WISCONSIN HOSPITAL ASSOCIATION

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June 10, 2025

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

RE: CMS-1833-P, RIN 0938-AV45 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 our more than 150 member hospitals and integrated health systems, the Wisconsin Hospital Association (WHA) appreciates the opportunity to provide comments on the Centers for Medicare & Medicaid Services' (CMS) proposed FY 2026 rule related to the Medicare Program Hospital Inpatient Prospective Payment Systems.

WHA was established in 1920 and is a voluntary membership association. We are proud to say we represent all of Wisconsin's hospitals, including small Critical Access Hospitals, mid, and large-sized academic medical centers. We have hospitals in every part of the state—from very rural locations to larger, urban centers like Milwaukee. In addition, we count close to two dozen psychiatric, long-term acute care, rehabilitation and veterans' hospitals among our members.

Payment Update

For FY 2026, CMS proposes an overall payment update of 2.4%, continuing its recent trend of issuing woefully inadequate payment updates that are not keeping up with the true level of inflation impacting health care and the country as a whole. These inadequate updates fail to account for the record-high inflation and persistent labor, supply and drug costs the hospital field has experienced in recent years.

An April 2025 report by the American Hospital Association highlights some of the cost increases hospitals are bearing right now:

- Overall inflation grew by 14.1% from 2022 through 2024 — nearly 3 times as fast as Medicare reimbursement for hospital inpatient care, which increased by 5.1% during the same time.
- Labor costs continue to grow and remain largest category of hospital spending by far, at 56% or $890 billion.
- Medicare Advantage is having a growing deleterious impact on hospitals, with MA plans lengthening observation stays to around 37% longer than in traditional Medicare.
- Meanwhile, MA payments fell by nearly 9% on a cost basis from 2019 to 2024, as plans negotiate rates below the traditional Medicare DRG payment.

With these challenges, it's no surprise that hospitals are facing some of the hardest financial times in recent memory. According to data from WHA's most recent fiscal survey, in 2023, nearly one-third of Wisconsin hospitals operated with a negative margin.

The underpayments from Medicare have been driving these recent challenges. In Wisconsin, hospitals are paid only about 74% of what it costs to provide care to Medicare patients according to that same fiscal survey. And because Wisconsin is an aging state, it is seeing a large shift in people moving off private insurance and onto Medicare. From 2016 to 2023, the average payor mix for a Wisconsin hospital has seen Medicare grow from 45% to 55%, while commercially insured patients have shrunk from 37% of the payor mix to only 28% concurrently, according to claims data analyzed by WHA's Information Center. In fact, as of 2022, Wisconsin was tied for 11th among states with the highest percentage of their population covered by Medicare, at 21%. Due to this, **annual Medicare underpayments to Wisconsin hospitals have grown from $1.77 billion in 2016 to $3.3 billion in 2022, an 86% increase in 6 years.** This problem can be particularly challenging for rural areas which tend to have a higher percentage of their population at a Medicare eligible age.

What's more, hospitals are increasingly are not being reimbursed for long patient stays and post-acute care they are providing. The average length of a patient stay increased 9.9% by the end of 2021 compared to pre-pandemic levels in 2019, leading hospitals to have to devote more staff time and expenses per patient episode. On top of this, according to a Baker Tilly report commissioned by the Wisconsin Department of Health Services, Wisconsin hospitals lost an estimated $465 million in uncompensated care from patients they have not been able to discharge due to the lack of available nursing home beds – patients hospitals are not receiving reimbursement for after their hospital care concludes.

Despite numerous financial pressures, hospitals have worked hard in recent years to keep costs down and do not seem to be driving price increases - in 2022 (the last year for complete data and first year post pandemic), medical inflation was 4.0%, hospital prices went up 2.2% but insurer prices increased 5.9%.

With these historic fiscal challenges facing hospitals, **we urge CMS to focus on appropriately accounting for recent and future trends in inflationary pressures and cost increases in the hospital payment update, which is essential to ensure that Medicare payments for acute care services more accurately reflect the cost of providing hospital care.**

Rural Hospital Provisions - Medicare-Dependent and Low-Volume Hospitals

The March 2025 continuing resolution extended the current Medicare-Dependent (MDH) and Low-Volume Hospital (LVH) adjustment programs through September 30, 2025. These programs serve hospitals with low volumes by giving them slightly enhanced payments above the PPS rate, but below the cost-based rate CAHs receive. These enhanced payments are critical in sustaining "tweener" hospitals – those that are both too large to be eligible for critical access hospital status but too small to have the volumes that would otherwise help them offset the losses they experience treating Medicare and Medicaid patients.

WHA continues to advocate for a permanent extension of these important programs. In the meantime, we urge CMS to use its legal authority to make LVH payments to all current LVH hospitals. If Congress fails to act and CMS goes through with its current proposal, LVH payments would only extend to hospitals with less than 200 discharges, leaving only 21 of the current 585 LVH hospitals eligible for such payments. This could cut nearly $380 million annually in critical funding from these essential rural safety-net providers, threatening their financial viability. Losing these two programs would mean a nearly $230 million cut over 10 years to approximately sixteen Wisconsin hospitals.

Request for Information (RFI) on Deregulation

WHA appreciates the Trump Administration's request for information on ways to streamline regulations and reduce burden and waste in the Medicare program. WHA offers the following comments as ways to reduce unnecessary burdens on providers and improve health care for patients:

Make Telehealth and Hospital at Home Programs Permanent

Prior to waivers granted during the COVID-19 pandemic, Medicare had geographic and site restrictions. This means it only reimbursed for telehealth care provided to patients located in rural, health professional shortage areas (geographic) who traveled to a health care facility (site) to receive telehealth. The COVID waivers unleashed the potential of telehealth which has expanded availability of services and led to more convenient care options for patients and practitioners alike. Additionally, Medicare has continued to allow audio-only telehealth services for Medicare patients who are either uncomfortable using video applications or are unable due to poor internet coverage.

Likewise, the "Acute Hospital Care at Home" that began during the COVID pandemic has brought a significant innovation to health care by allowing patients to receive an inpatient level of care in the comfort of their own home for approved services. This program is a rare "win-win" proposition. Not only do patients prefer treatment at home (with some studies showing reduced complications and shorter lengths of stay), but the program also frees up physical space at hospitals to expand room for patients with higher-acuity needs. Additionally, initial studies have shown either savings or at least net-neutral cost to the Medicare program. There are currently five Wisconsin-based health systems approved for this program (with a sixth expected shortly) as well as six other approved systems based in other states that also have a Wisconsin presence.

Telehealth and Hospital at Home are key in assisting hospitals combat workforce shortages. Hospitals are currently utilizing telehealth to extend specialty care to more remote areas of the state and to staff essential services like hospitalists and ICUs when other providers are unavailable, often during late-night shifts.

Similarly, the Hospital at Home program helps hospitals free up onsite staff for higher-acuity care by serving approved lower-acuity patients in their own homes with trained home-based care providers working in tandem with hospital staff to treat episodes such as infections, respiratory, circulatory, and kidney care with the same level of care of an inpatient stay.

WHA urges the Trump Administration to work with Congress to permanently eliminate telehealth geographic and site restrictions while also permanently authorizing the Hospital at Home program.

Bringing Back COVID Waiver flexibility for the CAH 96 – Hour Rule and Nursing home 3-day Stay Rule

The CAH 96-hour rule requires (via CMS rule) physicians admitting patients into a CAH to certify the patient is expected to be discharged within 96 hours. The CAH *statute* also requires the annual average length-of-stay (ALOS) for CAHs be under 96 hours. When this rule was waived during COVID, CAHs found a way to improve their care and treat patients that they previously would have sent away to a tertiary hospital. This was a benefit to those patients, who were able to receive care in their local community. It also benefited the higher-level tertiary hospitals by increasing their capacity to serve patients that had higher acuity care needs. All of this was by necessity, as those tertiary hospitals were at capacity and could not accept as many patients from CAHs as they had previously.

Likewise, the waiver of the nursing home 3-day stay rule benefited hospitals by making it easier to transfer patients to a nursing home without having to worry about whether Medicare would pay for the nursing home stay. The waiver of this rule helped hospitals free up space for patients who needed hospital care by transitioning patients to a more appropriate care setting sooner.

Hospitals lost flexibility for both of these rules with the expiration of the public health emergency. These rules are based on antiquated thinking and should be permanently removed or at least have more flexible thresholds.

Improve Prior Authorization in Medicare Advantage

Prior Authorization was supposed to save money - but it is just adding to the high cost, bureaucracy and headaches of the U.S. Health Care System. According to a WHA survey of its members from 2023:

- 87% of commercial claims initially denied get overturned.
- Certain payers can routinely take 6 months or more to process claims.
- Some payers require appeals to be paper mailed, and can take no less than 60 days.

The system exacerbates workforce shortages by taking clinicians out of the role of providing care and into the role of denying, reviewing, and overturning claims – it also is a significant factor in clinician burnout. Data from Crowe RCA Consulting's *Time for a Commercial Break* report showed that 15.1% of all commercial/managed care hospital claims are initially denied, while most end up being overturned after hospital staff, including clinical staff, appeal the denial. And an article published by HFMA and written by Dr. Alan Kaplan, CEO, and Abigail Abongwa, VP Revenue Cycle at UW Health identified that prior authorization processes cost the health system $18.2 million and requires at least 65 FTEs – all at one Wisconsin health system.

The Trump Administration should streamline Medicare Advantage prior authorization requirements by making them fully electronic and standardized. It should also eliminate unnecessary prior authorization for services that are routinely approved and remove incentives for insurers to deny claims they know will ultimately be overturned, with stiff penalties for insurer noncompliance.

Hospital Quality Reporting and Value Programs

CMS monitors, rewards and penalizes quality performance in the inpatient setting through several quality incentive programs, including the Hospital IQR Program, Hospital Readmissions Reduction Program (HRRP), Hospital Value-Based Purchasing (HVBP) Program, Hospital Acquired Condition (HAC) Reduction Program, Medicare and Medicaid Promoting Interoperability Programs, and PPS-Exempt Cancer Hospital Quality Reporting (PCHQR) Program. The FY 2026 IPPS proposed rule aims to promote accountability, transparency, and continuous improvement in hospital care delivery, ultimately enhancing patient outcomes and satisfaction while reducing costs. Our Wisconsin hospitals remain in a good position to reinforce the necessary tools and approaches to support quality improvement.

Hospital Inpatient Quality Reporting (IQR) Program

Hospitals are required to report data on measures and meet other administrative requirements to receive the full annual percentage increase (and avoid a reduction) for IPPS services. The IQR program also includes a requirement to report on selected EHR-derived electronic clinical quality measures (eCQMs) using CMS-mandated reporting standards. The IQR eCQM reporting requirements align with the eCQM reporting requirements in the Promoting Interoperability Program.

In the FY 2026 IPPS/LTCH PPS proposed rule, CMS is requesting comment regarding measure concepts under consideration for future years, proposing to modify four current quality measures, and proposing to remove four quality measures. CMS is also proposing an update to the current Extraordinary Circumstances Exception (ECE) policy.

CMS is proposing to modify four current measures:

- (1) Hospital-Level, Risk-Standardized Complication Rate (RSCR) Following Elective Primary Total Hip Arthroplasty (THA) and/or Total Knee Arthroplasty (TKA) and (2) Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate (RSMR) Following Acute Ischemic Stroke Hospitalization with Claims-Based Risk Adjustment for Stroke Severity to add Medicare Advantage patients to the current cohort of patients, shorten the performance period from three to two years (reporting period would be April 1, 2023 through March 31, 2025), and make changes to the risk adjustment methodology.

  WHA supports being able to have a more comprehensive picture of the Medicare beneficiary performance, especially as Medicare Advantage (MA) enrollment continues to grow. Having the additional data eliminates gaps caused by only analyzing traditional Medicare patients and provides equity across payer types more accurately representing hospitals serving a higher percentage of MA patients that were historically underrepresented in public reporting and benchmarking.

  WHA would like to raise the point that MA patients differ demographically and clinically, however, from traditional Medicare patients and risk adjustments may not fully capture these differences potentially leading to inaccurate or lower scores for hospitals. Since the MA plans are privately managed, the need for transparent and complete data must be available. Also of important note would be the fact that prior authorization denials and the extreme number of hospital resources needed to deal with prior authorizations and appeals currently will increase the volume and complexity as the MA patients are added to these measures; especially for smaller facilities. For these reasons and the difficulty of post-discharge/post-acute care barriers, WHA would like to caution that additional work and evaluation is necessary before this modification.

- (3) Hybrid Hospital-Wide Readmission (HWR) and (4) Hybrid Hospital-Wide Mortality (HWM) measures to lower the submission thresholds to allow for up to two missing laboratory results and up to two missing vital signs, reduce the core clinical data elements (CCDEs) submission requirement to 70% or more of discharges, and reduce the submission requirement of linking variables to 70% or more of discharges. Before these proposed changes, hospitals participating in the Hospital Inpatient Quality Reporting (IQR) Program were required to meet the following data submission thresholds:
  - Linking Variables: Hospitals were required to submit linking variables for at least 95% of discharges
  - Core Clinical Data Elements (CCDEs):
    - Vital Signs: Hospitals were required to submit vital signs for at least 90% of discharges.
    - Laboratory Test Results: Hospitals were required to submit laboratory test results for at least 90% of discharges for non-surgical patients.

  These requirements were in place to ensure the accuracy and completeness of data used in calculating the hybrid measures, which combine electronic health record data with claims data to assess hospital performance on readmissions and mortality.

  WHA supports reducing these thresholds, but without understanding the current voluntary percent compliance with the reported difficulties in consistently capturing and submitting the CCDEs and linking variables, we are unsure of how the percent reductions were calculated or if they will meet the intent of the measures and would therefore recommend these remain voluntary.

CMS is proposing to remove four measures:

- (1) Hospital Commitment to Health Equity beginning with the CY 2024 reporting period/FY 2026 payment determination which requires hospitals to demonstrate their commitment to health equity through concrete activities across five key domains: strategic planning, data collection, data analysis, quality improvement, and leadership engagement. The data in CMS' provider data catalog shows that for 2023 hospitals recorded their attestation responses across these 5 domains. In past comment

periods, WHA has not supported structural measures, however, while CMS has proposed removing the Hospital Commitment to Health Equity attestation, Wisconsin hospitals remain firmly committed and recognize that addressing the root causes of health disparities—such as access to care, food insecurity, housing, and transportation—is essential to delivering high-quality, patient-centered care. Wisconsin hospitals will continue to invest in data-driven strategies, cross-sector partnerships, and culturally responsive care models to ensure all patients have a fair and just opportunity to achieve their best health. WHA ultimately supports the removal of these measures as they were not originally endorsed by a consensus-based entity prior to their adoption.

- (2) COVID-19 Vaccination Coverage among Health Care Personnel measure, beginning with the CY 2024 reporting period/FY 2026 payment determination. WHA expresses appreciation for CMS's efforts to streamline regulations and reduce burdens on providers, particularly the removal of outdated reporting related to staff vaccination rates that ended with the public health emergency in May 2023.
- (3) Screening for Social Drivers of Health and (4) Screen Positive Rate for Social Drivers of Health measures, beginning with the CY 2024 reporting period/FY 2026 payment determination.

For similar reasons cited earlier regarding the removal of the Hospital Commitment to Health Equity, Wisconsin hospitals will continue to invest in data-driven strategies, cross-sector partnerships, and culturally responsive care models to ensure all patients have a fair and just opportunity to achieve their best health through visibility into non-medical barriers that directly affect patient outcomes. WHA ultimately supports the removal of this measure as they were not originally endorsed by a consensus-based entity prior to their adoption.

Extraordinary Circumstances Exception

In the Hospital IQR, VBP program, RRP, and HAC reduction program, CMS is proposing to update and codify the ECE policy to include extensions of time as a form of relief and to further clarify the policy, as well as to align bthe Hospital IQR program with the quality reporting programs.

CMS proposed that a hospital may request an ECE within 30 calendar days of the date that the extraordinary circumstance occurred. The current policy allows a request within 90 days, but this proposed change aligns the IQR Program policy with other CMS quality programs. CMS proposed that CMS will notify the requestor with a decision in writing and will include if the hospital is exempted from one or more reporting requirements or if the hospital is granted an extension of time to comply with one or more reporting requirements. WHA supports the proposal to allow hospitals an exception, even if they have not requested one, but does not support the reduction of the notification period down to 30 days and ask CMS to retain the 90 days request period.

Future Consideration Request for Information – Well-being and Nutrition

CMS is seeking public input on measure concept for future years in the Hospital IQR program for the Well-being and Nutrition measures. The Well-being measure is a comprehensive approach that emphasizes person-centered care by promoting the well-being of patients and family members. CMS seeks input and comments on the applicability of tools and constructs that assess for the integration of complementary and integrative health, skill building, and self-care.

CMS adopted the Malnutrition Care Score (MCS) eCQM in the Hospital IQR program in the FFY 2023 IPPS final rule. This measure assessed adults 65 years of age and older admitted to inpatient hospital services who received care appropriate to their level of malnutrition risk and malnutrition diagnosis and was later expanded to include patients 18 years of age and older. CMS is seeking comments on tools and measures that assess optimal nutrition and preventive care in the Hospital IQR Program. This option is already in place.

WHA supports better understanding outcomes around well-being if there is no additional burden placed on hospitals for abstraction of the data.

Additionally, CMS invites comments on the use of Fast Healthcare Interoperability Resources (FHIR) in eCQM reporting. WHA supports the request for information and to give hospitals the opportunity to provide feedback about electronic processes to streamline quality measure reporting. WHA asks that enough time be allocated for hospitals to prepare for what processes are created and to ensure there is no financial or resource burden.

Hospital Readmissions Reduction Program

The Hospital Readmissions Reduction Program reduces payments to hospitals with excess readmissions. It also supports CMS' goal of improving health care for patients by linking payment to the quality of hospital care. In the FY 2026 IPPS/LTCH PPS proposed rule, CMS is proposing to:

- Modify the six readmission measures to add Medicare Advantage (MA) data, in addition to Medicare fee-for-service (FFS) data.
- Shorten the "applicable period" for measuring performance from three to two years and codify this update to the definition of "applicable period."
- Modify the calculation of aggregate payments for excess readmissions to include MA data in addition to Medicare FFS data.
- Update and codify the ECE policy to clarify that CMS has the discretion to grant an extension, rather than only an exception, in response to ECE requests. The program's update to the ECE policy would align with other quality programs.
- Remove a COVID-19 exclusions and risk-adjustment covariates from the six readmission measures.

As stated earlier, WHA supports being able to have a more comprehensive picture of the Medicare beneficiary performance, especially as Medicare Advantage (MA) enrollment continues to grow. WHA would like to raise the point that MA patients differ demographically and clinically, however, from traditional Medicare patients and risk adjustments may not fully capture these differences, potentially leading to inaccurate or lower scores for hospitals. This would in turn hold hospitals accountable for inappropriate coverage delays and denials by the Medicaid insurers. WHA recommends that the MA data collection period be initiated first, outside of the RRP program, to allow time for hospitals to collect, interpret, and act upon the data prior to it being tied to the RRP program. Therefore, we do not support incorporating this proposal to include the Medicaid patients at this time. WHA does support the removal of the COVID-19 exclusions from the RRP Readmission

These proposals would begin with the FY 2027 program year.

Hospital-Acquired Condition (HAC) Reduction Program

The HAC Reduction Program creates an incentive for hospitals to reduce the incidence of hospital-acquired conditions, reducing payment by 1% for applicable hospitals that rank in the worst-performing quartile on select measures of hospital-acquired conditions.

- In the FY 2026 IPPS/LTCH PPS proposed rule, CMS is proposing to update and codify the ECE policy to clarify that it has the discretion to grant an extension, rather than only an exception, in response to ECE requests. Additionally, CMS is providing notice of updating the CDC National Healthcare Safety Network (NHSN) healthcare-associated infections (HAI) chart-abstracted measures with the new 2022 baseline. The National Healthcare Safety Network (NHSN) 2022 Healthcare-Associated Infection (HAI) Rebaseline is a significant initiative by the Centers for Disease Control and Prevention (CDC) to update

the national baseline used for calculating Standardized Infection Ratios (SIRs) and Standardized Utilization Ratios (SURs) in the Patient Safety Component.

WHA appreciates the new models in the 2022 rebaseline use refined statistical methods and variables that better account for facility-specific risks and represent modern clinical practices, infection control protocols, and updated patient risk factors. This will allow for Wisconsin hospitals to compare their data to national averages using updated standards and not the outdated 2015 baseline. This rebaseline aligns infection prevention benchmarks with current healthcare trends and practices. WHA would like to caution that while the NHSN team has made significant progress, there have been some challenges and delays with bringing all infection measures to the new baseline. Healthcare providers have reported technical issues with the NHSN reporting system, including frequent changes to module tables, acceptance of incomplete data, and errors with data uploads. While utilizing the new baseline makes complete sense, ample time for hospitals to understand their data and align with federal requirements and reimbursement practices without penalty would be supported.

Hospital Value-Based Purchasing (VBP) Program

The Hospital VBP Program is a budget-neutral program funded by reducing participating hospitals' base operating DRG payments each fiscal year by 2% and redistributing the entire amount back to the hospitals as value-based incentive payments.

In the FY 2026 IPPS/LTCH PPS proposed rule, CMS is proposing to:

- Modify the Hospital-Level RSCR Following Elective Primary THA and/or TKA measure in alignment with updates proposed in the Hospital IQR Program.
- Remove the Health Equity Adjustment (HEA) from the Hospital VBP Program's scoring methodology beginning, with the FY 2026 payment determination.
- Update the program's ECE policy to align with other quality programs and to clarify that CMS has the discretion to grant an extension, rather than only an exception, in response to ECE requests.

Wisconsin has a diverse hospital landscape, with major academic medical centers alongside many rural and safety-net hospitals. The HEA specifically rewarded hospitals serving a high proportion of dual-eligible (Medicare + Medicaid) patients, many of whom are concentrated in urban Milwaukee and rural regions with high poverty rates. Some hospitals were able to receive benefit from the additional incentive will not agree with the removal of this, however, the complexity in calculation and transparency of the dual-eligible patient index has also brought confusion. WHA would support the acknowledgement of those hospitals that serve vulnerable populations that is clear and concise for any future measure additions.

In addition, CMS is notifying the public of:

- Technical updates to the Hospital-Level RSCR Following Elective Primary THA and/or TKA measure's risk adjustment model to use International Classification of Diseases (ICD)-10 codes instead of Hierarchical Condition Categories (HCCs).
- Technical updates to the five conditions and procedure-specific mortality measure to include patients with a principal or secondary diagnosis of COVID-19 in the measures' denominators.
- Technical update to the THA/TKA Complications measure to include patients with a principal or secondary diagnosis of COVID-19 in the measures' numerator and denominator.
- Updates to the CDC NHSN HAI chart-abstracted measures with the new 2022 baseline.
- Updates to performance standards for the FY 2027-FY 2031 program years.

WHA supports CMS' notification of the above bullet points.

Promoting Interoperability Program

In 2011, CMS established the Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs (now known as the Medicare Promoting Interoperability Program and the Promoting Interoperability performance category of the Merit-based Incentive Payment System) to encourage eligible professionals, eligible hospitals, and critical access hospitals (CAHs) to adopt, implement, upgrade, and demonstrate the meaningful use of certified EHR technology (CEHRT).

In the FY 2026 IPPS/LTCH PPS proposed rule, CMS is proposing to:

- Define the EHR reporting period in CY 2026 and subsequent years as a minimum of any continuous 180-day period within that CY for eligible hospitals and CAHs participating in the Medicare Promoting Interoperability Program and make corresponding revisions at 42 CFR 495.4. CMS proposed to maintain the EHR reporting period in CY 2026 and subsequent years as a minimum of any continuous 180-day period within that calendar year for eligible hospitals and CAHs participating in the Medicare PI Program**.**

Modified Measures:

- Beginning with CY 2026, CMS proposed modifications to the Security Risk Analysis measure and the SAFER Guides measure.
- For the Security Risk Analysis measure, CMS proposed to require eligible hospitals and CAHs to attest "yes" to having conducted security risk management in addition to the existing measure requirement to attest "yes" to having conducted security risk analysis. Under the proposed modified measure, eligible hospitals and CAHs would be required to attest that they have implemented policies and procedures to assess and manage security risks to electronic protected health information (ePHI) related to the use of EHRs, in accordance with the HIPAA Security Rule's risk analysis and risk management requirements.
- For the SAFER Guides measure, CMS proposed to require eligible hospitals and CAHs to attest "yes" to completing an annual self-assessment using the eight SAFER Guides published in January 2025. The 2025 SAFER Guides consist of eight guides organized into three broad groups of Foundational Guides, Infrastructure Guides, and Clinical Process Guides.
- Modify the Security Risk Analysis measure for eligible hospitals and CAHs to attest "Yes" to having conducted security risk management in addition to security risk analysis, beginning with the EHR reporting period in CY 2026.
- Modify the Safety Assurance Factors for EHR Resilience (SAFER) Guides measure by requiring eligible hospitals and CAHs to attest "Yes" to completing an annual self-assessment using all eight 2025 SAFER Guides, beginning with the EHR reporting period in CY 2026.

  WHA supports the decision to maintain a minimum 180-day EHR reporting period which offers flexibility and is appreciated. It provides organizations with more time to address vendor coordination, system updates, and operational planning — all critical considerations in a diverse state where hospital IT maturity levels vary. Hospitals will need sufficient time to implement any changes to this program as they are working with and through Electronic Health Record (EHR) vendors that all hospitals will draw upon simultaneously likely causing bottlenecks to making changes.

  However, the proposed modifications to the Security Risk Analysis measure and the SAFER Guides measure bring some concern. While Wisconsin hospitals understand the importance of strong cybersecurity and EHR resilience — especially in light of increasing cyber threats — the new

requirement to attest to both security risk analysis and active security risk management as an added compliance obligation may be difficult for smaller hospitals to operationalize without additional resources. In principal, WHA does not object to the security risk management expectations as it aligns with HIPAA, but recognizing that requiring a "yes" attestation to receive full credit is where our hesitation lies. Similarly, requiring annual completion of the newly updated 2025 SAFER Guides could pose logistical challenges for organizations with limited health IT staff, even if the intent to standardize safety and reliability is supported. WHA does not support the requirement of the time-consuming annual assessment for all 8 guides and the attestation likely overlaps the requirement of the security risk analysis .

Overall, Wisconsin hospitals support the goals of improved electronic health information security and system reliability but are likely to request technical assistance, streamlined reporting processes, and flexibility in implementation timelines to ensure successful adoption.

New Measure:

- Beginning with the CY 2026 EHR reporting period, CMS proposed adding an optional bonus measure to the Public Health and Clinical Data Exchange objective for eligible hospitals and CAHs that submit health information to a public health agency (PHA) using the Trusted Exchange Framework and Common Agreement (TEFCA). Under this proposal, an eligible hospital or CAH would be able to earn 5 bonus points under the Public Health and Clinical Data Exchange objective if the eligible hospital or CAH has attested that they are in active engagement (Option 2) with a PHA to submit electronic production data for one or more of the measures under the Public Health and Clinical Data Exchange objective using TEFCA. To attest "yes" for the Public Health Reporting Using TEFCA optional bonus measure, an eligible hospital or CAH must be a signatory to a TEFCA Framework Agreement.

  WHA appreciates CMS's proposal to add an optional bonus measure for Public Health Reporting Using TEFCA under the Promoting Interoperability Program beginning with the CY 2026 EHR reporting period. This aligns with advancing nationwide interoperability, and we support CMS's approach to incentivize — rather than mandate — early participation. Health systems in Wisconsin, including those already engaged with TEFCA-aligned networks like the Wisconsin Statewide Health Information Network (WISHIN), view this as a promising step toward strengthening data exchange with public health agencies. The use of bonus points encourages progress without penalizing providers still working toward technical readiness.

  However, we urge CMS to recognize the varied levels of preparedness across hospitals and public health agencies, particularly among rural and critical access hospitals that may face resource, staffing, and vendor limitations. Many of these facilities rely on EHR vendors that have yet to fully implement TEFCA functionality. We encourage CMS to provide additional technical guidance, consider extended implementation timelines, and explore funding support for smaller hospitals to enable equitable participation. Maintaining the measure as optional is critical, and we recommend CMS monitor implementation challenges closely before considering any future expansion or required use of TEFCA in the program.

CMS is also requesting information on:

- Future modifications to the Query of Prescription Drug Monitoring Program (PDMP) measure, including seeking public input on changing the Query of PDMP measure from an attestation-based measure ("Yes" or "No") to a performance-based measure (numerator and denominator), and expanding the types of drugs to which the Query of PDMP measure applies.
- The Medicare Promoting Interoperability Program's objectives and measures moving toward performance-based reporting.

- Improvements in the quality and completeness of the health information eligible hospitals and CAHs are exchanging across systems.

  WHA supports the transition away from structural attestation measures, however, would recommend that CMS consider working with hospitals and health systems, EHR vendors and other public and community agencies to identify the processes to expanding this requirement into a performance-based measure.

Changes to the Transforming Episode Accountability Model (TEAM)

In TEAM, selected acute care hospitals will coordinate care for patients with Original Medicare who are undergoing one of five surgical procedures. The five-year mandatory episode-based payment model will run from January 1, 2026, to December 31, 2030. Selected acute care hospitals will take responsibility for the cost and quality of care from a hospital-based surgery through the first 30 days after the patient's surgery. Proposed changes to TEAM would capture quality measure performance using patient-reported outcomes in the outpatient setting without increasing participant burden, improve target price construction, and expand the three-day Skilled Nursing Facility Rule waiver, giving patients a wider choice of and access to post-acute care.

Wisconsin hospitals are committed to delivering high-quality, cost-effective surgical care and support CMS's efforts to improve care coordination through models like TEAM. However, the mandatory nature of the model poses significant challenges, especially for hospitals that may not yet have the infrastructure to manage financial risk across episodes of care.

WHA appreciates the opportunity to provide comments on this proposed rule.

Sincerely,

Eric Borgerding
President & CEO