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June 4, 2026

**Mehmet Oz, MD**

Administrator  
Centers for Medicare & 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 2027 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) 2027 Hospital Inpatient Prospective Payment System (IPPS) proposed rule. IDSA is a global community of more than 13,000 clinicians, scientists and public health experts working together to address 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 diseases in patients of all ages. Infectious diseases physician care has been demonstrated to improve patient outcomes, reduce hospital length of stay and decrease costs, underscoring the essential role of infectious diseases expertise in high-quality inpatient care.

We are pleased to support several components of the FY 2027 IPPS proposed rule and to offer targeted recommendations to strengthen others, particularly those policies that affect antimicrobial stewardship, infection prevention and control, and quality measurement and data interoperability for infectious diseases care. IDSA's comments focus on ensuring that IPPS payment and quality policies adequately recognize the complexity and resource intensity of infectious diseases management, sustain and grow the infectious diseases workforce, and promote equitable access to high-quality care for all patient populations. We look forward to continued collaboration with the Centers for Medicare & Medicaid Services (CMS) to refine the IPPS in ways that advance patient safety, public health preparedness and the long-term sustainability of hospital-based infectious diseases services.

**FY 2027 IPPS payment rates**

**IDSA appreciates the proposed 2.4% increase in operating payment rates for general acute care hospitals under the IPPS for FY 2027.** As in prior years, this update represents an important investment in hospital capacity and directly affects the ability of hospitals to sustain core infectious diseases services, including antimicrobial stewardship, infection prevention and control, and coordination of care for medically complex patients with serious infections. At the same time, IDSA remains concerned that the payment update is generally too low and does not fully reflect the rising costs hospitals face, particularly with respect to recruiting, retaining and supporting the infectious diseases workforce. Adequate hospital reimbursement is closely tied to hospitals' ability to maintain infectious diseases programs, which are essential to patient safety and public health but often function as cost centers rather than revenue-generating service lines. Accordingly, IDSA urges CMS to maintain at least this payment update in the final rule, while also considering whether additional data sources and the current productivity adjustment more accurately capture the real-world cost pressures affecting hospitals and infectious diseases care delivery.

**Payment policies**



### **Medicare Severity Diagnosis Related Group (MS-DRG) title clarification for human immunodeficiency virus (HIV) cases**

IDSA supports the proposal to revise the Major Diagnostic Category 25 (HIV infections) header from “principal diagnosis of significant HIV related condition” to “principal diagnosis of HIV related condition” as a technical clarification to better align with existing MS-DRG terminology and logic. This change maintains the underlying assignment logic based on International Classification of Diseases, 10th Revision, Clinical Modification diagnosis code B20 (HIV disease) and the list of related conditions used for grouping, while reducing confusion between “significant” and “major” HIV related conditions as referenced elsewhere in the MS-DRG Definitions Manual. Because the proposal does not alter case assignment criteria or hospital payment and instead improves internal consistency and transparency in MS-DRG descriptions, IDSA views this revision as an appropriate and noncontroversial technical update.

### **New Technology Add-On Payment (NTAP) applications: Sepsis flagging and infectious diseases technologies; proposed repeal of the alternative pathway for NTAP and OPPI device pass-through**

IDSA appreciates CMS’ continued use of the NTAP policy to facilitate timely beneficiary access to innovative diagnostics, therapeutics and decision-support tools that address serious infectious diseases, including sepsis. **IDSA supports CMS’ proposal to continue NTAP for the Bayesian Health Sepsis Flagging Device under the alternative pathway for FY 2027, given the high morbidity, mortality and cost burden associated with sepsis and the potential for earlier recognition to improve outcomes when used in conjunction with clinician judgment and evidence-based sepsis care.** We urge CMS, however, to closely monitor real-world performance, including false positive and false negative rates across diverse patient populations and care settings, and to require robust post-implementation evaluation to ensure that algorithmic tools do not exacerbate disparities in sepsis recognition or treatment for historically marginalized communities. In addition, IDSA supports continuation of NTAP for qualifying infectious diseases diagnostics and therapeutics that remain in their newness period, while recognizing the importance of discontinuing NTAP once the three-year window has elapsed so that the IPPS can be recalibrated to reflect routine use of mature technologies.

At the same time, IDSA is concerned about CMS’ proposal to repeal the alternative pathway for NTAP (and the parallel pathway for OPPI device pass-through) beginning with applications for FY 2028, including for Food and Drug Administration-designated Qualified Infectious Disease Products (QIDP) and Limited Population Pathway for Antibacterial and Antifungal Drugs (LPAD) products, and to require all applicants to independently demonstrate substantial clinical improvement under a single, uniform standard. CMS has indicated that this change is intended to address concerns that the current alternative pathway relies heavily on FDA designation, rather than a full review of clinical improvement, and to better align spending with value. While IDSA supports rigorous evidence standards and appropriate stewardship of Medicare resources, we caution that eliminating the alternative pathway outright could create additional barriers and timing misalignments for urgently needed antibacterial and antifungal agents that target multidrug-resistant organisms and other high-consequence infections, as well as for other high-priority infectious diseases technologies.

**We therefore urge CMS to either maintain an appropriately structured alternative pathway for infectious diseases products or, at minimum, develop a modified framework that preserves an expedited, conditional approval process for qualifying infectious diseases technologies, allowing them to receive time-limited add-on payments while additional evidence is generated, with the expectation that these products ultimately meet the criteria for the traditional NTAP pathway through annual notice-and-comment rulemaking.** This approach would preserve streamlined access to high-priority infectious diseases diagnostics, therapeutics, and devices while still incorporating safeguards to ensure clinical benefit and prudent use of Medicare resources, and would avoid inadvertently slowing access to important QIDP, LPAD, and other critical ID products that previously relied on the alternative pathway for timely support.

### **Operating room (OR) and non-operating room designations: Review of methodology**

IDSA appreciates CMS’ continued attention to the methodology used to designate International Classification of Diseases, 10th Revision, procedure codes (ICD-10-PCS) as operating room or non-operating room procedures because these distinctions can materially affect the MS-DRG assignment and payment by determining whether the resource demands of a procedure are appropriately recognized. CMS continues to acknowledge that the original operating room and non-operating room designations were established many years ago and that subsequent updates have been



incremental, which underscores the need for a more systematic reassessment of whether current classifications accurately reflect contemporary clinical practice, procedural complexity and hospital resource use.

At the same time, IDSA is concerned that CMS has again deferred meaningful progress on the comprehensive, multiyear review it has discussed in prior rulemaking and states in the FY 2027 proposed rule that it needs additional time to develop its process and methodology. CMS is still preparing for this effort and intends to consider factors such as resources used, the effect of a procedure on MS-DRG assignment, the effect of specific surgical approaches, Medicare Provider Analysis and Review claims data, clinical advisor input, current MS-DRG assignments and current surgical hierarchy. While those are appropriate considerations, the absence of further methodological development in this year's proposed rule prolongs uncertainty for hospitals and clinicians whose services may be affected by outdated procedure classifications.

**IDSA therefore encourages CMS to move from general statements of intent to a more transparent and actionable framework in future rulemaking, including a clear timeline for review, opportunities for specialty society input and explicit criteria for evaluating procedures whose resource intensity may not be well captured by legacy operating room versus non-operating room categories.** This transparency is particularly important where advances in technology, minimally invasive techniques and evolving infectious diseases care pathways may alter the staffing, monitoring, equipment and ancillary resource needs associated with procedures in ways that are not fully reflected in current coding designations. In the interim, IDSA supports CMS' continued solicitation of stakeholder feedback and urges the agency to ensure that any future revisions preserve clinical coherence and payment accuracy rather than relying on assumptions tied to outdated procedural norms.

#### **Quality proposals**

##### **Modified mortality measures in the Hospital Inpatient Quality Reporting (IQR) Program**

IDSA recognizes CMS' rationale for proposing to adopt five modified mortality measures, including MORT-30-PN, in the Hospital IQR Program beginning with the FY 2028 payment determination, to include Medicare Advantage beneficiaries in addition to Medicare fee-for-service patients, and to shorten the performance period from three years to two years. CMS found that the inclusion of Medicare Advantage beneficiaries would allow the modified measures to maintain satisfactory reliability over a two-year reporting period and stated that it does not anticipate that small or rural hospitals would be unduly burdened by this change. Although IDSA appreciates CMS' efforts to refine these measures, **we are concerned that simultaneously expanding the denominator population, shortening the performance period and revising the risk-adjustment approach represents a fundamental re-specification of the measures. Accordingly, IDSA encourages CMS to clearly communicate to hospitals and other stakeholders that these modified measures should be understood as materially revised measures with newly calculated benchmarks and performance baselines, rather than as simple continuations of the existing measures.**

IDSA also appreciates CMS' intent to provide hospitals with performance information on the expanded patient cohort through annual confidential hospital-specific reports beginning with the FY 2028 program year and through annual Provider Participation Summary Reports under the Hospital Value-Based Purchasing Program beginning with the FY 2032 program year. These reports should give hospitals sufficient detail to understand how the revised specifications affect their performance, including the impact of the Medicare Advantage population, the shorter measurement window and the revised risk-adjustment methodology.

If CMS wishes to trend performance over time, IDSA recommends that any such analysis be clearly identified as bridging across old and new specifications and accompanied by appropriate explanatory context. CMS also proposes to update risk adjustment for the five modified mortality measures by using individual International Classification of Diseases, 10th Revision, codes instead of hierarchical condition categories, based on research suggesting that this approach could improve model performance and better capture condition-specific or procedure-specific severity. While this change may represent a methodological improvement, IDSA believes CMS should provide additional, stakeholder-facing information, including stratified analyses by hospital size, safety-net status and case mix, demonstrating how these revisions affect comparability, fairness and stability across hospitals serving different patient populations before the modified measures are fully incorporated into payment programs.

##### **Adult Community-Onset Sepsis Standardized Mortality Ratio measure**

IDSA appreciates CMS' request for comment on the potential future use of the Adult Community-Onset Sepsis Standardized Mortality Ratio measure in the Hospital IQR Program, as sepsis remains a major driver of inpatient



morbidity, mortality and resource use. IDSA notes that this measure has recently undergone multistakeholder review, and we appreciate CMS' interest in using it as an outcome-focused complement to existing sepsis process measures.

A thoughtfully specified sepsis mortality measure could help focus attention on comprehensive, hospital-wide approaches to sepsis care, including timely recognition, diagnostic optimization, evidence-based antimicrobial management and stewardship, infection prevention, and hospital-wide quality improvement for one of the most serious infectious syndromes treated in acute care settings. **Consistent with comments IDSA and partner societies have previously submitted in support of this measure and our shared goal of shifting from SEP-1 toward more meaningful outcome-based sepsis metrics, IDSA supports CMS' continued development and future use of the Adult Community-Onset Sepsis Standardized Mortality Ratio measure in the Hospital IQR Program.** In particular, IDSA is encouraged by the development and testing to date of a digital mortality measure anchored in CDC Adult Sepsis Event surveillance criteria, which has the potential to provide a more clinically credible and scalable approach to national sepsis quality measurement than existing manually abstracted process measures or ICD-10-based sepsis identification methods. **IDSA is especially supportive of approaches that limit reliance on billing code-based cohort identification, given longstanding concerns that coding practices can be manipulated to exclude higher-risk patients or include lower-risk patients in ways that produce misleading changes in observed outcomes without reflecting true improvements in sepsis care.**

IDSA encourages CMS to maintain a deliberate and transparent approach as it prepares this measure for adoption, including clear communication with stakeholders about any refinements to the specifications, attribution rules and data requirements. Any sepsis mortality measure should continue to be supported by a clear and clinically credible case definition, robust risk adjustment and testing that demonstrates the measure can distinguish quality of care from differences in patient acuity, comorbidities and presentation patterns across hospitals. As part of this work, IDSA urges CMS to provide analyses that explicitly assess the potential impact of coding behavior and to demonstrate that the measure is resilient to shifts in coding intensity or strategy over time. IDSA would welcome continued stakeholder engagement on this measure to ensure that any future proposal advances accountability and patient outcomes without creating unintended consequences for hospitals caring for the sickest and most medically complex patients.

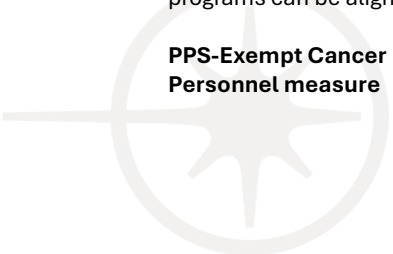
#### **Hospital Readmissions Reduction Program: Proposed sepsis readmission measure**

IDSA agrees that sepsis readmissions are an important quality concern but has significant reservations about CMS' proposal to adopt the Hospital 30-Day, All-Cause, Risk-Standardized Readmission Rate Following Sepsis Hospitalization measure directly into the Hospital Readmissions Reduction Program beginning with the FY 2029 program year. CMS' analyses suggest the measure is reliable; uses risk adjustment for age, comorbidities, frailty and sepsis severity; and incorporates both Medicare fee-for-service and Medicare Advantage beneficiaries, yet the Partnership for Quality Measurement's Hospital Recommendation Group did not reach consensus and recommended additional monitoring in a non-penalty context before broader program use.

Given these methodological and implementation concerns, IDSA believes this measure should, at most, be implemented in the Hospital IQR Program for further testing and public reporting. IDSA appreciates CMS' proposal to provide an "early look" at measure performance beginning with the FY 2028 program year, and strongly recommends that this non-penalty testing period be extended and used solely for confidential feedback and public reporting, not for payment adjustments, while hospitals gain experience with the measure and CMS evaluates its performance across diverse settings and patient populations. **IDSA therefore opposes adoption of the sepsis readmission measure into the Hospital Readmissions Reduction Program at this time and instead urges CMS to limit its use, for now, to non-penalty testing in the Hospital IQR Program with transparent reporting of model performance and stratified results; only after robust testing and stakeholder review should CMS reconsider whether it is appropriate to use this measure for financial penalties.**

While IDSA supports efforts to improve post-sepsis transitions, recovery and readmission outcomes as part of comprehensive sepsis care, we also note that this proposed measure relies on claims-based sepsis identification methods that differ from the emerging digital CDC/NHSN sepsis measurement framework proposed for the Adult Community-Onset Sepsis Standardized Mortality Ratio measure. CMS should carefully consider how future sepsis quality programs can be aligned to minimize unnecessary complexity and conflicting signals for hospitals.

#### **PPS-Exempt Cancer Hospital Quality Reporting Program: Removal of the COVID-19 Vaccination Among Healthcare Personnel measure**





**IDSA strongly opposes CMS' proposal to remove the COVID-19 Vaccination Among Healthcare Personnel measure from the PPS-Exempt Cancer Hospital Quality Reporting Program beginning with the calendar year (CY) 2026 reporting period and FY 2028 program year.** Cancer hospitals care for highly immunocompromised patients who remain at elevated risk of severe outcomes from respiratory viral infections, and continued measurement of health care personnel vaccination remains an important, low-burden indicator of institutional commitment to infection prevention and patient safety. Although CMS has proposed removing similar vaccination measures from other quality reporting programs, IDSA does not believe that program alignment alone justifies eliminating this measure in settings that serve uniquely vulnerable populations. In PPS-exempt cancer hospitals especially, maintaining transparency around health care personnel vaccination supports accountability, reinforces evidence-based prevention practices, and helps protect patients, staff and the broader care environment from avoidable transmission risks. **Given these considerations, IDSA recommends that CMS retain the COVID-19 Vaccination Among Healthcare Personnel measure in the PPS-Exempt Cancer Hospital Quality Reporting Program, or at minimum engage stakeholders in further discussion of alternative approaches that would continue to highlight and support vaccination for health care personnel caring for highly immunocompromised patients.**

#### **Long-Term Care Hospital Quality Reporting Program: Removal of COVID-19 vaccination measures**

**IDSA strongly opposes the proposal to remove both the COVID-19 Vaccination Among Healthcare Personnel measure and the COVID-19 Vaccine Percent of Patients/Residents Who Are Up to Date measure from the Long-Term Care Hospital Quality Reporting Program beginning with the CY 2026 reporting period and FY 2028 program year.** Long-term care hospitals serve patients with prolonged lengths of stay, high medical complexity and serious underlying illnesses, making continued visibility into both workforce vaccination and patient vaccination status especially important for infection prevention, outbreak mitigation and patient safety. In this setting, the two measures capture distinct and complementary dimensions of preparedness: One reflects the degree to which facilities protect patients by maintaining vaccination coverage among personnel, while the other reflects whether patients and residents themselves remain up to date against a pathogen that continues to pose substantial risk to medically fragile populations.

Although IDSA notes CMS' interest in alignment with other post-acute care settings and the agency's proposal to publicly report patient/resident vaccination data for the last time in the September 2026 Care Compare refresh, IDSA does not believe administrative alignment is a sufficient rationale for eliminating measures that remain clinically relevant in long-term care hospitals. **IDSA therefore urges CMS to retain both COVID-19 vaccination measures in the Long-Term Care Hospital Quality Reporting Program to maintain attention to prevention practices for patients at exceptionally high risk of severe outcomes.**

#### **Transforming Episode Accountability Model (TEAM)**

IDSA appreciates CMS' continued efforts to advance care coordination and accountability through TEAM, particularly for surgical episodes that extend into the post-discharge period. At the same time, because these episodes frequently involve medically complex patients and can include serious postoperative infections, sepsis and other complications requiring specialty input, CMS should ensure that the model does not create unintended incentives to limit infectious diseases consultation, appropriate antimicrobial therapy or other clinically necessary services.

#### **Exclusions from episode spending**

IDSA supports CMS' effort to exclude clinically unrelated items and services from TEAM episodes so that hospitals are not held accountable for care that falls outside the relevant surgical episode. IDSA also recognizes that CMS' goal in excluding certain admissions, Major Diagnostic Category 25 (HIV), and selected high-cost drugs and biologicals is to avoid creating incentives for hospitals to shift unrelated, high-cost care outside the episode window. However, CMS should carefully assess how these exclusions operate in practice, including the exclusion of certain admissions, Major Diagnostic Category 25 (HIV), and certain high-cost drugs and biologicals, to confirm that the policy is not inadvertently affecting access to clinically appropriate infectious diseases services for patients with complex needs. Patients with complex infectious diseases, including HIV and severe postoperative infections, may require specialized services and costly therapies that are essential to achieving good clinical outcomes.

**To guard against unintended consequences, IDSA recommends that CMS: (1) monitor patterns of use for excluded admissions and high-cost anti-infective therapies over time, including by hospital type and patient risk profile; (2) engage clinicians and hospitals to identify any emerging access barriers or delays in care attributable to episode design; and (3) be prepared to adjust the exclusions list or related guidance if evidence suggests that the policy is**



**discouraging timely, appropriate treatment of serious infections.** CMS should therefore clarify in guidance and future rulemaking that TEAM's exclusions policy will not undermine access to necessary infectious diseases care, antimicrobial stewardship or appropriate use of advanced therapies when those services are directly related to prevention or treatment of complications arising during the episode.

#### **Quality measurement and patient safety**

IDSA agrees that robust quality and patient safety monitoring is essential in a mandatory episode-based model such as TEAM, particularly to ensure that efforts to reduce spending do not compromise outcomes for medically complex patients. At the same time, IDSA has concerns about relying heavily on broad, all-cause measures such as the Hybrid Hospital-Wide All-Cause Readmission Measure within TEAM, given its wide clinical scope, complex risk adjustment and potential to obscure infection-specific issues that are central to our members' practice.

Because several TEAM episode categories involve meaningful risk of postoperative infection, respiratory failure and other serious complications, IDSA urges CMS to ensure that any measures used for quality adjustment in TEAM are clinically credible, appropriately risk adjusted, and able to distinguish differences in quality from differences in case mix, social risk and referral patterns. Broad hospital-wide measures may be useful for high-level surveillance and public reporting, but they are not always the best tools for assessing performance within narrowly defined surgical episodes or for guiding improvement in infection-related outcomes.

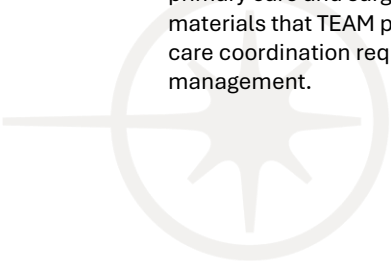
**IDSA therefore opposes CMS' use of the Hybrid Hospital-Wide All-Cause Readmission Measure and the CMS Patient Safety and Adverse Events Composite in TEAM for payment adjustment or accountability purposes.** These broad, hospital-wide measures are not sufficiently tailored to the specific clinical circumstances of TEAM episodes and risk obscuring meaningful differences in patient complexity, infection risk, social risk and referral patterns across hospitals. Rather than relying on measures that may inadequately capture the quality of care delivered to high-risk surgical patients, CMS should, in future performance years, prioritize development and testing of more clinically relevant, episode-specific measures and measure concepts, such as postoperative infection and sepsis rates, procedure-specific surgical site infection measures, timely and appropriate peri-operative antimicrobial prophylaxis, and measures of effective post-discharge care coordination and follow-up for high-risk patients. IDSA would support piloting such measures on a voluntary or pay-for-reporting basis within TEAM before they are used for payment adjustment. IDSA is particularly concerned that incorporating these measures into TEAM could create misleading performance signals and inappropriate financial consequences for hospitals caring for medically complex patients, without meaningfully advancing patient safety or quality improvement.

#### **Monitoring access to appropriate care**

IDSA appreciates CMS' commitment to monitoring for access to care, quality of care, delayed care and beneficiary protections under TEAM. Those safeguards are essential in a model that creates financial accountability for episode spending and therefore could create pressure to reduce use of specialty consultation, post-acute services, or high-cost but medically necessary therapies. **CMS should specifically monitor whether TEAM affects access to infectious diseases consultation, outpatient parenteral antimicrobial therapy, medically necessary follow-up and appropriate post-acute placement for patients with postoperative, device-related or other serious infections.** CMS should also monitor for patient selection concerns and for any evidence that model participants are avoiding medically complex or high-risk patients whose care may require greater resource use and should make refinements in future rulemaking if the model adversely affects access, quality or patient safety.

#### **Referral and care coordination requirements**

IDSA supports CMS' emphasis on care coordination and continuity, including the model's referral to primary care services requirement. At the same time, CMS has appropriately clarified that this requirement is not intended to replace clinically necessary specialty follow-up, including follow-up with surgeons and other specialists, and that beneficiaries must retain freedom of choice in selecting providers. That clarification is important for patients recovering from serious infections or surgical complications, who may require close follow-up with infectious diseases physicians in addition to primary care and surgical teams. CMS should continue to reinforce in sub-regulatory guidance and implementation materials that TEAM participants must preserve access to medically necessary specialty care and should not interpret care coordination requirements in ways that delay or substitute for needed infectious diseases evaluation and management.





## Conclusion

Thank you for the opportunity to comment on the FY 2027 IPPS proposed rule. IDSA appreciates CMS' consideration of these comments and its continued work to strengthen hospital payment policy, quality measurement and value-based care initiatives in ways that support high-quality care for patients with infectious diseases and the clinicians and hospitals that serve them. As detailed above, IDSA supports several aspects of the proposed rule and urges CMS to modify other policies to ensure they do not inadvertently weaken infection prevention, antimicrobial stewardship, access to specialty care or the ability of hospitals to care for medically complex and immunocompromised patients. Infectious diseases continue to present major challenges across inpatient and post-acute care settings, and Medicare payment and quality policies should recognize the critical role that infectious diseases physicians and related hospital programs play in improving outcomes, protecting patient safety and supporting public health. IDSA thanks CMS for its attention to these issues and hopes these comments are helpful as the agency finalizes the FY 2027 IPPS rule. Should you have any questions or wish to discuss these recommendations further, please contact Amanda Jezek, IDSA's senior vice president for public policy and government relations, at [ajezek@idsociety.org](mailto:ajezek@idsociety.org).

Sincerely,

A handwritten signature in black ink that reads "Ronald Nahass". The signature is written in a cursive, flowing style.

Ronald G. Nahass, MD, MHCM, FIDSA  
President  
Infectious Diseases Society of America

