FLORIDA HOSPITAL ASSOCIATION
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AN ASSOCIATION OF
HOSPITALS & HEALTH SYSTEMS

June 9, 2026

The Honorable Mehmet Oz, M.D., Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Submitted via regulations.gov

Re: Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Perspective Payment System and Policy Changes and Fiscal Year 2027 Rates; Requirements for Quality Programs; and Other Policy Changes

Dear Administrator Oz:

On behalf of our more than 260 member hospitals and health systems, the Florida Hospital Association ("FHA") appreciates the opportunity to express our support and concerns related to the Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Perspective Payment System and Policy Changes and Fiscal Year 2027 Rates; Requirements for Quality Programs; and Other Policy Changes (the "Proposed Rule").

I. INTRODUCTION

Founded in 1927, FHA is the leading voice for health care in the state of Florida. Through representation and advocacy, education and informational services, FHA supports the mission of our member hospitals and health systems to provide the highest quality of care to the patients they serve.

Hospitals play a vital role in the nation's health care system, delivering essential and life-saving services to millions of Americans each year. They serve as hubs for emergency care, specialized treatment, and ongoing management of chronic conditions, while also functioning as major employers and economic anchors in communities across the country. As demand for health care services continues to grow, it is critical that Medicare payment policies adequately support hospitals' ability to maintain access to care and meet the needs of the patients and communities they serve.

While we appreciate CMS's efforts to expand the reach of value-based models, mandatory participation presents significant challenges, particularly for hospitals that lack the scale or financial capacity to make the necessary investments in care redesign. We believe a phased or

voluntary approach would better support success, allowing organizations to build the infrastructure and partnerships needed to achieve shared savings and improved outcomes.

Additionally, as hospitals continue to face mounting financial pressures, CMS has proposed another inadequate update to inpatient payment rates, another extremely high productivity cut, and reductions to disproportionate share payments—all in the face of rising need for care and higher uninsured rates. We urge CMS to balance these realities to preserve access to comprehensive care while driving sustainable transformation.

II. INPATIENT PPS UPDATE

Florida hospitals continue to experience cost growth that far exceeds the proposed Medicare payment update. Between 2020 and 2024, Florida's acute care hospitals experienced average annual operating expenditure increases of 4.6 percent per patient day, reflecting sustained growth in labor, pharmaceutical, supply, technology, and other operating costs necessary to maintain access to care for Florida's patients.

Despite these cost pressures, the FY 2027 proposed rule would result in a net reduction in Medicare payments to Florida hospitals. The proposed market basket update is insufficient to keep pace with actual hospital cost growth, and when combined with the productivity adjustment and significant wage index reductions affecting Florida hospitals, Medicare payments to the state's hospitals are projected to decrease by approximately 0.31 percent, or nearly $29 million.

The impact is even more significant when the continuing effects of Medicare sequestration are considered. Including sequestration, Florida hospitals would experience an effective payment reduction of approximately 2.31 percent, representing a loss of more than $211.5 million in Medicare reimbursement. Such reductions come at a time when hospitals continue to face substantial workforce challenges, increasing patient acuity, growing demand for services, and ongoing financial pressures.

These figures demonstrate that the proposed payment update does not adequately reflect the actual costs of providing hospital care and will further widen the gap between Medicare reimbursement and the resources required to serve Florida's rapidly growing Medicare population.

Hospitals remain fundamentally different from many sectors of the economy in that they must maintain around-the-clock readiness to care for patients regardless of fluctuations in demand. Unlike other industries, hospitals cannot readily reduce staffing levels or scale back operations in response to inflationary pressures without jeopardizing patient access and quality of care. As a result, the proposed update does not adequately account for the real-world cost environment in which hospitals currently operate.

FHA is particularly concerned with the application of the multifactor productivity adjustment. The proposed rule reduces the market basket update by 0.8 percentage points based on assumptions regarding economy-wide productivity growth. However, hospitals are highly labor-intensive organizations that do not experience productivity gains in the same manner as manufacturing or other sectors from which these measures are derived.

Hospitals face increasing patient acuity, workforce shortages, documentation requirements, care coordination responsibilities, and quality reporting obligations. These demands often require additional personnel and resources rather than fewer. Consequently, the productivity adjustment effectively assumes hospitals can provide more services with fewer resources despite evidence to the contrary.

FHA urges CMS to utilize its statutory authority to reduce or eliminate the productivity adjustment for FY 2027. At a minimum, CMS should evaluate whether current productivity assumptions accurately reflect the operational realities facing hospitals.

FHA is also concerned that forecast-based payment updates may fail to capture periods of rapid inflation and economic disruption. Hospitals bear substantial financial risk when actual costs exceed projected costs used to establish payment updates. When forecast errors occur, hospitals generally do not receive full retrospective adjustments to account for those differences, creating a cumulative erosion in payment adequacy over time. CMS should evaluate mechanisms to address significant forecast deviations and ensure that Medicare payment updates more accurately reflect actual hospital cost growth.

In Florida, these concerns are compounded by other provisions of the proposed rule that may reduce payments to hospitals, including significant proposed wage index reductions affecting many

hospitals throughout the state. The combined effect of these policies may substantially exceed the impact suggested by the headline operating payment update.

Sustained payment inadequacy ultimately threatens patient access to care. Insufficient reimbursement limits hospitals' ability to recruit and retain clinical staff, maintain critical service lines, invest in new technologies, and support infrastructure necessary to meet the needs of growing communities.

Florida is among the nation's fastest-growing states and continues to experience significant increases in its Medicare population. Ensuring adequate hospital reimbursement is essential to preserving access to inpatient, emergency, behavioral health, obstetrical, trauma, and other vital services for Medicare beneficiaries.

FHA respectfully urges CMS to strengthen the FY 2027 IPPS operating payment update by:

- Reconsidering the application and magnitude of the multifactor productivity adjustment;
- Evaluating whether current market basket methodologies accurately reflect hospital labor and operating costs;
- Considering mechanisms to address significant forecast errors when actual inflation exceeds projected inflation; and
- Ensuring that the combined effect of payment policies supports adequate reimbursement and continued access to care for Medicare beneficiaries.

Absent such changes, the proposed update risks further widening the gap between Medicare reimbursement and the actual costs of providing care, particularly in states such as Florida that are simultaneously facing substantial wage index reductions under the proposed rule.

FHA also has concerns regarding the proposed increase in the fixed-loss outlier threshold. The outlier policy is intended to protect hospitals from substantial losses associated with unusually costly cases that cannot be adequately captured through standard DRG payments. Increasing the threshold reduces the effectiveness of this protection and shifts greater financial risk to hospitals that care for the most medically complex Medicare beneficiaries.

As previously stated, hospitals are continuing to experience significant increases in labor, pharmaceutical, supply, and specialty treatment costs that are not fully reflected in Medicare payment updates. The policy effectively raises the amount hospitals must lose on a case before Medicare shares in the financial burden.

Higher outlier thresholds disproportionately affect hospitals that serve as regional referral centers and treat the most clinically complex patients. These hospitals play a critical role in maintaining access to specialized services that are unavailable in many communities.

Florida hospitals are uniquely affected by the combination of a significant wage index decline, discussed later in this letter, and a substantial increase in the fixed-loss outlier threshold. Together, these policies reduce Medicare's recognition of both hospitals' underlying labor costs and the extraordinary costs associated with the most complex patients. CMS should evaluate the cumulative impact of these policies on access to specialized care in high-growth states such as Florida.

III. DISPROPORTIONATE SHARE HOSPITAL PAYMENT CHANGES

Additionally, while not proposed in the Proposed Rule, we urge the agency to reconsider and revoke the rule adopted in the FY 2024 Hospital IPPS and LTCH PPS final rule that excludes patients receiving uncompensated care pool benefits from the DSH Medicaid Fraction numerator, beginning with discharges on October 1, 2023. 88 Fed. Reg. 58640, 59332 (Aug. 28, 2023). This rule—which is a relic of the previous administration—is contrary to the plain language of the statute enacted by Congress and penalizes safety net hospital providers in fiscally responsible states like Florida that chose not to expand Medicaid.

As an initial matter, the rule has been held unlawful by the federal district court for the Northern District of Texas, which concluded that the rule contradicts the plain text of the statute duly enacted by Congress. *See Baylor All Saints Med. Ctr., et al. v. Becerra*, Case No. 4:24-cv-00432 (N.D. Tex. Aug. 15, 2024) (citing *Forrest Gen. Hosp. v. Azar*, 926 F.3d 221 (5th Cir. 2019)). In concluding the rule to be unlawful, the court observed that other courts had reached the same conclusion:

> Section 1395ww(d)(5)(F)(vi)(II) requires HHS to “include days that a hospital treated patients eligible under a Medicaid-approved state plan in the Medicaid fraction’s numerator.” The only other court to address this question—the D.C. Circuit—agrees. *Bethesda Health v. Azar*, 389 F. Supp. 3d 32, 43-44 (D.C. 2019), *aff’d*, 980 F.3d 121 (D.C. Cir. 2020)…

> HHS again argues the Secretary has discretion to decide which days go in the calculation... But the Fifth Circuit addressed this point in *Forrest General*, noting "[t]he Secretary may exercise discretion, and the Secretary did exercise discretion when he authorized the [state plan]." *Forrest*, 926 F. 3d at 233.

Becerra, Case No. 4:24-cv-00432 *11.[1]

The rule is also patently unfair because it penalizes states that seek to offer medical assistance in a manner other than Medicaid expansion under the Affordable Care Act. The purpose of the DSH adjustment is "to recognize the higher costs to hospitals of treating low-income individuals covered under Medicaid." 88 Fed. Reg. at 59013. Uncompensated care pools promote this purpose and the objectives of Medicaid—as the Secretary found when he approved the pools—because they "help hospitals that treat the uninsured and underinsured stay financially viable so they can treat Medicaid patients." *Id.* at 59015.

Fundamentally, this rule harms safety net hospitals and the vulnerable communities and patients they serve. We urge the agency to reconsider and revoke this rule adopted under the previous administration to safeguard access to health care for Medicaid recipients.

CMS should reconsider its proposed reduction in the national uncompensated care (UCC) payment pool for FY 2027. CMS is proposing to reduce uncompensated care payments using FY 2021–2023 data precisely when hospitals are experiencing measurable increases in uninsured patients due to coverage losses that occurred after those data were collected. At a time when hospitals are experiencing increasing levels of uncompensated care and face the prospect of significant coverage losses, the UCC pool should be expanded rather than reduced. The proposed methodology relies on historical data that no longer reflect the current coverage environment and therefore understates the uncompensated care burdens hospitals are expected to face in FY 2027.

[1] Although the *Becerra* decision has been remanded back to the district court by the Fifth Circuit Court of Appeals, the basis for the remand was purely on jurisdictional grounds. Following the Fifth Circuit's jurisdictional ruling, the issue is now squarely back within the district court's jurisdiction, with a ruling expected any day.

Florida illustrates this concern particularly well. Under the proposed rule, Florida hospitals are estimated to experience a $27.8 million reduction in uncompensated care payments at the same time the state faces the prospect of substantial growth in its uninsured population.

Florida is uniquely vulnerable to these changes because it has the largest Marketplace enrollment in the nation. Approximately 29 percent of all individuals enrolled in Marketplace coverage nationally reside in Florida. Consequently, policy changes affecting Marketplace affordability and enrollment are likely to have a disproportionately large impact on Florida hospitals compared to hospitals in other states.

The expiration of the enhanced premium tax credits is expected to result in significant coverage losses, with estimates suggesting that between 750,000 and more than 1 million Floridians could lose health insurance coverage. Because these coverage losses are occurring after the years used in the UCC calculation, the resulting increase in uncompensated care is not reflected in the proposed FY 2027 payment methodology.

Recent hospital experience suggests these impacts are already materializing. A Florida Hospital Association survey found that responding hospitals experienced a 15.4 percent increase in uninsured patients in April 2026 compared with April 2025. Even more concerning, uninsured inpatient admissions increased by 23.3 percent year over year. These findings indicate that hospitals are already absorbing growing levels of uncompensated care that are not captured in the historical data used to allocate FY 2027 UCC payments.

CMS should therefore reconsider the proposed reduction in the UCC payment pool and evaluate whether additional funding or a supplemental adjustment is warranted to account for rapidly changing coverage conditions. At a minimum, CMS should acknowledge the limitations of relying on FY 2021–2023 uncompensated care data in an environment where hospitals are experiencing significant and measurable increases in uninsured patient volume. Reducing uncompensated care payments while hospitals face growing uncompensated care demands undermines the statutory purpose of the Medicare DSH uncompensated care program.

To better align uncompensated care payments with current coverage and utilization trends, CMS should consider the following policy options in the FY 2027 final rule:

1. Maintain the FY 2026 National Uncompensated Care Payment Pool

At a minimum, CMS should reconsider the proposed reduction in the national uncompensated care payment pool and maintain FY 2026 funding levels for FY 2027. Hospitals across the country are experiencing increasing financial pressure associated with rising uncompensated care costs, and emerging coverage losses are not reflected in the historical data used to determine FY 2027 payments. Maintaining the current funding level would help prevent further erosion of support during a period of significant coverage uncertainty.

2. Establish a Temporary Adjustment for States Experiencing Significant Coverage Losses

CMS should consider a temporary adjustment for hospitals located in states experiencing substantial increases in uninsured populations due to federal policy changes affecting Marketplace enrollment and affordability. Such an adjustment could be based on documented changes in state uninsured rates, Marketplace disenrollment, or other objective indicators of coverage loss. This approach would allow Medicare uncompensated care payments to better reflect current patient coverage patterns while preserving the integrity of the existing UCC methodology.

3. Create a One-Year Supplemental Uncompensated Care Payment

CMS should establish a one-year supplemental uncompensated care payment for hospitals that demonstrate significant increases in uninsured patient volume or uncompensated care costs occurring after the data years used in the FY 2027 calculation. Eligibility could be based on documented increases in uninsured emergency department visits, inpatient admissions, charity care, or bad debt. A targeted supplemental payment would help bridge the gap between historical payment calculations and current uncompensated care realities until more recent data can be incorporated into future payment years.

Taken together, these options would help ensure that Medicare's uncompensated care payment system continues to fulfill its intended purpose of supporting hospitals that provide care to uninsured and underinsured patients. Without such adjustments, hospitals may face declining uncompensated care payments at precisely the time they are experiencing growing uncompensated care demands.

IV. AREA WAGE INDEX MODIFICATIONS

Florida hospitals are projected to experience one of the most significant adverse wage index changes in the nation under the FY 2027 IPPS proposed rule. Florida's statewide average wage index declines from 1.0369 in FY 2026 to 0.9851 in FY 2027, a 5.0 percent reduction. Florida has the second-largest percentage decline in wage index of any state despite continued growth in hospital labor costs and extraordinary population increases that have intensified demand for healthcare services and workforce recruitment.

The proposed wage index fails to reflect current labor market realities in Florida because it relies on historical hospital cost report data that no longer represents the wages hospitals must pay to recruit and retain staff. The FY 2027 wage index is based on wage data originating from 2022 cost reports, meaning Medicare payment adjustments in FY 2027 will be driven by labor market conditions that existed approximately five years earlier. During this period, Florida has experienced unprecedented population growth and health care workforce demand.

Florida's average hourly wage has continued to increase, rising from $49.72 in FY 2025 to $51.45 in FY 2026 and $51.62 in FY 2027. At the same time, Florida hospitals have made substantial investments in workforce recruitment and retention. Acute care hospitals spent approximately $27.1 billion on labor costs in 2022 and $31.7 billion in 2024, an increase of $4.6 billion, or 17 percent, in just two years. On a per-adjusted-patient-day basis, labor costs increased 9.3 percent over the same period. These increases reflect sustained labor market pressures rather than temporary fluctuations.

The disconnect between current workforce costs and the wage index methodology is particularly problematic in Florida because of the state's rapid population growth. Between 2022, when the wage data used in the FY 2027 calculation were collected, and 2027, when the payment adjustments will take effect, Florida is projected to add approximately 2 million residents. That population increase alone exceeds the entire population of nearly one-quarter of U.S. states. Hospitals have had to expand capacity, recruit additional staff, and compete aggressively for health care workers to meet the needs of this growing population.

Despite these workforce investments and demographic pressures, Florida hospitals are expected to experience a 0.31 percent reduction in aggregate IPPS payments from FY 2026 to FY 2027. After accounting for sequestration, the reduction increases to approximately 2.31 percent. The primary driver is a negative 2.13 percent wage index adjustment, compared with a national average increase of 0.02 percent. As a result, hospitals that have successfully invested in workforce stabilization and

expanded access to care are being penalized by a methodology that relies on outdated data and does not adequately account for rapidly changing labor markets.

CMS should consider policies that mitigate abrupt year-over-year wage index reductions when they are driven by historical data that no longer reflects current labor costs. Such policies could include additional transition protections, smoothing methodologies, or other approaches that better align Medicare payment adjustments with contemporary labor market conditions. Without such modifications, Florida hospitals face substantial payment reductions despite continuing increases in workforce expenses and growing demand for hospital services.

Florida hospitals are concerned that the FY 2027 wage index methodology does not adequately reflect current labor market conditions and may result in significant payment reductions despite continued growth in workforce costs. While CMS's existing 5 percent cap on annual hospital-level wage index decreases provides important protection against abrupt payment disruptions, additional refinements are warranted to ensure that Medicare payments more accurately reflect hospitals' actual labor expenses and workforce challenges. We respectfully recommend that CMS consider the following policy options in the FY 2027 final rule:

1. Implement a Multi-Year Rolling Average of Wage Data

CMS should adopt a multi-year rolling average for wage index calculations rather than relying on a single year of wage data. A rolling average would reduce volatility caused by temporary economic conditions, reporting anomalies, and unusual labor market fluctuations. This approach would better capture long-term workforce trends and provide a more stable and predictable payment methodology for hospitals. It would also reduce the likelihood that a single year's data could produce payment adjustments that do not accurately reflect ongoing labor market conditions.

2. Incorporate More Current Wage Data into Wage Index Calculations

CMS should explore opportunities to incorporate more current wage information into the wage index methodology. Under the current process, hospitals' FY 2027 Medicare payments are based on wage data that predate the payment year by several years. In rapidly evolving labor markets, historical cost report data may not accurately reflect current workforce expenses. Using more recent wage information would improve the accuracy of the wage index and better align Medicare payments with hospitals' actual labor costs.

3. Establish Additional Transition Relief for States Experiencing Extraordinary Wage Index Declines

Although the existing five percent cap on hospital-level wage index reductions provides important protection, CMS should consider supplemental transition relief for states experiencing unusually large aggregate wage index declines. States facing wage index reductions that substantially exceed national trends may experience significant statewide payment impacts even when individual hospitals are protected by the existing cap. A targeted transition policy would help mitigate abrupt payment reductions while allowing hospitals time to adjust to revised wage index calculations.

4. Evaluate the Impact of Rapid Population Growth on Wage Index Accuracy

CMS should examine whether the current wage index methodology adequately captures labor market conditions in states experiencing exceptional population growth and healthcare workforce demand. Hospitals in rapidly growing states must make substantial investments in recruitment, retention, and workforce expansion to meet increasing patient demand. These labor market realities may not be fully reflected in historical wage data used for wage index calculations. CMS should evaluate whether supplemental adjustments or alternative methodologies are appropriate when demographic growth significantly outpaces national averages.

5. Review the Interaction of Occupational Mix and Other Wage Index Adjustments

CMS should further evaluate whether occupational mix adjustments and other wage index policies accurately reflect regional workforce costs. To the extent that significant wage index reductions are driven by methodological factors rather than actual declines in hospital wage expenses, refinements may be warranted to ensure that Medicare payments appropriately reflect hospitals' labor market conditions. CMS should analyze the extent to which occupational mix adjustments, reclassifications, and related policies contribute to substantial year-over-year wage index changes and consider modifications where necessary.

Collectively, these recommendations would improve the stability, predictability, and accuracy of the wage index while preserving CMS's commitment to budget neutrality and equitable payment policies. Hospitals should not experience substantial Medicare payment reductions when workforce costs continue to increase, and demand for healthcare services continues to grow.

V. HOSPITAL READMISSIONS REDUCTION PROGRAM

Florida hospitals continue to struggle with reducing readmissions, with many of the hospitals in the state receiving a penalty under the Hospital Readmissions Reduction Program (HRRP). Reducing readmissions is a priority for our hospitals and the association but some of the drivers of readmissions – patient complexity, need for post-acute support, management by a primary care physician and then social factors – are only partially within a hospital's control.

While we support CMS's move to shorten the time for measurement to two years, the inclusion of Medicare Advantage patients does present other types of challenges in ensuring the patients get the necessary post-hospital support which could prevent rehospitalization. Discharge data reported to the state of Florida show that Medicare Advantage patients have longer lengths of stay compared to traditional Medicare patients (7.2 days compared to 5.6 days). Additionally, our analysis found almost half (48%) of Medicare Advantage patients were discharged home without home care. Compared to traditional Medicare, MA patients are 23% more likely to go home with no support than traditional Medicare, 22% less likely to go to SNF and 66% less likely to go to an inpatient rehabilitation facility. If the MA patients stay longer in the hospital, it seems they will need more support after discharge. That is not what we are seeing in Florida.

Data from our Days Awaiting Discharge survey from 2025 shows that prior authorization accounted for 46% of the Medicare Advantage patients stuck in the hospital after being medically cleared for discharge. Approximately 34% of the Medicare Advantage patients waiting to be discharged were due to network adequacy issues. We believe these discharge delays ultimately contribute to higher readmission rates for Medicare Advantage patients. We recommend CMS closely monitor differences in care and outcomes for Medicare Advantage patients compared to traditional Medicare patients. As a result, we caution CMS on penalizing hospitals through the HRRP for readmissions for MA patients where access to the necessary post-hospital care is not available.

In the proposed rule, CMS plans to adopt the Hospital 30-Day, All-Cause Risk-Standardized Readmission Rate Following Sepsis Hospitalization Measure into the HRRP starting with FY 2029 program year. CMS's proposal to add sepsis to the Hospital Readmissions Reduction Program (HRRP) underscores the importance of addressing a high-impact and costly condition, but it also raises significant concerns regarding timing and fairness. Sepsis is uniquely challenging to define

and diagnose due to its clinical complexity, variability in presentation, and evolving coding practices, which can lead to inconsistency in case identification and risk adjustment across hospitals.

Some of the concerns include lack of a standardized definition for sepsis. Sepsis remains clinically complex with competing definitions (Sepsis-2, Sepsis – 3, SEP-1) and differences in clinical criteria versus coding practices can result in different identification across hospitals.

Additionally, another factor is Medicare Advantage plans' increasing use of Sepsis-3 clinical criteria for payment determination. This introduces important implications for the Hospital Readmissions Reduction Program (HRRP) since Sepsis-3 relies on clinical indicators such as organ dysfunction (e.g., SOFA score) rather than billing codes alone, which can lead to **discordance between how hospitals document and code sepsis and how payors adjudicate claims**.

When payors downcode or deny sepsis cases based on Sepsis-3 criteria, hospitals may see shifts in case mix, severity profiles, and index admission classification—factors that directly influence risk-adjusted readmission rates. This misalignment creates potential distortions in HRRP performance, as hospitals could appear to have higher readmissions among a "less severe" population due to reclassification rather than true differences in care quality. Additionally, inconsistency between clinical definitions, coding standards, and payor policies adds administrative burden and introduces variability that is outside the hospital's control. As a result, incorporating conditions like sepsis into HRRP—without addressing these definitional and payment discrepancies—raises concerns about measure validity, fairness, and the risk of unintended financial penalties tied to factors driven by payor policy rather than patient care.

While the proposed measure does exclude admissions resulting in patients being discharged to hospice, some patients refuse to go to hospice, even when it is inevitable they are not going to survive.

Introducing a sepsis readmission measure directly into HRRP—without first vetting and refining it through the Inpatient Quality Reporting (IQR) program—limits the opportunity for providers to understand performance drivers, validate measure specifications, and improve documentation and care processes before facing financial penalties. This is particularly concerning given the stakes associated with HRRP and the potential for unintended consequences. At the same time, CMS's use of confidential preview reports is a valuable step, as it allows hospitals to assess their performance, identify data gaps, and begin internal improvement efforts; however, many stakeholders believe a

longer glide path within IQR would better support reliable measurement and equitable implementation.

We support Sepsis in the IQR program first, then as we get more experience, add it to the HRRP.

VI. HOSPITAL VALUE BASED PURCHASING PROGRAM

In the proposed rule, CMS is planning to adopt substantive measure updates to five condition-specific and procedure-specific mortality measures, in the Clinical Outcome domain, beginning with July 1, 2028, through June 30, 2030, performance period for the FY 2032 program year. CMS noted these updates will be contingent on adopting the same refined mortality measures in the Hospital Inpatient Quality Reporting Program. Since this change includes Medicare Advantage patients in the calculation of the performance scores, we reiterate the concerns stated above about Medicare Advantage policies and challenges which could impact patient outcomes and unfairly penalize hospitals.

Reducing mortality rates depends on several factors, including ensuring that patients are discharged to the most appropriate settings. Patients going to a lower level of care than their physician recommends, places the patient at greater risk for complications and other adverse outcomes. We recommend that CMS closely monitor MA plan discharge location approvals to examine differences in mortality rates compared to traditional Medicare that could result in financial penalties on hospitals.

VII. INPATIENT QUALITY REPORTING PROGRAM

Adoption of Advance Care Planning eCQM Measure

CMS's proposal to adopt the Advance Care Planning (ACP) eCQM into the Inpatient Quality Reporting (IQR) program reflects an important goal of promoting patient-centered care and ensuring that care aligns with patients' preferences; however, there are notable implementation challenges that warrant consideration. Many patients remain hesitant to engage in advance care planning discussions or to formally document and share their wishes due to cultural beliefs, health literacy barriers, or discomfort with end-of-life conversations, which can limit measure performance independent of hospital effort. We support CMS's focus on the need for advance care planning and encourage CMS to engage in broader education on why patients need to develop ACPs and the

importance of sharing that with their providers and hospitals. Since this includes MA patients, we believe that the MA plans should be encouraging ACPs in their membership.

Additionally, the reliance on an electronic clinical quality measure (eCQM) introduces broader concerns related to data capture, workflow integration, and variability in electronic health record (EHR) capabilities. Hospitals continue to face challenges with eCQM reliability, including inconsistent data extraction, differences in documentation practices, and the administrative burden required to ensure accurate reporting. As a result, while the intent of the ACP measure is strongly supported, successful implementation will require additional time, education, and technical refinement to ensure that performance accurately reflects meaningful patient engagement rather than documentation or system limitations.

Measuring Emergency Care Access and Timeliness Request for Information

We appreciate CMS's focus on addressing emergency department (ED) boarding and improving patient access to timely inpatient care. ED boarding is a significant challenge that can negatively affect patient outcomes, staff well-being, emergency department throughput, and overall hospital operations. We support CMS's efforts to increase visibility into this issue and recognize the value of measures that promote system-wide accountability for patient flow and care transitions. At the same time, we encourage CMS to carefully evaluate the extent to which inpatient hospitals can reasonably influence all factors captured by the Emergency Care Access & Timeliness (ECAT) eCQM before incorporating the measure into the Hospital Inpatient Quality Reporting (IQR) and Hospital Value-Based Purchasing (VBP) Programs.

Key Barriers and Challenges

While inpatient providers play an important role in facilitating patient flow, many drivers of ED boarding extend beyond the control of inpatient clinical teams. These include:

- Capacity constraints resulting from high patient volumes, seasonal surges, workforce shortages, and limited inpatient bed availability.
- Delays in discharge due to shortages of post-acute care capacity, including skilled nursing facilities, inpatient rehabilitation facilities, behavioral health facilities, and home health services. Our survey on patients medically cleared for discharge found many of these patients stay on average 3 days while they are waiting on approvals, a post-acute bed or resources to be supported at home.

- Lengthy insurance authorization requirements and administrative delays associated with care transitions. Our survey found 40% of the patients waiting discharge were due to delays in obtaining authorization for post-acute care.
- Increased use of the ED as a source for primary care, with more individuals losing coverage due to the expiration of the enhanced tax subsidies.
- Staffing shortages across hospitals and post-acute care settings, which can limit a hospital's ability to safely open staffed beds even when physical capacity exists.
- Increasing patient acuity and complexity, requiring specialized beds or services that may not be immediately available.
- Behavioral health boarding challenges, including limited access to psychiatric treatment beds and community-based services.
- External factors such as public health emergencies, infectious disease outbreaks, and regional capacity shortages that significantly affect patient flow.

Because many of these factors are outside the direct control of inpatient providers, CMS should ensure that any measure used for accountability purposes appropriately recognizes system-level constraints and external influences on ED boarding performance.

Best Practices

Across the state, Florida hospitals have been exploring strategies for reducing ED boarding. While the state of Florida requires each hospital to develop and implement a Non-Emergency Care Access Plan (NCAP), assisting patients with finding primary care resources continues to be challenging so these plans have not made a significant reduction in the use of the emergency departments for nonemergency care. However, some of the practices our hospitals are trying with some success include:

- Daily multidisciplinary capacity management meetings involving emergency medicine, hospital medicine, nursing leadership, case management, environmental services, and hospital administration.
- Real-time bed management systems and dashboards provide visibility into admissions, discharges, transfers, and anticipated bed availability.
- Early discharge planning initiated at admission and supported by case management and social work teams.
- Standardized escalation protocols that facilitate communication between emergency departments, inpatient units, and hospital leadership during periods of capacity strain.

- Formal partnerships and communication pathways with post-acute care providers to improve care transitions and reduce discharge delays.
- Regional coordination efforts among hospitals, post-acute providers, emergency medical services, and community organizations.

However, providers often face significant barriers when implementing these approaches. Rural hospitals, in particular, may have limited post-acute care options, fewer community partners, workforce shortages, and limited health information exchange infrastructure. Geographic distance between facilities and lack of interoperability among electronic health records can further impede timely communication and coordination. In many rural communities, there may be only a small number of post-acute providers, leaving hospitals with few alternatives when placement delays occur.

CMS should consider these challenges when evaluating performance and avoid creating incentives that disproportionately disadvantage providers operating in resource-constrained environments.

Measure considerations

We encourage CMS to carefully assess whether all components of the ECAT eCQM are appropriate for use in inpatient quality reporting and payment programs.

In particular, CMS should consider whether hospitals should be held accountable for delays that are primarily attributable to factors outside the inpatient setting, including:

- Lack of available post-acute care placements.
- Limited behavioral health treatment capacity.
- Delays associated with payor authorization requirements.
- Regional workforce shortages.
- Community-wide capacity constraints affecting transfers and discharges.

To the extent the measure includes boarding time that is influenced by these external factors, CMS should consider exclusions, stratification methodologies, or risk-adjustment approaches that better isolate hospital-controllable processes from broader system constraints.

CMS should also evaluate whether the measure appropriately accounts for hospitals with specialized patient populations, high-acuity referral centers, safety-net providers, and rural hospitals that may face unique operational challenges. Additional testing may be warranted to

ensure that measure performance reflects meaningful differences in hospital operations rather than differences in community resources or patient populations.

Finally, if CMS moves forward with adoption of the measure in the Hospital IQR Program, we recommend an initial period of public reporting and performance monitoring before incorporating the measure into value-based purchasing or payment programs. This phased approach would allow CMS and stakeholders to better understand measure performance, identify unintended consequences, and refine accountability mechanisms before financial incentives are attached.

We support CMS's efforts to improve emergency care access and reduce ED boarding. However, because boarding is often the result of complex system-wide challenges that extend beyond the inpatient setting, any quality measure used for public reporting or payment purposes should appropriately account for factors outside the direct control of hospitals and inpatient providers.

Adult Community-Onset Sepsis Mortality Measure – Request for Information

CMS requests input on the potential use of the Adult Community On-Set Sepsis mortality measure, highlighting the prevalence of sepsis being treated in hospitals and being the leading cause of mortality, hospitalization and readmission in the United States. We agree with CMS on the challenges with tracking sepsis incidence and outcomes due to a definite diagnostic test and wide variation in diagnosis and coding practices. We agree with the limitations of using claims data only for tracking sepsis and, given the potential adverse outcomes, the increased screening for sepsis.

We strongly support measuring sepsis outcomes - mortality is an important outcome for patients with community-onset sepsis, and standardized measurement may help drive improvements in recognition and treatment. We do believe there is much promise in the work CMS is doing with the CDC’s National Healthcare Safety Network team to advance the digital quality standard through the use of digital quality measures. We believe a well-designed sepsis mortality measure would help drive improvement in outcomes and lower mortality rates for patients diagnosed with sepsis.

To ensure a focused and consistent approach to measuring sepsis care, we recommend CMS phase out the sepsis bundle measure (SEP-1), which is in the hospital IQR and VBP programs. While there is a role for process measures, such as the sepsis bundle, we believe a sepsis outcome measure would help focus on impacting outcomes, not just ensuring that the required components of the bundle were provided.

One key consideration is to ensure the community on-set sepsis measure incorporates a robust risk adjustment, which accounts for patient severity, comorbidities, social risk factors, and pre-hospital clinical status to ensure fair comparisons across hospitals serving different populations.

We encourage CMS to continue stakeholder engagement and pilot testing to ensure the measure accurately reflects quality of care while promoting equitable outcomes for patients with sepsis.

New Measures for the Hospital Quality Reporting Program Measure Set Excess Days in Acute Care Measures

CMS is proposed to add a new measure, Excess Days in Acute Care (EDAC) for patients with diabetes and to modify the existing EDAC measures to include Medicare Advantage patients.

We agree that CMS should explore adding a measure to improve care for patients discharged with diabetes. However, we have concerns about the EDAC measures since it is difficult for hospitals to monitor and track given challenges with accessing data on observations and ED visits for patients, which could be incurred at another facility. Given the challenges with the EDAC measures in general, we urge caution in adding the EDAC for diabetes to the reporting requirements. If CMS is going to prioritize a measure for diabetes, we recommend adopting a readmission measure instead of the EDAC measure.

Regarding adding Medicare Advantage patients to the EDAC measures, we reiterate the issues we face with MAOs in general as stated above. Additionally, all aspects of care, including ED visits and observation stays.

Hospital Harm – Postoperative Venous Thromboembolism eCQM

CMS is proposing to adopt the Hospital-Harm- Postoperative Venous Thromboembolism eCQM beginning with the CY 2029 reporting period/FY 2030 payment determination. We support the focus on VTE prevention, with Florida becoming the first state in the country to adopt specific requirements for hospitals, nursing homes and assisted living facilities to adopt protocols and training for the identification and treatment of VTEs along with creating a statewide VTE registry.

We support the focus on VTE but note there are some significant challenges with the measure, including the ability to reliably capture postoperative VTE events that occur at different hospitals or

settings within 30 days of the index surgical procedure. This will create completeness and attribution issues, as hospitals may be held accountable for outcomes they cannot fully observe or verify.

This measure does have merit and once the digital quality measures (dQMs) are fully developed and operational, we would support CMS in adopting this measure. The dQMs will allow longitudinal patient tracking across settings, which would improve the accuracy of the measure, along with reducing manual burden, embedding into the clinical decision support tools and allow for faster feedback and quality improvement.

If CMS does adopt the VTE eCQM, we encourage removal PSI-12 from the PSI-90 composite measure to prevent potential confusion due to the differing methodologies and reduce duplicative measurement.

Proposed Removal of Three IQR Measures

FHA supports the proposal to remove three measures from the IQR program - VTE prophylaxis eCQM, the ICU VTE prophylaxis eCQM, and Discharged on Antithrombotic Therapy eCQM.

Mandatory Reporting of Malnutrition Care Score

We support the inclusion and continued development of the Malnutrition Care Score eCQM as an important step toward addressing a high impact but historically under-measured clinical domain. Malnutrition is prevalent among hospitalized patients and is associated with worse outcomes, including longer length of stay, higher readmissions, and increased mortality. Because MCS requires complex documentation across multiple clinicians, there are concerns about nutrition documentation being consistently captured and significant manual intervention is required. We encourage CMS to maintain it is a voluntary eCQM in the short term to allow time for workflow standardization, EHR optimization, and staff training.

Mandatory Reporting of Hospital Harm eCQMs After Two Years of Voluntary Reporting

CMS is proposing mandatory reporting of the hospital harm eCQM measures after two years of self-reporting and noted that moving to mandatory reporting of the hospital harm measures, could serve as potential replacements for the claims-based measures, such as PSI-90 which hospitals have major concerns about the reliability of that measure. Allowing two years for hospitals to set up the ability to pull the data and get a better understanding of the measure is important. With the issue that

some hospitals might not have sufficient volume to report certain hospital harm measures, we encourage CMS to adopt guidance on minimum volumes for reporting and how to interpret performance when minimum volumes aren't met and how it is displayed for public reporting.

Update to Maternal Morbidity Structural Measure Reporting

CMS is proposing to update the Maternal Morbidity Structural Measure, which currently asks whether a hospital or health system participates in a Statewide and/or National Perinatal Quality Improvement Collaborative Program, to require reporting of the name of the perinatal quality improvement collaborative program, if the hospital answers "yes" to the measure. Florida requires all maternity hospitals to participate in at least two quality improvement collaboratives led by our state perinatal quality collaborative. We fully support this measure modification.

Birthing- Friendly Hospital Designation Criteria

CMS seeks input on the potential modifications to the Birthing-friendly Hospital Designation. We appreciate CMS's continued commitment to improving maternal health outcomes and strengthening accountability for maternity care quality through the Birthing-Friendly Hospital designation. In particular, we support the agency's proposal to move beyond a process-focused attestation framework and incorporate outcome measures into the designation criteria. Including measures such as severe maternal morbidity recognizes the importance of assessing the actual health outcomes experienced by pregnant and postpartum patients and aligns the designation more closely with the goals of improving maternal safety and reducing preventable complications.

At the same time, we have concerns regarding the proposal to incorporate the cesarean birth rate measure into the designation scoring methodology. While reducing unnecessary cesarean deliveries is an important quality goal and a priority for Florida hospitals, cesarean rates can be influenced by a range of patient, clinical, demographic, and community factors that may not be fully captured through existing risk adjustment methodologies. Hospitals that serve higher-risk populations, including patients with complex medical conditions, prior cesarean deliveries, or significant social risk factors, may face challenges in achieving lower cesarean rates despite providing high-quality, evidence-based care.

We are concerned that the inclusion of a cesarean rate measure as a scoring component could create unintended incentives or produce results that do not accurately reflect the quality of maternity care delivered. Unlike severe maternal morbidity, which directly measures adverse

outcomes, cesarean delivery is a utilization measure that requires careful interpretation within the clinical context of individual patients and populations.

We encourage CMS to continue evaluating the validity, reliability, and risk adjustment of the cesarean measure before assigning substantial weight to it within the Birthing-Friendly Hospital designation. CMS should also consider whether additional stratification, peer grouping, or enhanced adjustment for clinical and social risk factors is warranted to ensure fair comparisons across hospitals and to avoid penalizing facilities that care for more medically complex populations.

CMS requests feedback on potential scoring methodologies for the Birthing Friendly Designation that would be similar to the Overall Star Ratings Program. CMS proposes a three-icon approach, which varies from how the Overall Star Rating and the Patient Satisfaction Star Rating program is displayed using a five-star approach. These approaches to develop ratings that accurately reflect meaningful differences in quality is extremely challenging and should be done carefully. Given the limitations in the number of maternal health outcomes that truly reflect hospital quality, we encourage CMS to not adopt a rating method for the Birthing Friendly hospital designation.

VIII. PROPOSED CHANGES TO THE OFF-CAMPUS PROVIDER-BASED LOCATION RULES

FHA is concerned that the proposed changes to the patient population criteria may unintentionally jeopardize legitimate provider-based arrangements that are clinically, operationally, and financially integrated with the parent hospital.

Florida hospitals increasingly rely on integrated systems of care that extend beyond traditional local service areas. Many hospital-operated facilities, including rehabilitation hospitals, behavioral health facilities, specialty hospitals, cancer centers, trauma programs, and other tertiary and quaternary service lines, are intentionally designed to serve patients across broad geographic regions. As a result, patient residence patterns often differ significantly from those of the main hospital campus despite the facility functioning as an integral component of the hospital's delivery system.

The proposed limitation of the 75-percent patient overlap methodology for inpatient facilities places substantial weight on geographic patient distribution rather than on the operational and clinical integration that provider-based regulations were originally intended to assess. Patient travel patterns frequently reflect the specialized nature of services offered, not the degree of integration between

facilities. Hospitals that provide highly specialized services may appropriately draw patients from multiple counties, regions, or even statewide referral networks.

FHA is concerned that the proposal could disproportionately affect states such as Florida, where large geographic service areas, substantial population growth, seasonal population fluctuations, and extensive referral networks routinely result in patient populations that differ from those of the main provider. These factors do not diminish the clinical, financial, or operational integration of these facilities.

For the above reasons, FHA recommends that CMS continue to allow inpatient facilities to demonstrate service to the same patient population through patient overlap analyses where appropriate.

IX. CMMI TRANSFORMING EPISODE ACCOUNTABILITY MODEL

FHA appreciates CMS' efforts to improve the accuracy and predictability of episode-based payment models. However, we have several concerns regarding the proposed TEAM modifications.

CMS proposes adding new MS-DRGs 523, 524, and 525 as spinal fusion episode initiators under TEAM. We are concerned that this proposal would substantially expand the scope of the model by including cases that CMS previously determined should not serve as TEAM anchor hospitalizations.

Before finalizing this policy, CMS should clearly explain why these previously excluded cases are now appropriate for inclusion and provide stakeholders with sufficient data regarding the clinical characteristics, episode spending patterns, and expected financial impacts associated with these newly included episodes. In addition, Florida hospitals participating in TEAM should not be subjected to expanded financial accountability absent a transparent demonstration that these episodes are clinically comparable to existing TEAM episodes and appropriate for bundled payment accountability.

FHA supports CMS' proposal to improve target price accuracy using APC and MS-DRG update factors and the use of the full baseline period for normalization and risk adjustment calculations. However, because TEAM began on January 1, 2026, hospitals have already made operational and financial decisions based on the original model specifications. Any revisions to target price methodologies applied to Performance Year 1 should be implemented on a prospective basis or, at

a minimum, should only result in favorable adjustments for participating hospitals. Hospitals should be held harmless from any retroactive changes that increase repayment obligations or otherwise worsen their financial position.

Finally, FHA recommends that CMS monitor TEAM performance in states experiencing major wage index reductions (including Florida) and adjust benchmarks if payment policy changes materially affect hospitals' ability to succeed under the model.

X. MANDATORY CJR-X MODEL

As proposed in the rule, the Comprehensive Care for Joint Replacement Expanded Model (CJR-X) would be the first nationwide mandatory episode model implemented through CMMI expansion authority rather than a limited demonstration. FHA recommends that CMS initially implement CJR-X as a time-limited demonstration with robust evaluation and stakeholder feedback before establishing a permanent nationwide model. FHA appreciates CMS' recognition of safety-net and rural hospital challenges but encourages the agency to further limit downside risk during the early years of CJR-X participation.

CJR-X would heavily weight complications and patient experience measures when determining financial performance. Quality measures account for the composite quality score and payment adjustments. CMS should ensure that quality measures are appropriately adjusted for social risk factors and patient characteristics so that hospitals are evaluated based on performance rather than patient population differences.

In addition, FHA recommends that CMS provide hospital-specific benchmark calculation files and methodology documentation prior to implementation so participants can validate episode pricing and identify opportunities for improvement.

Finally, Florida's Medicare Advantage penetration is among the highest in the country. CMS should evaluate the impact of high Medicare Advantage penetration on benchmark reliability and participant accountability under CJR-X. States such as Florida may experience unique challenges due to declining traditional Medicare episode volume.

XI. CONCLUSION

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FHA thanks the agency for the opportunity to provide these comments. If you have any questions, please do not hesitate to contact Kristen Dobson, the FHA's General Counsel and Vice President of Regulatory Affairs, at kristend@fha.org.

Sincerely,

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President and CEO
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