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June 9, 2026

The Honorable Mehmet Oz
Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
P.O. Box 8016
Baltimore, MD 21244-8013

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

Dear Administrator Oz:

I am writing on behalf of the Alliance of Safety-Net Hospitals (ASH), a coalition of private community safety-net hospitals serving low-income patients in hard-working but medically underserved communities to convey to the Centers for Medicare & Medicaid Services (CMS) our views on the proposed FY 2027 Medicare inpatient prospective payment system (IPPS) regulation that was published in the *Federal Register* on April 14, 2026.

ASH would like to bring to your attention our views on the following aspects of the proposed regulation:

- Proposed Payment Changes
- Comprehensive Care for Joint Replacement (CJR) Model Expansion
- Transforming Episodic Accountability Model (TEAM) updates
- Cost Reporting Proposals

We address each of these subjects individually below.

Proposed Payment Changes

CMS proposed increasing inpatient rates by 2.4 percent, the result of a projected FY 2027 hospital market basket percentage increase of 3.2 percent reduced by a 0.8 percentage point productivity adjustment. CMS also proposed a cut of $564 million in Medicare disproportionate share hospital (DSH) uncompensated care payments. The proposed outlier threshold is $51,704, a substantial increase from the FY 2026 threshold of $40,397.

Rate Update

CMS's proposed FY 2027 payment update is not sufficient to account for the sustained cost growth and fiscal pressures affecting hospitals. Providers continue to undertake significant efforts to improve efficiency, manage labor and supply costs, and respond to increased uncompensated care needs associated with coverage instability and rising uninsured rates. These efforts include care redesign strategies such as hospital-at-home models, expanded telehealth capacity, and greater emphasis on preventive care and lower-cost sites of service. While such strategies may help regulate cost growth over time, they are not equal to the exponentially increased costs for hospital labor and supplies that have continued to grow unabated since 2020. Safety-net hospitals require a payment update that more fully reflects hospitals' current cost environment, especially the operational realities facing the hospitals serving the most low-income working families and seniors.

ASH urges CMS to reconsider the assumptions that play into the calculation of the productivity adjustment for IPPS rates and offer an additional non-budget neutral rate adjustment to account for flaws in the calculation. The Social Security Act requires the Secretary to apply an adjustment to the market basket increase that is based on the 10-year moving average of changes in economy-wide private non-farm business productivity. This methodology assumes that hospitals can achieve productivity gains comparable to those observed across the broader private non-farm business sector. ASH is concerned that this assumption does not adequately reflect the operational and cost structure of hospitals, where labor-intensive services and limited flexibility with respect to non-labor inputs limit opportunities for productivity gains of a similar magnitude. Accordingly, ASH urges CMS to consider a one-time forecast error adjustment in FY 2026 to account for prior discrepancies between projected and actual hospital cost growth.

DSH Payments

CMS has proposed a decrease of approximately 3.3 percent in available DSH uncompensated care payments for FY 2027. ASH is concerned that this reduction may further strain hospitals that serve communities with significant unmet health needs. For safety-net hospitals, uncompensated care payments remain an important source of support for maintaining access to services and advancing care delivery to low-income and underserved populations, particularly as CMS projects growth in the national uninsured rate. Accordingly, ASH urges CMS to reconsider these proposed payment reductions and to ensure that DSH payment policy appropriately reflects the continuing role of safety-net hospitals in furnishing care to Medicaid beneficiaries and other underserved patients.

Outlier Threshold

CMS proposed a fixed-loss acute outlier threshold of $51,704, which is considerably higher than the FY 2026 final rule threshold of $40,397. Outlier payments are a fail-safe for safety-net hospitals that cannot carry these higher-than-average costs without CMS's support. As noted above, the cost of providing care is rising faster than Medicare payments and patient acuity is not stagnating, making strong outlier payment policies more important than ever. We urge CMS to reconsider the calculation of the FY 2027 threshold and finalize an amount that protects hospitals from such a large year-over-year swing in outlier payments.

Post Acute Transfer Policy Changes

CMS's post-acute care transfer policy mandates that when a patient is transferred from an IPPS hospital to a post-acute care facility and their length of stay is less than the geometric mean length of stay for their assigned MS-DRG, the transferring hospital is reimbursed on a lower, per diem basis rather than receiving the full MS-DRG payment. Based on its analysis of MedPAR data, CMS is proposing to add 13 new or revised MS-DRGs to the list of those MS-DRGs subject to the post-acute care transfer policy, bringing the number of

MS-DRGs subject to the policy up to almost 300. ASH cautions CMS against expanding this policy, which places additional financial strain on hospitals that treat short-stay patients who have complex and costly needs.

Patients treated at safety-net hospitals—particularly Medicaid beneficiaries and uninsured individuals—often present with greater clinical complexity, untreated chronic conditions, and significant non-medical barriers that complicate recovery and increase the cost of care. Those costs are concentrated in the earliest days of the inpatient stay, when hospitals must stabilize the patient, address longstanding unmet needs, and initiate treatment that cannot be deferred without jeopardizing outcomes. Transferring these patients to post-acute settings earlier than expected does not eliminate those front-loaded hospital costs; it simply leaves safety-net hospitals with less reimbursement for care they have already provided. CMS's graduated per diem methodology appropriately recognizes that the first day of hospitalization is especially resource-intensive, by doubling the calculated per diem rate for that first day. For the patients safety-net hospitals serve – patients who have gone without regular medical care and so are sicker than most others – that same logic extends beyond the first day, because the highest-cost interventions and care coordination efforts often continue through the first several days of the admission.

For these reasons, ASH strongly urges CMS not to expand the list of MS-DRGs subject to the post-acute transfer policy. If CMS nonetheless moves forward, it should adopt explicit safeguards for safety-net hospitals, including targeted exceptions or payment protections that recognize the higher cost of caring for these complex patients. Without such protections, the proposal would disproportionately penalize hospitals that already operate with the thinnest margins while serving the patients and communities with the greatest need.

Comprehensive Care for Joint Replacement Expansion

CMS proposes to reintroduce and expand the Comprehensive Care for Joint Replacement (CJR) model nationwide and to require participation by most hospitals in the CJR Expanded (CJR-X) model beginning October 1, 2027. ASH urges CMS to adopt a voluntary approach to participation in CJR-X. Although ASH supports the development and testing of value-based payment models, mandatory participation in this context may impose significant operational and financial burdens on hospitals without sufficient flexibility to account for variation in provider readiness, patient mix, and local market conditions. While the original CJR model generated savings in certain circumstances, it was not designed as a mandatory nationwide model. Because episode-based payment models hold hospitals accountable for spending and performance across providers and settings beyond their direct control, mandatory participation may be particularly challenging for hospitals that lack the infrastructure, alignment, or market leverage necessary to manage post-acute care effectively. Accordingly, ASH urges CMS to finalize a voluntary participation framework for CJR-X rather than a broad mandatory expansion.

CJR Environment Was Different

When CJR was first introduced, CMS selected nearly all hospitals in 34 randomly selected, metropolitan statistical areas (MSAs) that had high historical Medicare payments for lower-extremity joint replacement (LEJR) surgery. The agency hypothesized that higher-payment areas had a greater need and more opportunities for payment reductions. Hospitals were permitted to volunteer to participate in CJR but were later removed after their entrance impacted the savings to the Medicare program. If all hospitals must participate in CJR-X, this will include hospitals who do not have as great a potential to find savings compared to their historic data.

In addition, there has been pronounced growth in Medicare Advantage (MA) enrollment since the time CJR was designed and implemented. At the time CJR arrived on the scene and historical hospital spending on LEJR was examined, about 32 percent of Medicare patients were enrolled in MA plans. In 2025, MA

enrollment included 54 percent of Americans. This shift in enrollment has two important implications for CJR-X. First, it reduces the traditional Medicare claims base on which historical spending benchmarks are derived. Second, it leaves hospitals with fewer fee-for-service Medicare beneficiaries and fewer qualifying episodes through which to implement care redesign strategies and achieve savings under the model.

Prevent Losses for Safety-Net and Rural Providers

Safety-net hospitals were more likely than other hospitals to owe Medicare reconciliation payments in CJR. In the Transforming Episodic Accountability Model (TEAM) design, CMS has protected safety-net hospitals from any downside risk. In finalizing TEAM, CMS recognized the unique position of safety-net providers and exempted them from losses in response. CMS described the challenges facing safety-net hospitals, including their high-need patient demographics, low health literacy, and language barriers that make it more difficult for these hospitals to improve Medicare spending. CMS also acknowledged that safety-net hospitals are more likely to initiate lower volumes of the clinical episodes in TEAM, including the LEJR episodes that would be included in CJR-X. In CJR-X, CMS proposes applying a five percent stop-loss threshold to safety-net hospital reconciliation amounts rather than exempting these providers from losses in the model. We believe an exemption is more appropriate.

We also recommend CMS mirror the rural definition employed in CJR's opt-out policy when applying a stop-loss for rural CJR-X participants. CMS has proposed to treat hospitals as rural for purposes of this loss protection only when the hospital is physically located in a rural area, but CJR recognized the importance of some hospitals being able to receive rural treatment for Medicare purposes and included those hospitals in its rural protections. For consistency among models and to ensure the stability of rural hospitals in CJR-X, CMS should apply rural policies to all rural hospitals including those that are treated as rural for Medicare payment purposes.

Requests for Information related to TEAM

CMS included in the rule a request for information (RFI) on the future incorporation of ambulatory surgical center (ASC) episodes and voluntary participation of hospitals with physician ownership. ASH continues to believe that participation in TEAM should be voluntary for all hospitals and we offer the following feedback in response to the idea of ASC or physician-owned hospital participation.

ASC Episode Inclusion

In the proposed rule, CMS seeks comment on the potential future inclusion of ASC-initiated episodes in TEAM. ASH recognizes CMS's interest in aligning a broader range of providers with value-based payment objectives as additional procedures migrate to ambulatory settings. However, we urge CMS to proceed with caution. Incorporating ASC-initiated episodes into a hospital-focused mandatory bundled payment model raises significant operational and fairness concerns, particularly for safety-net hospitals.

Safety-net hospitals serve as essential community providers and must maintain capacity to furnish care to all patients who present for treatment, including individuals with greater clinical complexity, multiple comorbidities, unstable housing, limited caregiver support, and other non-medical health factors that can affect episode costs and outcomes. By contrast, many ASCs have greater ability to structure service lines, scheduling, and patient selection in ways that concentrate lower-acuity, more predictable cases. As a result, including ASCs in TEAM without carefully calibrated safeguards could intensify existing differences in case mix and leave safety-net hospitals disproportionately responsible for higher-risk patients and higher-cost episodes.

ASH does not support the inclusion of ASC-initiated episodes in TEAM at this time. If CMS nonetheless considers future incorporation of ASCs, the agency should, at a minimum, establish a separate methodology for ASC episodes rather than blending ASC and hospital experience into a common benchmark or target

price. Given material differences in patient acuity, service mix, overhead, standby capacity, and statutory obligations, a combined pricing framework could systematically disadvantage safety-net hospitals. CMS should also consider whether any future ASC participation framework includes meaningful protection for hospitals that furnish a disproportionate share of patients with medically complex needs and that cannot compel alignment from independent ambulatory providers.

Voluntary Participation for Physician-Owned Hospitals

Physician-owned hospitals can likewise be selective in the patients they treat and the case mix they maintain to support profits for their ownership. ASH would be similarly concerned about permitting their participation in TEAM. In addition to differences in patient mix and negotiating leverage, physician-owned hospitals can sometimes operate without an emergency department if the state permits, making their patient acuity skew lower than community or safety-net hospitals. We do not believe there is a place for physician-owned hospitals in TEAM.

Cost Reporting Proposals

CMS discusses two potentially major changes to cost reporting instructions in this rule: 1) clarification on how purchased products or services should be allocated among cost centers; and 2) details on how hospitals should report overhead costs for nursing and allied health education programs. ASH offers feedback on these two items below.

Allocation of Purchased Services

ASH is concerned that CMS's proposed clarification regarding purchased services and the allocation of accumulated administrative and general (A&G) overhead costs would depart from longstanding cost-finding principles while increasing administrative burden for hospitals. Under current practice, hospitals may use the accumulated costs statistic as a simplified and rational method for allocating overhead, consistent with the design of the Medicare cost report and the step-down methodology. CMS's proposal appears to single out certain purchased service costs for different treatment without establishing a uniform revision to the underlying allocation framework.

ASH is concerned that this selective approach could undermine consistency across the cost report, create subjectivity in overhead allocation, and effectively limit reimbursable costs without the transparency of an explicit disallowance. To the extent indirect costs are removed from certain cost-based lines, those costs will instead be shifted elsewhere within the cost report, raising concerns about cost apportionment and consistency with Medicare cost-finding requirements under 42 C.F.R. Part 413.

These concerns are particularly significant for safety-net and other resource-constrained hospitals, which rely on simplified and administratively workable cost-reporting methodologies to be efficient with their cost reporting preparation. Over the past 20 years since CMS instructed hospitals to allocate costs in this way; health systems have found efficiencies in statistic calculations and report preparation that we fear may be lost. In the context of the entire Medicare cost report, the impact of excluding purchased items from overhead allocation in these scenarios is likely to be immaterial to reimbursement overall. The costs at issue represent a small proportion of total overhead allocation pools, but the new administrative burden could be great, especially on safety-net hospitals. Given this minimal financial impact, we urge CMS to balance the stated goal of clarification with the operational burden placed on providers and withdraw its proposal.

Safety-net hospitals are more likely to be harmed by this allocation shift since fewer reimbursable costs for hospitals will produce downstream impacts on DSH surveys or other reporting that relies on the cost report

and uses cost data such as a community benefit report. Hospitals are not currently able to estimate the future impact on DSH and other safety-net supports, but we encourage CMS to monitor this very closely.

For these reasons, the proposed policy raises significant concerns related to consistency, transparency, cost apportionment, and compliance with established Medicare cost-finding regulations. CMS should reconsider this approach and, if it seeks to revise cost allocation methodologies, the agency should do so in a manner that is uniform, transparent, and fully consistent with the requirements of 42 CFR Part 413.

Nursing and Allied Health Education Costs

CMS discusses related, but more specific guidance, on the identification of overhead costs of approved educational activities, including nursing and allied health education (NAHE) programs operated by hospitals. CMS proposed that these hospitals must identify any general service cost center that comprises costs of multiple overhead functions, where some of those functions provide a benefit to the hospital's NAHE programs and others do not. For each such general service cost center, the hospital would be required to create one or more subscripts that contain only those costs that provide a benefit to its NAHE programs.

ASH urges CMS not to codify this policy at this time. Although CMS characterizes the proposal as a clarification, the treatment of overhead costs for NAHE programs has not been clearly resolved through prior rulemaking, MAC guidance, or the courts. ASH is concerned that CMS's proposed NAHE overhead policy would impose significant administrative burden without sufficient policy justification. ASH is also concerned that CMS has not substantiated its suggestion that hospitals are inappropriately allocating related organization or home office costs to NAHE cost centers.

The proposal would require hospitals to create multiple subscripts within general service cost centers to isolate overhead costs that benefit NAHE programs. The proposal is inconsistent with existing cost-finding principles, including the treatment of direct costs through Worksheet A-6 and the proportional allocation of remaining overhead costs across benefiting departments.

If CMS believes further guidance is needed, it should pursue a more transparent and administratively feasible approach that is consistent with longstanding Medicare cost-reporting principles and mindful of the operational constraints facing safety-net hospitals.

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The Alliance of Safety-Net Hospitals appreciates the opportunity to comment on the proposed rule and welcomes any questions CMS may have about the views we have expressed in this letter.

Sincerely,

Ellen Kugler, Esq.
Executive Director