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Mehmet Oz, MD
Administrator
Centers for Medicare and Medicaid Services
U.S. Department of Health and Human Services
200 Independence Avenue SW
Washington, DC 20201

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 Infectious Diseases Society of America (IDSA) appreciates the opportunity to comment on the fiscal year (FY) 2026 Hospital Inpatient Prospective Payment System (IPPS) Proposed Rule. IDSA is a global community of 13,000-plus clinicians, scientists and public health experts working together to solve humanity's smallest and greatest challenges, from tiny microbes to major outbreaks. Infectious diseases remain among the most pressing challenges facing health care systems, frequently causing and complicating chronic disease in patients of all ages. ID physician care has been proven to improve patient outcomes, reduce hospital length of stay and reduce costs.

We are pleased to support several components of the FY 2026 IPPS Proposed Rule as well as offer suggestions to strengthen some provisions, as detailed below.

FY 2026 IPPS payment rates

IDSA supports the proposed 2.4% increase in operating payment rates for general acute care hospitals under the IPPS for FY 2026. This increase, derived from a 3.2% market basket update with a 0.8% productivity adjustment, represents a critical investment in hospital infrastructure that directly impacts infectious disease care delivery. For example, the payment increase will help fund and sustain antimicrobial stewardship programs, support improvements in infection control and prevention measures and support improved coordination of patient care.

However, this increase is generally too low and not reflective of the overall rising costs that hospitals face, particularly as relates to retaining and increasing the vital infectious diseases workforce. **IDSA urges CMS to use additional data sources when calculating the annual update and determine if the productivity adjustment is an appropriate indicator.**

IDSA encourages CMS to maintain this payment increase in the final rule, as adequate hospital reimbursement is directly linked to hospitals' ability to prioritize infectious disease services, which often serve as cost centers rather than revenue generators despite their critical importance to patient care, safety and public health.

Operating room and non-operating room procedures

IDSA respectfully disagrees with CMS' proposal to maintain ICD-10 procedure codes 0N9T0ZZ (drainage of right mandible, open approach) and 0N9V0ZZ (drainage of left mandible, open approach) as non-O.R. procedures. While CMS states these procedures can be performed in outpatient settings, IDSA wishes to emphasize that when performed in the inpatient setting, these procedures often involve complex infectious disease cases requiring significant resources.

Open drainage of the mandible

Patients requiring inpatient open drainage of the mandible frequently present with severe odontogenic infections, osteomyelitis of the mandible or deep space infections that have progressed to involve the mandibular bone and the surrounding tissue. These infections typically require:

1. Specialized infectious disease consultation for complex antimicrobial management and recommendations
2. Surgical intervention under controlled conditions, often necessitating general anesthesia
3. Postoperative monitoring for both surgical complications and antimicrobial efficacy
4. Multidisciplinary care involving oral surgeons, infectious diseases specialists and other health care professionals

IDSA's registry data and clinical experience suggest that these procedures, when performed on hospitalized patients, are substantially different and more complex when compared to routine outpatient drainage procedures and more closely align with other O.R.-designated procedures in terms of resource utilization. The infectious nature of these cases specifically requires additional resources beyond the procedure itself, including extended antimicrobial therapy, infectious diseases consultation and potential management of sepsis or other systemic complications. As a result, **IDSA urges CMS to change the designation of ICD-10 procedure codes 0N9T0ZZ (drainage of right mandible, open approach) and 0N9V0ZZ (drainage of left mandible, open approach) from non-O.R. to O.R.**

Changes to MS-DRG diagnosis codes

IDSA supports CMS' comprehensive approach to evaluating complication and comorbidity (CC) designations, especially as they relate to infectious diseases. We particularly applaud the inclusion of guiding principles that recognize:

- Organ system instability or failure
- Chronic illness with susceptibility to exacerbations
- Conditions requiring higher levels of care
- Systemic impact

These principles appropriately capture the resource intensity associated with managing complex infectious diseases. However, IDSA recommends that CMS consider additional factors specific to infectious disease management when evaluating CC and major complication/comorbidity (MCC) designations:

1. **Antimicrobial resistance considerations:** IDSA recommends that infections caused by multidrug-resistant organisms be appropriately classified as MCC given the substantial additional resources required for isolation, specialized antimicrobial therapy and infection prevention measures. Current coding often fails to capture the increased resource utilization associated with resistant infections.
2. **Immunocompromised host factors:** Infections in immunocompromised hosts often require specialized diagnostic and therapeutic approaches beyond what is needed for immunocompetent patients. Biologic use is currently expanding in the use of transplant patients. IDSA recommends that CMS ensure these distinctions are reflected in CC/MCC designations.
3. **Role of antimicrobial stewardship:** IDSA supports recognition of the resource investment required for proper antimicrobial stewardship, which may not be adequately reflected in current MS-DRG assignments. Proper stewardship activities, while sometimes increasing short-term resource utilization, support long-term improvements in outcomes and reductions in antimicrobial resistance.

IDSA urges CMS to expedite its comprehensive CC/MCC analysis with particular attention to infectious disease conditions where current designations may not accurately reflect resource utilization patterns in contemporary practice.

We appreciate CMS' commitment to refining the MS-DRG system to better reflect hospital resource use and would like to collaborate on further improvements that accurately capture the complexity of infectious disease management in the inpatient setting, particularly in with patients that have multiple comorbidities or are immune compromised.

Toward digital quality measurement in CMS Quality Programs – request for information

Approach to Electronic Clinical Quality Measure (eCQM) reporting using Fast Healthcare Interoperability Resources (FHIR) in CMS Quality Programs

IDSA strongly supports CMS' transition to FHIR-based quality reporting and believes this standardization will ultimately improve the collection and utilization of infectious disease-related quality measures. However, we identify several specific challenges that merit particular attention:

1. **Antimicrobial stewardship measures**: The complexity of antimicrobial stewardship metrics presents unique challenges for FHIR conversion. These measures often require sophisticated logic to evaluate appropriateness of antimicrobial therapy based on multiple variables including culture results, patient characteristics, infection site and local antibiograms. We recommend CMS prioritize the development of FHIR resources specifically designed to capture antimicrobial stewardship activities, including:
    - Standardized representation of antimicrobial susceptibility data
    - Documentation of antimicrobial indication and duration review
    - Integration of clinical decision support interventions
2. **Infection-related diagnosis specificity**: Current FHIR resources may inadequately capture the nuanced nature of infectious disease diagnoses, particularly for syndromes with microbiologic confirmation pending or where empiric therapy is initiated. IDSA recommends developing enhanced value sets that accommodate the evolving diagnostic precision common in infectious diseases care.
3. **Outbreak detection parameters**: IDSA recommends CMS incorporate standardized FHIR resources capable of supporting public health surveillance and outbreak detection, particularly for health care-associated infections and emerging pathogens, enabling more seamless data exchange between health care facilities and public health entities.

To encourage additional engagement in FHIR testing activities, IDSA recommends:

- Creation of ID-specific implementation guides with example cases
- Establishment of infectious diseases quality measure working groups, including ID physicians and information technology specialists
- Development of specialized testing environments that simulate complex infectious disease scenarios
- Additional patient-specific risk factors, culture volumes and infectious source be integrated into eCQM for health care-associated infections (e.g., hospital onset bacteremia measure) and events that are not preventable be excluded

Data standardization for quality measurement and reporting

IDSA identifies several critical gaps that must be addressed before FHIR can be effectively used for infectious diseases quality reporting:

1. **Standardization of antimicrobial resistance data**: Current FHIR resources inadequately standardize the representation of antimicrobial resistance patterns. We recommend expedited development of standardized FHIR profiles for antimicrobial susceptibility reporting that align with Clinical and Laboratory Standards Institute guidelines.
2. **Integration with laboratory information systems (LIS)**: Many infectious disease quality measures rely heavily on microbiology data that may reside in laboratory information systems with varying degrees of EHR integration. IDSA recommends CMS develop specific guidance for laboratory data integration using FHIR and work with ASTP (formerly ONC) on this issue as the ASTP site has information regarding LIS interoperability.
3. **Representation of time-course data**: Infectious diseases management often requires tracking temporal patterns of clinical parameters (fever curves, inflammatory markers, etc.). IDSA recommends enhancement of FHIR resources to better capture and represent time-series clinical data relevant to infection monitoring.
4. **Social determinants of health**: Given the significant impact of social determinants on infectious diseases outcomes, IDSA recommends expanded FHIR resources to capture relevant social and environmental factors that influence infection risk, treatment response and complications.

Timeline under consideration for FHIR-based eCQM reporting

IDSA supports a measured transition to FHIR-based reporting but emphasizes several considerations specific to infectious disease reporting:

1. **Phased implementation by measure complexity**: We recommend CMS adopt a tiered implementation approach, beginning with simpler infectious disease measures (e.g., timely administration of appropriate antibiotics for sepsis) before progressing to more complex measures (e.g., appropriate de-escalation of antimicrobial therapy).
2. **Extended testing period**: Given the complexity of infectious disease data, IDSA recommends an extended voluntary testing period of at least 18-24 months before mandatory implementation to ensure systems reliably capture the nuanced data elements required for infectious disease quality assessment.
3. **Resource considerations for ID programs**: Many infectious diseases programs, particularly antimicrobial stewardship programs, operate with limited resources and technical support. IDSA

recommends CMS provide targeted technical assistance and financial support for these programs during the transition period.

4. **Alignment with public health reporting**: IDSA strongly recommends synchronizing the FHIR implementation timeline with CDC's modernization of infectious diseases reporting to minimize duplicate reporting burdens for health care facilities.

Measure development and reporting tools

IDSA recommends CMS prioritize the following capabilities in FHIR-based eCQM reporting:

1. **Antimicrobial use and resistance analytics**: Development of specialized tools that integrate antimicrobial prescribing data with microbiology results to generate meaningful stewardship metrics.
2. **Outbreak detection algorithms**: Incorporation of statistical process control and cluster detection algorithms that can leverage FHIR-standardized data to identify potential health care-associated infection outbreaks.
3. **Predictive modeling capabilities**: Tools that utilize standardized infectious diseases data elements to predict outcomes, risk-stratify patients and support clinical decision making.
4. **Benchmarking functionality**: Capabilities that allow facilities to compare their infectious diseases metrics against appropriate peers while accounting for case-mix complexity, facility type and regional resistance patterns.

Proposed changes to the Hospital Inpatient Quality Reporting (IQR) Program

Proposed removals in the Hospital IQR Program measure set

IDSA strongly opposes CMS' proposal to remove both the Hospital Commitment to Health Equity measure and the COVID-19 Vaccination Coverage Among Health Care Personnel measure from the Hospital IQR Program beginning with the CY 2024 reporting period/FY 2026 payment determination. IDSA believes the removal of these measures would undermine crucial efforts to enhance health of all patient communities in failing to address persistent disparities in infectious diseases outcomes that disproportionately affect racial and ethnic minorities, rural populations and economically disadvantaged communities. These disparities have been clearly documented across numerous infections including COVID-19, HIV, tuberculosis and health care-associated infections. **IDSA emphasizes that maintaining health care personnel vaccination reporting remains essential for infection prevention and control efforts, health care workforce protection and patient safety.**

IDSA strongly opposes the proposed removal of the COVID-19 Vaccination Coverage Among Health Care Personnel (HCP COVID-19 Vaccination) measure from the Hospital IQR Program. While we acknowledge CMS' cost-benefit analysis estimating a burden of $1.4-$1.6 million annually across all hospitals, IDSA believes this cost is substantially outweighed by the measure's continued public health value. The end of the public health emergency does not signify the end of COVID-19's impact on health care settings, where vulnerable immunocompromised patients remain at significant risk for severe outcomes. Vaccination of health care personnel remains a critical infection prevention strategy that protects both the health care workforce and patients. Discontinuing systematic tracking and reporting of vaccination status could lead to decreased institutional attention to vaccination programs, potentially reducing coverage rates and increasing transmission risk. Furthermore, this data collection infrastructure provides essential surveillance capacity that would be difficult to rapidly reconstruct during future respiratory virus surges or emerging infectious disease threats. IDSA urges CMS to maintain this measure, which aligns with the fundamental principles of infection prevention and health care epidemiology and represents a modest investment in ongoing outbreak and pandemic preparedness and health care system resilience.

While COVID-19 has evolved to an endemic state, it continues to pose significant risks to vulnerable hospitalized patients. The removal of these measures could diminish institutional accountability for health care worker vaccination programs that protect both health care workers and patients from preventable infectious diseases. **IDSA urges CMS to retain both measures.**

Hospital-Acquired Condition (HAC) Reduction Program updates and changes

Proposal to codify the Extraordinary Circumstances Exception policy for the HAC reduction

IDSA strongly supports CMS' proposal to codify the Extraordinary Circumstances Exception policy in the HAC Reduction Program regulations at 42 CFR 412.172(c), particularly the specification that extensions of time would be included as a form of relief. The 30-calendar day application window following an extraordinary circumstance represents a reasonable timeframe for hospitals to document and request exceptions. During public health emergencies, infectious disease outbreaks or other extraordinary circumstances, hospitals often face significant disruptions to normal operations that can affect their ability to collect, validate and submit quality measure data. These same circumstances frequently place exceptional demands on infectious diseases specialists and infection prevention teams who are otherwise responsible for HAC prevention and monitoring activities. IDSA believes this codification provides essential regulatory clarity and operational flexibility that will allow hospitals to appropriately prioritize direct patient care and emergency response during extraordinary circumstances without fear of financial penalties related to quality reporting requirements. **We encourage CMS to implement this proposal as written and to ensure that future interpretations of "extraordinary circumstances" appropriately recognize infectious disease emergencies and their downstream impacts on health care systems.**

Proposed changes to the Medicare Promoting Interoperability Program

Proposal to modify the Public Health and Clinical Data Exchange Objective: Adoption of an optional bonus measure for public health reporting using the Trusted Exchange Framework and Common Agreement

IDSA supports CMS' proposal to add an optional five-point bonus measure under the Public Health and Clinical Data Exchange Objective for health information exchange with public health authorities using the Trusted Exchange Framework and Common Agreement (TEFCA). As infectious diseases reporting and surveillance are cornerstone public health functions, IDSA recognizes the critical importance of streamlined, secure and standardized information exchange between health care facilities and public health entities. The proposed bonus measure appropriately rewards hospitals that have achieved validated data production status and are simultaneously advancing interoperability through TEFCA participation. This alignment incentivizes technical modernization while ensuring continued focus on actual data production for public health purposes. **IDSA believes this bonus measure will accelerate adoption of standardized approaches to public health data exchange, which is particularly crucial for infectious disease surveillance, outbreak detection and response coordination.** The increased interoperability facilitated by TEFCA participation will ultimately enhance situational awareness during infectious disease threats, improve case reporting completeness and timeliness and strengthen the nation's public health data infrastructure. We encourage CMS to implement this proposal and consider future expansion of TEFCA-based exchange options for additional infectious diseases reporting requirements.

The Transforming Episode Accountability Model (TEAM) proposals

While IDSA recognizes CMS' efforts to advance value-based care, we have significant concerns about several aspects of TEAM that may adversely impact infectious diseases care delivery and outcomes.

IDSA is particularly concerned about the mandatory nature of the model, which fails to account for the diverse capabilities and resources of hospitals to implement complex care coordination systems, especially those serving vulnerable populations with high infectious disease burdens. The model's 30-day

episode duration, while appropriate for tracking immediate post-discharge complications, may be insufficient for capturing the full course of many infectious disease treatments that require longer-term monitoring and management. For conditions such as complicated bacteremia, osteomyelitis or endocarditis, clinical outcomes may not be fully apparent within a 30-day window, potentially creating misaligned incentives for premature service reduction. **Additionally, we urge CMS to establish appropriate low-volume exclusions that protect small and rural hospitals where infectious diseases expertise is often limited and where mandatory participation could disproportionately impact financial stability and patient access to care.**

We are deeply concerned about CMS' decision to reduce social determinants of health policies within this model, including the elimination of health equity plan requirements and reduced sociodemographic data collection. Many infectious diseases disproportionately affect socially disadvantaged populations, and effective episode-based care must account for these disparities to achieve maximal outcomes across all patient communities.

The quality measurement approach finalized in TEAM inadequately captures infectious diseases care quality, with insufficient attention to appropriate antimicrobial use, infection prevention measures and long-term outcomes. IDSA recommends that CMS work directly with infectious diseases specialists to develop condition-specific quality measures relevant to infectious disease episodes before mandatory implementation. **Given these substantial concerns, IDSA recommends that CMS either significantly modify the TEAM model to address these critical issues or consider implementing it as a voluntary model with appropriate risk adjustment for infectious diseases care before mandating nationwide participation.**

IDSA thanks you for your attention to these important issues impacting our hospitals' approach to preventing, tracking and reporting on infectious diseases. We hope that our comments are useful as you work to finalize the FY 2026 IPPS rule. If you have any questions or if we may be of any assistance to you, please do not hesitate to contact Amanda Jezek, IDSA senior vice president for public policy and government relations, at ajezek@idsociety.org.

Sincerely,

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President

Infectious Diseases Society of America