



June 10, 2025

The Honorable Mehmet Oz, MD, MBA
Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
P.O. Box 8013
Baltimore, MD 21244-8013

Re: CMS–1833–P: Medicare Program: Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Policy Changes and Fiscal Year 2026 Rates; Requirements for Quality Programs; and Other Policy Changes

Dear Administrator Oz:

On behalf of Iowa's 123 hospitals, including 33 prospective payment system hospitals, the Iowa Hospital Association (IHA) appreciates the opportunity to provide comments on the Centers for Medicare & Medicaid Services' (CMS) proposed rule on the Fiscal Year (FY) 2026 Inpatient Prospective Payment System (PPS). IHA also wishes to express support for the comments to the proposal submitted by the American Hospital Association.

To understand the context within which Iowa hospitals are operating and the rationale behind our comments on the proposed rule, it is important to consider their pivotal role in supporting both the health and economic stability of the state and its communities. Their impact is substantial, as evidenced by the following:

Economic Contributions

- **Employment:** Iowa hospitals provide \$5.6 billion in wages and benefits, supporting 72,000 direct jobs.
- **Job Support:** They indirectly support an additional 138,000 jobs across the state.
- **Economic Impact:** Hospitals contribute \$21.3 billion to Iowa's economy, accounting for 12% of the state's gross domestic product.

Community Benefits

- **Annual Contributions:** Hospitals provide \$1.2 billion in community benefit each year.
- **Charity Care:** In 2024, they delivered \$280 million in charity care, aiding those unable to afford medical services.

Despite these significant contributions, Iowa hospitals face several challenges that threaten their financial stability and capacity to serve the community effectively. Key trends and issues include:

Shifts in Care Patterns

- There is a notable increase in outpatient care combined with a decrease in inpatient care, impacting the revenue models of hospitals.

Public Payor Dependence

- The 2024 average payor mix for Iowa hospitals shows a heavy reliance on public payors, with 60% of Iowa hospitals revenue coming from these programs. Specifically, 44% of revenue comes from Traditional Medicare and Medicare Advantage, while 16% comes from Medicaid.

Financial Pressure

- A sizable portion (42%) of Iowa hospitals operate with negative or unsustainable margins.
- Inflation and other factors drove a \$2.3 billion increase in expenses from 2021 to 2024, including:
 - An additional \$163 million was spent on supplies
 - Contracted labor costs increased \$257 million
 - Pharmaceutical expenses rose \$329 million
 - Payroll and benefits increased by \$800 million

Iowa hospitals are essential to the state's health and economic well-being but are currently operating under significant financial strain. These challenges underscore the importance of supportive policies and adequate funding to ensure these institutions can continue to provide vital services and maintain their crucial role in the community.

Inpatient PPS Payment Update

For Fiscal Year 2026, CMS has proposed a market basket update of 3.2%, offset by a 0.8 percentage point productivity adjustment, resulting in a net payment increase of just 2.4%. While this methodology follows statutory requirements, the resulting update does not adequately reflect the persistent financial pressures hospitals face. When combined with years of insufficient updates, this proposal further compounds Medicare's chronic underpayments to hospitals and health systems.

IHA urges CMS and policymakers to reexamine the assumptions and methodologies used in determining Medicare payment rates. The current time-lagged approach fails to capture the real-time economic conditions hospitals are navigating—particularly the sustained inflation in labor, supply, and infrastructure costs detailed above. As a result, the proposed 2.4% update falls short of what is needed to maintain access to care and financial stability across the hospital sector.

This concern is especially urgent given the broader fiscal landscape, including potential reductions to Medicaid funding currently under discussion in Congress. Without a more responsive and data-driven approach to Medicare rate-setting, hospitals will face mounting challenges in delivering high-quality care to Medicare beneficiaries.

Hospital Quality Reporting and Value Program

As general comments related to hospital quality reporting and value programs, hospitals must often report the same data to multiple systems and platforms, each with its own interface and requirements. Locating the most current measure specifications can be time-consuming and confusing, leading to inefficiencies and potential errors. CMS should explore opportunities to streamline reporting processes, such as consolidating reporting portals or allowing submission to a single entity. Reducing duplication and improving access to specifications would significantly ease the burden on providers.

Several electronic clinical quality measures (eCQMs) are currently required under both the Inpatient Quality Reporting (IQR) and Promoting Interoperability programs. This redundancy increases reporting burden without clear added value. CMS should consider consolidating these requirements to reduce duplication and allow hospitals to focus on improving performance rather than navigating overlapping mandates.

Within this year's proposal, CMS proposes to remove four measures from the IQR program – COVID-19 vaccination coverage among health care personnel, Hospital Commitment to Health Equity structural measure, Screening for Social Drivers of Health, and Screen Positive Rate for Social Drivers of Health. IHA supports the removal of these measures.

The COVID-19 vaccination measure has become increasingly outdated and difficult to report accurately. Hospitals have noted that the data collection process is cumbersome and no longer reflects current public health priorities. Ending this requirement would allow hospitals to redirect resources toward more pressing clinical and operational needs.

Implementing the health equity and social drivers of health measures have proven challenging. Many hospitals lack the infrastructure, training, and staff capacity to collect and act on this data in a meaningful way. One hospital reported exploring third-party technologies such as Notable and patient portals to gather this information, but concerns persist about collecting data solely to meet federal requirements without a clear path to using it for care improvement. Removing these measures would alleviate reporting burden and allow hospitals to focus on building sustainable, patient-centered equity strategies.

CMS also proposes to modify several IQR measures, including lowering the data completeness threshold for core clinical data elements and laboratory values for hybrid hospital-wide readmission and mortality measures. Lowering the data completeness threshold is a welcome change. Hospitals have reported technical limitations in their electronic health record (EHR) systems that make it difficult to meet higher thresholds. For example, one hospital noted that when patients are transitioned to comfort care, vital signs and lab data often do not transfer, resulting in incomplete records. Lowering the threshold acknowledges these real-world challenges and helps ensure hospitals are not penalized for factors beyond their control.

Further, CMS proposes to include Medicare Advantage (MA) patients in several quality measures, including stroke mortality, elective total hip and knee arthroplasty, and all six measures in the Hospital Readmissions Reduction Program (HRRP). While expanding the denominator may improve statistical reliability, the rationale for including MA patients in some measures but not others is unclear.

Hospitals have expressed concern that defining quality measures based on insurance type is problematic. The same clinical care is provided regardless of whether a patient is enrolled in traditional Medicare or Medicare Advantage. Moreover, the inclusion of MA patients may introduce variability in risk adjustment and payment calculations. This would effectively hold hospitals accountable for excessive and inappropriate coverage delays and denials on the part of MA plans. CMS should clarify how risk adjustment methodologies will be adapted to account for differences in MA populations and ensure that hospitals are not unfairly penalized.

Thank you for considering our comments. We look forward to continuing collaboration with CMS to ensure these regulations are both fair and effective.

Sincerely,

A handwritten signature in black ink, appearing to read "Chris Mitchell". The signature is fluid and cursive, with a prominent initial "C" and "M".

Chris Mitchell
President/CEO
Iowa Hospital Association