June 10, 2025

The Honorable Dr. Mehmet Oz
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS–1833–P
P.O. Box 8013
Baltimore, MD 21244–8013

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

Dear Administrator Dr. Oz:

On behalf of Families USA, thank you for the opportunity to comment on the proposed Medicare Hospital Inpatient Prospective Payment System (IPPS) regulation for Calendar Year 2026. Changes made through the IPPS rule offer an important opportunity to both strengthen the Medicare program and to signal to other payers the urgent need to realign the economic incentives of health care payment and delivery to drive toward a higher value health care system.

As consumers across the county grapple with skyrocketing health care costs,[1] insufficient health care access,[2] and poor health care quality,[3] Medicare payment policy updates should reflect the deepest needs of patients. Our country is in a health care affordability and quality crisis that is largely driven by broken economic incentives throughout the health care system. As a result, health care price increases are based on market power and not improved health outcomes, and the system rewards providers that generate high volumes of high-priced services instead of those that deliver primary and preventive care and address the socioeconomic factors that drive the majority of health outcomes.[4] Fee-for-service (FFS) economics, the predominant U.S. health care payment model, are simply not designed to reward successes in promoting the health and well-being of people and communities, nor to bolster the independent, rural, and safety net providers working on the frontlines to treat illness and keep our families healthy. Instead, U.S. health care payment structures produce more than $1.4 trillion dollars of wasteful spending across the health care system, much of that due to high and irrational price increases driven by unchecked health care consolidation and wasteful fee-for-service payments.[5] These are major obstacles to building and maintaining a high-value U.S. health care system that provides affordable, high quality health care to our nation's families.

The Centers for Medicare & Medicaid Services (CMS) has made significant strides over the past decade, including through the previous Trump Administration, to catalyze the transformational

change needed in our payment system to drive high-value care in health care markets throughout the country. CMS and the Trump Administration should retain and build upon this progress, and not rescind key policy reforms that improve the ability of the health care system to meet people's health needs and make America healthy, a clearly stated goal of this administration.

To that end, the comments detailed in this letter represent the consensus views of the undersigned 31 organizations urging CMS to make specific changes in the proposed rule that will better support the development of a high-value health care system that meets the needs of Americans in every community. We ask that these comments, and all supportive citations referenced herein, be incorporated into the administrative record in their entirety.

Our comments are focused on the following sections of the proposed rule:

- **VI.L** Changes to the Hospital Value-Based Purchasing (VBP) Program
- **X.C**. Requirements for and changes to the Hospital Inpatient Quality Reporting (IQR) program
- **XI.A** Proposed changes to the Transforming Episode Accountability Model (TEAM) model

VI.L Changes to the Hospital Value-Based Purchasing (VBP) Program

We oppose the CMS proposal to remove the Health Equity Adjustment (HEA) in the Hospital Value-Based Purchasing (VBP) Program. This proposed change would remove a critical safeguard and payment adjustment within the Hospital VBP Program intended to support some of our nation's most vulnerable hospitals and health care providers, including rural and independent hospitals – a direct threat to the financial security of these providers and their ability to provide essential, life-saving care to the communities and patients that rely on them.

The Hospital VBP Program adjusts hospital inpatient Medicare payments based on hospital performance on a set of quality and efficiency measures.[6] Under this pay-for-performance (P4P) program, CMS adjusts part of hospitals' IPPS Medicare payment based on a total performance score that reflects improvements in care quality compared to a baseline period.[7] When hospitals perform better than the baseline period on a set of measures (i.e. mortality and complication rates, healthcare-associated infections, patient safety, patient experience, and cost reduction), they receive a positive adjustment to their Medicare payment.[8] If hospitals perform poorly, they risk losing revenue through a negative payment adjustment.[9]

The Hospital VBP Program has been an important P4P program that takes meaningful steps to create financial alignment and accountability between hospital payment and hospital performance, but it will ultimately be less successful without the Health Equity Adjustment (HEA) included. That is because while P4P payment arrangements in general are an important

stepping stone in the shift towards higher-value reimbursement models, they are largely problematic for two reasons: 1) they continue to be anchored in fee-for-service economics where reimbursement is tied to a FFS base payment with either penalties or a bonus based on performance on a set of process measures, rather than outcome measures; and 2) many studies have shown that P4P actually reduces access to care for socioeconomically disadvantaged populations by incentivizing providers to avoid treating low-income patients who may have unique barriers to achieving improvements in their health.[10] The HEA is a key factor in mitigating this harm.

The ultimate goal of value-based payment efforts is to shift hospital reimbursement to a "total cost of care model" that holds hospitals accountable for both health care costs and the health outcomes of their patient populations. As strides are being made toward that goal, there are critical steps that policymakers must take to strengthen existing value-based payment models, as exemplified by the introduction of the Health Equity Adjustment in the Hospital VBP program. CMS established the HEA in the FY 2024 IPPS/LTHC PPS final rule to address the longstanding issue of hospitals that treat a disproportionate number of patients with greater socioeconomic need being penalized under the Hospital VBP program.[11] The HEA aims to adjust Hospital VBP performance scores by assigning additional points to the performance scores of hospitals that treat a larger proportion of patients with greater socioeconomic needs, reducing the risk of negative payment adjustments that occur on account of treating more complex patients. [12] This is important because hospitals who disproportionately treat patients with greater social need are more likely to have higher rates of complication and mortality as well as higher treatment costs attributable to serving a more vulnerable patient population.[13] Moreover, independent and rural hospitals who frequently have higher levels of uncompensated care and smaller operating margins than major hospital systems, but also often serve more vulnerable patient populations, are more likely to experience greater financial strain when exposed to payment reductions under the Hospital VBP Program.[14]

The HEA payment adjustment is a critical step in driving towards higher-value health care while more accurately adjusting Medicare payments for hospitals based on the complexity of their patient populations.[15] If implemented, the HEA would help to provide hospitals serving higher proportions of dually eligible patients with payment adjustments that better recognize the additional resource intensity associated with serving higher-need and more vulnerable populations. In fact, as a result of HEA score adjustments, safety-net hospitals were projected to receive an estimated $29 million in additional payment adjustments.[16] If CMS moves forward with repealing this key financial safeguard under this proposal, these safety-net hospitals and the patients they serve will bear the brunt of the negative impact.

Development of the HEA was a notable step towards strengthening existing value-based care reforms to recognize the socio-economic conditions that influence health. This aligns with the Trump Administration's repeated emphasis on a new approach to health care that factors in

nutrition and environmental impacts, with dual eligibility status acting as a proxy for the socioeconomic challenges that affect a hospital's patient population. Rescinding the HEA would penalize hospitals on the front lines of treating Medicare's most vulnerable seniors by exposing them to greater financial penalties and losses just for doing their job – treating the patients in their communities that walk through their hospital doors. **As a result, we strongly oppose the repeal of the HEA and recommend that CMS rigorously implement the Health Equity Adjustment in the Hospital VBP Program to ensure that hospitals receive appropriate financial resources that enable them to best meet the needs of their patients.**

X.C. Requirements for and Changes to the Hospital Inpatient Quality Reporting (IQR) Program

We oppose the CMS proposal to remove the Hospital Commitment to Health Equity (HCHE) measure, the Screening for Social Drivers of Health (SDOH-1) measure, and the Screen Positive Rate for Social Drivers of Health (SDOH-2) measure from the Inpatient Quality Reporting (IQR) Program.

The IQR program is a "pay-for-reporting" program, in which CMS provides hospitals that successfully report on designated quality measures with a higher annual update to their payment rates.[17] While IQR does not tie payments to performance on measures, the program was designed with the goal of driving improvements in quality through measurement and transparency.[18] The IQR program remains an important source of data on hospital quality and operations that can be used by hospitals to support internal assessments of hospital quality and engagement in improvement efforts.[19]

In 2023, CMS adopted three new measures into the Hospital IQR Program: HCHE, SDOH-1, and SDOH-2. The HCHE measure is a structural measure designed to encourage hospitals to build systems that improve data collection and analysis, enhance the quality of care delivered, and develop long-term strategic plans to improve health outcomes. Including the HCHE measure in the IQR program helps create a financial incentive for hospitals to report on their efforts to make strategic system improvements that could lead to improved care quality and access.[20] SDOH-1 and SDOH-2 are quality measures that incentivize hospitals and providers to better understand the non-clinical factors impacting patients' health. SDOH-1 requires hospitals to report on how many patients were screened for food insecurity, housing instability, transportation needs, utility difficulties, or interpersonal safety issues. SDOH-2 collects data on whether a patient has screened positive for any of the SDOH-1 domains. Both SDOH-1 and SDOH-2 work to equip providers with the complete picture of their patients' health to better improve health outcomes, and strengthen the ability of the health care system to drive broader population health improvements.[21] By incentivizing hospitals to report on these measures through the IQR program, CMS supports hospitals in identifying operational shortcomings that can inform improvements in hospital quality.

HCHE measure

The HCHE measure requires hospitals to develop and report on their commitment to hospital improvements across five key domains: (1) equity as a strategic priority, (2) data collection, (3) data analysis, (4) quality improvement, and (5) leadership engagement. Incentivizing hospitals to report on their long-term planning and infrastructure improvements is critical not only to providing high quality care to Medicare beneficiaries but also to ensuring that our nation's hospital infrastructure continuously evolves with the tools needed to effectively manage the individual and population health needs of the patients they serve.[22] The HCHE measure is a tool designed to do just that - incentivize hospitals to improve data systems and make quality improvements to ensure that our nation's hospitals are equipped to meet the evolving needs of patients.

Evidence demonstrates that the HCHE measure is already working to improve patient health outcomes, hospital efficiency, and the overall economy.[23] Long-term investments in hospital quality can further improve how hospitals address gaps in patient care, improve patient health outcomes, and ultimately lead to lower health care costs for the system and consumers.[24,25]

These effects are not merely incidental to HCHE measure goals: inefficient and low-quality hospital operations have far-reaching economic impacts, including lost labor market productivity that can hurt local economies.[26] For example, chronic unmet mental and physical health conditions cost U.S. business $7 billion annually due to missed work days, $45 billion annually due to reduced productivity, and $63 billion annually due to unemployment.[27] These costs are largely avoidable, and building health system-led solutions can help to reduce this economic burden.

The HCHE measure and the IQR program broadly are modest steps in addressing the economic incentives that drive waste and inefficiency in our health care system, but as hospitals work towards understanding and improving gaps in care access and delivery through the HCHE measure requirements, they will be better equipped to improve patient health outcomes and reduce costs for patients by eliminating inefficient and low-quality care. Removing this measure from the IQR program would **undermine critical investments that encourage hospitals to build long-term solutions to improve hospital systems and health outcomes. To that end, we oppose the proposal to remove the HCHE measure and recommend that CMS retain the measure in the IQR program.**

SDOH-1 and SDOH-2 measures

The SDOH-1 and SDOH-2 measures promote the collection of comprehensive data on factors that affect health outside of the clinical setting. Despite most hospitals collecting some form of social needs data, only about half (54%) of hospitals report doing so routinely.[28] The inclusion of SDOH-1 and SDOH-2 in the IQR program promotes greater SDOH screening and data collection,

which in turn is associated with better health care interventions and improved health outcomes.[29]

Collection and reporting of SDOH-1 and SDOH-2 support the goals of holding hospitals accountable for health care costs and health outcomes, and equipping hospitals with the information needed to more effectively manage health at both the individual and population level. Removing these measures would directly undermine the Trump Administration's stated goal of improving the health of Americans by addressing the non-clinical factors that contribute to poor health and chronic disease.

Socioeconomic factors, such as nutrition access, neighborhood safety, and housing conditions influence 80 to 90% of people's health, and as a result have a significant impact on health care spending.[30] The collection of SDOH data allows providers and health systems to assess the external factors that influence their patients' health and opens dialogue that helps providers build care plans that fit with each patient's life circumstances, leading to improved health and reduced costs.[31] An assessment of an Arizona-based care management organization's Medicare members found a 31% reduction in health care spending for patients whose SDOH data was collected compared to patients who did not have SDOH data collected.[32] Much of these cost savings were due to the deployment of interventions for identified risk factors and improved treatment compliance informed through the collection of SDOH data, which also led to better health outcomes. Patients who were screened for SDOH data reported improved blood pressure and increased diabetic screening.[33]

Incentivizing the collection of SDOH-1 and SDOH-2 data is an important step in reducing costs and making patients truly healthy, inside and outside the clinic, but it is not the end goal. While we agree with CMS' assessment that SDOH-1 and SDOH-2 do not go far enough in providing real-time benefits to patients, we oppose CMS' proposed solution to simply rescind the collection of these measures. Ultimately, hospitals should be incentivized to not just collect social risk factor data but also to connect patients who screen positive on the SDOH-1 and SDOH-2 measures with resources to effectively manage and improve their health outcomes, such as providing nutritional support services or connecting them with housing coordinators. Rather than rescind these measures, CMS should strengthen their impact by developing and adopting a new measure that will hold hospitals accountable for appropriately responding to positive SDOH-1 and SDOH-2 screenings.

As a result, we oppose CMS' proposal to remove SDOH-1 and SDOH-2 measures from the Inpatient Quality Reporting program. We strongly recommend that CMS retain these measures and the ability to collect social risk factor data in order to hold hospitals accountable for health outcomes, and ultimately recommend that CMS build on these measures by developing a measure in the IQR program that accounts for social need interventions following a positive SDOH screening, such as the HEDIS Social Needs Screening and Intervention measure (SNS-E). [34]

XI.A Proposed changes to the Transforming Episode Accountability Model (TEAM)

We strongly support the continued implementation of the mandatory Transforming Episode Accountability Model (TEAM) and the proposed updated risk adjustment methodology—but we oppose modifications laid out by CMS that would weaken social needs reporting options. TEAM is a five-year, mandatory, episode-based payment reform model that will hold select hospitals accountable for the quality and cost of care for beneficiaries undergoing certain high-cost surgical procedures.[35] Episode-based payments, also known as bundled payments, provide a fixed payment rate for all health care services across a patient's entire treatment for an illness or "episode." Bundled payments are used for the comprehensive treatment of specific conditions – for example, in cancer care where providers would be held accountable for the total cost and quality for the full course of treatment rather than only a course of chemotherapy – and offer real promise for reducing costs and improving outcomes by certain providers managing chronic conditions for their patient population.[36]

Bundled payment models shift away from smaller fee-for-service units of care to larger "episodes" of care (for example, 60, 90 or 180 days) and adjust payments based on quality performance.[37] By doing so, bundled payments create financial incentives for providers to enhance care coordination and increase efficiencies to improve health outcomes and lower costs during the episode. As a result, bundled payments are an important step in moving towards higher-quality, more coordinated and less costly care. Yet these payments have inherent limitations: bundles can result in pressure to increase the volume of services (that is, volume of bundles) being provided, and do not hold providers accountable for outcomes outside of the window of the episode of care. For this reason, they should be used to move provider organizations on a path to true population-based payments – and not be the end goal.[38]

Efforts to implement and scale payment models that shift the underlying economic incentives of U.S. health care payment away from fee-for-service and toward payment models that hold providers accountable for health care costs and health outcomes are essential tools to drive efficiency in the U.S. health care system. The TEAM model is particularly promising as it is one of a limited number of *mandatory* models that aim to realign the economic incentives of the health care sector with the health and financial security of our nation's seniors and families. To that end, **we support CMS' efforts to improve the risk adjustment methodology of the model by replacing the use of the Area Deprivation Index (ADI) with the updated Community Deprivation Index (CDI) methodology**. Incorporating socioeconomic risk adjustment into TEAM's risk adjustment methodology is critical to being able to accurately and adequately estimate the cost of treating and caring for patients based on patient characteristics and health conditions.[39] Under the current TEAM risk adjustment methodology, the target price, or the fixed price intended to cover all costs associated with an episode of care, are adjusted if a

beneficiary meets one of the following criteria: (1) is dually eligible for Medicare and Medicaid, (2) resides in an area with an ADI score above the 80th percentile, or (3) qualifies for the Medicare Part D Low Income Subsidy (LIS).[40]

In our comments on the proposed FY 2025 IPPS/LTHC PPS, Families USA applauded CMS's incorporation of socioeconomic risk adjustment into the model but noted that ADI, which is used to evaluate an area's level of socioeconomic need, can provide distorted results and mask deprivation in select communities.[41] Under ADI, Census Block Groups representing neighborhoods receive a score based on a series of deprivation indicators including income, education, employment, and housing. Census blocks are then ranked nationally and assigned a percentile based on their ADI score, with higher numbers representing greater socioeconomic need (deprivation).[42] While ADI calculates deprivation scores using 17 different variables, the value of each of those variables is not standardized, which results in certain measures with higher numeric values having a disproportionate weight in the final ADI score.[43] Generally, two variables yield the highest values: median household income and median home value, resulting in a majority of the final score being determined by only those two variables.[44] This means that an urban area with high levels of wealth disparity may appear to have less deprivation due to a moderate or high median household income or home value even when other variables indicate high rates of deprivation or need. For example, the Bronx, NY, reports higher median home value and median family income which leads to an ADI score that indicates low levels of deprivation despite also reporting low education rates, high poverty rates, and high unemployment rates.[45] Due to this improper standardization of variables, ADI frequently masks true deprivation and fails to adequately account for community need when informing payment adjustments.

CMS proposes to replace the use of the ADI with the community deprivation index (CDI) in the TEAM risk adjustment methodology. CDI corrects for inaccuracies in ADI by updating and standardizing variables so that scores more accurately represent the characteristics associated with deprivation.[46] Improving this methodology within TEAM means target prices for each episode of care will more accurately reflect the resources needed to support patients across an episode of care. **We therefore support CMS' proposal to replace ADI with CDI in TEAM. We also recommend that CMS continuously monitor the efficacy of CDI as a variable in beneficiary-level risk adjustment and make any necessary improvements to ensure the risk adjustment methodology meets the intended goal of accurately anticipating the resources required to treat beneficiaries with higher levels of need.**

While we applaud CMS' efforts to improve the beneficiary-level risk adjustment, our organizations strongly oppose attempts to weaken TEAM reporting requirements. **Specifically, we oppose CMS' proposal to remove the voluntary health equity plan (HEP) and health-related social needs data from TEAM. These efforts run counter to the Trump Administration's stated goals of understanding and reducing rates of chronic illness through "fresh thinking on nutrition, physical activity, [and] healthy lifestyles".**[47] Consumer advocates

have long supported transitioning our health care system to one that accounts for the socioeconomic and environmental conditions that drive health and health outcomes in order to achieve a more holistic and person-centered view on illness prevention. The collection of SDOH data and reporting of HEPs are critical to identifying the ways in which a person's environment, economic well-being and experiences shape their health, and to supporting hospital initiatives to address disparities and drive improvements.[48]

These plans encourage participating hospitals to examine data on patient outcomes, experience and needs in order to implement targeted approaches that improve quality and health outcomes. This is particularly important given that CMMI evaluations on the precursor models to TEAM (Bundled Payments for Care Improvement Advanced and the Comprehensive Care for Joint Replacement), demonstrated decreased readmissions, but no improvement in patient experience or reductions in emergency department use.[49] The use of HEPs enable hospitals to examine metrics of quality, like patient experience or emergency department use, and drive improvements in patient outcomes. By supporting hospitals in identifying the preventable differences in the burden of disease, establishing targeted goals that address patient health disparities, and measuring the performance of interventions, HEPs promote hospital-led initiatives that drive quality improvement.[50] For these reasons, **we urge CMS to maintain the optional HEP in TEAM.**

Thank you again for the opportunity to comment on this important array of issues impacting the health and well-being of people across the country who receive inpatient hospital care. IPPS and other Medicare payment rules hold the key to addressing the failures of our current health care payment system and should be leveraged to align the way health care is paid for with the needs of our nation's families. Please contact Alicia Camaliche (Acamaliche@familiesusa.org), Senior Policy Analyst at Families USA, with any questions.

Sincerely,

Families USA
ACA Consumer Advocacy
Autistic Women & Nonbinary Network
Asian Pacific Community in Action, Arizona
Asian & Pacific Islander American Health Forum
Black Maternal Health Federal Policy Collective
BLKHLTH Inc.
Center for Elder Law & Justice
Coalition on Human Needs
Colorado Consumer Health Initiative
Consumers for Affordable Healthcare, Maine
Consumers for Quality Care

Democratic Disability Caucus of Florida
Iowa Citizen Action
Georgia Watch
Lupus and Allied Diseases Association, Inc.
Medicare Rights Center
Moms Rising
National Consumers League
National Organization for Women
National Partnership for Women and Families
Protect Our Healthcare Coalition, Rhode Island
Public Advocacy for Kids (PAK)
Serving At-Risk Families Everywhere, Inc.
South Carolina Appleseed
Tennessee Healthcare Campaign
The Coalition for Hemophilia B
Third Way
Transgender Awareness Alliance
Utah Health Policy Project
Voices of Health Care Action

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