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June 10, 2025

The Honorable Mehmet Oz, MD
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
7500 Security Boulevard
Baltimore, MD 21244

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 the Council of Academic Family Medicine (CAFM), including the Society of Teachers of Family Medicine, Association of Departments of Family Medicine, Association of Family Medicine Residency Directors, and the North American Primary Care Research Group, as well as the American Academy of Family Physicians (AAFP), we write to provide comments on the Fiscal Year (FY) 2026 Medicare Inpatient Prospective Payment System (IPPS) proposed rule.

Proposed Payment Adjustment for Low-Volume Hospitals (§ 412.101; Proposed Changes in the Medicare-Dependent, Small Rural Hospital (MDH) Program (§ 412.108)

The Medicare Low-Volume Hospital (LVH) payment adjustment plays a critical role in helping geographically isolated hospitals manage the higher costs associated with low patient volume. When first implemented, only five rural hospitals qualified for the adjustment. Today, due to a temporary but substantial expansion of the program, nearly 500 rural hospitals receive this additional payment, which helps offset fixed operating costs that often exceed revenue. The LVH adjustment remains an essential tool for supporting the financial viability of rural hospitals facing persistent challenges in scale and sustainability.[i]

Similarly, the Medicare-Dependent Hospital (MDH) program was designed to support hospitals that serve a high proportion of Medicare patients and are particularly vulnerable to inadequate Medicare payments.[ii] Unlike other hospitals, MDHs have limited ability to offset shortfalls through private insurance payments. Both programs have been routinely reauthorized by Congress but are currently set to expire on September 30, 2025, absent further legislative action.

Our organizations support efforts to extend critical financial protections for rural hospitals. Without congressional action, the expiration of these programs would place many facilities under

significant financial strain, jeopardizing access to care in rural communities. The ongoing uncertainty has already discouraged much-needed investment in primary care infrastructure, workforce, and patient services, and has made it difficult for hospitals to plan confidently for the future.

While we recognize CMS is bound by current law and cannot act preemptively in place of Congress, the agency can take meaningful administrative steps to help mitigate disruptions if there were to be a lapse in authorization. These actions can provide greater predictability for hospitals operating under tight margins and ensure continuity of care during periods of uncertainty.

Prior to September 30, 2025, CAFM and the AAFP recommend CMS:

- Clearly communicate how it will implement program extensions if such extensions are passed after the expiration date;
- Prepare systems to facilitate expedited retroactive payments in the event of a temporary lapse of either/both programs;
- Engage stakeholders early to establish lines of communication, minimize confusion, and mitigate any potential delays in reimbursement; and
- Signal readiness to support impacted hospitals with technical guidance and financial planning resources.

We urge CMS to proactively plan for both scenarios—extension or lapse—to ensure continuity of care and financial stability for rural physicians serving some of the nation's most under-resourced communities.

Payment for Indirect and Direct Graduate Medical Education Costs (§§ 412.105 and 413.75 through 413.83)

Currently, sole community hospitals (SCHs) and MDHs may be reimbursed either under the standard IPPS rate or through a hospital-specific rate based on historical costs. However, only hospitals paid under the federal IPPS rate receive both direct graduate medical education (DGME) and indirect medical education (IME) payments. SCHs and MDHs reimbursed under the hospital-specific rate, which often more accurately reflects their financial and operational realities, only receive DGME payments.[iii]

This discrepancy creates a significant disincentive for rural hospitals to establish or expand residency training programs, despite their strong potential to serve as high-quality training sites. Many SCHs and MDHs are the sole source of care in their communities and play an essential role in the rural health care delivery system.

A proportion of hospitals eligible to serve as rural training sites are designated as SCHs or MDHs, and many of these are reimbursed using the hospital-specific rate rather than the federal

IPPS rate. Without access to IME payments, these hospitals face greater financial challenges when trying to develop or sustain residency programs—despite their critical role in expanding the rural physician workforce.[iv,v]

Allowing IME payments for SCHs and MDHs reimbursed under the hospital-specific rate would help offset the additional costs associated with training residents and provide these hospitals with more equitable access to graduate medical education (GME) funding. These hospitals are often the only training sites available in rural areas and are well-positioned to serve as hubs for workforce development. Expanding IME eligibility would support the creation and sustainability of residency programs in underserved regions, contributing to a more geographically distributed physician workforce and improving long-term access to care in communities with the greatest need.

CAFM and the AAFP urge CMS to address this policy gap through the FY 2026 IPPS rulemaking process, ensuring that all eligible rural hospitals can access the full spectrum of GME funding needed to sustain and grow the rural physician workforce.

Proposed Changes to the Medicare Promoting Interoperability Program

CMS proposes the following updates to the current interoperability requirements in the Medicare Promoting Interoperability Program, which the agency believes will improve interoperability and enhance the security analyses and actions hospitals undertake to safeguard patient data.

1. Maintaining the electronic health record (EHR) reporting period for eligible hospitals and critical access hospitals (CAHs) as a minimum of any continuous 180 days within the given calendar year;
2. Modifying the Security Risk Analysis measure to require hospitals to attest to having conducted security risk management in addition to the existing measure requirement to attest to having conducted a security risk analysis;
3. Amending the Safety Assurance Factors for EHR Resilience (SAFER) Guides measure to require hospitals attest to completing an annual self-assessment using the eight SAFER Guides published in January 2025; and
4. Adding an optional bonus measure to the Public Health and Clinical Data Exchange objective for hospitals that submit health information to a public health agency (PHA) using the Trusted Exchange Framework and Common Agreement (TEFCA).

The AAFP and CAFM support these four proposals and believe they appropriately balance the need for risk assessments while minimizing mandatory reporting requirements. We also appreciate the consistency that CMS proposes to maintain for the 180-day reporting period. Our organizations have long supported policies that guarantee the appropriate security of protected health information while working to improve patients' access to their data, as well as the ability to share patients' health information across their chosen care team. **We are strongly supportive of making data reliably interoperable while maintaining patient confidentiality, and we**

believe these proposals correctly strike the balance of better safeguarding patients' data without unnecessarily burdening hospitals or the medical professionals who work there.

Transforming Episode Accountability Model (TEAM)

CMS proposes amendments to and seeks public comment on multiple areas of the Transforming Episode Accountability Model (TEAM), including changes that would update financial risk and participation obligations, target price methodology, and care delivery. The agency believes these changes will improve the quality of care delivered to patients and reduce Medicare spending.

Financial Risk and Participation Obligations

Within TEAM, hospitals are required to participate in the model if they are located in specified core based statistical areas (CBSAs). All model participants have the option of deferring downside financial risk for the first year. To ensure that new hospitals opening in these CBSAs have appropriate time to prepare for financial risk, CMS proposes that only hospitals established by Dec. 31, 2024, will be required to participate in TEAM when it begins on Jan. 1, 2026. Any hospital opening after Dec. 31, 2024, would have at least one performance year (but not more than two performance years) before being required to participate in TEAM.

As finalized in the FY 2025 IPPS final rule, CMS established that select hospitals may elect up to three years without downside financial risk, followed by a lower risk track for the remainder of the model. Qualifying hospitals include rural hospitals, safety net hospitals, SCHs, MDHs, and essential access community hospitals. The agency notes that the MDH program is currently only congressionally authorized through Sept. 30, 2025, though Congress has traditionally extended the MDH program—and in some cases, the program has been retroactively reinstated. CMS proposes to honor MDH classifications as long as the MDH program is active at the time that participation track selections are due to CMS. In addition, CMS is seeking comment but not proposing that the agency offer technical assistance to MDH programs if the program expires.

Our organizations support these proposals and are especially appreciative of the consideration shown for rural, safety net, sole community, Medicare-dependent, and essential access community hospitals, which tend to have minimal profit margins and therefore a higher risk of closure. These hospitals often exist in communities where there are no other sources of health care, with patients already likely to face long travel times for primary and emergency care. Proposals like these, which ultimately support hospitals' financial viability, help protect patients' access to care in rural and underserved communities. **We strongly support CMS' decision to offer rural and safety net hospitals three years without downside financial risk**. Additionally, CAFM and the AAFP support the proposal to honor MDH hospital designations as long as the program is active at the time of TEAM track selections, and we strongly encourage CMS to offer technical assistance to hospitals if the MDH program were to lapse.

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Target Price Methodology

CMS proposes several changes to the Area Deprivation Index (ADI), including renaming the social needs risk adjustment factor to the beneficiary economic risk adjustment factor and replacing the use of ADI with a similar but slightly modified "Community Deprivation Index" (CDI), which uses the Accountable Care Organization (ACO) Realizing Equity, Access, and Community Health (REACH) Model methodology to adjust for housing costs. CMS proposes to keep the CDI threshold at the 80th percentile but to only use national percentiles—as opposed to state and national—to ensure a specific area's income and home values do not dominate the metric's calculation.

The agency proposes a 180-day lookback period for Hierarchical Condition Categories (HCCs) used in the risk adjustment methodology. CMS examined other time periods but believes 180 days strikes the appropriate balance between episode volume and data capture considerations. The agency also proposes to update the current risk adjustment factor, which uses HCC version 22, to HCC version 28. This updated HCC version is being implemented across CMS and relies on updated diagnosis codes, and the agency believes this change will support their goal of simplifying risk adjustment methodology while also accurately capturing spending.

The AAFP and CAFM support the proposed changes to the ADI and the proposal to instead use the CDI going forward. Primary care scholars have consistently objected to the ADI and supported the federal government's efforts to improve it, finding that without standardization, the ADI can be reducible to a weighted average of just 2 measures: income and home values. Studies have shown that federal programs that choose to incorporate the ADI are at risk of allocating resources ineffectively, which prevents the reduction of health disparities.[vi] Our organizations appreciate CMS' acknowledgement of the ADI's shortcomings and efforts to increase its accuracy. Additionally, CAFM and the AAFP support the proposed risk adjustment factor update to HCC version 28, and we do not object to the 180-day look back period for HCCs used in the risk adjustment methodology. However, we reiterate the recommendation from our FY 2025 IPPS proposed rule comment letter for CMS to use a one-year look back for HCCs, comparable to Medicare Advantage risk adjustment methodologies.

Our organizations also believe CMS should amend a policy from the FY 2025 IPPS final rule. Last year, the agency determined that it will not update the target prices each fall when fee-for-service rates are updated, which we oppose. This regulation will harm TEAM participants by applying previous prices that are no longer current—and often lower than the updated price—leading to an apples-to-oranges comparison. As a result, the actual costs incurred under the episodes in the later part of a given year would have higher costs than those predicted by the outdated prices, which would undermine the model's goals and participants' ability to succeed.

Care Delivery

Under the FY 2025 IPPS final rule, TEAM participants are required to determine a patient's

primary care physician (PCP) status as part of the initial admission for the clinical episode and refer said patient to a PCP as part of the discharge planning process. In this proposed rule, CMS considered but is not proposing two alternatives: requiring the TEAM participant to refer a patient to a PCP they've seen in the past two years or removing this requirement entirely. The agency seeks comment on whether specifically requiring patients be referred back to PCPs with whom they have an existing relationship could disrupt "fair competition" or limit access to high-value care.

Our organizations applaud CMS' ongoing recognition of the importance of primary care continuity by finalizing last year's proposal to confirm a patient's PCP status during the hospitalization or procedure initiating the episode, as well requiring TEAM participants to refer patients to primary care following the anchor hospitalization or procedure. CAFM and the AAFP support the role of family physicians in providing continuity of care to their patients in all settings, both directly and by coordinating care with other health care professionals. Involving the patient's physician-led primary care team in ongoing health management is essential to ensuring care continuity, a hallmark and primary objective of family medicine. We appreciate CMS' recognition of the importance of primary care's role in well-managed transitions in care to achieve optimal patient outcomes.

The AAFP and CAFM support the current policy requiring hospitals to connect patients to PCPs prior to discharge, as it recognizes the important role of PCPs in providing continuity of care to their patients in all settings. To ensure continuity and alignment across care settings for patients, we encourage CMS to clarify that TEAM participants ensure the PCP referral is consistent with the patient's PCP status recorded at initiation of the procedure or hospitalization. However, we do not believe claims are an accurate source for identifying a patient's current, preferred PCP. Therefore, we do not support CMS requiring hospitals refer a patient specifically to a PCP they have visited in the past two years, as shown in the claims. This requirement could potentially prevent a hospital from connecting a patient to a more appropriate source of care, given that a patient may have moved, changed insurance providers, or purposely changed their source of care in the previous two years. Our organizations support patients having the autonomy to specify which PCP they would like to be referred to when checking in for their hospital procedure. If a patient does not have a current PCP at the time of check-in, the AAFP and CAFM support the hospital assisting the patient in identifying a PCP that will best meet their post-discharge health care needs. We believe this additional support would be superior for both patient experiences and outcomes compared to a PCP referral based exclusively on claims data.

While our organizations support the continued prioritization of PCPs in the TEAM model, we urge CMS to consider the impacts of the national physician shortage. Hospitals, depending on their location, might experience challenges when referring patients after discharge. We continue to encourage CMS to implement safeguards that would prevent clinicians from being penalized for situations beyond their control.

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Conclusion

Thank you for your consideration of our comments. We look forward to a continued partnership with CMS to streamline processes for physicians and patients, address the primary care physician shortage, and strengthen the Medicare GME program. Should you have any questions, please contact Nina DeJonghe, CAFM Director, Government Relations at ndejonghe@stfm.org and Mandi Neff, AAFP Regulatory and Policy Strategist, Government Relations at mneff2@aafp.org.

Sincerely,

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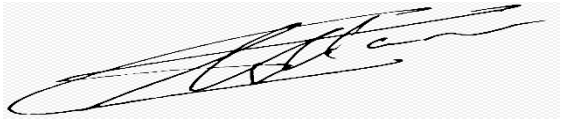

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[v] American Hospital Association. February 2019. Rural Report: Challenges Facing Rural Communities and the Roadmap to Ensure Local Access to High-quality, Affordable Care.
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