SHEA
The Society for Healthcare Epidemiology of America

June 10, 2025

Dr. Mehmet Oz
Administrator
Centers for Medicare and Medicaid Services
U.S. Department of Health and Human Services
CMS-1833-P
P.O. Box 8013
Baltimore, MD 21244-8013
Submitted via http://www.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; Requirements for Quality Programs; and Other Policy Changes

Dear Administrator Oz,

The Society for Healthcare Epidemiology of America (SHEA) appreciates the opportunity to submit comments on the on the Centers for Medicare and Medicaid Services' (CMS) Fiscal Year (FY) 2026 Medicare Hospital Inpatient Prospective Payment System (IPPS) and Long-Term Care Hospital Prospective Payment System (LTCH PPS) proposed rule (herein referred to as "proposed rule").

SHEA represents more than 2,000 physicians and other healthcare professionals globally across the private and public health sectors with expertise in healthcare epidemiology, infection prevention and antibiotic stewardship. SHEA is dedicated to advancing the science and practice of healthcare epidemiology and preventing and controlling morbidity, mortality and the cost of care linked to healthcare-associated infections (HAIs) and antibiotic resistance.

SHEA respectfully submits comments on the following sections of the proposed rule:

- **Crosscutting Quality Program Proposals and Request for Comment**
- **Hospital Readmissions Reduction (HRR) Program**
- **Hospital Value-Based Purchasing (VBP) Program**
- **Hospital Acquired Conditions (HAC) Reduction Program**
- **Hospital Inpatient Quality Reporting (IQR) Program**
- **Medicare Promoting Interoperability Program**

Thank you in advance for your consideration of our comments. Please do not hesitate to reach out with questions to Lynne Batshon, Director of Policy

and Practice, at (703) 684-0761 or lbatshon@shea-online.org.

Sincerely,

David J. Weber, MD, MPH, FIDSA, FSHEA, FRSM
President
SHEA

Crosscutting Quality Program Proposals and Request for Comment

Proposed Removal of the COVID-19 Exclusion from the Hospital Readmissions Reduction (HRR) Program Beginning with the FY 2027 Program Year, Hospital Value-Based Purchasing (VBP) Program Beginning with the FY 2027 Program Year, and Hospital Inpatient Quality Reporting (IQR) Program Beginning with the FY 2027 Program Year

On p. 18286, CMS states:

> *"We are providing notice in this proposed rule that we intend to remove the COVID–19 exclusion from the readmission measures [of the Hospital Readmissions Reduction Program Measures] beginning with the FY 2027 program year."*

On p. 18292, CMS states:

> *"Accordingly, we are providing notice in this proposed rule that we intend to remove the COVID–19 exclusions from the five condition- and procedure-specific mortality measures and one procedure-specific complication measure beginning with the FY 2027 program year. This technical update will modify the technical specifications of the MORT–30–AMI, MORT–30–CABG, MORT–30–COPD, MORT–30– HF, and MORT–30–PN measures to include the ICD–10 codes that identify patients with a principal or secondary diagnosis of COVID–19 in the measure denominators. The technical update will also modify the technical specifications of the COMP–HIP–KNEE measure to include the ICD–10 codes that identify patients with a principal or secondary diagnosis of COVID–19 in both the measure numerator and denominator. Lastly, the technical update will remove the covariate adjustment for patient history of COVID–19 in the 12 months prior to the admission for all six measures in the Clinical Outcomes domain for the Hospital VBP Program beginning with the FY 2027 program year."*

On p. 18337, CMS states:

> *"We are removing the COVID-19 exclusion from all of the following Hospital IQR Program measures: MORT–30–STK…COMP–HIP–KNEE…Excess Days in Acute Care after Hospitalization for Acute Myocardial Infarction (AMI Excess Days)…Excess Days in Acute Care after Hospitalization for Heart Failure (HF Excess Days)…Excess Days in Acute Care after Hospitalization for Pneumonia (PN Excess Days)…Hybrid Hospital-Wide All-Cause Readmission Measure (HWR)…Hybrid Hospital-Wide All-Cause Risk Standardized Mortality Measure (HWM)."*

SHEA supports the proposed removal of the COVID-19 exclusion. Additional research on chronic conditions associated with long COVID can inform future rulemaking.

Proposed Removal of Two Social Drivers of Health Measures from the Hospital IQR Program Beginning with the CY 2024 Reporting Period/FY 2026 Payment Determination and Hospital PPS-Exempt Cancer Hospital Quality Reporting (PCHQR) Program Beginning With CY 2024 Reporting Period/FY 2026 Program Year

On p. 18337, CMS states:

> *"We propose to remove two social drivers of health (SDOH) process measures from the Hospital IQR Program beginning with the FY 2026 payment determination: Screening for*

Social Drivers of Health (SDOH–1) measure (adopted at 87 FR 49201 through 49215); and Screen Positive Rate for Social Drivers of Health (SDOH–2) measure (adopted at 87 FR 49215 through 49220).”

On p. 18345, CMS states:

“We propose to remove two social drivers of health (SDOH) process measures from the PCHQR Program beginning with the CY 2024 reporting period/FY 2026 program year: Screening for Social Drivers of Health measure (adopted in the FY 2024 IPPS/LTCH PPS final rule (88 FR 59210 through 59219)); and Screen Positive Rate for Social Drivers of Health measure (adopted in the FY 2024 IPPS/LTCH PPS final rule (88 FR 59219 through 59222)).”

SHEA supports efforts to understand social drivers of health, recognizing that socioeconomic conditions impact factors such as access to fresh food, medications, and physical activity. These factors, in turn, affect health outcomes for patients and place additional burdens on hospitals, health systems and non-acute healthcare settings. The reporting should favor variables that are most beneficial and least burdensome to healthcare facilities. For example, lack of health insurance has been associated with increased risk of healthcare-associated infections and other medical complications.[1] [2] People without insurance coverage are less likely to access care and more likely to delay or forgo care because of costs.[3] However, it would be of value to have these alternatives in place prior to retiring current data sources. Safety net hospitals serve a higher number of patients with poor socioeconomic status. We urge CMS to retain the Screening for Social Drivers of Health measure and Screen Positive Rate for Social Drivers of Health measure until such a time when more effective predictors of poor healthcare outcomes are identified.

Proposed Measure Updates to the Hospital-Level Risk-Standardized Complication Rate (RSCR) Following Elective Primary Total Hip Arthroplasty (THA) and/or Total Knee Arthroplasty (TKA) in the Hospital VBP Program Beginning with the 2023 Program Year and in the Hospital IQR Program Beginning with the FY 2027 Payment Determination

On p. 18290, CMS states:

“We are proposing to adopt substantive measure updates to the Hospital-level Risk-Standardized Complication Rate (RSCR) Following Elective Primary Total Hip Arthroplasty (THA) and/or Total Knee Arthroplasty (TKA) (hereinafter referred to as the COMP– HIP–KNEE measure), beginning with the FY 2033 program year. We are proposing these updates contingent on our adopting the same updates to the COMP–HIP–KNEE measure for use in the Hospital IQR Program beginning with the FY 2027 payment determination, which we discuss further in section X.C… The proposed substantive updates to the COMP–HIP–KNEE measure would expand the measure’s inclusion criteria to (1) include Medicare Advantage (MA) patients and (2) shorten the performance period from 3 years to 2 years. The addition of MA data to the measure would approximately double the cohort size, demonstrate measure reliability, and more accurately reflect the quality of care for both FFS and MA beneficiaries. Additionally, the proposed update to reduce the performance period from 3 to 2 years would allow for more recent data for assessing performance. Being able to report measures with only 2 years of data with satisfactory reliability would provide more relevant and up to date

[1] https://journals.lww.com/aosopen/fulltext/2023/03000/association_of_insurance_type_with_inpatient.23.aspx
[2] https://pubmed.ncbi.nlm.nih.gov/21605427/
[3] https://www.kff.org/uninsured/issue-brief/key-facts-about-the-uninsured-population/

quality information for actionable quality improvement insights."

On p. 18332, CMS states:

> *"We propose modifications to the current COMP–HIP–KNEE measure in the Hospital IQR Program beginning with the FY 2027 payment determination. Specifically, we propose to modify the COMP–HIP–KNEE measure with two substantive updates: (1) expand the measure's inclusion criteria to include MA patients; and (2) shorten the performance period from 3 years to 2 years. The addition of MA encounter data to the measure roughly doubles the cohort size, improves measure reliability, and more accurately reflects the quality of care for both Medicare FFS and MA beneficiaries. If finalized, we would remove the updated COMP–HIP–KNEE measure in the Hospital IQR Program beginning with the FY 2030 payment determination, as finalized in the FY 2024 IPPS/LTCH PPS final rule (88 FR 59168 through 59170), to prevent duplicative reporting of the measure in a quality reporting program and value-based program, and to simplify administration of both programs."*

SHEA supports the continued focus on patient outcomes relating to total hip and knee arthroplasty procedures.

Proposal To Update and Codify the Extraordinary Circumstance Exception (ECE) Policy for the HRR Program, Hospital VBP Program, HAC Reduction Program, Hospital IQR Program, and PCHQR Program

On p. 18289, CMS states:

> *"We propose to update and codify our ECE policy at 42 CFR 412.154(d) to include extensions of time as a form of relief and to further clarify the policy. Specifically, at proposed § 412.154(d)(1), we propose that CMS may grant an ECE with respect to reporting requirements in the event of an extraordinary circumstance—defined as an event beyond the control of a hospital (for example a natural or manmade disaster such as a hurricane, tornado, earthquake, terrorist attack, or bombing)—that affected the ability of the hospital to comply with one or more applicable reporting requirements with respect to a fiscal year."*

On p. 18301, CMS states:

> *"We propose to update the current ECE policy codified at 42 CFR 412.165(c) to include extensions of time as a form of relief and to further clarify the policy. Specifically, at proposed § 412.165(c)(1), we propose that CMS may grant an ECE with respect to reporting requirements in the event of an extraordinary circumstance—defined as an event beyond the control of a hospital (for example, a natural or man-made disaster such as a hurricane, tornado, earthquake, terrorist attack, or bombing)—that affected the ability of the hospital to comply with one or more applicable reporting requirements with respect to a fiscal year."*

On p. 18303, CMS states:

> *"We propose to codify the ECE policy at 42 CFR 412.172(c) and include extensions of time as a form of relief. Specifically, at proposed § 412.172(c)(1), we propose that CMS may grant an ECE with respect to reporting requirements in the event of an extraordinary circumstance—defined as an event beyond the control of a hospital (for example a natural or man-made disaster such as a hurricane, tornado, earthquake, terrorist attack, or bombing)—that affected the ability of the hospital to comply with one or more applicable reporting requirements with respect to a fiscal year."*

On p. 18344, CMS states:

> *"We propose to update the current ECE policy codified at 42 CFR 412.140(c)(2) to include extensions of time as a form of relief and to further clarify the policy. Specifically, at proposed § 412.140(c)(2)(i), we propose that CMS may grant an ECE with respect to reporting requirements in the event of an extraordinary circumstance—defined as an event beyond the control of a hospital (for example a natural or manmade disaster such as a hurricane, tornado, earthquake, terrorist attack, or bombing)—that affected the ability of the hospital to comply with one or more applicable reporting requirements with respect to a fiscal year."*

On p. 18348, CMS states:

> *"We propose to update the current ECE policy codified at 42 CFR 412.24(e) to include extensions of time as a form of relief and to further clarify the policy. Specifically, at proposed § 412.24(e)(1), we propose that CMS may grant an ECE with respect to reporting requirements in the event of an extraordinary circumstance—defined as an event beyond the control of a PCH (for example a natural or man-made disaster such as a hurricane, tornado, earthquake, terrorist attack, or bombing)—that affected the ability of the PCH to comply with one or more applicable reporting requirements with respect to a fiscal year."*

SHEA supports the proposed update and codification of the ECE policy for the HRR Program, Hospital VBP Program, HAC Reduction Program, Hospital IQR Program, and PCHQR Program.

Request for Information on Measure Concepts Under Consideration for Future Years in the Hospital IQR Program and Long-Term Care Hospital Quality Reporting Program (LTCH QRP)

On p. 18328, CMS states:

> *"We are seeking input on well-being and nutrition measures for future years in the Hospital IQR Program. Well-being is a comprehensive approach to disease prevention and health promotion, as it integrates mental and physical health while emphasizing preventative care to proactively address potential health issues. This comprehensive approach emphasizes person-centered care by promoting the well-being of patients and family members. We are seeking comments on tools and measures that assess overall health, happiness, and satisfaction in life that could include aspects of emotional well-being, social connections, purpose, and fulfillment. We would like to receive 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."*

On p. 18352, CMS states:

> *"We are seeking input on the importance, relevance, appropriateness, and applicability of each of the quality measure concepts under consideration listed in Table X.E.–02 for future years in the LTCH QRP…[including] well-being."*

SHEA supports the exploration of measures focused on nutrition and well-being for patients as well as well-being of healthcare personnel. To maximize utilization of readily available data, we recommend using malnutrition ICD-10 codes E40 to E46, which are a significant set of diagnoses on the complications or comorbidities exclusion list from a reimbursement perspective. Malnutrition is an important risk factor

for surgical site infections and prolonged inpatient stays.[4] CMS is in a unique position to analyze this data to quantify the proportion of United States population suffering from malnutrition and make recommendations for designing public health programs to improve the nutritional status of our population. We believe the adoption of nutrition-related measures is a promising first step. In future years, additional data collection could focus on specific nutrients and coexisting conditions that contribute to malnutrition. Much of this data is already available to CMS. To maximize the use of existing data, public reporting patients' nutrition status could also provide a valuable framework for initiatives aimed at addressing food deserts, increasing access to fresh foods, and improving nutrition among hospitalized patients.

Regarding well-being, SHEA asks the CMS to consider using available data on patient loneliness, which is currently collected as part of the social drivers of health screening data. This measure supports the current administration's desire to take a comprehensive approach to person-centered care. We urge the CMS to consider retaining elements of previously implemented screening practices that could support both current and future CMS initiatives.

In addition to the well-being of our patients, SHEA encourages CMS to consider measures examining the mental and physical health of healthcare personnel. Burnout is a significant challenge among infection prevention and healthcare epidemiology professionals that can impact patient care. We recommend the adoption of qualitative structural measures designed to sufficiently monitor staffing levels for infection prevention, antimicrobial stewardship, quality, and safety programs. Ensuring the presence of trained personnel to oversee these programs is necessary for the safety of healthcare delivery in our health systems and avoid burnout among healthcare personnel, including infection prevention and healthcare epidemiology professionals. We suggest CMS consider using the Malasch Burnout Inventory, which is considered the "gold standard" for measuring burnout by assessing emotional exhaustion, depersonalization, and personal accomplishment.[5]

To ensure the wellbeing of the U.S. healthcare workforce, SHEA supports encouraging healthcare facility-specific reporting on the proportion of healthcare personnel who are up to date on recommended preventive services. Such services include healthcare personnel vaccinations (e.g., hepatitis B vaccine to prevent blood borne acquisition of hepatitis B infection). Ensuring healthcare personnel compliance with wellness screenings and related guidelines could help to address this growing concern for healthcare personnel's well-being.

Hospital Readmissions Reduction (HRR) Program

Proposal To Integrate Medicare Advantage (MA) Beneficiaries Into the Cohorts of the Hospital Readmissions Reduction Program Measure Set Beginning With the FY 2027 Program Year

On p. 18283, CMS states:

> *"The proposed updates to the Hospital Readmissions Reduction Program measure set would include integrating MA beneficiaries into each measure's cohorts and reducing the applicable period from a three-year period to a two-year period. In addition, we propose to make a non-substantive modification; we would update the risk adjustment model to use individual International Classification of Diseases (ICD)-10 codes instead of Hierarchical Condition*

[4] https://pubmed.ncbi.nlm.nih.gov/20647925/
[5] https://meridian.allenpress.com/jgme/article/10/5/532/33731/Comparing-the-Maslach-Burnout-Inventory-to-Other

Categories (HCCs).”

While SHEA supports CMS’ efforts to expand the patient cohorts included in the HRR Program, we are concerned that hospitals could face double penalties – first through reimbursement reductions under the HRR Program for excess readmissions, and second through reimbursement denials from MA plans for those same readmissions. Therefore, the burden of financial risk will fall primarily on hospitals. Moreover, there are conflicting analyses comparing readmission rates and chronic disease burden between MA and FFS enrollees. For example, a retrospective cohort study analyzing Healthcare Effectiveness Data and Information Set data found MA beneficiaries had higher risk-adjusted 30-day admission rates than traditional Medicare beneficiaries.[6] SHEA supports future efforts by CMS to delineate the impact of including the MA cohort on hospital reimbursement, including regional and local trends.

SHEA supports the proposals to reduce the applicable period from a three-year period to a two-year period.

Hospital Value-Based Purchasing (VBP) Program

Proposed Removal of the Health Equity Adjustment (HEA) from the Hospital VBP Program Beginning with the FY 2026 Program Year

On p. 18301, CMS states:

> *“In this proposed rule, we are proposing to remove the HEA because simplifying the Hospital VBP Program’s scoring methodology by removing the HEA will improve hospitals’ understanding of the program and provide clearer incentives to hospitals as they seek to improve the quality of care for all patients.”*

SHEA opposes the proposed removal of the HEA. The HEA appropriately recognizes the resource intensity expended by hospitals that serve a higher proportion of patients dually eligible for Medicare and Medicaid. This form of risk-adjustment incentivizes hospitals in areas with less resources to invest more in the population. We urge the CMS to retain the HEA.

Hospital Acquired Conditions (HAC) Reduction Program

Technical Update to CDC’s National Healthcare Safety Network Healthcare-Associated Infection Measures for the HAC Reduction Program

On p. 18302, CMS states:

> *“During this update, HAI SIR calculations of infections reported beginning in CY 2025 will reflect the use of both the new 2022 standard population data and the 2015 standard population data. We anticipate that the new 2022 standard population data will affect the HAC Reduction Program beginning with the FY 2028 program year when both years of the 2-year applicable period (also referred to as the ‘‘performance period’’ of the measures), CY 2025 and CY 2026, will use the 2022 update to the standard population for the CDC’s NHSN measures.”*

[6] https://pmc.ncbi.nlm.nih.gov/articles/PMC6736728/

SHEA supports the adoption of an updated baseline for benchmark comparison of HACs.

Additionally, SHEA asks CMS to share its plans for future measures that may be incorporated into the HAC Program. Specifically, SHEA is interested to learn whether CMS plans to consider healthcare facility-onset, antibiotic-Treated *Clostridioides difficile* Infection (HT-CDI) and hospital onset bacteremia (HOB), which are two new measures proposed by the Centers for Disease Control and Prevention's National Healthcare Safety Network (NHSN). More broadly, it would be highly valuable to allow stakeholder input early in the process of considering any future measures.

SHEA recommends CMS adopt measures to track hospital performance in antimicrobial stewardship. NHSN has developed reporting structures for antimicrobial utilization and resistance, which could serve as a framework for such measures. Integrating existing NHSN measures on antimicrobial use and resistance for antimicrobial stewardship can maximize the return on financial and human capital investments. Specifically, SHEA suggests that *Clostridioides difficile* infection (CDI) be considered for an antimicrobial stewardship measure in future rulemaking. In practice, antimicrobial stewardship teams, along with infection prevention and control teams, would be responsible for CDI. The majority of patients at risk for clinical CDI arrive at healthcare facilities already colonized with *Clostridioides difficile* and subsequently develop infection after receipt of antimicrobials within the healthcare facility.

SHEA urges CMS to improve risk adjustment for hospitals caring for highly medically complex or socially vulnerable populations to mitigate unintended penalization. Lack of such adjustments can disproportionately impact safety net hospitals that are already resource-constrained. Heavily penalized hospitals are unfairly stigmatized and lose operating revenue as a result of the current process. One example includes the lack of exclusions in the colon surgery surgical site infection (COLO-SSI) measure for penetrating abdominal trauma. The current structure penalizes facilities for patients who develop infection after injury with non-sterile instruments that are often complicated by significant fecal contamination. Many of these patients are likely to develop infections regardless of the actions taken by a surgeon or facility. Facilities that treat high volumes of trauma cases will invariably see higher rates of COLO-SSI infections, even when strong infection prevention practices are in place. A retrospective review analyzing medical records and NHSN document for colon surgery procedures found that risk factors currently included in the model for COLO-SSI may not adequately account for the increased risk from penetrating trauma with fecal spillage.[7] In another retrospective cohort study, patients undergoing colon surgery at level 1 trauma centers had increased complexity of surgery compared to patients in other hospitals.[8] Therefore, SHEA proposes an exclusion for penetrating abdominal trauma for the COLO-SSI measure.

Lastly, SHEA highlights the NHSN catheter-associated urinary tract infection (CAUTI) measure's lack of specificity in patients whose primary symptom is fever. As with the central line-associated bloodstream infection (CLABSI) measure, allowances should be made for patients with clear secondary sources of infection. Secondary infection criteria as defined in the CDC/NHSN Surveillance Definitions for Specific Types of Infections (Chapter 17) should be applicable for patients where fever is used as the sign or symptom to meet Symptomatic Urinary Tract Infection (SUTI) criteria.[9] Some modifications would be needed to define which criteria are appropriate for CAUTI.

[7] https://academic.oup.com/ofid/article/8/Supplement_1/S60/6449544
[8] https://pubmed.ncbi.nlm.nih.gov/37462117/
[9] https://www.cdc.gov/nhsn/pdfs/pscmanual/17pscnosinfdef_current.pdf

Hospital Inpatient Quality Reporting (IQR) Program

Proposed Removal of the COVID-19 Vaccination Coverage among Healthcare Personnel Measure Beginning with the CY 2024 Reporting Period/FY 2026 Payment Determination

On p. 18336, CMS states:

> *"We propose to remove the HCP COVID–19 Vaccination measure beginning with the CY 2024 reporting period/FY 2026 payment determination under removal Factor 8, the costs associated with a measure outweigh the benefit of its continued use in the program. We note that reporting on this measure currently requires reporting data on COVID–19 vaccination coverage among HCP for at least 1 week every month. This requires hospitals to track current vaccination status for all employees, licensed independent practitioners, adult students/trainers and volunteers and other contract personnel and log in to the National Healthcare Safety Network (NHSN) system to report the data monthly either manually in NHSN or by uploading a comma-separated value (CSV) file (86 FR 45377)."*

SHEA supports the retirement of the HCP COVID–19 Vaccination measure as we transition into an endemic phase with COVID-19. It may be of value to consider a new measure for HCP COVID-19 vaccination once a stable vaccine regimen is established in the coming years.

Medicare Promoting Interoperability Program

Proposal To Add an Optional Bonus Measure Under the Public Health and Clinical Data Exchange Objective Beginning With the EHR Reporting Period in CY 2026

On p. 18360, CMS states:

> *"We propose to add an optional bonus measure under the Public Health and Clinical Data Exchange objective for health information exchange with a PHA that occurs using TEFCA. Specifically, beginning with the EHR reporting period in CY 2026, we propose the following optional bonus measure: Public Health Reporting Using TEFCA."*

SHEA supports the addition of an optional bonus measure for participating in public health reporting. The proposed financial incentive will encourage the sharing of health information between public health and health care systems. Integrating health systems with public health is critically important to improving surveillance and enhancing interventions.

RFI Regarding Performance-Based Measures

On p. 18375, CMS states:

> *"For this RFI, we are seeking to further refine our discussion of possible future measures to address commenter concerns and seek information to ensure any future proposals align with our goals of ultimately improving public health outcomes. Specifically, we are interested in new measure concepts for public health that would allow us to better focus on aspects of the data quality of public health reporting… In recent years, ONC has finalized updates to ONC Health IT Certification Program certification criteria that are included in CEHRT to provide technical capabilities based on FHIR, an advanced, modern interoperability standard*

developed by HL7 to facilitate efficient, scalable and standardized health information exchange. ASTP, CMS, and CDC plan to continue to explore opportunities to leverage FHIR-based capabilities within certified health IT to support public health reporting, and we are seeking comment on how such future updates could impact the potential measure strategies discussed in this section."

SHEA is concerned about the variability and irregularity of HAI quality measures. Fast Healthcare Interoperability Resource (FHIR) is a promising standard to improve accuracy, timeliness, and objectivity of reported data. In particular, we support prioritizing high volume adverse events to avoid overemphasizing rare outliers and to focus on the quality of care that affects the majority of patients. Automating the data collection process can also substantially reduce the time and effort required by infection prevention programs that currently rely on manual data collection.

SHEA recommends that CMS collaborate with professional organizations that possess clinical expertise in design and methodology. Potential challenges include variability in the location of data elements within an electronic health record and whether relevant data are captured by discrete fields that can be easily extracted for data transfer. Additionally, the underlying validity of these data may be unknown and could require assessment before an eligible hospital can participate in FHIR. Moreover, some health systems who are new to FHIR may require technical assistance to verify that the algorithm used for analysis is performing correctly. It must also have a method to confirm that any bonuses or penalties assessed are accurate and fair. While implementing FHIR would benefit public health and, over the long term, improve the quality and accuracy of public reporting measures, it may necessitate substantial upfront investment in time and financial resources to identify and validate data sources for FHIR integration, reduce administrative burden, and incorporate clinical variables into risk adjustment methodology.

Conclusion

SHEA thanks CMS again for the opportunity to provide feedback on the Hospital IPPS LTCH PPS proposed changes. We would be happy to provide CMS with any additional detail or address any questions you may have as you work to finalize the rule. For questions, contact SHEA Policy & Practice Director Lynne Batshon (lbatshon@shea-online.org).