMS apply similar quality measures to ASCs that apply to hospitals for the same procedures (e.g., complications, infections, unplanned ED visits/admissions and readmissions) to ensure there is comparable information across sites of care if ASCs are included in TEAM in the future.

Clarification and Codification of Cost Allocation Principles

CMS proposes to codify a change to the cost reporting guidance requirements so hospitals will no longer report certain costs under their indirect costs as administrative and general (A&G) expenses. Specifically, CMS proposes to require hospitals to remove high-value purchases, such as organs purchased by transplant hospitals from outside Organ Procurement Organizations (OPOs), from the accumulated-cost statistic that is used to allocate A&G indirect overhead across cost centers.[56] In the Proposed Rule, CMS explains that when a hospital purchases an organ from an outside OPO, that purchase is recorded as a direct cost that already includes the OPO's overhead. CMS has concerns that if the hospital also counts that purchase in the accumulated-cost statistic used to allocate A&G overhead, the same overhead would effectively be counted twice and could lead to overpayment of A&G

[54] The APC update factor would be calculated at the MS-DRG/HCPCS episode-type and region level as the ratio of benchmark prices using the performance-year APC weights to preliminary benchmark prices using the prior-year APC weights. For MSDRGs - For episodes ending in the fourth quarter, CMS would calculate this factor at the MS-DRG/HCPCS episode-type and region level as the ratio of benchmark prices using second-fiscal-year inputs to those using first-fiscal-year inputs, publish it after the annual IPPS/LTCH final rule, and multiply it into the prospective trend factor to produce an updated prospective trend.
[55] In the Proposed Rule, CMS highlights that should ASCs be included in TEAM in the future and subsequent TEAM evaluation reports produce data to support ASC inclusion in CJR-X, any such participation change would be proposed through future notice and comment rulemaking.
[56] CMS states that it believes when the cost of the organ purchase from the OPO is included in the direct cost category, it already includes the overhead costs incurred by the OPO and that including the cost in the accumulated cost statistic could overpay the transplant hospital for overhead costs, (e.g., A&G costs). CMS explains this proposal is to prevent double-counting OPO overhead and avoids overpaying hospitals for A&G costs.

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costs to the transplant hospital. Transplant and teaching hospitals deliver much of this care and are essential to the nation's organ acquisition and transplant infrastructure. The investments these hospitals make in transplant and organ acquisition programs enable them to perform some of the most advanced, lifesaving procedures.

Vizient disagrees with CMS's conclusion that excluding purchased organ costs from the accumulated-cost statistic is necessary to prevent improper A&G allocation. Even when an organ is purchased externally, transplant hospitals incur significant administrative, financial, clinical and operational costs to support organ procurement and transplantation. This proposal, if finalized, would prevent the inclusion of high-value purchased items in the overhead costs, effectively under-reimbursing transplant hospitals for transplant and organ procurement costs and threatening patient access to these critical services. To preserve access to essential transplant care and protect program stability, Vizient suggests that CMS withdraw the proposal.

Conclusion

Vizient appreciates CMS's efforts to gain additional feedback regarding the FY 2027 IPPS Proposed Rule. Vizient membership includes a variety of hospitals ranging from independent, community-based hospitals to large, integrated health care systems that serve acute and non-acute care needs. In closing, on behalf of Vizient, I would like to thank CMS for providing the opportunity to respond to this Proposed Rule. Please feel free to contact me, or Jenna Stern at Jenna.Stern@vizientinc.com, if you have any questions or if Vizient may provide any assistance as you consider these recommendations.

Respectfully submitted,

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