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Advancing High Performance Health

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The Honorable Dr. Mehmet Oz
Administrator
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244-1850

Re: [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:

On behalf of AMGA, we appreciate the opportunity to comment on the Centers for Medicare & Medicaid Services (CMS) Fiscal Year (FY) 2027 Inpatient Prospective Payment and Long-Term Care Hospital (LTCH) proposed rule.

Founded in 1950, AMGA is a trade association leading America's health care transformation. Representing multispecialty medical groups and integrated systems of care, we advocate, educate, innovate, and empower our members to deliver the next level of high-performance health. AMGA is the national voice promoting awareness of our members' recognized excellence in the delivery of coordinated, high-quality, high-value care. Over 177,000 physicians practice in our member organizations, delivering care to more than one in three Americans. Our members are also leaders in value-based care delivery, focusing on improving patient outcomes while driving down overall healthcare costs.

AMGA is pleased to offer comments on the FY 2027 Inpatient Prospective Payment System (IPPS) Proposed Rule for your consideration. Specifically, we are providing comments on the following proposals:

- **Payment Update:** AMGA urges CMS to acknowledge that the proposed IPPS update does not fully account for sustained labor, inflationary, and cross-system Medicare payment pressures, and to communicate to Congress the need for more accurate update methodologies.

- **Uncompensated Care Payments:** AMGA urges CMS to revisit its uncompensated care methodology and consider adjustments that more accurately reflect the current uninsured landscape and the operational realities facing hospitals and health

systems following the Medicaid continuous enrollment unwinding period.

- **Wage Index:** AMGA urges CMS to ensure wage index policies accurately reflect regional labor costs and do not disproportionately disadvantage hospitals already facing workforce and financial strain.

- **Graduate Medical Education:** AMGA recommends CMS provide clear, scalable compliance guidance for any new GME conditions while working with Congress to expand federally supported residency slots and strengthen the broader healthcare workforce pipeline.

- **Quality Programs:** AMGA generally supports CMS's FY 2027 hospital quality reporting proposals that advance clinically meaningful, outcomes-focused measurement while reducing unnecessary administrative burden, including new IQR measures, inclusion of Medicare Advantage beneficiaries in quality programs, and updates to the Promoting Interoperability Program. However, AMGA urges CMS to ensure robust clinical and social risk adjustment for the proposed sepsis readmission measure, carefully assess operational feasibility for new eCQMs, and retain health equity-related measures or establish alternative mechanisms that preserve accountability for identifying and addressing disparities in care delivery.

- **CJR-X Model:** AMGA recommends CMS make CJR-X voluntary rather than mandatory while continuing to align the model with TEAM and prior CJR policies to reduce administrative burden, leverage existing provider infrastructure, and support more effective care coordination and model participation.

Our detailed comments follow.

Payment Update

AMGA recognizes the proposed 2.4% operating payment update, derived from a 3.2% market basket increase reduced by a 0.8% productivity adjustment, reflects the agency's established methodology and existing statutory constraints. However, the update does not adequately reflect the financial pressures confronting AMGA members, particularly when viewed alongside concurrent developments across the Medicare payment landscape.

The market basket, by design, relies on historical cost report data, meaning the labor cost increases that reshaped hospital workforce budgets in the post-pandemic period are not yet fully captured in the proposed update. This lag is not merely a technical artifact — it represents a material and sustained mismatch between what current hospital labor costs and the assumptions embedded in the updated methodology. Hospital labor expenses, which typically account for 50% to 60% of total operating expenses, were fundamentally disrupted beginning in 2020 and have not normalized. Accelerated base wages, signing bonuses, and retention incentives became necessary to recruit and retain staff in a market where demand for nurses, technicians, and allied health professionals significantly outpaced supply.

In addition, reliance on contract and travel nursing staff — which carries a substantial cost premium over employed staff — became structural rather than episodic for many systems and

has proven difficult to fully unwind, even several years after the end of the public health emergency. The U.S. Bureau of Labor Statistics projects approximately 193,000 openings for registered nurses annually through 2032, reflecting continued retirements, workforce attrition, and sustained demand for nursing services nationwide. Against this backdrop, a productivity adjustment derived from economy-wide data is particularly ill-suited to inpatient healthcare delivery. The ACA-mandated productivity offset assumes hospitals can achieve gains comparable to sectors where capital substitution and automation are more readily available, an assumption that does not align with the realities of labor-intensive, clinically complex inpatient care.

AMGA members experience Medicare payment policy not as a series of isolated program silos, but as a combined financial reality spanning inpatient, outpatient, and ambulatory services. The Calendar Year (CY) 2025 Medicare Physician Fee Schedule conversion factor decreased by 2.83%, the fifth consecutive year of reductions for physicians. When modest Part A increases compound with Part B payment cuts across an integrated health system, the combined financial effect is materially worse than either figure in isolation suggests. Multispecialty groups and integrated delivery systems absorb these reductions simultaneously across inpatient and ambulatory operations, with limited ability to offset losses in one area through gains in another. This dynamic is especially acute for AMGA members serving a high proportion of Medicare and Medicaid beneficiaries and operating with limited ability to cross-subsidize losses through commercial reimbursement.

At the same time, federal and state Medicaid funding faces projected declines, while the uninsured rate is expected to rise to 9.1% in FY 2027.[1] As a result, safety-net providers within AMGA membership face a convergence of financial pressures the IPPS update formula was not designed to capture. AMGA addresses the proposed decrease in Disproportionate Share Hospital (DSH) uncompensated care (UC) payments in greater detail below; however, we note here that the simultaneous combination of an inadequate payment rate update and reduced supplemental DSH support — at precisely the moment when uninsurance projected to increase — compounds these financial pressures in ways that cannot be evaluated in isolation.

AMGA urges CMS to acknowledge these cumulative pressures in its assessment of the update's adequacy and, where the agency lacks statutory discretion to act, to communicate clearly to Congress the limitations of current update methodologies in reflecting the true cost of providing care to Medicare beneficiaries.

Decrease to Uncompensated Care Payments to Disproportionate Share Hospitals

AMGA is concerned that CMS's proposal to decrease Disproportionate Share Hospital (DSH) uncompensated care (UC) payments to approximately $7.46 billion in FY 2027 does not adequately reflect current Medicaid enrollment trends or the growing uninsured population resulting from the unwinding of the Medicaid continuous enrollment requirement.

CMS's methodology relies on a three-year lookback using the most recent audited cost report data to estimate uncompensated care and uninsured rates. However, this approach significantly

[1] https://www.cms.gov/files/document/certification-rates-uninsured-fy-2027-proposed-rule.pdf

lags current coverage realities and fails to capture the substantial coverage losses that have occurred following the end of the COVID-19 continuous enrollment protections. CMS Medicaid enrollment data, released in January 2026, shows a 20% decline (representing about 20 million disenrollments) between March 2023 and January 2026.[2] CMS's proposal to use data from the three most recent years of audited cost reports underestimates the uninsured by failing to account for the unwinding of continuous enrollment, which began in April 2023.

Any projection of uncompensated care payments in FY 2027 must account for changing enrollment dynamics and require a more informed modeling methodology to better incorporate real-time Medicaid enrollment trends, changes in the uninsured rate, and emerging indicators of the uncompensated care burden.

AMGA members serve patients in communities where financial barriers, lack of coverage, and unmet social needs drive high rates of uncompensated care. Reducing uncompensated care payments at a time of significant Medicaid disenrollment destabilizes safety-net providers, which are essential to preserving access to services for vulnerable populations, forcing them to absorb uncompensated care costs amid an already strained economic environment.

Removal of the Low Wage Index Policy

AMGA appreciates CMS's continued efforts to transition away from the temporary low wage index policy and recognizes the agency's proposal to implement a final year of transition relief for hospitals most significantly impacted by the policy's expiration. While the low wage index policy was initially implemented to support hospitals with wage indexes below the 25th percentile, the policy has also introduced broader budget neutrality impacts across the Medicare wage index system that have affected hospitals in other labor markets, including many AMGA members operating in high-cost areas.

AMGA supports CMS's efforts to provide a measured transition approach that balances stability for hospitals that benefited from the policy with the need to gradually restore the underlying wage index methodology. At the same time, AMGA continues to encourage CMS to carefully evaluate the cumulative effects of wage index-related policies, including the rural floor, permanent 5% cap, and Medicare Geographic Classification Review Board reclassifications, which together can create significant re-distributional impacts across hospitals and regions.

As CMS continues to refine the wage index methodology using more recent cost reporting data, AMGA encourages the agency to ensure that payment adjustments appropriately reflect regional labor cost differences and support hospitals' ongoing investments in workforce recruitment, retention, and access to care.

Graduate Medical Education

CMS proposes to condition Graduate Medical Education (GME) payments on non-discrimination within residency training programs, while applying equivalent standards to approved nursing and allied health education programs and their accreditors. Regardless of how this condition is ultimately structured in the final rule, CMS should provide clear and detailed compliance

[2] https://www.medicaid.gov/medicaid/program-information/medicaid-and-chip-enrollment-data/report-highlights/index.html

guidance before implementation. Smaller teaching hospitals and rural training programs, which often operate with limited administrative infrastructure and narrower financial margins, face a disproportionate compliance burden relative to larger academic medical centers with dedicated legal and regulatory staff. CMS should ensure that guidance is specific, accessible, and scalable to programs of all sizes, while also providing adequate implementation time to demonstrate compliance without jeopardizing critical GME funding.

Given a projected shortage of up to 86,000 physicians by 2036, expanding the supply of clinicians is not a peripheral issue, but one of the most consequential healthcare policy challenges facing the nation.[3] Policies that create unnecessary administrative complexity or financial uncertainty for training programs risks constricting the very workforce pipeline the healthcare system urgently needs to expand.

More broadly, AMGA urges CMS and Congress to view the FY 2027 rule as an opportunity to address the physician workforce crisis more directly. Medicare currently provides more than $16 billion annually in GME funding, covering approximately 75% of residency training costs; however, this investment has not kept pace with growing physician demand.[4] Despite a 33% increase in medical school enrollment since 2002, the number of federally supported GME positions has not proportionally expanded, largely due to longstanding statutory caps.[5] Section 126 of the Consolidated Appropriations Act of 2021 represented an important, though modest, step forward, yet nearly half of the residency slots authorized under that provision remain undistributed.

AMGA urges CMS to prioritize redistribution of these unused slots to hospitals and integrated systems that are best positioned to train physicians in high-need specialties and underserved communities. More fundamentally, AMGA calls on Congress to lift the cap on federally funded residency slots altogether. AMGA members employ more than 177,000 physicians across multispecialty and integrated delivery systems; an adequate pipeline of residency-trained physicians is not an abstraction for our members, but an operational necessity for meeting the healthcare needs of Americans.[6]

AMGA also notes with concern the Department of Education's recently finalized RISE rule, which narrows the definition of "professional student" for federal loan purposes to 11 designated fields, excluding nursing, physician assistants, physical therapy, occupational therapy, and other allied health professions from the higher annual borrowing limits available to professional degree students. AMGA members operate integrated, multispecialty delivery systems in which physicians work closely alongside these healthcare professionals, making the adequacy of those workforce pipelines just as operationally critical as physician supply itself.

Reducing loan access for students entering these professions—at a time when workforce shortages in nursing and allied health are already severe, and approximately 107 million Americans live in a primary care Health Professional Shortage Area—risks exacerbating the very

[3] https://www.aamc.org/media/75236/download?attachment
[4] https://www.gao.gov/assets/gao-21-391.pdf
[5] https://www.aamc.org/media/47726/download
[6] https://www.amga.org/

gaps that expanded GME investment is intended to address.[7] AMGA therefore urges CMS to communicate to Congress and relevant federal agencies that workforce policy must be evaluated in a coordinated and integrated manner across agencies and programs, and that policies which constrict the allied health workforce pipeline directly undermine broader efforts to expand the nation's healthcare workforce.

Quality Reporting Programs

AMGA appreciates CMS's continued efforts to refine quality reporting programs in ways that reduce provider burden while improving measure reliability and clinical relevance. AMGA's Value Measure Set, endorsed by our Board of Directors in 2018 and reflected in CMS's Universal Foundation of Measures, informs our longstanding contention that quality measurement should be evidence-based, outcomes-focused, clinically meaningful, and streamlined to avoid duplicative reporting while preserving accountability for the outcomes that matter most to patients. AMGA evaluated the FY 2027 quality reporting proposals through that lens.

Hospital Inpatient Quality Reporting Program — New Measures

AMGA supports the addition of new IQR measures addressing excess days in acute care following diabetes hospitalization, postoperative venous thromboembolism, and advance care planning, as these measures are broadly consistent with the principles underlying AMGA's Value Measure Set: evidence-based, outcomes-focused, and clinically meaningful quality measurement. The diabetes excess days measure, in particular, aligns with AMGA's longstanding emphasis on reducing preventable utilization among patients with poorly managed chronic disease, which is reflected in our Value Measure Set through measures focused on HbA1c poor control and ambulatory sensitive condition admissions.

At the same time, AMGA continues to emphasize that quality measurement should remain parsimonious and strategically aligned. The addition of new measures should ideally replace or consolidate existing reporting requirements, rather than create additional layers of administrative burden. AMGA therefore encourages CMS to ensure these measures are integrated into the Universal Foundation framework and used to streamline reporting obligations where possible.

AMGA also urges CMS to carefully evaluate the operational feasibility of the proposed advance care planning eCQM across diverse EHR platforms and care settings before mandatory implementation. Providers may face significant workflow integration and documentation challenges depending on system capabilities and interoperability limitations. Early and ongoing provider engagement will be critical to identifying implementation barriers before these measures carry reporting or payment consequences.

Hospital Readmissions Reduction Program — Sepsis Measure

AMGA supports CMS's proposal to add a 30-day all-cause readmission measure following sepsis hospitalization to the Hospital Readmissions Reduction Program. The reduction of avoidable readmissions is directly reflected in AMGA's Value Measure Set, and extending this accountability framework to sepsis hospitalizations is consistent with our members' commitment to improving care transitions, reducing preventable harm, and limiting

[7] https://data.hrsa.gov/topics/health-workforce/shortage-areas/dashboard

unnecessary utilization.

However, AMGA notes that sepsis patients often present with substantial clinical complexity and significant social risk factors that vary considerably across patient populations and geographic regions. As a result, AMGA urges CMS to ensure that the measure incorporates robust clinical and social risk adjustment methodologies before the measure is tied to payment penalties. Without adequate adjustment, the policy could disproportionately disadvantage safety-net, rural, and other providers caring for medically and socially complex populations, potentially undermining the goals of the HRRP.

Health Equity Measures

AMGA strongly opposes CMS's proposal to remove health equity-related measures from the IQR program, including the Hospital Commitment to Health Equity, Screening for Social Drivers of Health, and Screen Positive Rate measures. As AMGA noted in prior comments, social drivers of health play a substantial role in patient outcomes and healthcare utilization, and these measures serve as important tools for transparency, accountability, and quality improvement efforts across patient populations.

Removing these measures would come at a time when many providers are facing increasing social complexity among their patient populations due to rising uninsurance rates and Medicaid coverage disruptions. AMGA believes that maintaining visibility into patient social risk factors is essential to advancing equitable care delivery and improving outcomes.

Medicare Advantage Population Inclusion

AMGA supports CMS's proposal to include Medicare Advantage beneficiaries in mortality and readmission measures across hospital quality reporting programs. Incorporating MA populations will improve the accuracy and representativeness of performance comparisons by more fully reflecting the patient populations served by providers operating across both Traditional Medicare and Medicare Advantage.

AMGA encourages CMS to continue monitoring the statistical reliability of these measures, particularly for low-volume hospitals and specialties, to ensure that inclusion of MA beneficiaries does not unintentionally introduce instability or distort performance assessments.

Medicare Promoting Interoperability Program

AMGA supports CMS's proposed updates to the Promoting Interoperability Program to align with current Office of the National Coordinator for Health Information Technology certification standards. Digital health capabilities, including telehealth and remote patient monitoring, are increasingly central to care coordination, chronic disease management, and patient engagement in value-based care models.

As CMS continues to advance interoperability and public health data exchange initiatives, AMGA encourages the agency to explicitly recognize the role these technologies play in reducing administrative burden, improving longitudinal care management, and supporting proactive patient engagement between episodes of care. Consistent with AMGA's longstanding position, these capabilities should be recognized not as supplemental tools, but as core infrastructure supporting integrated, value-based healthcare delivery.

Proposed Expanded Comprehensive Joint Replacement (CJR-X) Model

While AMGA supports CMS's broader goal of advancing accountable care relationships by 2030, AMGA strongly urges CMS to make the proposed CJR-X model voluntary rather than mandatory. Given the significant financial pressures currently facing hospitals, ongoing workforce shortages, and continued instability across the post-acute care sector, mandating participation in a significantly expanded payment model is both premature and potentially counterproductive.

Importantly, the previous CJR model was not tested across a broad or diverse set of Metropolitan Statistical Areas (MSAs) to justify expansion into a nationwide mandatory model. A voluntary approach would allow CMS to continue building a more mature and operationally informed model based on additional real-world experience. At a time when many hospitals continue to face financial and operational strain, CMS should avoid policies that could inadvertently increase financial risk or destabilize access to care. Making CJR-X voluntary would encourage participation from providers that are prepared to succeed, while allowing others additional time to develop the infrastructure, care coordination capabilities, and post-acute partnerships necessary for effective participation.

Alignment with Other Models

AMGA greatly appreciates and supports CMS's proposal to align certain policies within CJR-X with both the Transforming Episode Accountability Model (TEAM) and the previously ended CJR Model. Greater alignment across Innovation Center models represents an important step toward reducing unnecessary administrative burden for participating hospitals and providers. Consistency in model design, quality measures, target price calculations, financial arrangements, and waivers will allow providers to leverage existing infrastructure and institutional experience developed under prior models. By promoting greater standardization across models, CMS can help providers devote more time and resources toward improving care coordination, operational efficiency, and patient outcomes.

We thank you for your consideration of our comments. Should you have questions, please do not hesitate to contact AMGA's Darryl M. Drevna, Senior Director of Regulatory Affairs, at 703.838.0033 ext. 339 or at ddrevna@amga.org.

Sincerely,

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