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June 10, 2025

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 and the Long-Term Care Hospital Prospective Payment System and Policy Changes and Fiscal Year 2026 Rates; Requirements for Quality Programs; and Other Policy Changes (CMS-1833-P)

Dear Administrator Oz,

Vizient, Inc. appreciates the opportunity to comment on the Centers for Medicare and Medicaid Services (CMS) proposed rule regarding the fiscal year (FY) 2026 Hospital Inpatient Prospective Payment System (IPPS) for Acute Care Hospitals and Fiscal Year 2026 Rates and Requirements for Quality Programs (CMS-1833-P) (hereinafter, "Proposed Rule"). Many of the topics in the Proposed Rule have a significant impact on our provider clients and the patients they serve. Given the complex nature of the healthcare system, 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, serves more than 65% of the nation's acute care providers, including 97% of the nation's academic medical centers, and more than 35% of the non-acute market. The Vizient contract portfolio represents $140 billion in annual purchasing volume enabling the delivery of cost-effective, high-value care. With its acquisition of Kaufman Hall in 2024, Vizient expanded its advisory services to help providers achieve financial, strategic, 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.

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Proposed IPPS Payment Rate Updates for FY 2026

CMS indicates that the Proposed Rule would increase IPPS operating payment rates by 2.4% in FY 2026 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 regarding how the market basket and productivity adjustment were reached, including the underlying assumptions. For example, and as further detailed below, Vizient is concerned that the market basket update is inadequate, but we are challenged in identifying the specific reasons why the rate is so low given the lack of transparency. To help stakeholders provide additional feedback, Vizient encourages CMS to provide additional information and related reports regarding the market basket and productivity adjustment.

Market Basket

As CMS may be aware, hospitals' expenses for supplies, labor, purchased services, and drugs are significantly higher in 2025 compared with 2024.[1] For example, Kaufman Hall's February 2025 Hospital Flash Report indicates that hospitals' supply expense per calendar day is 10% greater in 2025 versus 2024. In addition, a recent Kaufman Hall article highlights that hospitals' days cash on hand medians are still declining, as expense growth has outpaced the growth of cash reserves.[2] Also, based on Vizient's Spend Management Outlook Winter 2025, the projected change in the price of pharmaceuticals between July 1, 2025, to June 30, 2026, is 3.84%, which will exceed the proposed market basket of 3.2%.[3] 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 2026 given hospitals' financial circumstances.

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. Since February, new tariffs have been imposed on goods from Canada, Mexico, and China, in addition to a 10% global minimum tariff that went into effect in April 2025 and tariff increases on other products (e.g., steel, aluminum).[4,5] Further, the Department of Commerce has opened a Section 232 investigation into pharmaceuticals and pharmaceutical ingredients, which may result in tariffs specific to these products; and numerous other tariffs, which have been temporarily delayed, are expected to go into effect in the near future.[6,7] While litigation is ongoing related to some of these tariffs, Vizient believes it is imperative that CMS clarify how it is accounting for tariffs in payment policy for FY 2026 and should also study the effects of such tariffs in the current fiscal year to

[1] The Kaufman Hall February 2025 Hospital Flash Report shows a year over year change from 2024 to 2025 for total expenses per calendar day (8%), labor expenses (6%), non-labor expenses (9%), supply expenses (10%), drug expenses (9%), and purchased services (13%). https://www.kaufmanhall.com/sites/default/files/2025-04/KH-NHFR_Report-Feb-2025-Metrics.pdf
[2] https://www.kaufmanhall.com/insights/article/2025-healthcare-credit-and-capital-markets-outlook
[3] Vizient Spend Management Outlook - Winter 2025
[4] *See* HSTUS, Chapter 99, available at: https://hts.usitc.gov/
[5] https://www.whitehouse.gov/presidential-actions/2025/06/adjusting-imports-of-aluminum-and-steel-into-the-united-states/
[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/presidential-actions/2025/04/modifying-reciprocal-tariff-rates-to-reflect-trading-partner-retaliation-and-alignment/

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determine if baseline data needs to be modified based on more recent data. As such, Vizient urges CMS to provide additional transparency regarding the factors considered for the market basket forecast, particularly as related to tariffs.

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

In the Proposed Rule, CMS stated that a stakeholder requested clarification on the agency's rationale for assigning a noncancer gene therapy to CAR T-Cell and Other Immunotherapies (MS-DRG 018). In response to this request, CMS notes that this category of therapies continues to evolve, and the agency is considering the feedback regarding how the agency can continue to appropriately reflect resource utilization while maintaining clinical coherence and stability in the relative weights under the IPPS MS-DRGs. Vizient appreciates the agency's efforts to learn more about appropriate reimbursement for services that involve high-cost cell and gene therapies. Consistent with our prior comments, Vizient continues to emphasize that inadequate reimbursement coupled with significant logistical challenges and financial risks, can deter hospitals from providing these treatments and related services to patients.

Vizient anticipates that 35 novel therapies will be in the market by 2026, with many more in the pipeline, to treat rare disorders such as sickle cell disease, hemophilia, spinal muscular atrophy and several oncology disease states. However, providers face numerous challenges in providing these therapies, particularly given the substantial upfront costs (e.g., training staff, implementing new workflows, purchasing products, becoming a qualified treatment center) and under-reimbursement. As such, ensuring adequate reimbursement is critical to support patient access to these needed medications. While Vizient understands the agency's cautious approach to reimbursement given the high cost of these treatments and related services, we believe it is imperative that the agency consider opportunities to increase and refine reimbursement for these products for FY 2026. In addition, we recommend CMS work closely with providers on a longer-term reimbursement framework that accounts for differences in treatment and more effectively addresses challenges providers face related to these therapies.

Proposed Payment Adjustment for Medicare Disproportionate Share Hospitals (DSH) for FY 2026

Factor 1 Recommendations

To estimate Factor 1, CMS includes a table in the Proposed Rule that delineates the components CMS applied for FYs 2023 through 2026 to estimate Factor 1.[8] This table contains an "Other" column that reflects the additional factors (e.g., estimated changes of Medicaid enrollment, certain other payment rate adjustments, certain discharge data) that contribute to the Medicare DSH estimates, but CMS does not clearly explain the data or methodology behind the "Other" factors used in its DSH payment calculations. For example, it is unclear how changes in Medicaid enrollment and differences in discharge data are accounted for in the "Other" column. This lack of transparency makes it difficult for stakeholders to understand or validate CMS's calculations. Vizient believes sharing this information beginning with FY 2026 rulemaking will help increase transparency regarding Factor 1 calculations. Vizient recommends CMS consistently publish a detailed methodology

[8] https://public-inspection.federalregister.gov/2025-06271.pdf

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for its "Other" calculation, including information related to all contributing components and the year-to-year estimates utilized.

Factor 2 Recommendations

To calculate Factor 2 of the uncompensated care payment, 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 2024, estimate the uninsured rate will be 7.7 percent in calendar year (CY) 2025 and 8.7 percent in CY 2026. For FY 2026, CMS proposes to continue using the same methodology to calculate Factor 2 that has been applied in rulemaking from FY 2018 through FY 2025.

Vizient is concerned that CMS may be underestimating the number of uninsured used in the calculation of Factor 2, as current estimates do not sufficiently account for the potential coverage losses resulting from recent proposals that would change ACA and Medicaid policies. For example, in March 2025, CMS released the Marketplace Integrity and Affordability Proposed Rule, which introduces provisions that will either shorten or eliminate various Health Insurance Marketplace enrollment periods.[9] This proposed rule has not yet been finalized, but CMS projects that these changes to enrollment will result in between 750,000 and 2 million fewer Marketplace enrollees in 2026. Furthermore, enhanced premium tax credits that reduce out-of-pocket cost of health insurance premiums for people who obtain insurance through Marketplaces are set to expire at the end of 2025. Without an extension through congressional action, the Congressional Budget Office (CBO) estimates an additional 2.2 million people will be uninsured in CY 2026.[10] As such, Vizient encourages CMS to reconsider the approach to calculate Factor 2, given these and other potential changes that may impact the estimated number of uninsured.

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

Discontinuation of the Low Wage Index Hospital Policy and Budget Neutrality Adjustment

CMS proposes to discontinue the low wage index hospital policy for FY 2026 and beyond after considering the D.C. Circuit court's decision in *Bridgeport Hosp. v. Becerra.*[11] The 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. As a result, in July 2024, CMS issued an interim final rule updating the FY 2025 IPPS Final Rule in a non-budget neutral manner, which revised Medicare wage index values for FY 2025 and established a transitional payment exception for low wage hospitals significantly impacted by those revisions.[12]

Considering this decision, CMS proposes adopting a transitional exception to the calculation of FY 2026 IPPS payments for low wage hospitals significantly impacted by the

[9] https://www.reginfo.gov/public/do/eoDetails?rrid=937019
[10] Congressional Budget Office, "The Effects of Not Extending the Expanded Premium Tax Credits for the Number of Uninsured People and the Growth in Premiums." (December 2024) https://www.cbo.gov/system/files/2024-12/59230-ARPA.pdf
[11] https://cases.justia.com/federal/appellate-courts/cadc/22-5249/22-5249-2024-07-23.pdf?ts=1721746878
[12] 89 FR 80405 (October 3, 2024)

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discontinuation of the low wage index. While the transitional exception provided in the Proposed Rule is similar to policy provided in the July 2024 interim final rule, it is different since CMS proposes to implement the policy in a budget neutral manner for FY 2026. Vizient is concerned that offsetting increases for low-wage hospitals by reducing payments to others only worsens continuing Medicare underpayment to hospitals. To align with the interim final rule and to minimize financial disruption, Vizient urges CMS to implement the transitional exception for FY 2026 IPPS payments in a non-budget neutral manner.

Hospital Readmissions Reduction Program (HRRP)

Addition of Medicare Advantage Beneficiary Data

CMS proposes, beginning with the FY 2027 program year (PY), adding Medicare Advantage (MA) beneficiaries into the cohorts of the six Hospital Readmissions Reduction Program (HRRP) measures.[13] CMS aims to make HRRP more representative of the Medicare population, particularly since more than half of Medicare patients are covered by an MA plan. While Vizient appreciates the importance of updating the HRRP measure cohorts given the growth of the MA program, we anticipate that additional steps are needed to ensure that MA data can be used alongside fee-for-service (FFS) data. For example, there may be differences in how FFS claims and MA encounter data are recorded, yet it is unclear if this type of analysis has been completed. Consistent with our prior comments to the Partnership For Quality Measurement, Vizient encourages CMS to analyze the data to ensure encounter data is accurate and comparable between FFS and MA before including MA beneficiaries in these measures.

Additionally, CMS proposes, beginning with the FY 2027 PY, to reduce the applicable period to evaluate hospital readmission rates from a three-year period to a two-year period. Vizient supports this proposed reduction, as relying more heavily on recent data will better reflect 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. Reducing the HRRP 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 period.

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

CMS provides notice of a technical update to the HRRP risk adjustment model to replace Hierarchical Condition Categories (HCCs) with individual ICD-10 codes to improve accuracy by using more specific clinical data beginning with the FY 2027 PY. Vizient believes ICD-10 codes offer precise and appropriate risk stratification. 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.

[13] These measures include: the Hospital 30-Day, All-Cause, Risk-Standardized Readmission Rate (RSRR) Following Acute Myocardial Infarction (AMI) Hospitalization; Hospital 30-Day, All-Cause, RSRR Following Heart Failure (HF) Hospitalization; Hospital 30-Day, All-Cause, RSRR Following Pneumonia (PN) Hospitalization; Hospital-Level, 30-Day, All-Cause, RSRR Following Chronic Obstructive Pulmonary Disease (COPD) Hospitalization; Hospital 30-Day, All-Cause, RSRR Following Total Hip Arthroplasty (THA) and Total Knee Arthroplasty (TKA) Hospitalization; and Hospital 30-Day, All-Cause, RSRR Following Coronary Artery Bypass Graft (CABG) Surgery measures

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Technical Updates to the Specifications of the Hospital Readmissions Reduction Program Measures

CMS provides notice in the Proposed Rule that, beginning with the FY 2027 PY, it intends to remove the exclusion of admissions with either a principal or secondary diagnosis of COVID–19 present on admission from the six readmission measures.[14] Should the agency proceed with removing the COVID-19 exclusion from the HRRP measures, Vizient recommends that CMS continue to closely monitor the data to ensure that the removal of this exclusion accurately reflects hospital performance and that hospitals are not being penalized due to variation in local disease spread.

Recommendation from the Pre-Rulemaking Measure Review (PRMR) Process on Reducing Readmission Time Period

In the Proposed Rule, CMS indicates that they are evaluating whether the readmission metrics should be shortened to a 7- or 14-day readmission time period in the HRRP. Consistent with our prior comments, Vizient supports the agency's consideration of shortening the readmissions window, particularly to a 7-day readmission time period, to better ensure that hospitals are not penalized for factors beyond their control.

Hospital Inpatient Quality Reporting (IQR) Program

Severe Sepsis and Septic Shock: Management Bundle (SEP-1)

While CMS is not proposing any changes to the Severe Sepsis and Septic Shock: Management Bundle (SEP-1) chart-abstracted measure in the Proposed Rule, this measure has long been included in the IQR Program, including for the FY 2026 payment determination as finalized in the FY 2025 IPPS Final Rule[15], and for FYs 2027-2029 and beyond payment determinations.[16] Consistent with prior comments, Vizient has concerns with the SEP-1 Bundle in the IQR Program, including the quarterly reporting requirement for specific mandated elements.[17]

Vizient recognizes the importance of sepsis prevention, but believes that because the measure is bundled, it has limited utility in quality improvement, as it does not produce actionable data on the individual elements of the measure. Additionally, collecting data to calculate this measure is extremely resource intensive for hospitals (e.g., hiring clinicians to manually abstract and validate data). Further, the measure is difficult to interpret. For example, identifying patients eligible to be part of the numerator can be challenging, particularly in cases where patients are transferred from another facility because of the time sensitive nature of the measure's requirements (e.g., repeating lactate level within 6 hours of severe sepsis presentation if initial lactate level was elevated). Given the challenges and burden associated with SEP-1, effective with the FY 2026 payment determination year, Vizient

[14] These measures include: Hospital 30-Day All-Cause RSRR Following AMI Hospitalization; Hospital 30-Day, All-Cause, RSRR Following CABG Surgery; Hospital-Level, 30-Day, All-Cause, RSRR Following COPD Hospitalization; Hospital 30-Day, All-Cause, RSRR Following HF Hospitalization; Hospital 30-Day, All-Cause, RSRR Following THA and/or TKA Hospitalization; and Hospital 30-Day, All-Cause, RSRR Following PN Hospitalization.
[15] https://www.federalregister.gov/documents/2024/08/28/2024-17021/medicare-and-medicaid-programs-and-the-childrens-health-insurance-program-hospital-inpatient
[16] CMS finalized inclusion of SEP-1 in the IQR Program in the IPPS FY 2015 final rule. https://www.govinfo.gov/content/pkg/FR-2014-08-22/pdf/2014-18545.pdf
[17] CMS Fiscal Year 2026 Hospital Inpatient Quality Reporting (IQR) Program Guide. https://www.qualityreportingcenter.com/globalassets/2024/06/iqr/2.-hospital-iqr-fy-2026-program-guide_vfinal508_c.pdf

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urges CMS to remove SEP-1 from the IQR Program and clarify that no additional quarterly reporting needs to be completed. We encourage CMS to continue efforts to develop electronic clinical quality measures (eCQMs) related to sepsis that would be less burdensome to report and provide more actionable information.

Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate (RSMR) Following Acute Ischemic Stroke Hospitalization (MORT-30-STK measure)

Consistent with measure proposals in the HRRP, CMS also proposes to update the MORT-30-STK measure, beginning with the 2025 reporting period/FY 2027 payment determination. Specifically, CMS proposes expanding the measure's criteria to include MA patients and reducing the performance period from 3 years to 2 years and updating the risk adjustment model to use ICD-10 codes instead of HCCs. For the same reasons provided in the above HRRP comments, Vizient suggests that CMS ensure the MA data is comparable to FFS data. Also, consistent with Vizient's HRRP comments, we support shortening the measurement period for the MORT-30-STK measure from three to two years and the proposed transition to using individual ICD-10 codes instead of HCCs in the risk adjustment model.

Hospital-Level, Risk-Standardized Complication Rate Following Elective Primary Total Hip Arthroplasty (THA) and/or Total Knee Arthroplasty (TKA) Measure (COMP-HIP-KNEE measure)

CMS proposes applying the same updates to the COMP-HIP-KNEE measure as those outlined for the MORT-30-STK measure, starting with the 2025 reporting period/ FY 2027 payment determination. Consistent with our previous comments, Vizient believes additional analysis is warranted to ensure the comparability of MA and FFS data. In addition, Vizient supports a shorter two-year measurement period for the COMP-HIP-KNEE measure, and the use of ICD-10 codes for more clinically relevant risk adjustment.

Additional Technical Updates to the Hospital IQR Program Measures

CMS proposes to remove the COVID-19 exclusion from seven measures[18] in the Hospital IQR Program, beginning with the FY 2027 PY. As noted in our prior remarks, Vizient recommends CMS perform additional analysis before removing the COVID-19 exclusion from these measures to provide an accurate reflection of hospital quality.

Proposed Changes to Reporting and Submission Requirements for Hybrid Measures

Based on its review of voluntary reporting in 2024 for the hybrid hospital-wide all-cause readmission (HWR) and hybrid hospital-wide all-cause risk standardized mortality (HWM) measure, which revealed that most hospitals did not meet the current submission thresholds, CMS is proposing to lower the requirements for submitting both core clinical data elements (CCDE) and linking variables. The proposed reduction would be 20% for CCDE and 25% for linking variables, setting the new threshold at a minimum of 70% of discharges. This change would apply to the Hybrid HWR and Hybrid HWM measures starting with the reporting period

[18] These measures include: MORT-30-STK measure, Hospital-Level, Risk-Standardized Complication Rate Following Elective Primary THA and/or TKA Measure, Excess Days in Acute Care after Hospitalization for Acute Myocardial Infarction, Excess Days in Acute Care after Hospitalization for Heart Failure (HF Excess Days), Excess Days in Acute Care after Hospitalization for Pneumonia (PN Excess Days), Hybrid Hospital-Wide All-Cause Readmission Measure (HWR), and Hybrid Hospital-Wide All-Cause Risk Standardized Mortality Measure (HWM)

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from July 1, 2025, through June 30, 2026, corresponding to the FY 2028 payment determination.[19] Vizient thanks CMS for proposing to lower the submission thresholds and reduce the number of required CCDE data elements.

In addition, Vizient agrees that a lower threshold is more reasonable, especially given the data collection challenges observed during the voluntary reporting period. One of the most significant challenges for hospitals in submitting this data is the extra review time needed to ensure the reports from different systems match properly. While reducing the threshold can help reduce burdens for hospitals by making compliance with IQR reporting requirements more attainable, the extent of such burden reduction remains to be seen. Given these insights, we encourage CMS to consider whether voluntary reporting should continue for the FY 2028 payment determination, while also potentially lowering the submission threshold and required CCDE data elements for future years.

Hospital Value-Based Purchasing (VBP) Program

SEP-1 Bundle

In the FY 2024 IPPS Final Rule, CMS finalized adding SEP-1 to the safety domain of the VBP Program, beginning with the FY 2026 program year.[20] While there are no proposed changes to SEP-1's use in the VBP Program in the Proposed Rule, CMS reiterates that it will continue to use SEP-1 in the Hospital VBP for the FY 2026 program year through the FY 2031 program year.[21] Consistent with previous comments, Vizient has concerns regarding use of SEP-1 in the VBP Program. As noted above, regarding SEP-1's use in the IQR Program, Vizient believes the measure has limited utility in quality improvement and is excessively burdensome to report. Furthermore, the limited benefits of the measure are drastically outweighed by the costs associated with the measure's chart-abstraction and data validation processes. Due to the excessive burdens caused by this measure, Vizient recommends CMS remove this measure, including for the VBP Program's FY 2024 performance year/FY 2026 program year, and exclude the measure for future years.[22]

Vizient notes that even if the SEP-1 measure is removed, hospitals may need to maintain the electronic infrastructure associated with SEP-1 for additional purposes (e.g., through the Joint Commission) until a less burdensome electronic clinical quality measure (eCQM) is available. However, given the administrative burden associated with SEP-1, we feel these changes will significantly ease burdens on hospitals. If CMS decides to finalize phasing out or suppressing the SEP-1 measure, we encourage the agency to communicate this policy as early as possible. Hospitals are currently making decisions regarding infrastructure and reporting strategies for future performance years, and early notice would allow for a more efficient transition. In addition, we encourage CMS to continue to develop an eCQM for future potential use.

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[19] Currently, hospitals must report 13 CCDEs for the Hybrid HWR measure (6 vital signs and 7 laboratory test results) and 10 CCDEs for the Hybrid HWM measure (4 vital signs and 6 laboratory test results).
[20] https://www.govinfo.gov/content/pkg/FR-2023-08-28/pdf/2023-16252.pdf
[21] CMS finalized inclusion of SEP-1 in the VBP Program in the IPPS FY 2024 final rule. https://www.govinfo.gov/content/pkg/FR-2023-08-28/pdf/2023-16252.pdf
[22] Vizient understands that hospitals have already submitted SEP-1 data for the VBP 2026 PY and that this information is expected to be publicly released in October 2025. Also, Vizient is aware that hospitals are currently working on collecting and submitting data for the 2027 PY, meaning hospitals are submitting and acting on data before the IPPS Final Rule is released later this year. However, given the ongoing concerns and challenges associated with the measure, Vizient requests immediate removal and that CMS issue guidance immediately regarding reporting for the 2027 PY to more promptly reduce reporting burden.

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Proposed Measure Updates to the Hospital-Level Risk-Standardized Complication Rate (RSCR) Following Elective Primary Total Hip Arthroplasty (THA) and/or Total Knee Arthroplasty (TKA) (COMP-HIP-KNEE Measure)

CMS proposes including MA beneficiaries in the VBP starting with the FY 2033 PY.[23] As stated above, Vizient suggests CMS ensure that MA encounter data is accurate and comparable to FFS claims before implementation.

In addition, CMS proposes reducing the VBP measurement period from three years to two starting in FY 2027 to better reflect recent data and improve hospital comparisons. Vizient supports this change, as it aligns with our current methodology and would improve timeliness, reduce data lag, and better capture hospital performance.

Technical Updates to the Specifications of the COMP-HIP-KNEE Measure to Update the Risk Adjustment Model

CMS proposes to update the risk adjustment methodology to use ICD-10 codes, instead of HCCs, beginning with the FY 2027 PY to better leverage the data and analytical advances since the measure was initially developed. Vizient notes that the success of this change to ICD-10 codes hinges on effective implementation and recommends that the agency ensure transparency regarding the performance of the updated risk adjustment model.

Technical Updates to the Specifications of the Five Condition- and Procedure-Specific Mortality Measures and the COMP-HIP-KNEE Measure

CMS provides notice in the Proposed Rule that, beginning with the FY 2027 PY, it intends to remove the exclusion of admissions with either a principal or secondary diagnosis of COVID–19 present on admission from the measure denominators for five condition- and procedure-specific mortality measures and the COMP-HIP-KNEE Measure.[24] Vizient appreciates CMS's acknowledgment of the significant impact of the COVID-19 public health emergency (PHE) and its efforts to adjust hospital quality measures accordingly. As the agency moves to remove the COVID-19 exclusion from the mortality and COMP-HIP-KNEE measures in the VBP, Vizient recommends that CMS continue to closely monitor the data to ensure that the removal of this exclusion accurately reflects hospital performance.

Technical Update to the Five National Healthcare Safety Network (NHSN) Healthcare Associated Infection (HAI) Measures

The Centers for Disease Control and Prevention (CDC) is currently updating its reporting of calculations of infections so that HAI standardized infection ratio (SIR) calculations will reflect the use of new 2022 standard population data as well as the 2015 standard population data.

[23] CMS is proposing these updates contingent on CMS adopting the same updates to the COMP-HIP-KNEE measure for use in the Hospital IQR Program beginning with the FY 2027 payment determination

[24] The measures impacted by the technical update are: Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate Following Acute Myocardial Infarction (AMI) Hospitalization (MORT–30– AMI), Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate Following Coronary Artery Bypass Graft (CABG) Surgery (MORT–30–CABG), Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate Following Chronic Obstructive Pulmonary Disease (COPD) Hospitalization (MORT–30 COPD), Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate Following Heart Failure (HF) Hospitalization (MORT–30–HF), and Hospital-Level Risk-Standardized Complication Rate Following Elective Primary Total Hip Arthroplasty (THA) and/or Total Knee Arthroplasty (TKA) (COMP–HIP–KNEE) measures.

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In the Proposed Rule, CMS indicates it plans to use the 2015 baseline data to calculate performance standards and calculate and publicly report measure scores until the FY 2029 program year for the Hospital VBP Program. For the FY 2029 program year and subsequent years, the VBP Program will use CY 2022 data to calculate performance standards. Vizient acknowledges the importance of updating the baseline year given that the current baseline is outdated. However, since the CY 2022 baseline data is not yet available for review, we are unable to provide meaningful feedback on its use or impact. We encourage CMS to carefully evaluate any potential impacts on the CY 2022 data, including residual effects of COVID-19, until we can offer specific feedback on the updated baseline data.

Hospital-Acquired Condition Reduction Program (HACRP) Updates and Changes

Technical Update to CDC's National Healthcare Safety Network Healthcare-Associated Infection Measures for the HACRP

In the Proposed Rule, CMS indicates it plans to use the 2015 baseline data to calculate performance standards and calculate and publicly report measure scores until the FY 2029 program year for the HACRP. For the FY 2029 program year and subsequent years, CY 2022 data will be used to calculate performance standards. Consistent with our comments for the VBP Program, Vizient is unable to offer detailed input without access to the CY 2022 data, and we recommend CMS thoroughly examine any potential influences as it considers adopting the updated baseline.

Furthermore, while Vizient believes enhancing patient safety is a vital area for improvement, we suggest removal of the PSI 90 composite measure in HACRP.[25] The PSI 90 measure is challenging for hospitals to use for quality improvement purposes due to its composite structure and the unequal weighting of its ten component indicators, which make it difficult to identify and target opportunities for improvement. Furthermore, although PSI 90 is a composite measure, typically four or five component indicators disproportionately influence the overall score, leading to an unbalanced and potentially misleading assessment of hospital performance. PSI 3 (Pressure Ulcer Rate), PSI 6 (Iatrogenic Pneumothorax Rate), PSI 9 (Perioperative Hemorrhage or Hematoma Rate), PSI 11 (Postoperative Respiratory Failure Rate), and PSI 13 (Postoperative Sepsis Rate) may be more useful indicators for quality improvement and reporting purposes than PSI 90. Therefore, Vizient recommends CMS to consider replacing the PSI 90 composite measure with specific individual patient safety indicators, as doing so would offer hospitals more targeted and actionable data for quality improvement. In addition, Vizient recommends CMS work with stakeholders to evaluate and refine the weighting of these individual patient safety indicators if this recommendation is adopted.

Proposed Changes to the Medicare Promoting Interoperability (PI) Program

Proposal to Modify the Security Risk Analysis Measure

To qualify as a meaningful EHR user, CMS proposes updating the Security Risk Analysis measure, starting in CY 2026, by requiring eligible hospitals and critical access hospitals (CAHs) to attest "yes" to having conducted security risk management as CMS believes is

[25] CMS Patient Safety Indicators PSI-90 (NQF #0531), https://www.cms.gov/priorities/innovation/files/fact-sheet/bpciadvanced-fs-psi90.pdf

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required under the Health Insurance Portability and Accountability Act (HIPAA) Security Rule's implementation specification for risk management.[26] While Vizient appreciates CMS's attention to cybersecurity, we question the necessity of the update given the existing need for hospitals to comply with HIPAA and discourage CMS from finalizing this proposal.

Request for Information (RFI) Regarding Data Quality

Chart-Abstracted Measures

As CMS considers future approaches to enhance the quality and usability of the exchange of health information, Vizient urges the agency to eliminate the use of chart-abstracted measures from CMS quality programs. As noted in our comments on the Hospital IQR and Hospital VBP Programs, chart-abstracted measures (e.g., SEP-1) require extensive manual input by clinical staff which includes reviewing patient charts, extracting relevant data elements, entering information into vendor software systems, and additional expenses to verify abstracted data accuracy. Also, data collection for the Hospital Outpatient Quality Reporting (OQR) Program (e.g., measure OP18, Median Time from Emergency Department (ED) Arrival to ED Departure for Discharged ED Patients), relies on abstractors to manually enter time stamps, which can introduce the possibility of human error and lead to the production of unreliable data that does not reflect actual hospital performance.

Additionally, vendor software used for chart-abstracted measures tends to be inefficient and can lead to discrepancies in reliability and raise quality concerns. For example, inter-rater reliability (IRR) functionality is required within vendor software. This feature requires two abstractors (e.g., nurses) to independently abstract the same cases to assess how closely their responses align, with vendors typically targeting a 95% or higher match rate. The need for IRR highlights the subjectivity in the accuracy between the individual abstractors that exists, and the unnecessary burden and redundancy that could be avoided should chart-abstracted measures be removed from CMS quality programs. Moreover, hospitals are often billed hourly for this service and, effectively, must pay twice for the same case to ensure the abstractors are putting in the same answers, which is both wasteful and costly. As a result, removing such measures could also reduce providers' expenses and allow for more clinicians in roles involving direct patient care. Therefore, Vizient urges CMS to take swift action to remove chart-abstracted measures from CMS quality programs.

Given the agency's effort to transition to digital quality measurement and reduce burden, Vizient urges prompt removal of all chart-abstracted measures from CMS's inpatient and outpatient hospital quality programs, including IQR, OQR and VBP. If this recommendation is adopted, we suggest CMS clarify that hospitals that do not report their CY 2024 reporting period data for these measures would not be considered noncompliant with the measure for purposes of their FY 2026 payment determination. Additionally, if adopted, we encourage CMS to provide that any chart-abstracted measure data received by CMS would not be used for public reporting or payment purposes. Vizient believes these recommendations align with the agency's goal of moving forward with collection of quality data in the least burdensome manner possible and continuing to incentivize improvement in the quality of care provided to

[26] Under the proposed modified measure, eligible hospitals and CAHs would be required to attest that they have implemented policies and procedures to support analyzing and managing the security risks to ePHI associated with the implementation and use of EHRs as required by the HIPAA Security Rule implementation specifications for risk analysis and risk management.

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patients. The unnecessary burdens associated with chart-abstracted measures, intended to improve data quality, impose costs on hospitals that outweigh their potential benefits.

Diagnosis Code Limits

The current limit of reporting is 25 diagnosis codes on hospital inpatient claims, which requires staff to manually identify and prioritize which codes to report.[27] While emerging software may eventually help streamline this task, implementation will take time, and until then, the manual approach remains inefficient and resource intensive. Additionally, Vizient is concerned that the current 25-diagnosis code limit may prevent CMS from fully recognizing the severity and complexity of individual patient cases. If hospitals are unable to report more relevant diagnosis codes, risk adjustment models may not adequately reflect the complexity of a given patient. This limitation can have the unintended consequence of inaccurate assessments of hospital performance and may inadvertently penalize institutions caring for more medically complex patients.

As CMS is looking to expand data quality efforts, we recommend the agency consider significantly increasing the 25-diagnosis code limit submitted with claims to enhance data quality and improve the accuracy of risk adjustment. Accepting all relevant codes or increasing the limit (e.g., allowing for 99 diagnosis codes) would better reflect patient complexity, reduce administrative burden, particularly for hospitals with limited coding resources, and minimize variation in hospital performance measures.

Transforming Episode Accountability Model (TEAM)

In the Proposed Rule, CMS proposes new policy and modifications to TEAM, which is anticipated to start on January 1, 2026. Consistent with Vizient's prior comments regarding TEAM, we have numerous concerns with the model – primarily that it is mandatory for providers.

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 and these steps may not be feasible for all types of providers, particularly given resource constraints may prevent certain providers from taking these steps to improve their participation outcomes. In addition, given the need to adapt regulations due to the mandatory TEAM model, this may present an opportunity to reduce regulations, such as those associated with mandatory participation. Consistent with prior comments and aligned with the Administration's deregulation approach, Vizient urges CMS to change the model from mandatory to voluntary.[28]

[27] https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R2028CP.pdf
[28] https://www.whitehouse.gov/presidential-actions/2025/01/unleashing-prosperity-through-deregulation/

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Proposed Episodes

In prior rulemaking, CMS provided policy to test five surgical episodes in the model: Coronary Artery Bypass Grafting (CABG),[29] Lower Extremity Joint Replacement (LEJR),[30] Surgical Hip and Femur Fracture Treatment (SHFFT),[31] Spinal Fusion,[32] and Major Bowel Procedure.[33] Although CMS previously finalized these surgical episodes, Vizient remains concerned about the potential implications of each selected episode, in addition to the overall size of the model by including such episodes. These concerns are heightened given the variable levels of participation in Center for Medicare and Medicaid Innovation (CMMI) models across different provider types, particularly those that have not participated in prior models. While Vizient believes CMS should make the model voluntary, we also believe more flexibility can be provided related to which surgical episodes are tested. For example, a provider who wishes to participate in the model, but only test one or two surgical episodes, should be permitted to do so. Vizient believes such flexibility regarding the number and types of surgical episodes tested would help enable hospitals to make more focused strategic investments and relationships with careful consideration of the communities they serve and limited resources available.

Community Deprivation Index

In prior rulemaking, CMS finalized policy to use the Area Deprivation Index (ADI) with other factors for beneficiary social risk adjustment. In the Proposed Rule, due to standardization concerns with the ADI, CMS proposes to replace the ADI with a similar, but slightly modified, census block group deprivation index known as the Community Deprivation Index (CDI). Vizient has consistently raised concerns with the use of the ADI for numerous purposes, as noted in our prior comments, and we applaud the agency for considering an alternative index. However, Vizient urges CMS to work with stakeholders and collaboratively identify the best index for the agency's use.

While CMS proposes using the CDI, the agency does not indicate how it decided which indices would be evaluated to replace the ADI. For several years, due to concerns regarding the ADI, Vizient has recommended that CMS should consider other, superior indices, such as the Vizient Vulnerability Index™. For example, the Vizient Vulnerability Index™ is a reliable tool in a wide range of geographic locations, including rural areas and American Indian, Alaska Native, and Native Hawaiian (AIANNH) areas. However, it is unclear whether the CDI

[29] The proposed CABG episode category would include beneficiaries undergoing coronary revascularization by CABG. CMS proposes to define the CABG episode category as any coronary revascularization procedure that is paid through the IPPS under MS-DRG 231–236, including both elective CABG and CABG procedures performed during initial acute myocardial infarction (AMI) treatment.
[30] CMS clarifies the proposed LEJR episode category would include hip, knee, and ankle replacements, including total ankle arthroplasty (TAA), performed in either the hospital inpatient or outpatient setting. CMS proposes to define the LEJR episode category as a hip, knee, or ankle replacement that is paid through the IPPS under MS-DRG 469, 470, 521, or 522 or through the OPPS under HCPCS code 27447, 27130, or 27702.
[31] CMS clarifies the proposed SHFFT episode category would include beneficiaries who receive a hip fixation procedure in the presence of a hip fracture. It would not include fractures treated with a joint replacement. CMS proposes to define the SHFFT episode as a hip fixation procedure, with or without fracture reduction, but excluding joint replacement, that is paid through the IPPS under MS-DRG 480–482. The SHFFT episode would include beneficiaries treated surgically for hip and femur fractures, other than hip arthroplasty. SHFFT procedures include open and closed surgical hip fixation, with or without reduction of the fracture.
[32] The proposed Spinal Fusion episode category would include beneficiaries who undergo certain spinal fusion procedures in either a hospital inpatient or outpatient setting. CMS proposes to define the spinal fusion episode category as any cervical, thoracic, or lumbar spinal fusion procedure paid through the IPPS under MS–DRG 453-455, 459-460, or 471-473, or through the OPPS under HCPCS codes 22551, 22554, 22612, 22630, or 22633.
[33] The proposed Major Bowel Procedure episode would include beneficiaries who undergo a major small or large bowel surgery. CMS proposes to define the Major Bowel Procedure episode category as any small or large bowel procedure paid through the IPPS under MS- DRG 329-331.

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was validated in these types of areas. Without a more robust evaluation of existing tools, Vizient is concerned that limitations of the CDI will eventually become more apparent and cause disruption to providers, as replacement of such tools happens more frequently. At a minimum, and to avoid switching indices in the future, Vizient recommends CMS conduct additional analysis regarding the geographic validity of the CDI and a more robust comparison of the CDI with other, existing tools, including the Vizient Vulnerability Index™.

Hierarchical Condition Categories (HCC) in Risk Adjustment: Lookback Period

In the Proposed Rule, CMS notes that while specific HCCs were finalized for each episode category in TEAM in prior rulemaking, CMS had not yet finalized a lookback period duration to capture HCCs. As a result, CMS proposes to conduct a 180-day lookback period for each beneficiary, beginning with the date prior to the anchor hospitalization or anchor procedure. However, CMS seeks feedback on alternative lookback periods, including a 365-day lookback period. Vizient encourages CMS to provide a longer lookback period to improve data accuracy and risk adjustment.

While CMS indicates that a 365-day lookback period produced only marginally different results in the agency's analysis, the specifics of these differences are not provided in the Proposed Rule. In addition, Vizient notes that since Annual Wellness Visits happen once a year, a 180-day lookback period may limit the inclusion of these important visits for risk adjustment purposes. Further, Vizient is concerned that the 180-day lookback period may unintentionally drive additional utilization should participating hospitals be concerned that patient acuity would not be captured with the 180-day lookback period. As such, Vizient encourages CMS to replace the 180-day lookback window with a 365-day lookback window to better capture patient acuity, particularly as annual wellness visits can be important for these purposes.

Conclusion

Vizient appreciates CMS's efforts to gain additional feedback regarding the FY 2026 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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