

Advancing Health in America

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June 10, 2025

The Honorable Mehmet Oz, M.D. Administrator Centers for Medicare & Medicaid Services Hubert H. Humphrey Building 200 Independence Avenue, S.W., Room 445-G Washington, DC 20201

RE: Medicare Program; FY 2026 Inpatient Psychiatric Facilities Prospective Payment System – Rate Update (CMS-1831-P)

Dear Administrator Oz:

On behalf of our nearly 5,000 member hospitals, health systems and other health care organizations, and our clinician partners — including more than 270,000 affiliated physicians, 2 million nurses and other caregivers — and the 43,000 health care leaders who belong to our professional membership groups, the American Hospital Association (AHA) appreciates the opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS) inpatient psychiatric facility (IPF) prospective payment system (PPS) proposed rule for fiscal year (FY) 2026.

Ensuring timely access to high-quality psychiatric care remains one of the most pressing challenges in our health care system. IPFs play a vital role in stabilizing individuals in crisis and supporting recovery. As communities across the country face rising demand for mental health services, it is essential that Medicare payment policies support the sustainability and availability of these specialized providers.

To that end, we support several of the IPF PPS proposed rule provisions, including the proposed increases in the facility-level adjustments. We also appreciate the agency's interest in deregulatory activities in the Medicare program and have submitted our comments through the request for information (RFI) website. We also support several aspects of CMS' quality-related proposals, including its proposed removal of four measures from the quality reporting program.

However, we continue to have strong concerns about the proposed payment updates. The proposed net payment update of 2.4% is simply inadequate given the unrelenting financial headwinds faced by hospitals and health systems. Without



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adequate and sustainable payment updates, IPFs will struggle to maintain access to essential psychiatric services, particularly in underserved communities where these services are already limited. We are particularly concerned with the inappropriately large productivity cut that is being proposed. We urge the agency to re-examine the magnitude of this adjustment and its impact on Medicare payments.

MARKET BASKET UPDATE

CMS proposes to increase payments to IPFs by a net 2.4%, or \$70 million, in FY 2026 compared to FY 2025. This payment update includes a 3.2% market basket update minus a 0.8 percentage point productivity cut as required by the Affordable Care Act. **The AHA remains concerned about inaccurate and inadequate market basket updates.** In recent years, the market basket forecasts utilized by CMS have consistently under-forecast actual market basket growth. In addition, the actual market basket growth has fallen short of or has failed to exceed general inflation, despite well-documented medical inflation that surpasses that of the rest of the economy. **Especially combined with the misguided productivity adjustment, Medicare's payment updates to hospitals have become increasingly deficient.** As such, we urge CMS to re-examine the magnitude of this adjustment and its impact on Medicare payments.

Hospitals and Health Systems Continue to Face High Rates of Inflation

Hospitals, including IPFs, continue to face serious inflationary pressures that have raised labor, drug, supply and other costs. A recent report from the AHA found that in 2024 alone, hospital expenses grew by 5.1%.¹ A large portion of this growth is attributable to increased labor costs for the range of highly skilled individuals who help treat those with behavioral health needs, including psychiatrists, psychologists, psychiatric nurses, social workers, pharmacists, and different types of therapists, among others, as well as the critical environmental, food service and other professionals necessary to maintain 24/7 operations. The growth in labor costs alone make up almost 80% of the IPF PPS market basket, according to CMS itself. Indeed, an analysis by AHA found that hospital employee compensation grew by 45% from 2014 to 2023.² However, the net market basket update to the IPF PPS (market basket minus productivity), provided for only a 23.5% increase during this time. AHA has also found that advertised salaries for nurses have risen 26.6% in the last four years.³ Such labor-

¹ AHA. The Cost of Caring: Challenges Facing America's Hospitals in 2025 (April 2025) (<u>https://www.aha.org/costsofcaring</u>).

² AHA. America's Hospitals and Health Systems Continue to Face Escalating Operational Costs and Economic Pressures as They Care for Patients and Communities (April 2024) (<u>https://www.aha.org/system/files/media/file/2024/05/Americas-Hospitals-and-Health-Systems-Continue-to-Face-Escalating-Operational-Costs-and-Economic-Pressures.pdf</u>).

³ AHA. The Cost of Caring: Challenges Facing America's Hospitals in 2025 (April 2025) (<u>https://www.aha.org/costsofcaring</u>).

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related inflation has been driven in large part by a severe workforce shortage, which the Department of Health and Human Services (HHS) says will persist well into the future.⁴

Increasing drug and supply costs have also strained hospital finances. A recent report from HHS found that prices for nearly 2,000 drugs increased an average of 15.2% from 2017 through 2023, notably faster than the rate of general inflation.⁵ Further, the American Society of Health System Pharmacists has found that numerous drug shortages are having a critically negative impact on hospital operations.⁶ This has a substantial impact on IPFs as they care for patients with a wide range of complex conditions that often require multiple drug therapies to treat. For example, clonazepam and oxazepam, both used to treat anxiety disorders, are in shortage, as well as ketamine, which is used to treat major depressive episodes that are resistant to other treatments.

Adding to the uncertainty facing providers, the threat of increased tariffs across many sectors, including those essential to the health care system, is creating uncertainty. Despite ongoing efforts to build the domestic supply chain, the U.S. health care system relies significantly on international sources for many drugs, devices and other supplies needed to both care for patients and protect our health care workers. Tariffs, as well as any reaction of the countries on whom such tariffs are imposed, could reduce the availability of these life-saving items in the U.S. As we have detailed in our feedback regarding tariffs related to pharmaceutical and medical devices, the AHA is concerned about the potential for tariffs to raise the costs of delivering care. Indeed, a recent survey showed that 82% of health care experts expect tariff-related expenses to raise hospital costs by at least 15%.⁷

These escalating costs for clinicians, personnel, drugs, and other critical supplies and services, such as cybersecurity, have put a strain on the entire health care continuum. It has also forced hospitals, including IPFs, to divert funds that could have been invested in patient care, new technologies and other potential efficiencies. This makes CMS' inadequate psychiatric market basket update more concerning, especially given the existing dearth of inpatient psychiatric care. In addition, as discussed more below, the significant productivity adjustment for FY 2026 would exacerbate the ability of hospitals to keep up with efficiencies that could be realized with less financial strain.

⁴ ASPE Office of Health Policy. *Impact of the COVID-19 Pandemic on the Hospital and Outpatient Clinician Workforce*, HP-2022-13 at 1 (May 3, 2022).

⁵ ASPE. Changes in the List Prices of Prescription Drugs, 2017-2023. (Oct. 2023). (<u>https://aspe.hhs.gov/reports/changes-list-prices-prescription-drugs</u>)

⁶ American Society of Health-System Pharmacists. Severity and Impact of Current Drug Shortages (June 2023) (<u>https://news.ashp.org/-/media/assets/drug-shortages/docs/ASHP-2023-Drug-Shortages-Survey-Report.pdf</u>).

⁷ <u>https://www.beckershospitalreview.com/supply-chain/hospital-finance-supply-leaders-predict-15-increase-in-tariff-related-costs/</u>

Market Basket Forecasts Continue to Underestimate Actual Market Basket Growth

During this period of significant cost growth, the market basket forecasts for IPFs consistently failed to accurately predict actual market basket growth. Specifically, since the COVID-19 public health emergency, IHS Global Inc. (IGI) has under-forecasted actual market basket growth each year, as shown below.

Year	FY 2021	FY 2022	FY 2023	FY 2024	FY 2025	Total (Compounded)
Market Basket Update in Final Rule	2.2%	2.7%	4.1%	3.5%	3.3%	16.8%
Actual/Updated Market Basket Forecast	2.8%	5.3%	4.8%	3.8%	3.5%	21.9%
Difference in Net Market Basket Update and Actual Increase	-0.6%	-2.6%	-0.7%	-0.3%	-0.2%	-5.1%

Table 1: IPF Market Basket Updates, FY 2021 through FY 2025

These missed forecasts have a significant and permanent impact on IPFs and the patients they care for. Not only are they resulting in underpayments in the year that they occur, but also, as CMS knows, future updates are based on current payment levels. Therefore, absent action from CMS, these missed forecasts are permanently established in the standard payment rate for IPFs and will continue to compound.

While forecasts will never be perfect, in the past, they have been more balanced. The AHA remains concerned that there is a more systemic issue with IGI's forecasting that biases towards under-forecasting growth. Indeed, as AHA noted in prior <u>comment</u> <u>letters</u>, one such factor may be CMS' use of the Employment Cost Index (ECI) to measure changes in labor compensation in the market basket.⁸ By design, the ECI cannot capture changes in costs driven by shifts between different categories of labor; CMS itself has recognized this shortcoming.⁹ Yet, one major labor market change over the last several years has been increased utilization of contract labor. Therefore, the

⁸ 86 Fed. Reg. 25401 (May 10, 2021). "We use the ECI because it reflects the price increase associated with total compensation (salaries plus fringes) rather than just the increase in salaries. In addition, the ECI includes managers as well as other hospital workers. This methodology to compute the monthly update factors uses actual quarterly ECI data and assures that the update factors match the actual quarterly and annual percent changes."

⁹ 86 Fed. Reg. 25421 (May 10, 2021). CMS stated that ECI measures "the change in wage rates and employee benefits per hour... [and are superior] because they are not affected by shifts in occupation or industry mix."

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ECI may not be adequately capturing employment and labor cost growth. AHA continues to stand ready to work with CMS to examine the market basket compensation indices and proxies to improve the accuracy of these measures.

Productivity

Under the Affordable Care Act, the IPF PPS payment update is reduced annually by a productivity factor, which is equal to the 10-year moving average of changes in the annual economy-wide, private nonfarm business total factor productivity (TFP).¹⁰ For FY 2026, CMS proposes a productivity cut of 0.8 percentage points.

The use of the private nonfarm business TFP is meant to capture gains from new technologies, economies of scale, business acumen, managerial skills and changes in production. Thus, this measure effectively assumes the hospital field can mirror productivity gains achieved by private nonfarm businesses. However, as we discuss in more detail below and in the appendix, it is well proven by the economic literature that the hospital and health care field cannot do this. For example, by focusing only on private businesses, this measure excludes non-profit and government businesses, which account for more than 60% of hospitals and health systems. Thus, this measure is not an appropriate or reliable predictor of productivity for the hospital field. As such, we ask CMS to re-examine the magnitude of this adjustment and its impact on Medicare payments.

First, measures of productivity contained in the private nonfarm business TFP are not appropriate measures of productivity for the hospital field. Outputs in the TFP are measured as a function of the total quantity and prices of the goods and services produced in private nonfarm businesses. For sectors that sell tangible, physical products, measuring these outputs is relatively straightforward and often standardized. However, hospital quantity and prices do not operate in this way. For example, hospital quantity, such as volume of visits or procedures, is not necessarily an appropriate output measure; rather, it may be more reflective of the disease burden of a community. More hospital volume — thus more quantity — does not equate to more productivity in the same manner as it does for private nonfarm businesses.

In addition, hospital prices per unit of service often cannot be adjusted in response to changes in demand or quality; those of private nonfarm businesses can be. This is because much of hospitals and health systems' reimbursement is through fixed payments, such as through the IPF PPS. Thus, they cannot alter their prices in the same manner that private nonfarm businesses can. This is similarly true for their payments from private insurance. Hospitals and health systems do not set their rates. Instead, prices for commercially insured patients are determined through negotiations,

¹⁰ CMS. (February 2016). Hospital Multifactor Productivity: An Updated Presentation of Two Methodologies. <u>https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/ReportsTrustFunds/Downloads/ProductivityMemo2016.pdf</u>

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which often lock in rates for several years. Therefore, it makes relatively little sense to apply a TFP output function of quantity and prices that is experienced in the private sector to the hospital sector when the same output function does not apply.

Second, the TFP does not reflect specific challenges that prevent hospitals from achieving productivity improvements consistent with those in the broader economy. Specifically, the private nonfarm business sector encompasses a broad range of industries with stable and predictable production processes. In contrast, hospitals operate in a complex environment characterized by unpredictable patient volumes, rising input costs, and varying acuity levels, not to mention natural disasters and pandemics. Hospitals also face heavy regulatory burdens beyond those of other industries. For example, hospitals face unique fixed costs such as requirements to keep emergency departments open 24/7 so that patients can seek care at all times. Private nonfarm businesses rarely have such onerous challenges and requirements.

Furthermore, the hospital field is different from private nonfarm businesses because the services provided by hospitals are highly labor intensive. As discussed in more detail in the appendix, it has been long theorized in the economic literature that sustained productivity gains in service-intensive industries are difficult to achieve given their heavy reliance on labor, which cannot be scaled or automated. Hospitals are, in this way, more similar to fields like education and social assistance. These industries all experience lower total factor productivity rates. For example, the rates range from -0.4 for educational services to -0.1 for social assistance as compared to 1.9 to 4.9 for the mining, oil and gas, information, and professional services, according to the Bureau of Labor Statistics.

In fact, CMS itself has acknowledged that hospitals are unable to achieve the same productivity gains as the general economy over the long run. Specifically, it found that hospitals can only achieve a productivity gain that is one-third of the gains seen in the private nonfarm business sector.¹¹ Thus, using the private nonfarm business sector TFP to adjust the market basket inappropriately exacerbates Medicare's chronic underpayments to hospitals.

Additionally, it is puzzling to see how an indicator based on a 10-year moving average could yield such an increase to the productivity cut in a single year. Specifically, the FY 2025 cut was 0.5%, but this year CMS proposes a cut of 0.8%. In moving from one year to the next in calculating a 10-year moving average, one only changes a single one of the 10 years; as such, this methodology should smooth fluctuations to a very large degree. Instead, in moving from FY 2025 to FY 2026, we see the productivity cut increase by 60%. Unfortunately, the AHA is unable to fully analyze these projections due to a lack of transparency from CMS. That said, it appears that the updated 10-year

¹¹ Centers for Medicare and Medicaid Services. (February 2016). Hospital Multifactor Productivity: An Updated Presentation of Two Methodologies. <u>https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/ReportsTrustFunds/Downloads/ProductivityMemo2016.pdf</u>

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moving average periods used for the FY 2026 proposed rule exclude a period of low-TFP growth in 2016. We do not understand why this would be and are concerned it has artificially and inappropriately increased the productivity adjustment.

Finally, we find it particularly troubling that the productivity adjustment is used only when it *decreases* Medicare payments. For example, in FY 2021, the 10-year moving average growth of the productivity factor forecasted by IGI was -0.1%. CMS acknowledged that subtracting a negative growth factor from the hospital market basket would have *increased* it by 0.1 percentage points. However, the agency set the productivity factor at 0, stating that it is required to reduce, not increase, the hospital market basket by changes in economy-wide productivity.¹² Simply put, the agency applies the productivity factor only when it cuts Medicare spending. However, the cumulative, compounding of effect of these reductions year-over-year, and the asymmetric treatment of declines in economy-wide productivity led to an increasing gap between payments and the cost of providing services, leaving hospitals increasingly underfunded, as discussed above.

Given all the above, the AHA continues to have deep concerns about the proposed productivity cut, particularly given the extreme pressures in which hospitals and health systems continue to operate. Applying the private nonfarm business TFP to the hospital field is not appropriate, and in an economy marked by great uncertainty due to tariffs and demand and supply shocks, it generates significant departures from economic reality.

FACILITY-LEVEL ADJUSTMENT FACTORS

The Consolidated Appropriations Act (CAA) of 2023 requires CMS to implement revisions to the IPF PPS payment methodology. As such, CMS proposes to increase the IPF PPS facility-level adjustment factors for teaching status and rural location. The teaching hospital adjustment would increase from 0.5150 to 0.7981, and the rural adjustment from 17% to 18%.

The AHA supports both proposed changes. However, Medicare has a longstanding history of transitioning policies with significant impacts on providers to help maintain predictability and reliability in the PPS. Given that the proposed increase to the teaching adjustment is large (55%) and would be implemented in a budget-neutral manner, we urge CMS to consider a transition period for its implementation.

IPF QUALITY REPORTING PROGRAM

CMS proposes to remove four measures from the IPF quality reporting program (IPFQR), extend the reporting period for the 30-Day Risk-Standardized All Cause Emergency Department Visit measure (IPF ED Visit measure) and clarify that the agency may grant time extensions for data reporting under the extraordinary

¹² 85 Fed. Reg. 58797 (Sep. 18, 2020).

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circumstances exception (ECE) policy. CMS also proposes shortening the timeframe during which an IPF may request an exemption from data reporting.

<u>Measure Removals.</u> With a stated purpose of refocusing IPF reporting on clinical outcomes measures, alleviating administrative burdens and reducing costs, CMS proposes to remove the following four measures from the IPFQR effective with the CY 2024 reporting / FY 2026 payment determination periods:

- COVID-19 vaccination coverage among healthcare personnel (HCP).
- Facility commitment to health equity structural measure.
- Screening for social drivers of health.
- Screen positive rate for social drivers of health.

All four measures have data submission deadlines preceding the date by which the proposed rule will be finalized. As a result, CMS proposes that IPFs that do not report CY 2024 data would be considered non-compliant with the IPFQR, but only if CMS opts not to finalize its proposed measure removals. If CMS were to finalize the proposed measure removals, the agency would not use any data that hospitals submit for either public reporting or payment purposes.

The AHA greatly appreciates CMS' recognition of the importance of striking an appropriate balance of burden and value in quality measurement programs and supports the removal of these four measures from the IPFQR and other CMS programs. The AHA has long advocated that all federal quality reporting and value programs use "measures that matter" — that is, measures that are focused on the highest priority areas for quality improvement, are feasible to collect and report, and whose value outweighs their burden. Streamlining the number of measures in federal quality reporting programs can help hospitals focus their resources on high-priority topics of national importance while freeing up resources to help hospitals address the quality issues that matter most to their communities.

The AHA especially applauds CMS' proposal to sunset the COVID-19 vaccination coverage among HCP measure. While hospitals continue to support efforts to vaccinate health care workers for COVID-19 in a manner consistent with federal guidelines, the COVID-19 public health emergency (PHE) concluded in May 2023. Since then, the level of administrative effort and resources needed to collect and report the health care personnel COVID-19 vaccination measure has become impractical and untenable. In 2023, the Centers for Disease Control and Prevention (CDC) and CMS shifted the measure definition to measure the proportion of health care personnel who are "up to date" on COVID-19 vaccinations. The measure collection protocol uses a reference period for determining up-to-date vaccination status that changes every quarter. Practically speaking, this means that an HCP who counted as "up to date" during one quarter may no longer be up to date in the next quarter. Hospitals are also asked to take into consideration any recent positive COVID-19 tests, which would affect the timing of when an HCP should receive a vaccine. To collect and report the measure, hospitals

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must conduct near-continuous tracking of each employee's vaccination status, including obtaining documentation of either the vaccination, a recent COVID-19 test or an exemption.

Furthermore, the CDC's current vaccination guidance suggests that some individuals with certain risk factors should consider receiving an additional booster dose. Yet, hospitals usually do not have routine access to data to know which of their HCPs may need an additional booster. In short, the resource intensity of collecting data under the CDC's current definitions may outweigh its value, especially given that the COVID-19 pandemic has concluded. We believe removing this measure from CMS programs will allow hospitals to focus data collection resources on other important opportunities to improve care.

In addition, while hospitals continually work to improve the health outcomes of all patients and communities they serve, none of the three CMS social drivers measures was endorsed by a consensus-based entity (CBE) before being put into the IQR. The AHA has generally urged that measures in federal programs be endorsed by a CBE to help ensure they are accurate, reliable, feasible and based on a strong foundation of validated evidence. Furthermore, hospitals and health systems have raised concerns about the soundness of the scoring methodologies, the redundancy of measure data reporting between inpatient and outpatient settings, and the clarity of measure implementation guidance. For these reasons, we believe it is appropriate to remove these measures at this time.

Extension of emergency department visit reporting period. CMS proposes to expand the reporting period for the 30-Day Risk-Standardized All-Cause Emergency Department Visit Following an IPF Discharge measure from one year to two years to better align the measure with the Thirty-Day All-Cause Unplanned Readmission Following Psychiatric Hospitalization measure. The agency states this update would allow for a better comparison of the same cohort of patients and provide IPFs and the patients they serve with a more complete picture of acute care following discharge from an IPF. CMS also proposes to modify the first reporting period for the measure. If finalized, this extended reporting period would begin in Quarter 3 of CY 2025 for the FY 2029 payment determination, instead of for the FY 2027 payment determination.

The AHA supports the extension of the reporting period and the modification to the first reporting period. However, as we <u>commented</u> to CMS last year, we continue to believe this measure fails to evaluate IPF performance accurately and meaningfully. The measure's all-cause design means that it includes ED visits that have nothing to do with the quality of care delivered by the IPF. Furthermore, the measure failed its endorsement review because it was judged to have low scientific acceptability. For these reasons, we urge CMS to remove the measure from the program.

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<u>Updates to Extraordinary Circumstances Exception (ECE) policy.</u> CMS proposes several changes to the ECE policy. First, CMS proposes to update the ECE policy to clarify that the agency may grant extensions of time for data reporting when appropriate. Second, CMS proposes to shorten the timeframe for requesting an ECE from 90 days to 30 days. Finally, CMS proposes that under certain circumstances, such as an extraordinary circumstance that has affected an entire region or locale, CMS may grant exceptions to one or more IPFs even if those IPFs have not requested an exception. CMS also clarifies that it retains the authority to grant an exception under the ECE policy at any time.

The AHA supports CMS' proposal to allow the agency to grant exceptions to one or more IPFs even if those IPFs have not requested an exception. The AHA also supports CMS' proposal to offer time extensions for data reporting for facilities experiencing an extraordinary circumstance and appreciates CMS' recognition of varying needs for different facilities and different circumstances. However, we are concerned that the agency may replace reporting exemptions with time extensions, regardless of the circumstances necessitating an ECE. The AHA understands and shares CMS' commitment to transparency on the quality of care delivered in IPFs. At the same time, we urge CMS to continue to grant complete reporting exemptions in the case of an extraordinary circumstance, and to use time extensions sparingly.

The AHA does not, however, support CMS' proposal to shorten the timeframe for requesting an ECE. In the proposed rule, CMS states that shortening the timeframe to request an exception would better align the IPFQR ECE policy with other CMS systems implementation requirements across all quality reporting programs. While this might be true for some — but certainly not all — quality reporting programs, we believe a 90-day window to request an ECE is necessary given the increasing frequency of, and devastation caused by, storms, cyberattacks and other emergencies.^{13,14,15,16,17} In the early days and weeks following these types of extraordinary events, IPFs and other health care settings often struggle just to stay operational and care for their patients and

¹³ See Extraordinary Circumstances Exception policy for Skilled Nursing Facilities (Apr. 24, 2025), <u>https://www.cms.gov/medicare/quality/nursing-home-improvement/value-based-purchasing/extraordinary-circumstance-exception</u>; *see also* Skilled Nursing Facility (SNF) Quality Reporting Program (QRP) Reconsideration and Exception & Extension (Apr. 24, 2025), <u>https://www.cms.gov/medicare/quality/snf-guality-reporting-program/reconsideration-and-exception-extension</u>.

¹⁴ See Home Health Quality Reporting Reconsideration and Exception & Extension (Jan. 16, 2025), <u>https://www.cms.gov/medicare/quality/home-health/home-health-quality-reporting-reconsideration-and-exception-extension</u>.

¹⁵ See Inpatient Rehabilitation Facility (IRF) Quality Reporting Program (QRP) Reconsideration and Exception & Extension (Apr. 24, 2025), <u>https://www.cms.gov/medicare/quality/inpatient-rehabilitation-facility/irf-quality-reporting-reconsideration-and-exception-extension</u>.

¹⁶ See Extension and Exemption Requests (Jan. 16, 2025),

https://www.cms.gov/medicare/quality/hospice/hqrp-extensions-and-exemption-requests.

¹⁷ See Long-Term Care Hospital (LTCH) Quality Reporting Program (QRP) Reconsideration and Exception & Extension (Jan. 21, 2025), <u>https://www.cms.gov/medicare/quality/long-term-care-hospital/ltch-quality-reporting-reconsideration-and-exception-extension</u>.

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communities. Requiring IPFs to prioritize paperwork over patients just to get a one-time exception to reporting seems counter to the intended goals of the IPFQR program. We are concerned such a change to the process of requesting an ECE would divert critical staff at a time when they are needed most. For these reasons, we urge CMS to retain its current policy and allow IPFs to request an ECE for up to 90 days following a disaster or other extraordinary event.

RFI: QUALITY

In the proposed rule, CMS included multiple requests for information, seeking input on the development of a star rating system for IPFs, future measures for the IPFQR program and using the Fast Healthcare Interoperability Resources (FHIR) standard for patient assessment reporting.

<u>Star rating system.</u> CMS seeks public input on the development of a five-star rating system that would summarize quality measure data reported by IPFs. CMS currently makes data on IPFQR measures publicly available but does not utilize a star rating system. As longstanding supporters of quality transparency, the AHA shares CMS' goal of giving patients meaningful, accurate and understandable information regarding the quality of care in IPFs and other health care facilities. However, as with any report card or rating system, each data point must be interpreted in the proper context. Given the unique nature of the IPF setting and the population served, it is unlikely that a composite rating system could provide a reliable portrait of quality in such a facility. Instead, a composite score or ranking may provide an oversimplified, inaccurate and unreliable portrait of the quality of care provided.

The premise of a star rating, or any other quality ranking or rating system, is that available measures lend themselves to a fully representative quality score relevant to all patients. Yet the measures in the IPFQR were never selected to create this holistic picture of care and may be incorrectly interpreted as a failure on the part of a facility, rather than a reflection of the needs of the patient, the severity of their illness or the reasons for their hospitalization. Furthermore, as the AHA has repeatedly noted, the IPFQR measure set does not include enough measures that are specifically designed and tested to assess the provision of inpatient psychiatric care. Presuming CMS finalizes its proposed removal of four measures from the IPFQR, the IPFQR would include 12 measures for FY 2027. Of those 12 measures, only five measures restraint use, seclusion use, alcohol use screening, alcohol use treatment and discharge records — are geared towards assessing the delivery of IPF-level care. The remainder of the measures are focused on the post-discharge period, or other issues like immunization. One of the other measures that would potentially be included in a star ratings system is patient-reported experience of care. Including such data for purposes of "rating" the quality of care in an IPF presents could present significant conceptual and statistical reliability challenges. While all IPFs work to ensure their patients have the best possible experience, patient experience during an IPF stay presents unique challenges for this population due to the nature of the illness being treated or the

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circumstances under which the patient was hospitalized. Patients may not be able to respond to patient experience questions in the same way as patients at an acute care hospital. Other factors, like an involuntary hospitalization, may further impact how IPF patients perceive their care experience.

Given the unique nature of IPFs and the patient population they serve, we have serious concerns as to whether a star rating can accurately reflect a facility's performance or provide meaningful, actionable data for patients and families. The challenges in accessing appropriate mental health care, particularly inpatient care, are well-documented and widespread. In the context of inpatient psychiatric care, a rating or ranking system fails to account for the pervasive barriers to accessing care in this setting. Unlike choosing a particular doctor or acute care hospital, the location in which a patient receives inpatient mental health services is more dependent on bed availability, type of insurance and the level of care required. Presenting quality information without the necessary context will only serve to confuse and frustrate patients and their families. For these reasons, the AHA urges CMS not to pursue the development of a star ratings system for IPFs at this time. Instead, we recommend that the agency focus its resources on continuing to strengthen the IPFQR measure set to better reflect care delivery in IPFs.

<u>Future quality measures.</u> Although the proposed rule did not propose to add any new IPFQR measures, CMS is soliciting feedback on two potential measures that may be considered in future rulemaking. First, the agency is requesting input on a quality measure concept of "well-being," which would encompass preventive care, disease prevention and health promotion, integrating mental, social and physical health. CMS also requests feedback on tools and measures to assess a patient's overall happiness and satisfaction, including social connections, personal fulfillment and self-care, among other topics. Second, CMS seeks public input on a quality measure concept of nutrition that would assess a patient's eating and exercise habits, nutritional status, growth and overall well-being. As part of the RFI, CMS seeks feedback on tools and frameworks that promote healthy eating habits, optimal nutrition, physical activity and other areas to improve well-being.

The AHA appreciates CMS' focus on whole-person care and on improving the health of all Americans. However, we believe these two measure concepts would be of limited relevance in IPFs, given the unique nature of IPF-level care. At its core, the type of care provided in an IPF is intended to improve well-being, which is exactly what this measure concept would purport to assess. While we appreciate CMS' intent, the needs, concerns, goals and experiences of patients receiving care in an IPF are unique and not entirely comparable to those of patients receiving care in a general acute care hospital. Individuals receiving inpatient psychiatric care may be unable to identify or articulate their feelings in the same way as other patients due to the nature of their mental health issues. Others may not understand or even be aware of the condition(s) for which they are being treated. Indeed, performance on such a measure

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in this setting would only serve as an indicator of the reasons why an individual required inpatient care, not a reflection of the performance of the IPF.

In addition, the relationship between the proportion of patients receiving inpatient psychiatric care who may have nutritional deficits and the quality of the care provided to those patients is unclear, and the RFI offers no explanation. While the AHA agrees that healthy eating, physical activity and sleep are all important aspects of overall health and well-being, individual characteristics such as nutritional status or growth would likely have little connection to the quality of care provided in an IPF.

The AHA also believes that implementing these measure concepts raises significant methodological challenges. For example, a higher "score" for either of these concepts could simply mean an IPF is located in an area with better access to healthy foods, recreational opportunities or providers offering outpatient mental health services. None of these characteristics is related to the quality of care provided in an IPF. Furthermore, they provide little, if any, meaningful information that providers could use to improve performance.

<u>Digital Quality Measurement.</u> Beginning with the rate year 2028, IPFs participating in the IPFQR program are required to collect standardized patient assessment data using a new standardized patient assessment instrument (PAI). As part of its efforts to promote interoperability, create efficiency and facilitate safe and secure data sharing, CMS seeks feedback on advancing FHIR-based reporting of patient assessment data for the PAI. The agency also is interested in opportunities to generate, use and share FHIR-standardized data through electronic health records and other technologies, as well as any challenges that may arise while integrating different technologies. The RFI includes questions related to IPFs' use of different technologies, processes for data submission, guidelines for patient privacy and security, and other issues.

The AHA agrees that a digital and interoperable quality measurement enterprise is a laudable long-term goal that could have positive and far-reaching impacts on quality of care and the provider experience. The AHA also sees significant potential in expanding the use of FHIR, as this standard may provide greater flexibility than other available frameworks. However, the AHA does not believe a FHIR-based standard for reporting IPF QRP or IPF-PAI data is feasible in the short term. This is especially true of the IPF-PAI, whose clinical content is just beginning its beta testing to be ready for implementation in 2028.

The seminal statute for health information technology, the Health Information Technology for Economic and Clinical Health (HITECH) Act of 2009, resolved to spend \$25.9 billion to promote and expand the adoption of health IT; to implement the requirements of the HITECH Act, CMS offered incentives to eligible professionals and hospitals that adopted and demonstrated the meaningful use of electronic health records (EHRs). However, IPFs were not eligible for the EHR Incentive Programs (now known as the Promoting Interoperability Program) under the Act. In its 2019 RFI that The Honorable Mehmet Oz, M.D. June 10, 2025 Page 14 of 25

accompanied the Interoperability and Patient Access proposed rule, CMS largely attributed the slow rate of EHR adoption in IPFs and post-acute care settings to the lack of federal incentives available to those providers.

In addition to this lag, the experience with various health IT capabilities in IPF care is heterogeneous; while some providers have been able to successfully incorporate health IT with higher levels of sophistication, including certified EHR technology (CEHRT), others are using technologies with fewer capabilities for digital exchange. Given the intensity of EHR requirements for acute care hospitals, the shortages in health IT professionals and resources dedicated to health IT are particularly dire for IPFs. Because of these challenges, any approach to digital quality measurement in IPFs will have to be nuanced and gradual.

We encourage CMS to consider developing a "glide path" for IPF provider participation in digital quality measurement, one that provides technical assistance for providers who are less advanced in their health IT capabilities, as well as more opportunities for achievement for those who are well on their way. Adoption and implementation of health IT systems like CEHRT is not like flipping a switch; it involves painstaking and thoughtful groundwork to establish an infrastructure — including security and personnel as well as physical investments — that can support highly technical requirements. Standards and other requirements must be understandable for those providers who do not have as robust a technology infrastructure, so that they can work to someday achieve interoperability rather than abandon hope because the future is daunting and expensive. The AHA and our members are excited to work with CMS to build their digital quality measurement enterprise, and we would be happy to collaborate on more specific plans for the future.

RFI: REGULATORY RELIEF

On Jan. 31, 2025, President Trump issued Executive Order 14192, "Unleashing Prosperity Through Deregulation," which states the administration's policy to significantly reduce the private expenditures required to comply with federal regulations. Accordingly, CMS is soliciting public input on approaches and opportunities to streamline regulations and reduce administrative burdens on providers, suppliers, beneficiaries and other interested parties participating in the Medicare program. The agency has made available an RFI at https://www.cms.gov/medicare-regulatory-relief-rfi.

We applaud CMS for seeking recommendations on how to free the health care system from burdensome administrative requirements that prevent Americans from accessing the care they need to live their healthiest lives. As the administration has rightly pointed out, the health status of too many Americans does not reflect the greatness or wealth of our nation. Excessive regulatory and administrative burdens are a key contributor, as they add unnecessary cost to the health care system, reduce patient access to care and stifle innovation. The Honorable Mehmet Oz, M.D. June 10, 2025 Page 15 of 25

Addressing unnecessary administrative burdens and costs would go a long way to not only lower health system costs but also support the accessibility of care. Many hospitals are financially unstable, with nearly 40% operating with negative margins.⁷ This has led to closures of services and even entire hospitals, and the resulting loss in access to care is felt by entire communities.

The AHA is responding to the RFI directly through the provided website and looks forward to continuing to work with the administration on the much-needed effort to reduce regulatory red tape so that America's hospitals and health systems can best support the health of their communities. However, for your consideration, we also wish to call CMS's attention to a previous set of deregulation requests that we have provided to the administration. These actions include, for example, removing the in-person visit requirements for behavioral health telehealth, which are unnecessary, add a barrier to access and create a disparity between physical and mental health services.

Again, we thank you for your consideration of our comments. Please contact me if you have questions, or feel free to have a member of your team contact Joanna Hiatt Kim, AHA's vice president of payment policy, at <u>jkim@aha.org</u>.

Sincerely,

/s/

Ashley Thompson Senior Vice President Public Policy Analysis and Development

Attachment: Hospital Inpatient Prospective Payment System

JUNE 2025

Hospital Inpatient Prospective Payment System

Assessment of Productivity Adjustments and Applicability to the Hospital Sector

In the fiscal year ("FY") 2026 Inpatient Prospective Payment System ("IPPS") Proposed Rule and other FY proposed rules, the Centers for Medicare and Medicaid Services ("CMS") has proposed a 0.8 productivity adjustment, an increase from the 0.5 adjustment used in FY 2025 payment rates. The productivity adjustment fails to reflect the economic realities of the hospital sector and places undue financial pressure on hospitals during an already challenging period. Our analysis describes conceptual concerns related to using a productivity adjustment based on the private economic sector for hospitals and discusses methodological issues in the construction of the adjustment. Both factors suggest that the current implementation of the productivity adjustment is not appropriate for hospitals and other health care providers.



INTRODUCTION

Hospitals, health systems, and other health care providers rely on reimbursements are facing unprecedented financial and operational challenges that impact their ability to provide the high quality, accessible care hospitals strive to deliver. A recent report indicates that close to 40% of hospitals were operating at a loss in 2024.¹ Rising input costs, reimbursement pressures from payers and lingering effects of the COVID-19 pandemic are just a few examples of the challenges that hospitals are grappling with today. As individual hospitals differ greatly in size, patient populations and operating environment, each confronts its own distinct set of challenges.

Further compounding these issues, hospitals rely heavily on federal funding for certain patient populations, which is currently highly uncertain. Notably, the "One Big Beautiful Bill Act", passed by the

House on May 22, 2025 substantially cuts Medicaid funding. The Congressional Budget Office ("CBO") estimates that the bill would reduce Medicaid spending by \$700-723 billion over the next 10 years, representing an 11% reduction in federal Medicaid spending and leading to a decline of approximately 8 million enrollees.² The expiration of enhanced subsidies for enrollees in health insurance marketplaces under current law will also lead to increases in the uninsured population. Hospitals will be left to cover the costs of treating the uninsured, further exacerbating the financial strain.

Hospitals, health systems, and other health care providers rely on reimbursements rely on reimbursements from the Centers for Medicare and Medicaid Services ("CMS") as a major revenue stream not only because of the large proportion of patients that hospitals what Medicare would pay. A key component of hospital reimbursement is the market basket update, which is produced by the Office of the Actuary ("OACT") within CMS and adjusts payments to account for inflation and changes in the cost of goods and services. The market basket update is reduced by the application of a total factor productivity ("TFP") adjustment. However, the TFP adjustment fails to account for the distinct challenges hospitals face, leading to inadequate payments and ultimately threatening their ability to deliver care to patients.

CMS UPDATES HOSPITAL PAYMENT RATES USING TOTAL FACTOR PRODUCTIVITY

CMS updates the IPPS and other Medicare Prospective Payment Systems ("PPS") annually to adjust Medicare reimbursements for inpatient hospital stays and other health provider stays. These updates are published under the IPPS and other PPS final rules. As part of the IPPS rule, CMS publishes a percentage increase in operating payments to account for changes in hospital costs as reflected in a hospital market basket of goods, minus a productivity adjustment. This productivity adjustment, mandated by the Affordable Care Act ("ACA"), is intended to limit Medicare spending and encourage efficiency in healthcare delivery. The adjustment is based on estimates of TFP (previously referred to as multi-factor productivity) in the nonfarm business sector produced annually by the Bureau of Labor Statistics ("BLS").

The process for calculating and applying the productivity adjustment to the market basket update is comprised of two main steps:

- BLS computes and publishes historical annual TFP growth rates for the non-farm private business sector.
- CMS's contractor, IHS Global Inc., provides forecasts of TFP. The forecast methodology uses proxy series to predict the historical TFP measure calculated by the BLS and creates a projection of BLS' TFP index to create estimates of TFP growth through the end of the payment year.³

Table 1: CMS Final IPPS Operating Payment Updates (Percent)

	FINAL RULE	MARKET BASKET	PRODUCTIVITY	OTHER LEGAL
2014	0.7	2.5	-0.5	-1.3
2015	2.2	2.9	-0.5	-0.2
2016	0.9	2.4	-0.5	-1
2017	0.95	2.7	-0.3	-1.45
2018	1.2	2.7	-0.6	-0.9
2019	1.85	2.9	-0.8	-0.25
2020	3.1	3	-0.4	0.5
2021	2.9	2.4	0	0.5
2022	2.5	2.7	-0.7	0.5
2023	4.3	4.1	-0.3	0.5
2024	3.1	3.3	-0.2	0
2025	2.9	3.4	-0.5	0
2026*	2.4	3.2	-0.8	0
YEAR	PAYMENT UPDATES	INCREASE	ADJUSTMENT	ADJUSTMENTS

Source: CMS Hospital IPPS Final Rule (2014-2025), CMS Hospital IPPS Proposed Rule (2026)

The productivity adjustment is the average TFP growth rate over the ten year period ending with the payment year. For FY 2025, for example, CMS uses the TFP measure "reflecting historical data through 2023 as published by BLS and forecasted TFP growth for 2024 through 2025."⁴ This adjustment is then subtracted from the hospital market basket index to determine the net payment increase for IPPS.

TFP measures how efficiently outputs are generated from inputs and is calculated as the ratio of total outputs to total inputs. The BLS calculates output for the private non-farm sector (also called "value-added output") as an index based on GDP after excluding nonbusiness outputs (*e.g.*, government, non-profit, and household outputs) as well as excluding outputs from farms.5 Inputs included in the TFP calculation are the sum of capital and labor inputs. Capital inputs are the "services derived from the stock of physical assets and intellectual property assets" while labor input calculates the total cost of worker hours.6 The BLS also calculates TFP for specific industries of the economy using estimates of output, capital input, and labor input specific to the sector from sources such as the U.S. Census Bureau and the Bureau of Economic Analysis As required by the ACA, CMS bases the productivity adjustment used in the final rule on the entire non-farm business sector rather than on any specific sector. The productivity adjustment is intended to account for overall adjustment is intended to account for overall productivity and efficiency gains in the general economy, and is applied to reduce the annual market basket update. In FY 2025, the finalized productivity adjustment was 0.5 percentage points. For FY2026, the proposed productivity adjustment is 0.8 percentage points, thereby reducing the market basket update increase of 3.2% to 2.4%. Table 1 summarizes the historical market basket, productivity adjustments and other legal adjustments that are applied to obtain the final operating

payments rates from FY2014 through the proposed rates in FY2026.

As constructed, the productivity adjustment fails to account for hospital-specific productivity factors, including the ongoing impacts of COVID on the industry, and does not fully account for the expected impacts of economic conditions in the upcoming fiscal year. Since 2014, BLS's estimate of the annual percentage change

in the private nonfarm business sector total factor productivity has ranged from -0.9 to 3.8⁷ while CMS's computed productivity adjustment ranged from 0 to 0.8 percentage points, with the proposed 2026 reduction among the highest.

CMS has applied the productivity adjustment exclusively to restrict the increase in Medicare payments. In the one year where productivity in the non-farm business sector did not improve and measured TFP declined (FY 2021), CMS set the productivity adjustment to 0 rather than increasing payments, based on an untested interpretation of the statue. The cumulative effect of these reductions year over year, and the asymmetric treatment of declines in economy-wide productivity, lead to an increasing gap between payments and the cost of providing services, leaving hospitals increasingly underfunded, which ultimately restricts the amount of care they can provide.

Industry-specific challenges prevent hospitals from achieving productivity improvements in inpatient care consistent and concurrent with the private nonfarm business sector The use of the TFP adjustment assumes that productivity gains achieved in the private nonfarm sector should be applied broadly to the hospital sector. However, this holds hospitals to an unreasonable standard by requiring that they mimic the productivity gains obtained in industries that operate very differently in order to avoid compounding cuts to payments. The private nonfarm sector encompasses a broad range of industries, some with stable and predictable production processes and outputs. In contrast, hospitals operate in a complex environment characterized by unpredictable patient volumes, rising input costs, varying patient acuity levels, and onerous regulatory requirements. Furthermore, the services that hospitals provide occur in a complex market with multiple and overlapping interdependencies between the hospitals, the health insurers responsible for payment, and the consumer (patients) receiving services.

Multiple studies indicate that hospital sector productivity falls below the general productivity gains of the general economy. The 10-year average of published BLS TFP growth for the private nonfarm sector is 0.8 for the 10-year period of 2015 - 2024. CMS' own estimates of hospital TFP conclude that at least through 2019, hospital TFP growth remained below BLS estimates of the private nonfarm business TFP growth. CMS used two methodologies to compute hospital TFP and found that average growth rate of hospital TFP ranged from 0.2 to 0.5 percent, compared to the average growth of private nonfarm business TFP of 0.8 percent.⁸ In the 2021 Trustees Report, it was assumed that hospitals could achieve productivity gains of 0.4 percent year over year in the long run.9 Hospitals encounter substantial regulatory requirements unique to the healthcare sector. Hospitals must then bear the cost to maintain compliance with these regulations. Government-set reimbursement rates have not kept pace with inflation, covering only 83 cents for every dollar hospitals spent in 2023.10 Hospitals also face requirements to keep emergency departments open, such as the Emergency Medical Treatment and Labor Act ("EMTALA")¹¹, which requires hospitals to provide stabilizing treatment regardless of patients' ability to pay, or to provide an appropriate transfer. Hospitals must also meet certain accreditation requirements,

such as through The Joint Commission¹², which requires hospitals to meet certain quality standards and to undergo on-site survey inspections as a condition for participating in the Medicare program. There are also a variety of other legal requirements to maintain patient confidentiality, infection control protocols, and medication management systems to prevent errors that all add to the operational costs of running a hospital and require significant investment that does not necessarily contribute directly to productivity.

Hospitals vary widely across a range of characteristics, with each institution structured to address the unique healthcare needs of their local communities. They differ by ownership: 14.7% are public hospitals, 49.2% are private, non-profit hospitals and 36.1% are private forprofit hospitals¹³. Some belong to large health systems, while others are independent community hospitals. Safety-net hospitals focus on low-income, uninsured, or Medicaidheavy populations. Certain large systems, often university-affiliated, drive advanced research and medical training. Hospitals also differ in size, capacity, and service levels, which impacts their productivity based on patient types and care complexity. Assuming that all hospitals can achieve the same productivity gains as the general private sector economy is not appropriate.

The hospital sector is not the only industry where productivity gains do not mirror those of the general private sector economy. It has long been theorized that sustained productivity gains in service-intensive industries are difficult to achieve given their heavy reliance on labor, which cannot be easily scaled or automated. This leads to higher costs relative to other sectors.¹⁴ According to the most recent BLS data, the industries and associated North American Industry Classification System ("NAICS") codes accounting for the largest proportion of real sector outputs, including

Figure 1: 10-Year Moving Average TFP for Private Nonfarm Business Sector and Selected Industries,

CMS Productivity Adjustment (2014-2024)



BLS TFP for NAICS 622-623 conceptually reflects only for-profit hospitals, but also includes nursing and residential care facilities.

Support activities for mining (NAICS 213), Information (NAICS 51), Oil and gas extraction (NAICS 211), and Professional and business services (NAICS 54-56).

The 10-year average TFP for these sectors (20142023) ranged from 1.9 to 4.9. Given their higher-thanaverage growth, industries with higher productivity will account for a larger portion of the private nonfarm sector over time.

In comparison, sectors that face more stringent institutional constraints on increasing productivity, such as educational services, social support services, and the hospital industry, fall behind at an increasing rate over time. The educational and social support services sectors are similar to the hospital industry because they rely heavily on labor and also face similar constraints in measuring outputs¹⁵ (described further below). The hospitals and nursing and residential care facilities (NAICS 622-623) subsector¹⁶ had an average TFP of -0.1, Educational services (NAICS 61) sector had an average TFP of -0.4, and Social assistance (NAICS

624) had an average TFP of -0.1 over the same period.

Figure 1 describes the trends in TFP for the private nonfarm sector and these selected sectors/subsectors over time. Hospitals, educational services and social services productivity levels are consistently below the overall TFP. Of all 81 major industries for which BLS publishes TFP measures,¹⁷ NAICS 622-623 has the lowest standard deviation in the year over year percent change in TFP (standard deviation of 1.1) and Health care and Social Assistance (NAICS 62) has the second lowest, indicating the persistence of the lower productivity in the these sectors. Benchmarking hospital productivity against the

volatility in other industries represented in the private nonfarm sector TFP introduces additional sources of uncertainty to hospitals when they are already operating at lower productivity levels.

Even if the economy-wide productivity measure were an appropriate measure of productivity of the hospital sector, applying annual payment adjustments as in the current methodology assumes hospital productivity improves at the same rate and at the same time as the private sector. This ignores potential misalignments in timing between productivity growth in hospitals relative to other sectors. There are many reasons why hospital productivity may not align with private sector trends. Hospitals faced significant disruptions during the COVID-19 pandemic, resulting in strained resources and staffing. Hospitals also sustained large financial losses during the pandemic,18,19 mainly driven by a surge in demand for acute care services and declines in more profitable services, such as elective procedures. To further compound this issue, widespread supply chain problems caused by the pandemic drove up prices for medicines and personal protective equipment.²⁰ While the rest of the economy shut down, hospitals remained open and sustained large operational losses, and when measured productivity in the rest of the economy rebounded strongly, hospitals continue to face lingering effects as utilization rates have not rebounded to pre-COVID levels, particularly in surgical procedures.²¹ The COVID-19 pandemic worsened existing staffing shortages in hospitals, and these workforce challenges continue to impact operations now as hospitals need to offer competitive wages to retain and recruit staff.22 In addition to COVID-19, there are other reasons hospital productivity gains may not be timed similarly to those in the private sector. Capital investments by hospitals are expensive and advances in technology or upgrades to facilities may temporarily reduce productivity while increasing costs. Additionally, the

regulatory requirements described previously require substantial resources for hospitals to maintain compliance. These put further financial pressure on hospitals, thus impacting hospital productivity.

Some have argued in favor of the use of a hospital sector specific productivity metric to more accurately adjust payment rates for realized productivity gains in the hospital sector. However, even if one were to use such a measure, there are challenges in computing hospital productivity because it is not an industry where transactions are conducted within a single-price, perfectly competitive market.²³ Measuring hospital outputs, specifically, poses a unique challenge.

The BLS uses a deflated revenue model to capture outputs in order to calculate TFP. Outputs are measured as a function of the total quantity and prices from all goods and services produced, and are adjusted for inflation. For sectors that sell tangible, physical products, measuring outputs is relatively straightforward, especially when outputs are standardized units of goods or services produced. Hospital outputs are not as clearly measured and the transactions that occur for each unit of service fundamentally differ from transactions in other industries: namely, patients pay varying prices based upon their insurer and insurance status, and are not fully informed of nor exposed to the full prices of services they consume.24, 25 Because prices do not reflect marginal costs in such a market, using a deflated revenue model is not appropriate.

As an alternative, researchers have proposed volume-based output metrics.²⁶ This volume-based metric, if applied just to the inpatient setting, still has a key weakness: it does not account for shifts in patient volume to the outpatient setting. Productivity gains in the hospital sector are likely to shift low-cost patients to lower levels of care, such as the outpatient setting, leaving inpatient hospitals

with more acutely ill patients. This can manifest as lower levels of measured productivity in inpatient settings, when in reality, the hospital, as a whole, has achieved efficiency gains accounting for the shift between settings. In this context, the application of an adjustment based on narrowly construed hospital services will lead to underpayment for inpatient services.

Another issue with measuring hospital outputs is the need to account for changes in quality. Appropriately accounting for quality requires defining and measuring quality as well as constructing an appropriate method to incorporate it in the measure of outputs.27 The current practice is to treat a single service, such as a inpatient admissions as a unit of output, but there is consensus amount health economists and national accounting authorities that productivity of the medical sector over time is better measured on a disease-by-disease basis.²⁸ Economists also agree that the measurement of medical output should be adjusted for quality of the treatment, though the exact methodology for quality adjusting outputs remains an open question.

The methodology used to construct the productivity adjustment amplifies payment instability amid uncertain economic conditions

In addition to the conceptual issues raised by using growth in private nonfarm business TFP as a proxy for expected increases in hospital productivity, the methodology used to compute the 10-year moving average change in TFP produces problematic estimates. The 10-year moving average is intended to smooth out fluctuations in the private nonfarm business TFP that may occur year-to-year. As noted above, CMS computes the 10-year moving average for the period ending with the payment year using a combination of historical data and projections from IHS Global Inc. ("IGI") (i.e., for the 2026 IPPS, the 10year moving average covers the period ending with 2026

Q3 and includes historical data through the end of 2024). This methodology currently produces estimates of TFP that vary substantially from rule to rule and inject variability into the payment system, further straining hospital resources.

The historical data used for the productivity adjustment in the 2026 Proposed Rule include the COVID-19 pandemic, which led to large annual changes in TFP in 2021 and 2022. Specifically, the worldwide economic shock associated with the start of the pandemic in 2020 led to a growth rate of non-farm business TFP in 2021 that substantially exceeded any value reported for the last 30 years. Including this aberrant change substantially increases the historical

component of the 10 year moving average that CMS uses to determine the productivity adjustment. That is, the historical average is heavily influenced by the unprecedented fluctuations associated with the pandemic even when using a 10 year moving average. In addition to the direct impact of this unusual period on the 10 year moving average, the pandemic's disruptions to historical economic data series will impact the accuracy of models using those data series to project any future values.

Indeed, the projections used for the later quarters of the 10 year moving average period appear to vary dramatically as CMS incorporates additional data for each successive payment year. While CMS does not explicitly publish the projections, it is possible to extrapolate the average projected change in TFP based on the historical data and the productivity adjustment in each year's final rule. Based on the 2026 Proposed Rule, CMS's implied projections for TFP growth through 2026 are substantially larger than the projections in the previous payment update. This appears to be the key factor driving the large increase in the computed productivity adjustment we see for FY 2026 compared to FY 2025. CMS does not provide any justification for this large increase in productivity to the projections, which contradicts the general consensus that the near-term economic outlook has worsened, and has thus lowered productivity. Together, the overstatement of historical TFP growth generated by including the pandemic period and the unsupported increase in projected TFP growth through 2026 lead to a productivity adjustment that is unwarrentedly high given expected economic conditions.

Comparing the projections of TFP growth implied by the previous productivity adjustments to actual TFP growth suggests there is substantial error within the forecasts. In the five years prior to the pandemic, the average difference between the implied forecast and actual TFP growth during the projection period was about 90%, and this has ballooned in recent years as the pandemic's impact became apparent in the data. Given the unusual movements in economic time series introduced by the pandemic and the current uncertainty regarding near-term economic conditions, CMS must ensure that inaccurate estimates of TFP do not generate unjustified cuts to hospital payments. Conclusion

It is critically important to consider the economic realities that hospitals face as CMS reviews the public comments in response to the proposed FY 2026 IPPS final rule. Current economic conditions are creating uncertainty and financial strain for hospitals. The proposed 0.8 total factor productivity ("TFP") adjustment overestimates achieveable improvements in efficiency, worsening hospitals' financial pressures. Unlike private-sector industries, hospitals have historically not been able to achieve comparable efficiency gains. Additionally, using the private nonfarm sector metric to cut hospital payments is questionable, as hospitals operate in more complex regulatory and operational environments than private sector industries. Finally, TFP projections have proven unreliable, especially during uncertain times like the COVID-19 pandemic, undermining their use in setting hospital payments.

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