VANDERBILT UNIVERSITY MEDICAL CENTER

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June 10, 2025

The Honorable Mehmet Oz
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1833-P
P.O. Box 8013
Baltimore, MD 21244-8013

Submitted electronically via regulations.gov

Re: 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 [CMS-1833-P]

Dear Administrator Oz:

On behalf of Vanderbilt University Medical Center (VUMC), thank you for the opportunity to comment on the Centers for Medicare and Medicaid Services' (CMS) proposed rule for the fiscal year 2026 Hospital Inpatient Prospective Payment System (IPPS). We appreciate CMS' efforts to support access to medically necessary inpatient care, as well as efforts to improve the efficiency of data reporting and interoperability. However, we are concerned that reimbursement updates in the proposed rule do not adequately keep pace with inflation, placing financial strain on healthcare providers. Herein, we also provide responses to several RFIs included in the proposed rule.

I. Background on VUMC

VUMC is a comprehensive research, teaching, and patient care system headquartered in Nashville, Tennessee. VUMC operates three inpatient facilities—Vanderbilt University Hospital, the Monroe Carell Jr. Children's Hospital at Vanderbilt, and Vanderbilt Psychiatric Hospital—as constituent parts of its flagship campus. In addition, VUMC operates three regional hospitals, over 180 clinics throughout Tennessee and neighboring states, six surgery centers in Middle Tennessee, and joint ventures that include the Vanderbilt Stallworth Rehabilitation Hospital. In the fiscal year ending June 30, 2024, VUMC's approximately 43,000 employees provided 3.3 million clinic visits, 213,000 emergency department visits, 226,000 telehealth appointments, and treated 80,000 inpatients. Additionally, VUMC provides nearly $1 billion in annual charity care and other community benefits.

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II. VUMC Encourages CMS to Revise the IPPS Payment Rate Upwards

The proposed rule includes a 2.4% IPPS acute care hospital payment rate update. VUMC is concerned a below inflation payment adjustment will worsen an already challenging financial environment for many hospitals. As labor and medical supply cost pressures continue to rise, payment rates across CMS programs are not keeping pace with the rising costs of caring for Medicare beneficiaries. In 2022, CMS reimbursements on average covered only 82% of costs associated with providing care in hospital settings.[1] **Therefore, VUMC encourages CMS to revise upwards the FY2026 IPPS acute hospital payment rate in the final rule.**

III. Response to RFI "Toward Digital Quality Measurement in CMS Quality Programs"

As a pioneer of health information technology, VUMC has more than 20 years of experience developing, validating, and utilizing Electronic Health Record (EHR) systems[2]. VUMC agrees with CMS that electronic-based reporting of quality measures enables more efficient collection of quality data documented within EHRs. Leveraging the powerful capabilities of US-based EHR vendors to automate quality data collection and transition away from labor-intensive manual chart abstraction promises to provide substantial operational efficiencies for the healthcare system. We appreciate CMS' efforts to improve the efficiency of quality reporting programs and incorporate input from stakeholders.

We offer the below responses in relation to specific questions included in the RFI.

> **Question:** *"Would a minimum of 24 months from the effective date of a FHIR-based eCQM reporting option using ONC Health IT Certification Program criteria to support quality program submission provide sufficient time for implementation (including measure specification review, certified health IT updates, workflow changes, training, and testing)?"*
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> **Response:** As CMS moves to reporting for all programs through electronic means to decrease the burden on healthcare organizations, the steps to implement electronic reporting and any upcoming format changes of quality measures must be taken into consideration. The proposed 24-month timeline gives limited time for: 1) quality measure stewards to review and reformat existing quality measures; 2) EHR vendors to implement the quality measures within their products; and 3) healthcare organizations to determine the best method to include the reformatted quality measures into operational workflows. VUMC proposes that CMS extend the standard implementation timeline from 24 months to 36 months. This would provide 12 months for each of the three major steps in the process of converting dQMs/eCQM to the FHIR format for quality measures.

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[1] American Hospital Association, "Medicare Significantly Underpays Hospitals for Cost of Patient Care," AHA.org, May 22, 2025, https://www.aha.org/2024-01-10-infographic-medicare-significantly-underpays-hospitals-cost-patient-care.

[2] Fehintola Olumide, "VUMC Celebrates 20th Anniversary of Custom-Built EHR," *VUMC News*, December 2, 2021, https://news.vumc.org/2021/12/02/vumc-celebrates-20th-anniversary-of-custom-built-ehr/.

Question: *"Specific to FHIR-based quality reporting, are there any additional factors, or considerations to account for, that may help foster data harmonization and reduce reporting burden across entities?"*

Response: Consistent goals and direction in developing quality measures are crucial for promoting efficiency within CMS, provider organizations, and EHR vendors. Recent years have seen frequent changes for inpatient quality reporting, generating inefficiencies and lost opportunities. Substantial changes or elimination of measures during or after the development process have resulted in wasted resources and investments made by providers. VUMC maintains that transitioning to electronic quality reporting measures is a valuable investment. Minimizing the frequency and magnitude of changes to quality measures during and after development would help provide stability and reduce burdens associated with implementing changes to quality programs.

IV. VUMC Supports Reducing IQR Benchmarks for Hybrid Hospital-Wide Mortality and Hybrid Hospital-Wide Readmission Metrics

In the FY26 IPPS proposed rule, CMS proposed the lowering of the benchmarks for both the Core Clinical Data Elements (CCDE) and Linking Variables from 90% and 95% to a benchmark of 70% for the Inpatient Quality Reporting (IQR) program for Hybrid Hospital-Wide All-Condition All-Procedure Risk Standardized Mortality and Hybrid Hospital-Wide All-Procedure Risk Standardized Readmission Measures. VUMC agrees with CMS that this change would increase the feasibility of complying with the reporting requirement while preserving statistical rigor and reliability of the measures.

As CMS states in the proposed rule, healthcare organizations have struggled to reach the 90% and 95% benchmarks for CCDEs and Linking Variables during the voluntary reporting period. After reviewing internal data and engaging with other healthcare providers and our EHR vendor, we agree with CMS that several challenges exist with meeting such high thresholds. We thank CMS for acknowledging these challenges and proposing a well-reasoned reporting threshold.

V. VUMC Supports Proposed Changes to the Medicare Promoting Interoperability Program

VUMC supports CMS' proposals for the Medicare Promoting Interoperability Program, including: defining the EHR reporting period as a minimum of any continuous 180-day period; modifying the Security Risk Analysis measure for eligible hospitals and CAHs to attest "Yes" to having conducted security risk management and analysis; modifying the Safety Assurance Factors for EHR Resilience Guides measure to attesting "Yes" to completing annual self-assessment; and adding an optional bonus measure for data exchange with a public health agency using the Trusted Exchange Framework and Common Agreement.

VI. Response to RFI on "Changing the Query of Prescription Drug Monitoring Program (PDMP) Measure from an Attestation-Based Measure to a Performance-Based Measure"

VUMC is committed to the appropriate stewardship of controlled substances, and is proud of the work of the Vanderbilt Committee on Opioid Monitoring and Stewardship and our Controlled Substances Quality Oversight Committee to ensure compliance with federal, state and local laws and to guard against potential abuse and diversion.[1] Clinical teams at VUMC are committed to providing evidence-based care for patients with medical indications for the prescription of controlled substances, including substance use disorder treatment. We look forward to further partnership with CMS and the Drug Enforcement Agency on these critical public health challenges.

We offer the below responses in relation to specific questions included in the RFI.

> **Question:** *"Should CMS propose to adopt a performance-based (numerator/denominator) reporting requirement for the Query of PDMP measure? If so, how should the numerator and denominator be defined?"*
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> **Response**: We recommend a change to the proposed denominator to better reflect how controlled substances are prescribed, in compliance with DEA regulations and state law. **VUMC recommends altering the denominator to emphasize the number of encounters that resulted in the prescription of more than a three-day supply of controlled substances, and excluding direct inpatient administration of medications.**
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> As CMS acknowledges in the proposed rule, each state has their own prescription drug monitoring program (PDMP) and requirements on the frequency of PDMP queries. Under Tennessee state law, clinicians are required to query the PDMP for each new prescription within the first 90 days of an episode of care, and then every six months thereafter when a controlled substance remains part of a patient's care plan (TN Code § 53-10-310). Additionally, a patient may receive more than one controlled substance prescription in a single encounter, but clinicians are only required to check the PDMP once. Lastly, Tennessee state law does not require a PDMP query for direct administration of controlled substances during inpatient stays nor a 3-day supply of controlled substances for acute issues (TN Code § 53-10-310). Therefore, the requested change to the denominator would more accurately reflect the situations that a PDMP query is required.
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> Furthermore, clinicians or their staff may query the PDMP in the days leading up to an appointment if they know ahead of time that a controlled substance prescription may be refilled during an upcoming visit. In these instances, clinicians may be querying the PDMP directly in the state system and outside of the institution's EHR system. To help facilitate clinicians preparing to make the most of patient visits, we request CMS consider the timing and method of PDMP queries if this metric advances as a performance-based measure.

Question: *"What are potential barriers for eligible hospitals and CAHs meeting the Query of PDMP measure as a performance-based measure?"*

Response: The cost of integrating PDMPs within EHRs and technological capabilities of state agencies pose substantial challenges for a robust performance-based measure that relies on EHR integration. In Tennessee, our clinicians receive a PDF file within the EHR system from the state PDMP. While our EHR vendor supports discrete data, these data are not sent by the state as discrete data. VUMC clinicians based at our Kentucky locations must manually query state PDMP websites outside of the EHR system. Therefore, we request CMS consider the variety of methods states use to deliver PDMP query results when determining which actions fulfill the criteria of a PDMP query.

VII. Response to RFI Regarding "Performance-based Measures" for Public Health Data Sharing

As stated above, VUMC agrees with CMS that electronic reporting of clinical and quality data could provide substantial efficiencies for health care providers and government agencies alike. While we support efforts to advance electronic reporting, including for public health data, we are concerned about the technological capabilities of state agencies to receive these data.

We offer the below response in relation to the RFI.

Question: *"Approaches to public health reporting using FHIR have focused on greater automation of the interactions between health care providers and PHAs in order to reduce burden on providers, including eligible hospitals and CAHs, and increase PHAs' ability to obtain the information they need. How might FHIR approaches to the exchange of public health data impact measurement of eligible hospital and CAH performance?"*

Response: The capability of states to receive public health data via FHIR exchange standards varies greatly. State-level funding constraints have limited efforts to upgrade public health infrastructure at our partner public health agencies (PHA). Developing our current Health Level 7 (HL7) interfaces required several years and considerable investment from our PHA partners. VUMC is committed to enhancing data exchange to support this ongoing partnership to improve public health. However, if VUMC invested in upgrading our public health reporting to FHIR-based Application Programming Interfaces (API), it is not certain our PHA partners would have the necessary infrastructure to receive the data in this format. Historically, we have been able to attest an exclusion "due to operating in a jurisdiction for which no PHA can accept the specific standards required to meet the CEHRT definition." Therefore, performance-based measures related to sharing public health data via FHIR-based APIs with state PHAs may disadvantage providers in states lacking this capability. VUMC requests delaying the transition of Public Health and Clinical Data Exchange measures from attestation to performance-based measures until more states have adopted Trusted Exchange Framework and Common Agreement public health data exchange capabilities.

Thank you for the consideration of the above comments. If VUMC can provide any additional information or assistance to CMS on this matter, please do not hesitate to contact Nicholas Warren, PhD, of the VUMC Office of Federal Relations at nicholas.warren@vumc.org.

Sincerely,

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