C+TAC
COALITION TO TRANSFORM ADVANCED CARE

June 9, 2026

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-4201-P
P.O. Box 8013
Baltimore, MD 21244

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

Submitted electronically via www.regulations.gov

On behalf of the Coalition to Transform Advanced Care (C-TAC), we appreciate the opportunity to provide comments on this proposed rule regarding its effect on those living with serious illness.

C-TAC is a national, non-partisan, not-for-profit coalition dedicated to ensuring that all those living with serious illness, especially the sickest and most vulnerable, receive comprehensive, high-quality, person- and family-centered care that is consistent with their goals and values and honors their dignity. C-TAC comprises 200 national and regional organizations, including patient and consumer advocacy groups, practitioners, health plans, faith-based and community organizations, and others who share a common vision of improving care for serious illness in the U.S.

C-TAC defines serious illness as a health condition that carries a high risk of mortality and either negatively impacts a person's daily function or quality of life or excessively strains their family caregivers. This definition has been widely adopted, including by the National Committee for Quality Assurance (NCQA) and the National Quality Forum (NQF). Serious illness also differs by geography. People living in rural areas are older, sicker, and lack access to the full range of health care, and we advocate for improved care for any with less access to it.

Here are our comments on aspects of this proposed rule:

Hospital Inpatient Quality Reporting Program
C-TAC strongly supports the proposal to adopt a new advance care planning (ACP) electronic clinical quality measure (eCQM) for the Hospital Inpatient Quality Reporting (IQR) Program, PPS-Exempt Cancer Hospital Quality Reporting (PCHQR) Program, and the Medicare Promoting

Interoperability Program. I was personally involved in the development of this measure and, while it is not perfect, its focus on all adults 18+ is valuable as some with serious illness are younger than 65, the age specified in the current NQF #0326 ACP measure. All adults can benefit from having an advance care plan as one never knows when they might need medical care and not be able to speak for themselves.

C-TAC also appreciates CMS's goal of advancing person-centered, outcome-focused measurement. ACP is a foundational process for aligning care with patients' values, goals, and preferences. For people with serious illness, including those with dementia, advance care planning is a foundational element of high-quality hospital care because consequential decisions are often made in that setting and in moments of crisis. A hospital measure on advance care planning can help normalize earlier and more consistent discussions of values, goals, surrogate decision-makers, and treatment preferences, particularly when patients face progressive cognitive impairment and family caregivers must help interpret or carry out those preferences.

At the same time, CTAC urges CMS to make clear in subregulatory guidance and future measure maintenance that successful implementation should emphasize quality and usability of the documented information. Hospitals should be encouraged to ensure that advance care planning documentation is accessible across settings, reflects current surrogate decision-makers and care preferences, and supports real clinical decision-making during admissions, transfers, and discharge planning. We appreciate the agency's separate interoperability effort that has included advance directives.

CTAC also recommends that CMS monitor the measure's performance for populations at heightened risk of inequitable serious illness care, including people with dementia, people with disabilities, rural residents, dual-eligible beneficiaries, and people with limited English proficiency. Stratified analysis will help CMS determine whether the measure is promoting equitable uptake or whether some populations continue to receive less meaningful care planning and less caregiver engagement.

Finally, CTAC encourages CMS to view this measure as an important first step rather than an endpoint. In future years, CMS should build on the advance care planning measure by considering additional quality measures related to serious illness communication, symptom burden, caregiver experience, and goal-concordant transitions.

C-TAC's specific recommendations:

- Continue to validate the measure for use, ultimately, in all Medicare settings.
- Require structured fields that distinguish between: (1) new ACP discussions, (2) review and confirmation of existing ACP documents, and (3) updates or revisions to prior preferences, so that hospitals can track whether ACP is iterative over time rather than a one-time event.
- Provide guidance that specifies that simply uploading a scanned document without confirming its currency and relevance does not satisfy the intent of the measure; at

minimum, clinicians should document that the patient (or surrogate) confirmed that the document still reflects current wishes.

- Encourage capture of both narrative and coded elements, recognizing that short problem-list-style elements cannot fully reflect complex values but can help trigger clinical workflows and decision support.

MS-DRG Classification and Coding Changes

CTAC supports continued refinement of MS-DRG classification and coding policies but recommends closer attention to whether these methodologies reflect the full complexity of serious illness and dementia. These coding and severity-adjustment policies shape how hospitals classify and resource inpatient care for clinically complex patients. CTAC urges CMS to assess whether current DRG and coding logic sufficiently accounts for the combination of cognitive impairment, escalating functional dependence, behavioral symptoms, symptom burden, and caregiver instability that often accompanies dementia and other serious illnesses. A patient whose hospital stay is driven as much by complex communication and decision-making needs as by a discrete procedure may still require substantial hospital resources, and those needs should not be rendered invisible by coding policy.

New Technology Add-On Payment Policies

CTAC supports the continued use of New Technology Add-On Payment policies but recommends that CMS interpret innovation broadly and include technologies and tools that improve serious illness care delivery. As CMS evaluates technologies for additional payment, the agency has an opportunity to recognize innovations that improve not only disease treatment but also communication, symptom control, safety, and care coordination for people with serious illness.

That perspective is especially important for people living with dementia and their caregivers, for whom valuable innovations may include tools that reduce medication-related harm, support safer discharge, improve information transfer across settings, or facilitate access to documented goals of care. CTAC encourages CMS to avoid an innovation framework that disproportionately rewards high-cost procedural technologies while overlooking service-delivery advances that can materially improve quality of life and caregiver experience.

Readmissions, Excess Utilization, and Hospital Value-Based Purchasing

CTAC supports efforts to improve accountability for readmissions and value but does not support approaches that may inadvertently penalize goal-concordant care for people with serious illness. The proposed rule states that Table 15 will later display final FY 2027 readmissions payment adjustment factors and that Table 16 contains proposed proxy Hospital Value-Based Purchasing adjustment factors for FY 2027. These policies can drive important quality improvement, but they can also create unintended incentives if they are not interpreted in the context of serious illness trajectories and caregiver realities.

CTAC urges CMS to ensure that readmissions and value-based purchasing methodologies do not discourage appropriate hospice referral, intensive symptom management, or individualized

decision-making for patients whose goals may not center on repeated hospitalization. This is especially important for people with dementia, whose hospital use is often shaped by caregiver exhaustion, fragmented community supports, and the absence of timely outpatient serious illness care rather than by poor inpatient quality alone.

LTCH PPS and Long-Term Care Hospital Policies
CTAC generally supports maintaining and refining LTCH PPS policies but recommends stronger emphasis on informed decision-making and family communication. For people with serious illness, transfers to LTCHs and similar settings can have major implications for treatment burden, quality of life, prognosis, and caregiver strain. CTAC urges CMS to use LTCH-related policy and guidance to reinforce the importance of clear communication with patients and families before transfer. Families should understand the likely burdens and benefits of LTCH-level care, expected functional outcomes, alternatives such as palliative approaches or hospice when appropriate, and the extent to which the proposed plan aligns with the patient's goals and cognitive status.

Health Equity and Data Stratification Across the Rule
CTAC strongly supports applying an equity lens across the proposed rule and recommends more explicit stratified analysis relevant to serious illness, dementia, and caregivers. CMS has made impact files, wage index data, DSH supplemental data, and other supporting materials available to show the effects of the FY 2027 proposed rule on hospitals and payment policy. CTAC encourages CMS to build on that transparency by promoting stratified quality analysis wherever feasible so that disparities affecting people with serious illness are visible rather than masked within aggregate averages.

This recommendation is especially important for people living with dementia, who often experience inequitable diagnosis, delayed goals-of-care discussions, fragmented hospital-to-home transitions, and uneven support for family caregivers across lines of race, ethnicity, income, disability, geography, and language. The final rule should make clear that equitable hospital quality includes equitable communication, equitable access to advance care planning, and equitable support for the unpaid caregivers who make safe care at home possible.

Thank you for the opportunity to comment on this proposed rule. If you have any questions, please contact me at mgrant@thectac.org.

Sincerely,

Marian Grant

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