The Honorable Mehmet Oz
Administrator, Centers for Medicare & Medicaid Services
Hubert H. Humphrey
200 Independence Avenue, SW, Room 445-G
Washington, DC 20201

June 8, 2026

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; CMS-1849-P

Dear Dr. Oz:

On behalf of the Arizona Hospital and Healthcare Association (AzHHA) and our more than 80 hospital, healthcare and affiliated health system members, we appreciate the opportunity to comment on the Fiscal Year (FY) 2027 Inpatient Prospective Payment System (IPPS) Proposed Rule.

Our comments focus on key payment policies and structural issues within the IPPS that affect hospital reimbursement, particularly the proposed payment update and the implementation of the Comprehensive Care for Joint Replacement Expanded (CJR-X) model. We have also submitted separate comments on the Long-Term Care Hospital (LTCH) Prospective Payment System.

PAYMENT UPDATES

Market Basket Update

AzHHA is concerned that the proposed IPPS payment update does not adequately reflect the cost pressures acute care hospitals continue to face. CMS estimates that IPPS payments will increase by approximately 2.4% in FY 2027. However, that update — driven by a 3.2% market basket increase, less a 0.8 percentage-point productivity adjustment — still falls short of actual cost growth.

Hospital costs remain heavily driven by labor, which limits providers' ability to achieve the kind of productivity gains assumed under current law. At the same time, hospitals continue to face workforce shortages, higher wages and contract labor, along with elevated pharmaceutical and supply costs and increasing patient complexity. Even small gaps between payment updates and costs can create real operational challenges.

The productivity adjustment continues to be a key driver of this disconnect. Hospitals do not experience productivity gains in the same way as the broader economy, particularly given the labor-intensive nature of inpatient care. Applying this adjustment reduces payment updates in a way that does not align with how hospital costs actually behave.

Hospitals continue to face sustained cost pressures, and the proposed rule also reduces disproportionate share hospital (DSH) and uncompensated care payments, further compounding those challenges — particularly for hospitals serving vulnerable populations.

Recent federal policy changes (P.L. 119-21) also limit Medicaid state directed payments in expansion states such as Arizona to no more than 100 percent of the applicable Medicare rate. This effectively ties a significant portion of Medicaid reimbursement to Medicare's payment structure — even though Medicare payments already fall well below the cost of care. As a result, hospitals are increasingly reliant on payment sources that are both benchmarked to Medicare and do not fully cover costs. When Medicaid supplemental payments are similarly constrained, hospitals have fewer opportunities to offset these losses within the broader payer mix. What were once separate pressures across Medicare and Medicaid are now more tightly linked, amplifying the financial strain on hospitals.

The proposed update, therefore, does not occur in isolation. When below-cost Medicare updates are repeated year after year, their effects already compound over time. As Medicaid payment policies become more closely tied to Medicare rates, those compounding effects extend across multiple major payer sources that are anchored to the same underlying benchmark, even when that benchmark does not reflect the cost of care.

For hospitals operating on narrow margins, that compounded and increasingly linked shortfall directly affects staffing, service capacity and long-term sustainability. This is especially true for rural hospitals, where even modest financial changes can have an outsized effect on access to care.

We recognize CMS is constrained by statute in calculating the annual update. Even so, we encourage the agency to continue evaluating whether the current methodology reflects the realities of inpatient hospital care and to consider recommendations to Congress, as appropriate, to better align updates with providers' actual cost experience — particularly as payment dynamics across Medicare and Medicaid become more closely linked.

Inpatient PPS Outlier Threshold

We are concerned about the proposed increase in the high-cost outlier threshold for FY 2027. CMS proposes a fixed-loss threshold of $51,704, up 18% from the current threshold of $43,663. Continuing the upward trend in recent years and making it harder for cases to qualify for outlier payments.

CMS states that the increase is needed to maintain outlier payments at approximately 5.1 percent of total IPPS payments. However, a higher threshold means fewer qualifying cases and more financial risk for hospitals treating the most complex and costly patients. This is particularly important for rural hospitals, where a small number of high-cost cases can materially affect financial stability. We are also concerned that these increases are being driven by elevated cost-to-charge ratios reflecting unusually

high cost growth in prior years. As a result, the proposed threshold may not fully reflect current or moderating cost trends.

We urge CMS to take a closer look at the methodology and consider whether adjustments are needed to avoid sharp increases that weaken the outlier policy's role as a safeguard for exceptionally high-cost cases.

Disproportionate Share Hospital Payment Changes

The proposed rule also reduces Medicare DSH and uncompensated care payments, which further strains hospitals serving vulnerable populations. nder current law, CMS calculates uncompensated care payments using a three-factor methodology. Factor 1 reflects 75 percent of empirically justified Medicare DSH payments, Factor 2 reflects the projected uninsured rate, and Factor 3 determines each eligible hospital's share of the available uncompensated care pool using audited cost report data.In the FY 2027 proposed rule, CMS estimates that total DSH and uncompensated care payments will decline by approximately $564 million compared to the prior year.

The problem is that this methodology relies on lagged and projected national uninsured rate estimates that may not fully reflect what is happening on the ground. Recent policy changes — including more frequent Medicaid redeterminations, Marketplace volatility and new federal requirements — are expected to increase coverage instability and the number of uninsured individuals. Those shifts may not be fully or timely captured in the projections used to determine DSH payment levels.

In addition, the formula does not account for the growing number of patients who technically have coverage but are enrolled in programs that reimburse below the cost of care. As a result, the proposed reduction in DSH funding risks moving payments even further away from actual hospital financial need, particularly in expansion states such as Arizona.

COMPREHENSIVE CARE FOR JOINT REPLACEMENT EXPANDED (CJR-X) MODEL

Voluntary participation is the appropriate policy approach

AzHHA is concerned with CMS's proposal to implement the CJR-X model as a mandatory, nationwide program. While we support efforts to improve care coordination and accountability across episodes of care, we strongly recommend that CMS structure this model as voluntary participation.

CJR-X represents a significant departure from prior Innovation Center models. Historically, CMS has relied on voluntary models or mandatory models limited to specific geographic areas or subsets of hospitals. In contrast, CJR-X would require participation from nearly all acute care hospitals nationwide, making it the first model of its kind to mandate participation on such a broad scale.

Given the scale and operational complexity of episode-based payment models, a voluntary approach would allow hospitals to assess readiness, build appropriate infrastructure, and participate when they are able to do so successfully. It would also better align with CMS's model-testing approach, which emphasizes iterative learning and refinement prior to full national implementation.

Certain hospitals should have the option to opt out of mandatory participation

If CMS finalizes CJR-X as a mandatory model, CMS should allow certain hospitals to opt out of participation, rather than requiring universal inclusion.

Rural hospitals, sole community hospitals (SCHs), and other similarly situated providers face structural constraints that may limit their ability to succeed under an episode-based payment model, particularly on an accelerated timeline. Workforce challenges are especially acute. These hospitals often face difficulty recruiting and retaining clinicians, including surgeons, therapists, and care coordination staff necessary to effectively manage episodes of care.

In addition, access to newer clinical techniques and care models is not uniform across markets. For example, advances in joint replacement procedures—such as muscle-sparing surgical approaches that can reduce recovery time and post-acute utilization—require specialized training that may not be readily available in rural or underserved areas. Hospitals without access to these resources may face higher baseline costs and longer recovery trajectories despite delivering appropriate, high-quality care. Other hospitals may face similar structural challenges, including low-volume hospitals, Medicare-dependent hospitals, safety-net providers, and hospitals located in markets with limited post-acute care capacity.

Providing these hospitals with the option to opt out would allow them to participate when they have the necessary workforce, infrastructure, and clinical capabilities in place, rather than exposing them to premature financial risk.

Risk structure creates significant and immediate financial exposure

Under the proposed model, hospitals would be held financially accountable for the total cost of care across a 90-day episode, including the index procedure and all related post-acute care.

CMS establishes a target price for each episode and reconciles total spending against that target at the end of the performance period. Hospitals that reduce spending below the target while meeting quality thresholds may receive reconciliation payments, while hospitals that exceed the target would be required to repay Medicare, creating meaningful downside financial risk.

This structure introduces full two-sided financial risk on a mandatory, nationwide basis. At the same time, hospitals are held accountable for costs across the full episode of care, including services delivered by independent providers and post-acute facilities. Hospitals do not have full control over these services or over beneficiary choice of post-acute providers, creating a misalignment between financial accountability and operational control.

The model also introduces significant data and administrative demands. Hospitals will be required to track, manage, and analyze care across a 90-day episode, often spanning multiple providers and care settings. Hospitals without advanced data infrastructure may face challenges in effectively identifying cost drivers and managing performance in real time.

In addition, successful participation requires upfront investment in care coordination, analytics,

physician alignment, and post-acute partnerships. Smaller and resource-constrained hospitals may have limited ability to make these investments within the proposed timeframe.

Benchmarking methodology creates uneven and potentially unfair comparisons

Under the proposed methodology, hospitals are evaluated against CMS-established target prices that reflect both historical performance and broader regional or national benchmarks. While intended to promote efficiency, this approach requires hospitals to manage costs relative to benchmarks influenced by factors outside their control.

Hospitals operating in markets with workforce shortages, limited post-acute capacity, or reduced access to newer clinical techniques may face inherent disadvantages relative to peers included in these benchmarks. As a result, hospitals may be subject to financial penalties despite making meaningful improvements in care delivery.

In practice, this structure creates a situation in which hospitals are evaluated both against their own past performance and against broader external benchmarks, without fully accounting for differences in local resources, infrastructure, and patient populations.

High-performing hospitals face a "ceiling effect"

The proposed benchmarking approach may disproportionately disadvantage hospitals that are already high-performing.

Hospitals that have previously invested in care redesign, post-acute coordination, and efficient clinical practices may have limited remaining opportunities to further reduce episode spending. As a result, these hospitals may face a "ceiling effect," where continued improvement is incremental, yet they remain subject to downside financial risk if they are unable to achieve additional cost reductions.

By contrast, hospitals with higher baseline costs may have more immediate opportunities for savings, creating an uneven dynamic in which early gains are easier to achieve. This may unintentionally penalize hospitals that have already made significant progress in improving care efficiency and quality.

Low-volume policy should provide stability and predictability

CMS proposes to exclude low-volume hospitals from participation in the CJR-X model; however, this determination appears to rely on current volume thresholds rather than a fixed, multi-year designation. Because low-volume status is generally based on the most recent available utilization data, hospitals with fluctuating volumes may move into or out of the model across performance periods. This creates operational instability and limits hospitals' ability to make sustained investments in care redesign and infrastructure.

Support for CMS decision to exclude TEAM participants

AzHHA appreciates CMS's decision to exclude hospitals participating in the Transforming Episode Accountability Model (TEAM) from CJR-X during the duration of their participation. This approach appropriately avoids duplicative financial accountability for the same or similar episodes across multiple models and reduces unnecessary administrative complexity for participating hospitals.

Recommendation: phased glide path to downside risk

In addition to the recommendation made above, CMS should adopt a phased glide path to financial risk under the CJR-X model to support successful implementation:

- **Performance Year 1:**
  Data sharing only (no financial reconciliation)

- **Performance Years 2–3:**
  Upside-only risk, with eligibility for reconciliation payments but no repayment obligations

- **Performance Year 4 and beyond:**
  Gradual transition to full two-sided risk

A phased approach would allow hospitals to build infrastructure, strengthen care coordination, and develop post-acute partnerships before being exposed to downside financial risk.

CONCLUSION

Thank you for the opportunity to comment on the FY 2027 IPPS proposed rule. We appreciate CMS's ongoing work to support access to care for Medicare beneficiaries and look forward to continued engagement on policies that ensure hospital payment systems reflect the realities of patient care and support the long-term sustainability of providers and the communities they serve.

Sincerely,

Director of Financial Policy and Reimbursement, AzHHA

Phone
(602) 445-4300

2800 N. Central Ave., #1450
Phoenix, AZ 85004