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 Safety-Net Association of Pennsylvania (SNAP), a group of private safety-net hospitals that care for especially large numbers of Medicaid patients, 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.

SNAP 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. SNAP also offers comments below on the proposal related to the post-acute transfer policy.

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 reflect hospitals' commitment to innovation, efficiency, and responsible stewardship of limited healthcare dollars, including through hospital-at-home models, expanded telehealth, preventive care, and use of lower-cost sites of service where appropriate. While these strategies can help improve value over time, they cannot fully offset the sharp and sustained increases in labor, supply, and operational costs that hospitals have faced since 2020. Safety-net hospitals in particular play a vital role in preserving access to care for low-income working families, seniors, and other vulnerable patients who often have nowhere else to turn. A payment update that more accurately reflects today's cost environment is necessary to help these hospitals remain financially stable, continue serving their communities, and reduce the risk of cost-shifting or service reductions that would ultimately undermine local access to care.

SNAP joins other hospital advocates including the American Hospital Association in urging CMS to reconsider the assumptions used in 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 use of the 10-year moving average of changes in economy-wide private non-farm business productivity no longer makes sense for hospital productivity predictions when hospitals face the kind of labor-intensive services and limited flexibility that other economy-wide actors do not face. Accordingly, SNAP 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. SNAP is concerned that this reduction may further strain hospitals that serve communities with significant unmet health needs. For safety-net hospitals, uncompensated care payments are not a subsidy for inefficiency; they are a practical support that helps keep essential hospital services available for low-income working families, seniors, Medicaid beneficiaries, and other patients who depend on reliable local access to care. As CMS projects growth in the national uninsured rate, reducing these payments risks shifting greater costs onto hospitals that already operate with limited margins while continuing to treat every patient who comes through their doors. When safety-net hospitals are weakened, communities can face reduced service lines, longer travel times for care, more pressure on emergency departments, and greater downstream costs for taxpayers. Accordingly, SNAP urges CMS to reconsider these proposed payment reductions and to ensure that DSH payment policy reflects the vital role safety-net hospitals play in preserving access, supporting community stability, and caring for vulnerable patients in a fiscally responsible manner.

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. SNAP cautions CMS against expanding this policy, which places additional financial strain on hospitals that treat short-stay patients who have complex and costly needs.

Safety-net hospitals often treat Medicaid and uninsured patients with greater clinical complexity, untreated chronic conditions, and non-medical barriers that make care more costly, especially in the first days of admission. Early transfer to post-acute settings does not eliminate these front-loaded costs; it simply reduces reimbursement for care the hospital has already provided. While CMS appropriately recognizes that the first day is especially resource-intensive, that same reality often extends through the first several days for the patients safety-net hospitals serve.

For these reasons, SNAP urges CMS not to expand the list of MS-DRGs subject to the post-acute transfer policy. If CMS moves forward, it should include safeguards for safety-net hospitals, such as targeted exceptions or payment protections for hospitals caring for more complex patients.

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. SNAP urges CMS to adopt a voluntary approach to participation in CJR-X. While the original CJR model generated savings in certain circumstances, it was not designed as a mandatory nationwide model and mandatory participation may be particularly challenging for hospitals that lack the infrastructure, alignment, or market leverage necessary to manage post-acute care effectively. Accordingly, SNAP urges CMS to finalize a voluntary participation framework for CJR-X rather than a broad mandatory expansion.

CJR Environment Was Different

When CMS launched CJR, it applied the model in 34 metropolitan areas with historically high LEJR spending, where the agency believed savings opportunities were greatest. A nationwide mandatory CJR-X model would extend participation to hospitals with less ability to generate similar savings. In addition, Medicare Advantage enrollment has grown substantially since CJR was developed, rising from about 32 percent of Medicare beneficiaries at that time to 54 percent in 2025. This shift shrinks the traditional Medicare claims base used to set benchmarks and leaves hospitals with fewer fee-for-service episodes through which to redesign care and achieve savings.

Prevent Losses for Safety-Net and Rural Providers

Annual CJR evaluation reports showed that safety-net hospitals were more likely than other hospitals to owe Medicare reconciliation payments under CJR, underscoring that these providers often lack the same opportunity to generate savings under episode-based payment models. CMS recognized this reality in TEAM by shielding safety-net hospitals from downside risk and we recommend CMS do the same for them in CJR-X if it is finalized. These hospitals care for patients with greater medical and social complexity, face lower episode volume, and often have less control over post-acute care patterns and community resources—all of which make it harder to reduce spending without risking access or quality. For that reason, applying only a five percent stop-loss in CJR-X is not sufficient.

Similar concerns apply to rural hospitals, which often operate with low volume, limited post-acute care infrastructure, workforce shortages, and fewer opportunities to redesign care in ways that produce measurable savings under the model. These structural constraints make rural hospitals less able to succeed and more vulnerable to losses. CMS should therefore apply rural protections – specifically protections from downside risk – to all rural hospitals including those treated as rural for Medicare payment purposes, to avoid penalizing providers that simply do not have the scale or market conditions needed to generate savings.

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. SNAP 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. SNAP 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 given the foundational differences between licensed hospitals and licensed ASC providers.

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 and other non-medical health factors that can affect episode costs. By contrast, many

ASCs have the ability to structure service lines, scheduling, and patient selection in ways that concentrate lower-acuity, more predictable cases. 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. SNAP does not support the inclusion of ASC-initiated episodes in TEAM, and if CMS pursues this in future rulemaking, it must establish a separate methodology for ASC episodes rather than blending ASC and hospital experiences into a common benchmark or target price.

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. SNAP 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 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. SNAP offers feedback on these two items below.

Allocation of Purchased Services

SNAP is concerned that CMS's proposal would upend a longstanding and practical approach hospitals use to complete the Medicare cost report. Rather than creating clarity, the proposal could make cost reporting more complicated, less consistent, and more burdensome—especially for hospitals already operating with limited staff and resources – and have minimal effect on Medicare reimbursement overall.

For safety-net hospitals in particular, this matters because even small administrative changes can carry real operational consequences. These hospitals rely on workable reporting methods so they can focus their time and resources on patient care, not added paperwork. After many years of using this allocation approach, hospitals have built systems around it, and changing course now would create disruption with little clear benefit.

SNAP is also concerned that the proposal could reduce transparency by limiting how certain costs are recognized without clearly saying so. If CMS wants to revise hospital cost allocation rules, it should do so through a uniform, transparent approach that is consistent with longstanding Medicare principles and does not impose unnecessary burden on hospitals that are already stretched thin.

SNAP member hospitals are especially vulnerable to this change because cost report data affects important programs supporting these hospitals, including DSH surveys and community benefit reporting. Hospitals cannot yet estimate the full downstream impact, which makes this proposal even more concerning. At the same time, the financial effect of this policy appears limited. The costs involved make up only a small share of overall overhead allocations, so the proposal is

unlikely to meaningfully change reimbursement. What it would do, however, is add new administrative burden. In short, this proposal would create added complexity and potential unintended consequences without a clear payoff. If CMS wants to revisit cost allocation policy, it should do so through a uniform, transparent approach that is consistent with longstanding Medicare principles and does not place unnecessary strain on hospitals serving high-need communities.

Nursing and Allied Health Education Costs

CMS's proposal would require hospitals to break apart shared overhead costs for nursing and allied health education (NAHE) programs in a much more detailed way. While framed as a clarification, this would amount to a meaningful change in how hospitals complete the cost report and would add significant administrative work. SNAP urges CMS not to move forward with this policy at this time. The underlying rules in this area have not been clearly settled through prior rulemaking or guidance, and CMS has not shown that hospitals are broadly misallocating these costs. As a result, the proposal risks creating confusion and burden without a clear policy need.

For safety-net hospitals, that burden matters. These hospitals already operate with limited staff and resources, and added reporting complexity pulls time and attention away from patient care and workforce training. At a time when hospitals are working to sustain critical education programs, CMS should avoid imposing new paperwork requirements that offer little clear benefit.

If CMS believes additional guidance is necessary, it should pursue a more straightforward and transparent approach that is consistent with longstanding Medicare principles and practical for hospitals to implement.

Conclusion

The Safety-Net Association of Pennsylvania 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,

Michael Chirieleison
President