June 10, 2025

Administrator Mehmet Oz
Centers for Medicare and Medicaid Services
U.S. Department of Health and Human Services
200 Independence Avenue SW

Re: 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 2026 Rates; Quality Programs Requirements; and Other Policy Changes

Dear Administrator Oz,

On behalf of the more than 200 children's hospitals across the country, the Children's Hospital Association (CHA) appreciates the opportunity to provide comments on the *Hospital Inpatient Prospective Payment Systems (IPPS) for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System* proposed rule. Although most children's hospitals are exempt from the Medicare IPPS because they treat very few Medicare enrollees, oftentimes changes in Medicare policy influences the Medicaid program's policies and commercial insurance policies. Therefore, we are commenting on specific aspects of the proposed rule that could have implications for pediatric health care. In particular,

- We encourage further exploration of the possible impact of discontinuing the Hospital Low-Wage Index Policy on other policies and payment programs before finalizing.
- We oppose the removal of social determinants of health (SDOH) and Health Equity Measures from the Hospital Inpatient Quality Reporting (IQR) Program as these measures play a critical role in early interventions to prevent avoidable health complications and hospital stays.
- We highlight pediatric-relevant concepts related to potential wellness, nutrition, and preventive care measures in the Hospital IQR Program to support broader applicability across payers and systems in the future.

While Medicare only insures the very small subset of the pediatric population who suffer from end-stage renal disease, Medicaid is the backbone of coverage for children in the United States. Children represent nearly half of all enrollees in the Medicaid program, with approximately 30 million children receiving their health care coverage through Medicaid at some point during a year and account for 45% of all hospital days for children on Medicaid and provide highly specialized and complex care to many children with special health care needs.

Children's hospitals advance child health through innovations in the quality, cost, and delivery of pediatric care—regardless of payer—and serve as a vital safety net for uninsured, underinsured, and publicly insured children. We are regional centers for children's health, providing highly specialized pediatric care across large geographic areas. Although they account for less than 3% of hospitals in the United States, children's hospitals care for almost one-half of children admitted to hospitals and serve the majority of children with serious illnesses and complex and chronic conditions.

We are pleased to provide our detailed comments on aspects of the proposed rule with implications for children's hospitals and the children and families that rely on the care they provide.

Discontinuation of the Hospital Low-Wage Index Policy

We encourage further exploration of the possible impact of discontinuing the Hospital Low-Wage Index Policy on other policies and hospital payment programs before finalizing. For example, 59 IPPS-exempt teaching children's hospitals receive funding from the Children's Hospital Graduate Medical Education Payment Program (CHGME). The Health Resources and Services Administration uses the hospital wage index in the calculation to determine the hospital's CHGME payment and changes to the wage index could impact the payments that children's hospitals receive from this program.

Removal of SDOH and Health Equity Measures from the Hospital IQR Program

We appreciate CMS' efforts to streamline quality reporting under the Hospital IQR Program and the focus on measures that yield meaningful, actionable data. However, we do not support the proposal to remove SDOH and health equity measures from the Hospital IQR Program. Instead, we encourage CMS to explore refinements of these measures. When implemented thoughtfully—with attention to clinical relevance, risk adjustment and minimizing reporting burden—these measures can generate actionable insights without imposing unnecessary burden, and can promote consistency across payers and programs.

SDOH screening measurement is one of the few mechanisms in national quality programs that serves as a catalyst for hospitals to assess non-clinical social factors, such as housing instability, food insecurity, and lack of caregiver support, which deeply influence pediatric health, development, and well-being. Collecting and reporting this screening data enables providers to tailor care plans, improve care coordination, and intervene early to prevent avoidable health complications and hospital stays. For children, particularly those with chronic or medically complex conditions, regular screening for social needs is directly tied to reduced hospital readmissions, improved medication adherence, and ultimately, better long-term developmental outcomes.[1]

CMS' Request for Information on Wellness, Nutrition, and Preventive Care Measures for Future Consideration in the Hospital IQR Program

Children's hospitals appreciate the opportunity to provide input on CMS' request for information regarding wellness, nutrition, and preventive care measure concepts for future consideration in the Hospital IQR Program. While most children's hospitals are exempt from this program, Medicare quality measures often influence Medicaid, Children's Health Insurance Program, and commercial payer initiatives. We encourage CMS to engage pediatric stakeholders early in the development process to ensure emerging measures are meaningful, feasible, and reflective

[1] Whitman A, De Lew N, Chappel A, Aysola V, Zuckerman R, Sommers B. *Addressing Social Determinants of Health: Examples of Successful Evidence-Based Strategies and Current Federal Efforts*.; 2022. https://aspe.hhs.gov/sites/default/files/documents/e2b650cd64cf84aae8ff0fae7474af82/SDOH-Evidence-Review.pdf

of the needs of patients of all ages, including children, in the event state Medicaid programs or other payers choose to adopt them for their enrollees.

Many children's hospitals are leading efforts to integrate nutrition, emotional support, and family-centered care into clinical settings—approaches that are essential to long-term population health and chronic disease prevention. For example, children's hospitals are screening for food insecurity and malnutrition using validated tools; incorporating developmental and emotional health assessments into clinical workflows; and connecting families to community-based programs to promote food security, caregiver support, and social stability. Engaging children's hospitals and other pediatric stakeholders in measure development will allow CMS to build upon existing innovations and support the downstream development of measures that may be more readily adoptable by providers across care settings.

Furthermore, as CMS continues to advance person-centered, preventive quality measurement—including through the Make America Healthy Again (MAHA) initiative and its focus on reducing chronic disease—we urge the agency to ensure these efforts reflect the full life course, beginning in childhood. However, we caution that wellness, nutrition, and prevention-focused interventions often yield outcomes over extended periods of time, making them difficult to capture within traditional hospital-based measurement windows. While this is especially true for children, adult-focused preventative interventions may also require a long-term lens. It is critical that future wellness, nutrition, and preventive measures include intermediate and long-term outcomes and process measures to account for this extended time horizon, or they risk overlooking interventions that are essential, but not immediately measurable.

In addition, we appreciate CMS' interest in exploring broader indicators, such as well-being and happiness. We encourage you to confer with pediatric stakeholders as you consider how to define and measure these concepts. Direct input from pediatric providers, child development experts, and pediatric mental health professional is essential to ensuring that measures developed for the Medicare program can be adapted and modified into developmentally- and age-appropriate measures that are aligned with evidence-based practices, for potential use in payment systems that serve children. For example, children's cognitive and emotional development evolves rapidly over time, and their well-being is closely tied to caregiver support, social-emotional skill building and safe environments and may not be accurately captured through the same tools or metrics used for adults. Furthermore, the nation continues to face a pediatric mental health crisis, with rising rates of anxiety, depression, and suicide among youth. Ensuring future measures reflecting children's physical and mental health is critical to capturing a holistic picture of child well-being and guiding meaningful quality improvement throughout the lifespan.

We thank you for the opportunity to provide comments and look forward to continuing to work with you to improve children's health and health care. Please contact Sam Mitchell at sam.mitchell@childrenshospitals.org should you need more information.

Sincerely,

Aimee C. Ossman

Aimee Ossman
Vice President, Policy
Children's Hospital Association