Vol. 70, Issue 23
Thursday, June 11, 2026

WHA Comments on Proposed CMS 2027 Inpatient Rule

On June 9, the Wisconsin Hospital Association (WHA) submitted comments on the Centers for Medicare and Medicaid Services' (CMS) proposed 2027 Medicare Inpatient Rule.

WHA expressed continued concern about the inadequate increase in Medicare payment adjustments that do not account for the true level of inflation or cost increases felt by hospitals. As highlighted in a March 2026 report by the American Hospital Association, overall hospital expenses grew 7.5% in 2025 alone, more than double the rate of hospital price growth. Workforce costs—nearly 60% of total hospital spending—rose 5.6% as hospitals worked to maintain adequate staffing across nursing, physician and technical roles. At the same time, supply costs increased 9.9% and drug expenses climbed 13.6%, far outpacing general inflation and the meager 2.4% increase proposed by CMS, after taking into account the ACA-mandated productivity cut of -0.8%.

This is compounded by a demographic impact of Wisconsin being tied for 8th among states with the highest percentage of their population covered by Medicare, at 22%. Every day, more Wisconsinites move off commercial coverage and onto Medicare, which reimburses hospitals about 74% of what it costs them to care for such patients. From 2016 to 2024, the average payor mix for a Wisconsin hospital has seen Medicare grow from 43% to 49%, while commercially insured patients have shrunk from 37% of the payor mix to only 32% concurrently, according to claims data analyzed by the WHA Information Center. Due to this, **annual Medicare underpayments to Wisconsin hospitals have grown from $1.77 billion in 2016 to $3.6 billion in 2024, more than doubling in 8 years**.

WHA also acknowledged in its comment letter the importance of Congress extending the Medicare-Dependent (MDH) and Low-Volume Hospital (LVH) adjustment programs past their current expiration of December 31, 2026. Losing these two programs would mean a nearly $230 million cut in Medicare reimbursements over the course of 10 years for approximately 16 Wisconsin hospitals.

WHA also commented on the proposed changes to inpatient quality programs governed by CMS, offering support for CMS's continued shift toward outcome-based measurement and digital quality reporting which reduces the burden of manual chart abstraction, and affords more timely, two-year performance periods. However, WHA emphasized that these changes must be implemented in a prospective and phased manner that provides hospitals a clear opportunity to understand new requirements, validate data and improve performance before measures are tied to payment. WHA expressed concerns that applying significant changes (such as adding Medicare Advantage (MA) patients or revising specifications to performance periods that are already underway) creates an unfair and non-actionable environment and risks misrepresenting hospital performance. While many hospitals have made significant progress in building Electronic clinical quality measure (eCQM) infrastructure, these measures still require ongoing investment in IT systems, workflow design, data mapping and annual updates. As CMS expands required measures, such as hospital harm eCQMs and others, WHA strongly encouraged the agency to carefully consider cumulative reporting demands, alignment across programs and the need for adequate lead time and clear guidance.

For the Inpatient Quality Reporting (IQR) Program, WHA acknowledged the value of new outcome measures but raised concerns about growing measure burden and overlap. For example, the proposed Diabetes Excess Days in Acute Care (EDAC) measure adds another layer of accountability for post-discharge outcomes that are often influenced by factors beyond hospital control, while also overlapping conceptually with existing readmissions metrics. Similarly, as CMS expands hospital harm and other eCQMs, hospitals are managing increasing complexity from maintaining both claims-based and EHR-based measures, often with duplicative or misaligned priorities. WHA urged CMS to streamline measures, reduce redundancy and focus on the measures that provide the greatest value, while ensuring new measures are feasible and sufficiently vetted before adoption.

Finally, WHA expressed concern with broader proposals that expand accountability without sufficient readiness or control, including: the addition of MA patients across multiple programs, changes to mortality and EDAC measures that would be applied retroactively and the proposed nationwide expansion of the CJR-X bundled payment model. These changes represent significant shifts in patient populations, financial risk and operational expectations, particularly for rural and critical access hospitals. WHA recommended a phased or voluntary approach for major policy changes and stressed the importance of separating measure redesign from immediate payment consequences.

Across all programs, WHA encouraged CMS to use consistent, thoughtful implementation, alignment and adequate transition time, all of which are essential to ensure these initiatives drive meaningful and sustainable improvements in patient care.

Please contact WHA Vice President of Federal Affairs and Advocacy Jon Hoelter with questions.

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