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June 10, 2025

Dr. Mehmet Oz
Administrator
Centers for Medicare & Medicaid Services
Hubert H. Humphrey Building
200 Independence Ave., SW
Washington, D.C. 20001

SUBJECT: CMS-1833-P, Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospital Policy Changes and Fiscal Year 2026 Rates; and Other Policy Changes

Dear Administrator Dr. Oz:

The University of California Health (UC Health) appreciates this opportunity to submit the following comments regarding the Medicare Hospital Inpatient Prospective Payment System (IPPS) proposed rule for fiscal year (FY) 2026.

UC Health represents six University of California academic health centers: UC San Francisco, UC Los Angeles, UC Irvine, UC San Diego, and UC Davis, and its affiliate, UCSF Benioff Children's Hospital Oakland ("BCH Oakland"), and the University of California, Riverside School of Medicine. UC academic health centers are an essential part of California's health care safety net system. As designated public hospitals, UC's academic health centers provide high-quality care to those in need regardless of their insurance status or ability to pay. We provide care for patient's everyday health needs, as well as those with the most complex cases, including cancer, burn, transplant, and trauma care. These patients need and deserve these services, along with the ability to access them through their health coverage.

UC Health plays a leading role in California's health care safety net as one of the state's significant providers of Medicare and Medi-Cal inpatient and hospital outpatient services. UC Health is committed to providing world class health care to Californians with limited means and limited access to care. Considering the vital functions fulfilled by public health care systems like ours, we offer the following comments.

Government payors comprise two-thirds of our payor mix, with 36% of inpatient days at UC hospitals devoted to caring for Medicare patients. In the 2022-23 fiscal year, our academic health centers provided an estimated $3.7

billion in uncompensated care to patients insured by Medicaid and Medicare. Given these financial pressures and the specific challenges faced by UC Health, in a high-cost environment with substantial Medicare and Medi-Cal populations, a greater increase in Medicare payments is needed to ensure the financial stability of hospitals and health systems.

Providing Adequate Medicare Reimbursement Rates to Protect Access to Care

The proposed net payment update of 2.4% is inadequate and may exacerbate these financial challenges resulting in negative impacts for the Medicare beneficiaries we serve. The proposed update is insufficient relative to the input price inflation faced by hospitals and continues CMS' historic trend of advancing payment updates that do not accurately reflect the cost of providing hospital care. As such, UC Health urges CMS to appropriately account for recent and future trends in inflationary pressures and cost increases in the hospital payment update and make modifications to the proposed FY 2026 rate update and policies to reflect these realities:

Provide an Adequate Market Basket Update (MBU*)*: CMS should use data that better reflect the input price inflation that hospitals have experienced and are projected to experience in FY 2026. Further, the agency should make a one-time "forecast error adjustment" to account for the underestimation of the hospital MBU that occurred from 2021 to 2024 and either eliminate or reduce the productivity cut for FY 2026.

Revise Uncompensated Care (UCC) Disproportionate Share Hospital (DSH) Assumptions: We encourage CMS to recalculate Factor 2 of UCC DSH calculation using the most current data and assumptions to more accurately reflect the anticipated increases in the uninsured rate as a result of scheduled or pending federal policy changes that will result in loss of coverage under Medicaid and the health insurance marketplaces. CMS' projections underestimate the likely substantial increase in uninsured patients in FY 2026, which could leave safety net hospitals, including UC Health, underfunded.

Do not apply budget neutrality to transitional wage index adjustment: UC Health supports discontinuation of the bottom quartile low wage index hospital policy and associated budget neutrality adjustments. This policy has been deemed impermissible under the Medicare statute by multiple federal courts, and it redistributed payments away from many California hospitals, including UC Health, without demonstrable benefit to low-wage areas. UC Health also supports the proposed transitional relief for hospitals that have benefited from the bottom quartile policy and may see a drop in their wage index as a result of discontinuation. However, CMS should exercise its discretion under Section 1886(d)(5)(I) of the Social Security Act and implement a policy that is *not* budget neutral. Hospitals harmed by CMS' unlawful policy should not continue to experience payment cuts under budget neutrality adjustments to pay for a policy that multiple courts have deemed impermissible.

Revise Methodology Used to Calculate the Labor-Related Share*:* The methodology CMS uses to rebase and revise the labor-related share of Medicare payments for hospitals with a wage index of 1 or greater is premised on an incorrect assumption that some categories of labor costs are not subject to geographic variation. CMS should revise its methodology for rebasing the labor-related share, to account for the geographic wage variation inherent in all non-clinical professional services costs.

TEAM Model Bundled Payment Adjustments: If CMS proceeds with the TEAM payment model beginning Jan. 1, 2026, it may exacerbate access issues for safety net hospitals and the populations they serve. CMS should make important technical changes including establishing a sufficient low-volume adjustment policy, ensuring appropriate risk adjustment, and target pricing methodology.

Permit Subtraction of Revenues After Indirect Cost Allocation for Nursing and Allied Health Education (NAHE) Programs*:* With regard to NAHE program costs and determining the net costs that are allowed for pass-through payment, CMS determines the net cost of approved educational activities by deducting the revenues that a provider receives from tuition and student fees from the provider's total allowable educational costs that are directly related to approved educational activities. On Feb. 9, 2024, the U.S. District Court for the District of Columbia found that CMS' cost report instructions of subtracting eligible costs for NAHE activities *prior to* allocating indirect costs to be inconsistent with the regulation to subtract these costs *after* the indirect cost allocation is allocated.[1] CMS should adhere to the court's ruling in permitting subtraction of applicable costs *after* the indirect cost allocation and not seek to change the underlying regulation to comply with the agency's preferred policy.

Payment Proposals

a. Market Basket Update

CMS proposes a Market Basket Update (MBU) for FFY 2026 of 3.2%. This is then reduced by the 0.8 percentage point "productivity adjustment" required under the Affordable Care Act (ACA), resulting in a proposed net IPPS payment update of 2.4%. This update, especially when taken together with prior inadequate updates, continues and exacerbates Medicare's underpayments. For example, from 2019 through 2023, the average MBU finalized by CMS was 3.0% (prior to total factor productivity and other statutory adjustments). However, hospitals' risk-adjusted cost per discharge increased by a volume weighted average of 12.3%[2] during that same period when compared to pre-pandemic levels in 2019, deepening Medicare payment shortfalls.

Use the Most Recent and Accurate Data to Set Market Basket

UC Health urges CMS to base the final FY 2026 market basket update on the most current data available, and to incorporate more realistic projections of hospital input cost growth. The proposed 3.2% market basket for FY 2026 is significantly lower than recent inflation trends and does not account for rapidly escalating cost drivers, such as ongoing labor shortages (which drive up contract labor rates) and supply chain disruptions. UC Health appreciates that CMS will refresh the market basket with more recent data for the final rule; however, even an updated forecast may undershoot actual inflation, given the volatility and uncertainty in the economy. Notably, CMS itself acknowledged that setting payment updates during periods of economic uncertainty often results in large forecast errors. Relying on pre-pandemic market basket formulations (largely based on historical data) has proven inadequate in the post-pandemic environment of spiking labor, drug, and supply costs.

CMS should identify and use data inputs that better capture these price increases — for example, incorporating more recent wage data that include contract labor expenses, which the hospital market basket's wage index proxy (the Employment Cost Index or ECI) currently does not fully reflect. In addition, given the continued rise in input costs and the inadequate MBUs derived from use of the ECI,

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[1] *Mercy Health – St. Vincent Medical Center LLC d/b/a Mercy St. Vincent Medical Center, et al., v. Xavier Becerra*, Case No. 22-cv-3578

[2] CHA analysis of Medicare cost report data.

CMS may consider using the weighted average growth rate in allowable Medicare costs per risk-adjusted discharge for IPPS hospitals to calculate the final or future MBU for IPPS hospitals. Incorporating such data would make the market basket update more accurate and responsive to the current economic realities that drive hospital input costs.

b. Disproportionate Share Hospital (DSH) and Uncompensated Care Payments

UC Health appreciates that CMS proposes to increase total DSH uncompensated care to hospitals by approximately $1.5 billion in FY 2026 compared to FY 2025. This increase is largely driven by a higher projected uninsured rate and corresponding growth in the uncompensated care DSH pool. CMS indicates that it expects the uninsured rate for calendar year 2026 to rise to 8.7%, up from 7.7% in 2025, resulting in a blended uninsured rate of 8.5% for FY 2026. UC Health concurs that the uninsured population will likely grow in the coming years. There are many factors poised to increase the number of uninsured individuals in 2025–2026. For example, **the scheduled expiration of enhanced Marketplace premium tax credits (EPTCs) after the 2025 plan year (unless Congress acts to extend them):** If EPTCs expire, the Congressional Budget Office (CBO) estimates that the number of uninsured will rise by 2.2 million in 2026 and by 3.7 million in 2027, with an average increase of 3.8 million annually between 2026 and 2034.[3]

The uninsured rate is expected to climb significantly higher than CMS' estimate of 8.5%. If the actual uninsured rate exceeds the CMS projection, then Factor 2 in the DSH formula (which adjusts the uncompensated care pool based on the change in uninsured) will have been set too low, and the DSH pool will be insufficient. With this in mind, UC Health believes that CMS' methodology for Factor 2 likely underestimates the increase in uninsured. Accordingly, **UC Health urges CMS in the final rule to revisit the uninsured rate projection with the latest available data (i.e. Marketplace enrollment figures) and use administrative discretion to adjust Factor 2 upward if warranted**.

Even a small percentage-point difference in the uninsured population translates to hundreds of millions of dollars in the uncompensated care pool. Given the critical role of these funds for safety net hospitals, UC Health urges CMS to ensure the DSH pool is adequately funded in anticipation of declines in insurance coverage and to protect against surging rates of uncompensated care. UC Health relies on the Medicare uncompensated care DSH payments to help cover the costs of treating uninsured and under-insured patients. The combination of inflation (raising the cost of providing uncompensated care), higher uninsured volume, and the historic shortfall in Medicaid reimbursement (which leaves hospitals with heavy Medicaid caseloads financially strained) means that every additional DSH dollar is crucial to funding the safety net and ensuring patient access to care.

In addition, between FY 2021 and FY 2024, the total DSH dollars available to hospitals under the ACA formula decreased by approximately $1.9 billion due to reductions in the uninsured rate during that period. **The proposed $1.5 billion increase in the DSH pool for FY 2026 is appreciated and needed but still leaves DSH payments below their 2020 level**. with significantly reduced Medicare DSH funding compared to a few years ago, increasing the need to shore up the DSH pool this year.

Further, given the volatility of the insurance coverage landscape, CMS may also wish to consider other policy levers to bolster DSH payments, such as temporarily allocating additional funds outside the normal DSH formula to hospitals serving the most low-income patients. Section 1886(d)(5)(I) (the

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[3] Congressional Budget Office, Letter to Chairman Arrington and Chairman Smith Concerning Premium Tax Credits, https://www.cbo.gov/system/files/2024-12/59230-ARPA.pdf.

exceptions and adjustments authority) could potentially be used to provide a temporary add-on payment or upward adjustment for qualifying safety net hospitals. CMS is urged to use the full extent of the DSH formula to channel funds to where they are needed: update the data, accurately estimate need, and finalize the largest uncompensated care DSH pool possible for FY 2026.

c. Hospital Area Wage Index

CMS's ongoing year-over-year modifications to payment methodologies, particularly those involving wage index and labor share adjustments, create persistent financial instability for safety net hospitals. These institutions, including UC Health, already operate on thin margins while serving a disproportionate share of underinsured and uninsured patients. Repeated "tinkering" with core rate-setting elements compounds fiscal uncertainty and undermines the ability of safety net providers to plan, invest in workforce, and deliver essential services to vulnerable communities. UC Health recommends that CMS maintain a stable, evidence-based labor-related share methodology and refrain from changes that introduce further volatility into the inpatient payment system — especially in the absence of compelling data.

UC Health supports the permanent elimination of the low-wage index policy and associated budget neutrality adjustment in response to the United States Court of Appeals for the District of Columbia Circuit (D.C. Circuit) decision in *Bridgeport Hospital, et al., v. Becerra (Bridgeport)* in federal fiscal year (FFY) 2026 and future years. Medicare statute requires that the wage index reflects the relative wage levels of hospitals in different areas, compared to the national average. The low-wage index policy artificially inflated the wage index of certain low-wage areas beyond their actual relative wage level, funded by an across-the-board cut to all hospitals' base rates. Multiple courts have concluded that CMS exceeded its authority and engaged in redistribution by implementing a policy and related budget neutral adjustment that penalized some and rewarded others in the wage index outside of the established floor.

This policy has disproportionally affected California's hospitals, resulting in approximately $120 million in payment cuts since the policy was first implemented in FFY 2020. Hospitals in California pay the highest wages in the nation, reflecting the high cost of living throughout the state. For example, even when adjusted for cost of living, California nurses are still the highest paid in the country, with an adjusted average annual salary that is 34% higher than the national average.[4] While UC Health understands the concerns raised by disparities between wage index values for high- and low-wage index hospitals, California's hospitals should not have to fund this policy via a budget neutrality adjustment. UC Health supports CMS' proposal to permanently discontinue the low-wage index adjustment and will restore the wage index to a more accurate reflection of area wage levels.

d. Labor Related Share Updates

To calculate the payment that hospitals receive under the Medicare IPPS, a portion of the base payment is adjusted by a hospital's wage index. The portion that is adjusted is known as the labor-related share. This share is equal to either the standardized share of 62 percent or CMS' estimated national labor-related share, whichever results in a higher payment.[5] Hospitals with a wage index less than 1.000 will receive a labor-related share of 62 percent, while those with a wage index of greater than 1.000 will

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[4] CHA analysis of Bureau of Labor Statistics 2024 Annual Wage Survey Data Files

[5] Section 1886(d)(3)(E) of the Social Security Act

receive CMS' estimated national labor-related share. CMS updates the estimate of the national labor-related share every four years, and the estimate is due for an update in FY 2026. Currently in FY 2025, CMS' estimate is based on the 2018-based IPPS market basket for discharges after October 1, 2021, resulting in an estimated national labor-related share of 67.6 percent. CMS is proposing to recalculate the estimated national labor-related share using the proposed 2023-based IPPS market basket cost category weights for discharges occurring after October 1, 2025. This would reduce the labor related share from 67.6 percent to 66 percent, reducing the portion of the IPPS base payment rate subject to the wage index. (P.18236). This would disproportionally negatively impact hospitals with a wage index greater than 1.000.

Ensure Accuracy and Transparency in Payment Methodologies and Data Used to Calculate the Labor-Related Share

Included in the proposed rule are the cost category weights CMS utilizes for the labor-related share. Of these, all but the labor-related professional fees remained the same or were reduced from the 2018-based IPPS market basket cost weights to the new proposal based on 2023-based IPPS market basket data. (P.18246). However, in an analysis from KFF and Peterson Center that evaluated changes in hospital employment data, including wage data, from February 2020 at the start of the COVID-19 pandemic through early 2024, wages were found to have increased. These findings are puzzling when compared to what we observed in CMS' proposed cost weights. This analysis found that the average weekly earnings for healthcare employees had gone up 20.8 percent from $1,038 to $1,254 weekly in January 2024. Even more specific to IPPS, the report found that hospital workers wages saw a 20.3% increase between February 2020 to January 2024, going from $1,269 to $1,527 per week.[6] CMS also observed this shift in wages in the agency's analysis of audited wage data for FY 2020 to 2021 in the FY 2025 IPPS proposed rule, which saw larger increases in average hourly wages and wage indexes than compared to years prior.[7] Given these findings, we believe that CMS' methodology may not be accurately or fully capturing hospital labor expenses reflected in these trends.

To verify the validity of the agency's proposed changes, UC Health and other stakeholders often replicate CMS' calculations and estimates to verify the accuracy of proposed changes impacting hospital payment. Through this exercise, the California Hospital Association (CHA) was not able to replicate the proposed 66.0 percent labor-related share as CMS has not issued enough information on the intermediate steps used to determine the rebasing to allow stakeholders to fully replicate the agency's calculations with certainty and verify CMS' estimate. We understand the need for rebasing the labor share but request that CMS release additional information on how it arrived at its proposed estimate for the national labor-related share for FY 2026. **To accurately replicate and verify the labor related share, we request CMS publish a table of their intermediate steps reflective of the numerators and denominators utilized in each cost category and calculation step.** To that end, it would be helpful to also include the dollar values used to calculate the percentage of each cost category. Without this information and transparency, there are gaps in understanding that add challenges to interpreting how CMS calculates the proposed values used to establish the labor-related share. Lastly, this creates more challenges in providing valuable feedback without adequate understanding of how CMS has arrived at these proposed values for the labor-related share.

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[6] "What are the recent trends in health sector employment?" Peterson-KFF Health System Tracker, March 27, 2024.
[7] 89 FR 36151

Transforming Episode Accountability Model (TEAM)

In 2025, CMS finalized a new five-year mandatory episode-based payment model set to begin on January 1, 2026, to evaluate participating hospitals' performance on cost and quality metrics for five surgical episode categories:

- Coronary artery bypass graft (CABG)
- Lower extremity joint replacement (LEJR)
- Major bowel procedure
- Surgical hip/femur fracture treatment (SHFFT)
- Spinal fusion

TEAM will mandatorily enroll selected hospitals in certain geographic areas into retrospective bundled payments for these specified clinical episodes.

In response to the FFY 2025 IPPS TEAM proposals, UC Health shared detailed comments with CMS raising extensive concerns about the structure of the model including:

- Intentionally oversamples hospitals that can least afford to bear downside risk.
- Fails to account for all factors associated with medically complex patients
- Does not appropriately consider aggregate costs associated with hospital participation in the model, which are likely greater than CMS' projected savings from the program.
- May exacerbate access issues for safety net populations and providers.

UC Health submitted detailed 2025 comments that remain relevant today as CMS proposes to proceed with this mandatory model that has raised significant concerns among providers. UC Health appreciates CMS' proposed policy changes in response to stakeholder feedback and the agency's efforts to improve the model's design and more adequately account for appropriate risk adjustment factors, below we provide specific feedback on proposed TEAM proposals.

a. Low-Volume Threshold

CMS initially recommended a low-volume policy for TEAM in the FY 2025 IPPS proposed rule under which TEAM hospitals with less than 31 total episodes (across all episode categories) would be subject to Track 1 stop-loss and stop-gain limits in program year (PY) 1 and Track 2 stop-loss and stop gain limits in PYs 2-5. Considering public comments received and stakeholder concerns, however, CMS did not finalize this policy. In this proposed rule, CMS proposes to maintain its current policy of no low-volume episode policy for TEAM. However, CMS indicates it is considering potential future low-volume policies for TEAM and solicits public input on these ideas.

UC Health is concerned that CMS did not identify or propose an appropriate low-volume threshold in the rule. This is a problematic given the inherent volatility in episode-based payment models for organizations with insufficient volume. CMS notes that in prior CMMI models, including CJR and BPCI-A, low-volume hospitals faced challenges under two-sided financial risk arrangements due to year-over-year volatility in pricing resulting from low volumes of cases. Still, CMS does not propose any modification to address these identified challenges. **CMS should identify and adopt an appropriate low-volume threshold for the TEAM**.

Consistent with concerns raised by stakeholders after CMS' initial low-volume adjustment proposal last year, a low-volume threshold of 31 cases across five-episode categories across three baseline years is challenging. The purpose of a low-volume threshold is multi-faceted; it should ensure that hospitals have enough cases to integrate changes in care delivery and determine if they had an impact based on statistical significance. Additionally, it should ensure that the costs associated with standing-up infrastructure for model participation (like analytics infrastructure and staffing) can be offset by potential gains in the model. Financially, it also should provide protection against outliers and volatility inherent with small sample sizes. A threshold of 31 cases across five surgical episode categories and three baseline years would not accomplish any of these objectives.

In addition, it is concerning that CMS proposed only one, overarching low-volume threshold and not individual thresholds for each clinical episode category. For example, under the initially proposed low-volume threshold, a hospital could have 28 LEJR cases and one for each of the other clinical episode categories and still exceed the low-volume threshold required to participate in all 5-episode categories. This violates the principles of statistical significance and with only one case, a hospital has no opportunity for regression to the mean. If that one case is a complicated major bowel case, for example, which requires significant post-acute care, then they would be penalized even though the circumstances are beyond their control. This type of policy approach, or the absence of an adequate low-volume policy altogether, leaves TEAM participants vulnerable to the financial risks associated with random variation with low sample size.

UC Health supports CMS' consideration of a low-volume threshold that would apply to episode-specific categories in the baseline period for a given program year, similar to BPCI-A. Specifically, UC Health recommends CMS:

- **Increase the low-volume threshold to 91 cases across all five surgical episode categories** to ensure statistical significance and effectively mitigate potential impacts of outliers and volatility in cases.
- **Exclude hospitals not meeting the low-volume threshold from participation in the episode categories for which they do not have sufficient case numbers** so they are not unnecessarily exposed to financial risk for factors beyond their control.
- **Ensure that hospitals excluded from participation in certain episode categories as a result of not meeting the low-volume threshold still receive data for those episode categories.** This will help to ensure hospitals that may meet the threshold in future program years have appropriate baseline data to participate in future years if subsequently required.
- **Apply the low-volume threshold to all TEAM participants.** The threshold should not be arbitrarily limited to only safety net and rural hospitals. The statistical relevance of volume and the volatility associated with low case numbers exists regardless of the type of hospital.

b. Risk Adjustment

While CMS proposes certain modifications to improve the TEAM risk adjustment model, UC Health is concerned that the methodology continues to be insufficient to wholly account for differences in risk that result in spending variation and lacks transparency needed to ensure its adequacy. Specifically, the agency proposes to include adjustments for age, HCCs and social risk, in addition to MS-DRG-specific target pricing. However, this is not sufficient to fully account for patients' clinical factors that lead to spending variation. This lack of a robust risk adjustment methodology penalizes hospitals treating the sickest, most complicated and historically marginalized patients. Researchers have recently confirmed that this phenomenon has occurred in CMS' other bundled payment models, which in many ways share substantial or even identical design features to TEAM. For example, researchers found that CJR may penalize hospitals that treat medically complex patients.[8] The agency's own recent findings identified

[8] Ellimoottil C, Ryan AM, Hou H, Dupree J, Hallstrom B, Miller DC. Medicare's New Bundled Payment for Joint

that CJR may in fact exacerbate disparities in elective LEJR for non-white beneficiaries.[9]

Safety-net hospitals, including UC Health, serve patients with complex social needs that can drive higher costs (e.g., lack of transportation leading to readmissions, inability to afford medications, etc.). TEAM does not adequately adjust for these social determinants. Even with the use of the Community Deprivation Index – hospitals could still face penalties for factors beyond their control. **Sufficient risk adjustment is critical to ensuring fairness for TEAM participants being held to standardized target prices per episode and to accounting for the wide range of factors that influence spending and therefore payment adequacy**.

With this in mind, UC Health urges CMS to:

- **Increase the hierarchical condition code (HCC) lookback period for risk adjustment from 180 days to 12 months**. This is consistent with other CMMI models including BPCI-A and is necessary to ensure appropriate risk adjustment for episodes, especially in procedures for patients with certain chronic conditions.
- **Provide greater transparency in the specific risk adjusters being used for the TEAM**. CMS has not provided a complete list of risk adjusters that it plans to use, resulting in an opaque methodology where participants will see the target price for the episode before and after risk adjustment but will not have full visibility into the risk adjusters used to calculate the target price. If specific risk adjusters are transparently identified, TEAM participants can proactively address these areas to improve patient care, outcomes, and engagement with the model.
- **Ensure sufficient hospital-specific risk adjustment methodology**. CMS indicates that hospital-specific risk adjustment is included, but in the absence of greater transparency regarding the specific risk adjusters, UC Health wishes to emphasize the importance of organization-level adjustments. This is especially critical in a model using regional-based pricing approaches. For example, there are substantial differences between a large academic medical center in California, including UC academic medical centers, and a small community hospital in Alaska that are both within the same proposed region for the purpose of TEAM's regional target prices. CMS should ensure adequate hospital-level adjustment to account for these potentially vast differences in TEAM participants within the same region. The inclusion of hospital characteristics, such as rural/urban location, safety net status, size, and teaching status, among others, in the risk adjustment model will further improve the pricing accuracy for participants

c. Risk Adjustment for Major Bowel Procedures

Risk adjustment for the major bowel procedure episode category may be inadequate and CMS should evaluate whether additional adjustment is needed to appropriately reflect the differences in cost associated with elective versus non-elective major bowel procedures. Data reflect that the cost of non-elective major bowel procedures can be significantly higher than the cost of elective major bowel procedures, but it is unclear whether the TEAM risk adjustment methodology sufficiently accounts for this importance difference.

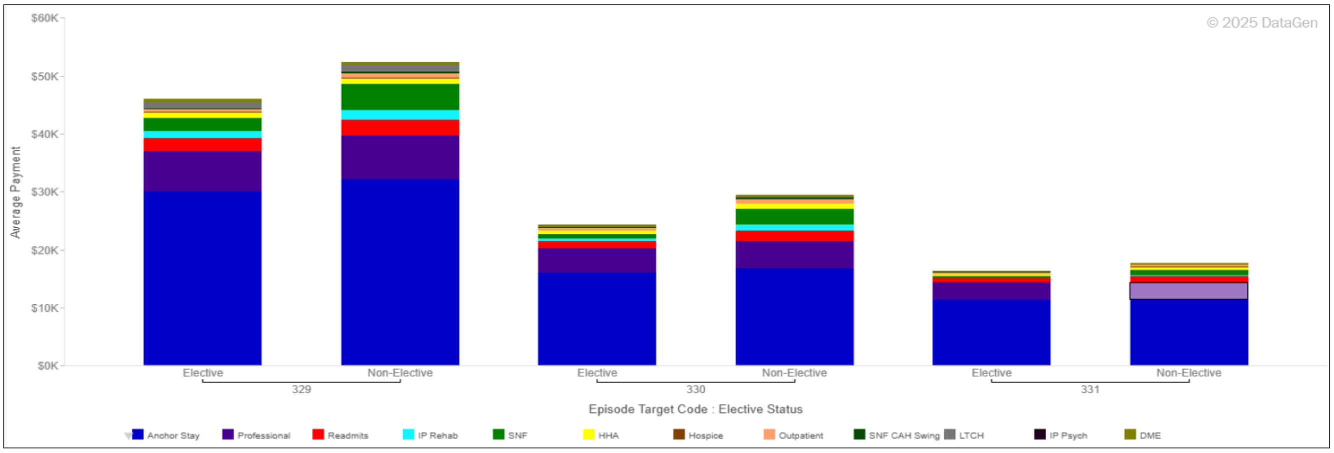
Specifically, a 2025 DataGen analysis of simulated episodes of care created according to the TEAM episode specifications published in the IPPS FY 2025 Final Rule suggests that additional risk adjustment may be needed to better understand Medicare spend for major bowel procedure episodes. A stratified

Replacement May Penalize Hospitals That Treat Medically Complex Patients. Health Aff (Millwood). 2016; 35(9):1651–7.

[9] https://www.cms.gov/priorities/innovation/data-and-reports/2023/cjr-py5-ar-findings-aag

analysis of major bowel procedure episodes by anchor admission MS-DRG and elective/non-elective status (defined by anchor admission admit type code) indicates a notable difference in Medicare episode spend. Using simulated episodes of care with anchor admission discharge dates in calendar year 2023 created from the national Medicare Standard Analytic File Limited Data Sets, **the percent change in Medicare episode spend comparing non-elective episodes to elective episodes is 14.0% for MS-DRG 329, 20.9% for MS-DRG 330, and 7.7% for MS-DRG 331.**[10,11]

Elective versus Non-Elective Major Bowel Procedure by MS-DRG



The visualization above represents the average Medicare episode spend (in standard/normalized dollars) for major bowel procedure episodes with an anchor admission discharge date during CY 2023. The average Medicare episode spend is stratified by the trigger code of the inpatient admission and elective/non-elective status. Elective/non-elective status was defined using the admit type code on the anchor admission claim. The stacked vertical bars indicate the average Medicare episode spend by the types of claims/services utilized during the episode time period.

There is significant divergence between the Medicare episode spend for elective and non-elective procedure categories. CMS must ensure these differences are appropriately captured in the TEAM risk adjustment methodology.

d. Primary Care Referral Requirements

In last year's 2025 IPPS final rule, CMS finalized a requirement for TEAM participants to refer participating beneficiaries to primary care services on discharge from an anchor hospitalization or after an anchor procedure. This would be required prior to discharge and in accordance with beneficiary choice requirements. Organizations that do not comply would be subject to remedial action. While many hospitals already provide such referrals, we urge CMS not to require this action and to remove

[10] ©2025 DataGen®, Inc.

[11] DataGen simulated Transforming Episode Accountability Model episodes of care according to the specifications detailed in the Inpatient Prospective Payment System Fiscal Year 2025 Final Rule using the national Medicare Standard Analytic File Limited Data Sets. The source data contains 100% of the claims for institutional settings of care (inpatient hospital, outpatient hospital, skilled nursing, home health, and hospice) and non-institutional claims (carrier and durable medical equipment) for a 5% statistical sample of Medicare FFS beneficiaries. Carrier and durable medical equipment expenditures for beneficiaries not included in the 5% statistical sample are extrapolated by episode parameters (i.e., anchor episode MS-DRG or HCPCS code, first setting of post-acute care, beneficiary age group, beneficiary dual eligibility status, region, and claim setting).

penalties for non-compliance. This requirement fails to account for many hospital circumstances, such as those that may be in provider shortage areas, or for situations where patients are offered a referral but decline the option.

CMS also requests stakeholder comment on whether the primary care referral should be made to a provider or supplier with whom the patient has an existing relationship. CMS is urged to avoid adopting this policy as a mandatory requirement. While efforts to secure appropriate discharge planning and follow-up care are standard operating practices for hospitals, a requirement for a referral to be to an existing provider may be impossible in cases where the is no such established provider, and at a minimum, would be administratively burdensome for hospitals to identify the other known care providers of every patient they treat. This is especially true for larger hospital systems, including UC Health, that frequently treat patients from a wide service area and cannot reasonably be aware of or have active referral practices with providers in remote cities or counties outside of their primary service area. Accordingly, UC Health urges CMS to not adopt this as a mandated requirement, and further, to avoid imposing specific referral requirements or penalties that hospitals may not reasonably be able to meet even when making good faith efforts to coordinate appropriate follow-up care post-discharge.

e. Additional TEAM Recommendations

There are several other policy approaches CMS proposes or seeks input on in the 2026 proposed rule, all of which may impact the success and participation of TEAM-mandated hospitals

UC Health recommends CMS:

- **Proactively notify TEAM participants as soon as possible whether they meet CMS' definition of safety net hospital.** Confirmation of participation as a safety net hospital is needed to provide participants with certainty regarding whether they qualify under CMS' definition of safety net hospital given the significant implications this has for the model track, risk sharing arrangement, and other requirements. Current model design suggests participants wouldn't be formally alerted to their track participation assignment and safety net status until the end of the year. With a model start date of January 1, this is simply too late. Participants need greater certainty about their participation track ahead of time. CMS should also be more specific regarding the information and documentation used to validate hospitals' participation as a safety net provider to ensure full clarity and transparency.

- **CMS should use real dollars instead of standardized dollars to calculate target prices and reconciliation amounts.** When setting target prices, CMS will use the standardized Medicare episode spend across the three-year baseline period for each region. This means the Medicare spend per episode will not reflect provider-specific payment adjustments like the wage index or penalties associated with various Medicare quality programs. In other words, any elements that would make one provider's Medicare payment different from another provider's payment for the same claim are removed and re-added later at reconciliation. CMS requests input on this methodology in the proposed rule. While UC Health recognizes the significant challenges inherent in standardizing dollars, CMS is urged to use real dollars instead of a market standardized dollar approach, consistent with the past CMMI models such as CJR to best account for differences in hospitals' episode expenditures in relation to the target.

- **Streamline and reduce the administrative burden of CMMI TEAM audits**. While program audits play an important role in ensuring compliance with federal rules and CMMI requirements, CMMI should streamline the audit process to ensure TEAM audits are conducted at the appropriate timing and intervals, are constructive in providing participants with usable feedback, and result in meaningful interaction between auditors and participants that support quality and performance improvement. Hospitals have reported that audits for prior CMMI models have been inconsistently timed, sometimes including multiple audits within a 3-month period, and yet provide limited opportunity for engagement or feedback that contributes to learning and/or performance improvement. A more streamlined and standardized process is needed to both reduce unnecessary administrative burden and spur more meaningful interaction and assessment.

Graduate Medical Education Provisions

UC Health appreciates CMS restating and clarifying its longstanding policies used to determine FTE counts and caps for Direct Graduate Medical Education (DGME) and Indirect Medical Education (IME) reimbursements in cost reporting periods other than twelve months. Because no resident may be counted as more than 1.0 full-time equivalent (FTE) in a twelve-month period, certain adjustments to the standard twelve-month FTE determination must be made in cost reporting periods other than twelve months. [12] While CMS is not proposing a new policy for determining FTE counts or caps in nonstandard cost reporting periods, the transparency and public evaluation of the current policies is welcomed by UC Health. Also, CMS's commitment to listen to stakeholders is helpful to refine the overall efficacy of these policies. If stakeholders raise legitimate concerns about this or other policies, CMS should thoughtfully consider their feedback and remain responsive to their input.

a. Nursing and Allied Health Programs

A hospital's reasonable costs for nursing allied health education are net of revenues received from tuition and student fees. Current CMS cost-reporting instructions require that revenues from tuition and student fees be subtracted from the costs of nursing and allied health education *prior to allocating indirect costs*. Several hospitals filed a suit against CMS, disputing the order of operations for determining net costs for pass-through payments. As a result, the U.S District Court of Columbia ruled in favor of the plaintiffs, finding that revenue from tuition and student fees should be subtracted from the cost of educational activities *after allocating indirect costs*.

In this rule, CMS is proposing to modify the regulations to indicate that revenues received from tuition, student fees, textbooks purchased for resale, and other revenue from or on behalf of students is subtracted *before completing the indirect cost allocation,* effective Oct. 1, 2025. In a circumstance where revenue from or on behalf of students reduces direct nursing and allied health education costs to zero, there would be no indirect costs to allocate to the nursing and allied health education cost center.

However, CMS will allow a hospital to seek permission from its Medicare Administrative Contractor to employ a different allocation method to mitigate the reduction in reasonable cost payment for nursing and allied health education. This alternative allocation of indirect costs would focus on only those costs that are directly related to the operation of approved educational activities. Such costs would not include nursing supervisors who oversee floor nurses and student nurses or costs that benefit the hospital as a whole and would also exclude the costs of a related organization (such as a home office).

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[12] Hospitals that successfully report quality measures and are meaningful users of electronic health records are eligible for the full payment update.

CMS' proposal appears counter to the court's decision, which for the purpose of the indirect cost allocation is to allocate administrative and general costs that support the entire institution to each direct cost center on the Medicare cost report. Direct costs are those expenses that can be directly related to the production of specific services within the hospital. Indirect costs, unlike direct costs, cannot be easily traced to a specific product or service. These expenses are necessary for the overall operation of the hospital but are not directly tied to any individual service the hospital provides.

By subtracting revenues received from tuition and books before the allocation, as CMS proposes, the nursing and allied health education cost center will receive less than its share of the allocation of indirect costs that are being used to support the department. **UC Health asks CMS to reconsider its proposed changes that would unfairly penalize hospitals that receive reasonable payment for nursing and allied health education**. As structured, even with the alternative allocation of indirect costs, CMS' proposed changes would preclude any indirect costs from being allocated to the nursing and allied health education cost center.

Thank you again for the opportunity to submit these comments on the FY 2026 Medicare IPPS Proposed Rule. If you have any questions, please contact Kent Springfield at (202) 993-8810 or kent.springfield@ucdc.edu.

Sincerely,

Tam Ma
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Health Policy and Regulatory Affairs