Illinois Health and Hospital Association

June 5, 2025

Honorable Mehmet Oz, MD
Administrator
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244

RE: CMS-1833-P: Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the and Policy Changes and Fiscal Year 2026 Rates; Requirements for Quality Programs; and Other Policy Changes

Dear Administrator Oz:

On behalf of our more than 200 hospitals and nearly 40 health systems, the Illinois Health and Hospital Association (IHA) appreciates the opportunity to comment on the fiscal year (FY) 2026 Inpatient Prospective Payment System (IPPS) proposed rule. We appreciate the focused and streamlined nature of the FY 2026 proposed rule, as well as the opportunity to provide input on regulatory burdensome requirements that would benefit from the agency's reexamination. To that end, we submit the following comments.

FY 2026 IPPS Proposed Payment Update

We have serious concerns about CMS' proposed IPPS market basket update of 3.2% less a productivity adjustment of 0.8 percentage points. The resulting net 2.4% rate increase is simply too low to adequately support our nation's hospitals, particularly considering the very real cuts to the Medicaid program currently being discussed by Congress. **We strongly urge CMS to reexamine the policies and methodologies utilized in updating hospital Medicare payment rates.** For the past several years, the current time-lagged approach has resulted in rate updates that are inadequate and inconsistent with the actual economic environment hospitals ultimately face.

In Illinois, we estimate CMS' proposed rule will only increase IPPS payments by 0.4% compared to FY 2025 IPPS payments. This extremely low proposed payment update comes at a time when hospitals face rising supply costs, pharmaceutical costs that are growing 15-35%,[1] and a workforce shortage that continues to get worse as our population ages. Coupled with the expected increase in uninsured Americans over the next several years, it is more important than ever that CMS reexamine the Medicare payment system. This inadequate proposed payment update, coupled with the fiscal

[1] https://www.aha.org/news/blog/2024-05-22-drug-prices-and-shortages-jeopardize-patient-access-quality-hospital-care

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pressures and policy headwinds our hospitals are facing, will lead to closures across the country.

DSH Payments and the Uninsured Rate

For FY 2026, CMS estimates that empirically justified disproportionate share hospital (DSH) payments will be $3.92 billion and the 75% pool will be approximately $11.76 billion. After adjusting the 75% pool to account for the uninsured rate, CMS estimates that the pool will total approximately $7.14 billion, resulting in an increase in DSH and uncompensated care payments of $1.5 billion compared to FY 2025.

The current DSH payment methodology was structured to decrease over time as coverage expansion established under the Affordable Care Act (ACA) took effect and the country realized reductions to uncompensated care. However, the coverage expansion envisioned under the ACA was never fully realized following the 2012 Supreme Court decision in *National Federation of Independent Business et al v. Sebelius*. This has become even more problematic as uninsured rates have increased since the COVID-19 pandemic[2] coupled with recent executive orders and regulatory proposals that would effectively cut Medicaid and result in fewer Americans gaining health insurance through the marketplace exchange.

Given the increasing uninsured rate and the increase in DSH payments proposed for FY 2026, we encourage the agency to reexamine the current methodology, particularly considering the Congressional Budget Office estimates that the uninsured rate will increase by 3.8 million people each year, on average, from 2026 to 2034.[3]

Low Wage Index Policy

IHA has long supported the spirit of the low wage index policy implemented via the FY 2020 IPPS final rule. This policy increased the wage indices for hospitals with a wage index value below the 25th percentile by half the difference between their otherwise applicable wage index value and the 25th percentile wage index value. However, CMS implemented this policy in a budget neutral manner through an adjustment to the standardized amounts for all hospitals, thereby penalizing all hospitals and undoing some of the benefit the policy was meant to bestow on low wage index hospitals. We have consistently held that the Secretary lacked authority to apply this policy in a budget neutral manner, an assertion that was upheld by the Court of Appeals for the D.C. Circuit on July 23, 2024.

Reacting to that court decision, CMS removed the low wage index policy last year for FY 2025, as well as the related budget neutrality factor. However, the agency did not indicate whether it would address the policy for FYs 2020-2024.

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[2] https://www.kff.org/uninsured/issue-brief/key-facts-about-the-uninsured-population/#:~:text=Without%20a%20permanent%20extension%2C%20the,of%20people%20who%20are%20uninsured.
[3] https://www.cbo.gov/system/files/2024-12/59230-ARPA.pdf

The reversal of this policy is once again addressed in the FY 2026 IPPS proposed rule, with the agency proposing a budget-neutral transitional exception policy for hospitals significantly impacted by the removal of the low wage index policy. However, the agency remains silent on FYs 2020-2024. **IHA echoes comments made by the American Hospital Association in Nov. 2024, urging CMS to refrain from seeking any claw back of funds that hospitals received because of the agency's mistakes.** These funds have long since been spent on patient care under a program that already pays far less than the cost of providing such care. Further, 42 U.S.C. § 1395ww(d)(3)(E) does not provide CMS or the Secretary of Health and Human Services the authority to claw back funds following an adverse judicial decision.

Removal of Social Drivers of Health Measures

IHA acknowledges CMS's decision to remove the social drivers of health (SDOH) screening measures from the Hospital Inpatient Quality Reporting Program. While our member hospitals appreciate the reduction in administrative burden associated with these reporting requirements, we maintain that screening for and addressing SDOH remains essential to patient care and directly supports CMS's goal of "Making America Healthy Again." Social factors such as food insecurity, housing instability, and transportation barriers significantly impact patient outcomes, readmission rates, and the ability to maintain wellness after discharge. Our members have made substantial investments in SDOH screening infrastructure, staff training, and community partnerships, and we appreciate the opportunity to operationalize this work in a way that is more appropriate than the one-size-fits-all approach previously implemented by CMS.

Illinois hospitals have found that systematic SDOH screening is crucial for identifying patients who may struggle to follow treatment plans, attend follow-up appointments, or maintain their health due to social barriers. This screening directly supports improved discharge planning, reduced readmissions, and better care coordination—all priorities outlined in CMS's TEAM Model and broader quality initiatives that ultimately make hospitals more efficient and have the potential to lower the cost of healthcare in this country. Importantly, these screening processes facilitate accurate identification and documentation of Z-codes in patient records, providing standardized data that supports population health management and risk stratification. Illinois hospitals have increased SDOH Z-code usage on claims by 109% from the start of 2022 to the end of 2024, and Z59-code usage [housing and economic circumstances] has increased by 191% over the same period. Of all claims with Z59-codes documented at the end of 2024, 40% were documenting homelessness, 23% were documenting food insecurity, and 18% were documenting transportation insecurity, demonstrating the substantial prevalence of these social needs across patient populations.

We appreciate the current reimbursement mechanisms tied to Z-59 codes for homelessness and strongly encourage CMS to consider similar reimbursement structures for other critical social risk factors such as food insecurity (Z-59.4) and transportation barriers, which would

incentivize appropriate identification and intervention for these equally impactful social determinants.

By maintaining robust SDOH screening and intervention programs, hospitals directly advance the wellness and nutrition goals central to Making America Healthy Again. Identifying and addressing food insecurity, for example, enables more effective nutrition counseling and ensures patients have access to healthy foods necessary for recovery and long-term wellness. Our hospitals remain committed to these efforts and look forward to collaborating with CMS on policies that support comprehensive, whole-person care while reducing unnecessary administrative burden.

Low-Volume and Medicare Dependent Hospitals

Our rural hospitals are the backbone of their communities, often serving as the economic engine for the families living in the towns in which they are located. There are several Illinois hospitals that receive a low-volume adjustment (LVA) or Medicare Dependent Hospital (MDH) consideration that rely on these payment adjustments to keep their doors open and continue serving their communities.

As in years past, the expiration of the current LVA and MDH policies on Sept. 30, 2025 would be devastating for these hospitals and the communities they serve. **While we understand it takes Congressional action to extend these programs, we urge CMS to exercise its influence with members of Congress to ensure the LVA and MDH programs are extended or, ideally, made permanent.** The continual need to extend these programs creates uncertainty and making them permanent would be a straightforward way to provide more financial stability to hospitals that provide essential, life-saving services.

Finally, IHA welcomes the agency's interest in considering additional ways to provide regulatory relief. We have submitted comments specific to Executive Order 14192, "Unleashing Prosperity Through Deregulation," through the website indicated in the proposed rule.

Long-Term Care Hospital High-Cost Outlier Threshold

For FY 2026, CMS proposes a high-cost outlier threshold of $91,247. This is the second year in a row that the high-cost outlier threshold has increased exorbitantly, requiring LTCHs to further absorb significant financial losses. This is counter to the original purpose of the LTCH PPS, which was to better recognize the severity of illness among LTCH patients while aligning payment for those services in a fashion that compensates providers for the efficient delivery of care to Medicare enrollees.

IHA appreciates the HHS Secretary's willingness to consider alternatives to mitigate the impact of the proposed high-cost outlier threshold increase, and we urge the Secretary to use the discretionary power granted to his office by Congress under the special adjustment authority to eliminate the proposed increase in the high-cost outlier threshold amount. The clinical and

financial challenges LTCHs have endured since the end of the pandemic have been difficult, with many LTCHs seeing marked increases in lengths of stay, base operating costs (salaries, benefits, supplies), and complexity of comorbid conditions as evidenced by higher case mix index levels. The proposed high-cost outlier threshold amount will create further disincentives for LTCHs to admit long-stay, high acuity complex cases.

Administrator Oz, thank you again for the opportunity to comment on this proposed rule.

Sincerely,

A.J. Wilhelmi
President & CEO
Illinois Health and Hospital Association