



June 9, 2026

The Honorable Dr. 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

**Re: Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals (IPPS) and the Long-Term Care Hospital Prospective Payment System and Policy Changes and Fiscal Year (FY) 2027 Rates; Requirements for Quality Programs; and Other Policy Changes**

Dear Administrator Oz:

On behalf of Families USA, the longtime leading national, non-partisan health care consumer advocacy organization, thank you for the opportunity to comment on the proposed Medicare Hospital Inpatient Prospective Payment System (IPPS) regulation for Calendar Year 2027 (herein after “the Proposed Rule”). To advance our shared goals on payment reform, we strongly support one section of the proposed rule related to joint replacement and strongly oppose another change for patients experiencing homelessness.

Families USA is dedicated to achieving high-quality, affordable health care and improved health for all – a vision that cannot be realized without fundamentally shifting health care payment systems to deliver better health outcomes and more appropriately center the needs of patients and their families. Through the IPPS rule, the Centers for Medicare & Medicaid Services (CMS) makes changes that offer an important opportunity to both strengthen the Medicare program and signal to other payers the need to realign the economic incentives of health care payment and delivery to move towards a higher-value health care system.

Our comments are focused on the following sections of the proposed rule:

- II.C. Proposed Changes to Medicare Severity Diagnosis-Related Group (MS-DRG) Diagnosis Codes for FY2027
- X.C. Proposed Expansion of the Comprehensive Care for Joint Replacement (CJR) Model

These proposals pull Medicare payment policy in opposite directions. In the first, CMS proposes to eliminate the additional inpatient reimbursement hospitals receive for care delivered to patients experiencing homelessness – a change that will deprive hospitals of a high value payment that connects patients to essential services, ultimately worsening health outcomes and driving up health care costs. Families USA opposes this change. In stark contrast to that approach, another CMS proposal would establish a new, mandatory, bundled payment model for lower extremity joint replacement (LEJR) – a reform that drives better coordination,

improves quality and generates meaningful Medicare savings. **We urge CMS to take the path highlighted in the CJR-X model and continue to make improvements to Medicare payment that result in better health outcomes and more affordable care.** Our detailed comments follow:

### **II.C. Proposed Changes to Medicare Severity Diagnosis-Related Group (MS-DRG) Diagnosis Codes for FY2027**

**Families USA strongly opposes CMS’s proposal to reduce the severity level for the set of ICD-10-CM Z codes that describe homelessness, inadequate housing, and housing instability from a “complication and comorbidity” (CC) to a “non-complication and comorbidity” (nonCC). This proposal would eliminate the additional Medicare inpatient reimbursement that hospitals rely on to deliver comprehensive care to one of the most medically complex and resource-intensive patient populations. CMS should rescind this proposal.**

The evidence is clear: patients experiencing homelessness present with higher rates of comorbidities, often need longer inpatient stays, and require far greater care coordination and social service support than the general patient population.<sup>1</sup> Housing instability is a direct driver of clinical complexity, readmissions risk, downstream costs and health outcomes.<sup>2</sup> Reclassifying these Z-codes as nonCC would misrepresent this clinical reality and strip hospitals of a key resource and financial incentive to provide higher-value health care in the health care system that meets the needs of patients facing housing instability.

This proposal takes a major step back from previous CMS efforts to align hospital payment incentives with the goals of improving population health outcomes and making our nation’s seniors healthy. CMS makes Medicare payments to hospitals through the IPPS payment system for each acute, inpatient hospital stay.<sup>3</sup> Each diagnosis and procedure is coded with an ICD-10-CM code which is assigned a predetermined Medicare reimbursement amount. Z-codes are a subset of the ICD-10-CM codes which providers can use to add relevant context to a patient’s diagnosis and care when billing Medicare for inpatient stays.<sup>4</sup> Z-codes can include information on prior diagnoses, medical implant status, drug use history, and notably, health-related social needs (HRSN) (e.g., food insecurity, housing instability), that would not otherwise be captured in medical records.

Z-codes are an important tool in inpatient coding because they help to provide a complete picture of a patient’s health status and, when coupled with additional reimbursement, help providers better support patients’ needs.<sup>5</sup> Appropriately classifying the complexity of housing insecurity in the billing system creates a billing pathway for hospitals to ensure the reimbursement for treating more complex patients is adequate to support not just the patient visit in the hospital but also discharge planning, behavioral health supports, and social service supports that unhoused patients require.<sup>6</sup> Absent these critical supports and needed care, unhoused patients often cycle back through the emergency department at far greater cost and

hospitals are then forced to absorb these excess uncompensated care losses that erode their capacity to serve vulnerable communities.<sup>7</sup> This cycle harms access to care for the patients caught in this pattern and drives up health care costs to the Medicare program in the long run.

Moreover, this proposal undermines CMS's own stated priorities. In the FY 2024 IPPS Final Rule, CMS recognized that housing instability meets the clinical threshold for the CC designation and upgraded these Z-codes accordingly.<sup>8</sup> Families USA strongly supported this reform.<sup>9</sup> Reversing that decision just two years later without new clinical evidence sends a damaging signal to providers working to integrate health-related social needs (HRSN) screening and intervention into hospital workflows. It undermines hospital investment in whole-person care and harms the ability of our health care system to meet the health needs of our nation's seniors. This repeal hurts seniors experiencing homelessness, as well as the health systems and the broader community seeking to remedy the issue.

**As such, Families USA strongly opposes CMS's proposal to reduce the severity level of the set of homelessness Z-codes and urges CMS to maintain the CC severity status to ensure that Medicare reimbursement rates reflect the complexity of delivering care to patients experiencing homelessness. Furthermore, CMS should not only maintain the CC designation, but also should ultimately expand HRSN recognition across the IPPS system.<sup>10</sup>** If this administration keeps to its stated commitments about addressing the root causes of chronic disease and reducing long-term health care costs, Medicare payment policy must align accordingly. Downgrading housing instability codes moves CMS and our health care system in the exact wrong direction.

### **X.C. Proposed Expansion of the Comprehensive Care for Joint Replacement (CJR) Model**

**Families USA strongly supports the expansion of the Comprehensive Care for Joint Replacement Model, or "CJR-X", and CMS's continued investment in shifting Medicare payments away from fee-for-service economics and towards alternative payment models.**

The newly proposed CJR-X model extends, expands, and improves the previous Comprehensive Care for Joint Replacement model, a retrospective, bundled payment model for lower extremity joint replacement (LEJR) procedures aimed to lower costs, coordinate care, and improve health outcomes. If finalized, the CJR-X would be the first, nationwide test of a mandatory, episode-based payment model that holds hospitals accountable for the cost and coordination of LERJ care.<sup>11</sup>

Episode-based payments, also known as bundled payments, are an alternative payment model that holds providers accountable for the cost and quality of care over a defined clinical period.<sup>12</sup> The CJR and CJR-X models are retrospective bundles, meaning all providers are paid through traditional fee-for-service Medicare, but the hospital bears financial risk for total episode cost — receiving a bonus if spending falls below the target price or owing a repayment if it exceeds

it.<sup>13</sup> The original CJR model generated \$112.7 million in savings for the Medicare program while maintaining quality of care for over 98,000 LEJR patients and was certified by the CMS actuary for expansion due to its ability to produce Medicare savings.<sup>14</sup> The proposed CJR-X model and its improvements have the potential to realize significant savings for the Medicare program LEJR episodes of care.<sup>15</sup> Critically, the national expansion of the CJR model, which will require most hospitals in the country to participate, reflects CMS’s continued investment in shifting Medicare reimbursement away from the perverse incentives of fee-for-service economics towards alternative payment models.

**Families USA supports the target pricing methodology proposed in the CJR-X model but cautions that more frequent rebasing can lead to annual price cuts that could inadvertently penalize providers who are delivering cost-efficient care.** CMS aims to establish more accurate target prices that better drive down episodic spending by annually updating— or “rebasing”— financial benchmarks. Specifically, the CRJ-X model will set target prices based on three-year historical, regional, risk-adjusted claims data that will be moved forward and rebased each year, compared to the blended hospital and regional level claims data rebased every two years in the original CJR model. Because benchmarks will be rebased and updated annually, if hospitals within a region are able to successfully reduce episode spending, those hospitals may face annual pressure to increase care efficiency as benchmarks are rebased and those efficiencies are captured.<sup>16</sup> This phenomenon, known as the ratchet effect, can result in high performing providers becoming financially penalized for their success in a model.<sup>17</sup> While Families USA encourages CMS to monitor regional performance data for evidence of the ratchet effect, we recognize that more frequent rebasing supports more accurate target prices that better represent the cost of delivering care and that the three-year baseline will support a more gradual phase-in of lower target prices.

**Families USA strongly supports CMS’s efforts to implement more mandatory payment models by making CJR-X mandatory for nearly all acute care hospitals nationally.** The mandatory nature of the CJR-X model eliminates the risk of selection bias interfering with model data that comes with voluntary participation.<sup>18</sup> The expansion of mandatory participation of the CJR-X model from the previous CJR model’s more limited mandatory participation of providers in just 67 metropolitan statistical areas, allows CMS to better understand the impact of value-based care models across diverse providers.<sup>19</sup> This will allow the model to achieve results that could be scalable across the health care system and ultimately increase Medicare savings.

**Families USA also supports the proposed risk assessment measures at both the individual and provider level in CJR-X that ensure target prices accurately reflect the cost of delivering care.** Risk adjustment is a critical mechanism to account for the differences in patients’ health care costs and underlying health care needs when determining how much a health plan or health care provider is paid in a value-based payment arrangement.<sup>20</sup> The CJR-X model risk adjustment methodology draws from and expands on the enhanced risk adjustment methodology in the TEAM model. Like TEAM, the CJR-X model will adjust payment based on a 180-day lookback of Hierarchical Condition Category (HCC) data (for example, history of disability, cancer, obesity,

or dementia), a comprehensive measure of socioeconomic status that takes into account dual-eligibility status, Low Income Part D Subsidy qualification, area-level socio-economic deprivation, and age. The CJR-X model proposes several LEJR specific adjustments, including prior post-acute care use, disability as the original reason for Medicare enrollment, and prior LEJR procedure. In contrast, the original CJR model had a very limited risk adjustment model, taking into account only a patient's age, HCC data, and dual eligibility status and did not have an explicit adjustment at the participant level.<sup>21</sup>

This methodology newly takes into account provider circumstances by providing adjustments for hospitals with small bed sizes and those that have a high proportion of dually eligible patients. These hospitals tend to have fewer resources and serve a more complex patient population, which makes meeting the same target prices set for large hospital systems a challenge. The provider level risk adjustment calibrates prices upwards for these hospitals, giving them more flexibility in how much they can spend on LEJR care episodes. The model also includes a stop-loss/stop-gain cap at 5% for safety-net, rural, Medicare-dependent and sole community hospitals, which caps any repayment to Medicare at 5% of target spending, further protecting providers who more often serve patient populations with higher needs and operate on razor thin margins.<sup>22</sup> The diversity of risk adjustment measures at both the individual and participant level, including several analogues for social and economic risk factors, strengthens the CJR-X model's prediction of health care needs and costs which will ultimately help the model to drive higher quality, lower cost care in the Medicare program.<sup>23</sup>

Thank you again for the opportunity to comment on these important payment issues impacting the health and well-being of people across the country who receive inpatient hospital care. IPPS and other Medicare payment rules are crucial to addressing the failures of our current health care payment system and should be leveraged to better align the way health care is paid for with the needs of our nation's families.

Please contact Christine Nguyen (CNguyen@familiesusa.org), Senior Policy Analyst at Families USA, with any questions.

Sincerely,



Sophia Tripoli  
Senior Director of Health Policy

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<sup>1</sup> *The American Journal of Managed Care*. (2024, March 28). Homelessness compounds hospital stay challenges: Study reveals prolonged discharge struggles. <https://www.ajmc.com/view/homelessness-compounds-hospital-stay-challenges-study-reveals-prolonged-discharge-struggles>

<sup>2</sup> U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation. (2020, June). *Individuals experiencing homelessness are likely to have medical conditions associated with severe*

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illness from COVID-19 [Issue brief]. <https://aspe.hhs.gov/reports/individuals-experiencing-homelessness-are-likely-have-medical-conditions-associated-severe-illness-0>; Banerjee, S., Yassin, M., Dyer, W. T., Thomas, T. W., Rodriguez, L. A., & Schmittiel, J. (2024). Hospital readmissions among patients experiencing homelessness: An electronic health record data study. *The Permanente Journal*, 28(1), 55–61. <https://doi.org/10.7812/TPP/23.075>; see also, Gu, K. D., Faulkner, K. C., & Thorndike, A. N. (2023). Housing instability and cardiometabolic health in the United States: a narrative review of the literature. *BMC public health*, 23(1), 931. <https://doi.org/10.1186/s12889-023-15875-6>

<sup>3</sup> Here is the APA 7th edition citation:

Centers for Medicare & Medicaid Services. (2026, March 10). *Inpatient prospective payment system (IPPS)*. CMS Guide for Medical Technology Companies and Other Interested Parties. <https://www.cms.gov/cms-guide-medical-technology-companies-and-other-interested-parties/payment/ipps>

<sup>4</sup> Centers for Medicare & Medicaid Services. (2023, June). *Using Z codes: The social determinants of health (SDOH) data journey to better outcomes* [Infographic]. <https://www.cms.gov/files/document/zcodes-infographic.pdf>

<sup>5</sup> Arteaga, K. (2025, January 14). Z codes 101: What you need to know for clinical documentation, value-based care. *IMO Health*. <https://www.imohealth.com/resources/z-codes-101-what-you-need-to-know-for-clinical-documentation/>

<sup>6</sup> Tsai, J. (2024). Increased Medicare payments for homeless patients provide new opportunities for care. *The American Journal of Managed Care*, 30(3), e63–e64. <https://doi.org/10.37765/ajmc.2024.89516>; see also, Marcus, E. R., Carreras Tartak, J. A., Halasz, H., Chen, D., Lee, J., & He, S. (2024). Discharge process for patients experiencing homelessness in the emergency department: A thematic qualitative study. *PloS one*, 19(6), e0304865. <https://doi.org/10.1371/journal.pone.0304865>

<sup>7</sup> Fabian, J. (2024, March 28). Homelessness compounds hospital stay challenges: Study reveals prolonged discharge struggles. *The American Journal of Managed Care*. <https://www.ajmc.com/view/homelessness-compounds-hospital-stay-challenges-study-reveals-prolonged-discharge-struggles>

<sup>8</sup> Centers for Medicare & Medicaid Services. (2023, August 1). *FY 2024 hospital inpatient prospective payment system (IPPS) and long-term care hospital prospective payment system (LTCH PPS) final rule — CMS-1785-F and CMS-1788-F fact sheet*. <https://www.cms.gov/newsroom/fact-sheets/fy-2024-hospital-inpatient-prospective-payment-system-ipps-and-long-term-care-hospital-prospective-0>

<sup>9</sup> Tripoli, S. (2024, June 10). *Re: CMS-1808-P, calendar year (CY) 2025 Medicare and Medicaid programs and the Children's Health Insurance 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 2025 rates; quality programs requirements; and other policy changes* [Comment letter]. Families USA. <https://familiesusa.org/wp-content/uploads/2024/06/Families-USA-IPPS-CY25-Comments.pdf>

<sup>10</sup> U.S. Department of Health and Human Services. (n.d.). *Make America healthy again*. <https://www.hhs.gov/maha/index.html>

<sup>11</sup> Centers for Medicare & Medicaid Services. (n.d.). *CJR-X model*. Center for Medicare and Medicaid Innovation. <https://www.cms.gov/priorities/innovation/innovation-models/cjr-x>

<sup>12</sup> American Hospital Association. (2013, January 25). *Moving towards bundled payment* [Issue brief]. <https://www.aha.org/issue-brief/2013-01-25-moving-towards-bundled-payment>

American Hospital Association. (n.d.). *Bundled payment*. <https://www.aha.org/bundled-payment/bundled-payment>

<sup>13</sup> Neiman HPI. (n.d.). *Bundled payment models*. ICE-T. <https://www.neimanhpi.org/ice-t/bundled-payments-models/>

<sup>14</sup> Centers for Medicare & Medicaid Services. (n.d.). *Innovation insight: Comprehensive Care for Joint Replacement (CJR) model generates savings for Medicare*. Center for Medicare and Medicaid Innovation. <https://www.cms.gov/priorities/innovation/innovation-insight-comprehensive-care-joint-replacement-cjr-model-generates-savings-medicare>

<sup>15</sup> American Hospital Association. (2021, April 30). *Comprehensive Care for Joint Replacement (CJR) final rule* [Issue brief]. <https://www.aha.org/system/files/media/file/2021/04/04-30-21-SB-Comprehensive-Care-for-Joint-Replacement-CJR-FinalRule.pdf>

<sup>16</sup> McDermott+. (n.d.). *The significance of the proposed CJR-X model: What it could mean for hospitals going forward*. <https://www.mcdermottplus.com/blog/regs-eggs/the-significance-of-the-proposed-cjr-x-model-what-it-could-mean-for-hospitals-going-forward/>

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<sup>17</sup> Medicare Payment Advisory Commission. (2022, June). *Report to the Congress: Medicare and the health care delivery system* (Chapter 1). [https://www.medpac.gov/wp-content/uploads/2022/06/Jun22\\_Ch1\\_MedPAC\\_Report\\_to\\_Congress\\_SEC.pdf](https://www.medpac.gov/wp-content/uploads/2022/06/Jun22_Ch1_MedPAC_Report_to_Congress_SEC.pdf)

<sup>18</sup> Congressional Budget Office. (2023, September). *The effects of CMMI's models on Medicare spending*. <https://www.cbo.gov/system/files/2023-09/59274-CMMI.pdf>

<sup>19</sup> Davis, J., & O'Brien, K. (2024, April 18). *CMMI proposes new mandatory episode-based payment model*. McDermott+. <https://www.mcdermottplus.com/blog/regs-eggs/cmmi-proposes-new-mandatory-episode-based-payment-model/>

<sup>20</sup> Commonwealth Fund. (2024, April). *The basics of risk adjustment* [Explainer].

<https://www.commonwealthfund.org/publications/explainer/2024/apr/basics-risk-adjustment>

<sup>21</sup> Centers for Medicare & Medicaid Services. (n.d.). *Comprehensive Care for Joint Replacement (CJR) model*. Center for Medicare and Medicaid Innovation. <https://www.cms.gov/priorities/innovation/innovation-models/cjr>

<sup>22</sup> Sutton, J. P., Washington, R. E., Fingar, K. R., & Elixhauser, A. (2016, October). *Characteristics of safety-net hospitals, 2014* (HCUP Statistical Brief #213). In *Healthcare Cost and Utilization Project (HCUP) Statistical Briefs* [Internet]. Agency for Healthcare Research and Quality. <https://www.ncbi.nlm.nih.gov/books/NBK401306/>

<sup>23</sup> Families USA. (n.d.). *Risk adjustment 101: Protecting access to high-quality health care*.

<https://www.familiesusa.org/resources/risk-adjustment-101-protecting-access-to-high-quality-health-care/>