American Hospital Association™
Advancing Health in America

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June 10, 2025

The Honorable Mehmet Oz, M.D.
Administrator
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244-1850

Re: Medicare Program; Inpatient Rehabilitation Facility Prospective Payment System for Federal Fiscal Year 2026 and Updates to the IRF Quality Reporting Program; 90 Fed. Reg. 18,534 (April 30, 2025).

Dear Administrator Oz:

On behalf of our nearly 5,000 member hospitals, health systems and other health care organizations, including approximately 900 inpatient rehabilitation facilities (IRF), our clinician partners — more than 270,000 affiliated physicians, two 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) fiscal year (FY) 2026 IRF prospective payment system (PPS) proposed rule.

IRFs play a critical role for Medicare beneficiaries in the continuum of care. These hospitals and units of acute-care hospitals care for patients with complex conditions as they undergo an intensive course of rehabilitation while being monitored and treated by a rehabilitation physician, which provides the optimal opportunity for maximum functional recovery following a serious injury or illness. The treatment provided by IRFs pays dividends down the road, allowing patients to return to their previous lives to the maximum extent possible.

The AHA has concerns that Medicare payment updates continue to lag inflation and may not be adequate for the continued success of the IRF field. As discussed more thoroughly below, we urge CMS to examine its market basket and productivity adjustments to ensure appropriate annual updates. The AHA appreciates, however, CMS' efforts to alleviate the reporting burden on providers. Specifically, the AHA supports CMS' proposal to remove four standardized patient assessment data elements

(SPADEs) from the IRF QRP and greatly appreciates CMS' recognition of the need to balance administrative burden and value in quality measurement programs. By streamlining reporting requirements, CMS can free providers to focus on the quality and safety issues that matter the most to their patients. In addition, the AHA appreciates CMS' efforts around deregulation and is responding to CMS' Request for Information (RFI) on approaches and opportunities to streamline regulations and reduce administrative burdens on providers.

Our detailed comments follow.

MARKET BASKET UPDATE

The AHA remains concerned about inaccurate and inadequate market basket updates. In recent years, the market basket forecasts utilized by CMS have consistently underforecast 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 reexamine its market basket updates and the magnitude of the productivity adjustment and its impact on Medicare payments.**

Hospitals and Health Systems Continue to Face High Rates of Inflation

Hospitals, including IRFs, continue to face serious inflationary pressures. As detailed in our comments on the FY 2025 IRF proposed rule, unprecedented levels of inflation 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, which make up nearly three-quarters of the IRF 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 IRF PPS (market basket minus productivity) provided for only a 23.7% 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-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] These shortages and rising costs

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

distinctly impact IRFs due to the intensive rehabilitation and close medical supervision provided to IRF patients.

Increasing drug and supply costs also have 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 IRFs as they care for patients with a wide range of complex medical conditions while they undergo their course of rehabilitation therapy.

In addition to direct costs of care, hospitals have also faced rising administrative costs. For example, the vast majority of Medicare Advantage (MA) plans require prior authorization for IRF admissions. As such, IRFs spend substantial amounts of time and resources navigating the prior authorization process. In addition, a study by the HHS Office of Inspector General found many of these post-acute care prior authorization requests were being denied inappropriately and, as a result, IRFs and other hospitals were being forced to spend valuable resources appealing erroneous denials.[7] This has prompted the OIG to initiate another investigation focused specifically on MA practices for access to post-acute care. Further, a 2023 study by Premier found that hospitals are spending just under $20 billion annually on appealing denials.[8] MA plans do not reimburse these costs, which instead must be absorbed by IRFs as they continue to care for a rising proportion of MA patients.

Adding to the uncertainty facing providers are the threat of increased tariffs across many sectors, including those essential to the health care system. 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 care for patients and protect our health care workers. Tariffs and potential retaliatory actions from affected countries could reduce the availability of these lifesaving 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

[5] ASPE. Changes in the List Prices of Prescription Drugs, 2017-2023. (October 2023) (https://aspe.hhs.gov/reports/changes-list-prices-prescription-drugs).
[6] American Society of Health-System Pharmacists. Severity and Impact of Current Drug Shortages (June 2023) (https://news.ashp.org/-/media/assets/drug-shortages/docs/ASHP-2023-Drug-Shortages-Survey-Report.pdf).
[7] HHS OIG. Some Medicare Advantage Organization Denials of Prior Authorization Requests Raise Concerns About Beneficiary Access to Medically Necessary Care (April 2022) (https://oig.hhs.gov/reports/all/2022/some-medicare-advantage-organization-denials-of-prior-authorization-requests-raise-concerns-about-beneficiary-access-to-medically-necessary-care/).
[8] Premier. Private Payers Retain Profits by Refusing or Delaying Legitimate Medical Claims (March 2024) (https://premierinc.com/newsroom/blog/trend-alert-private-payers-retain-profits-by-refusing-or-delaying-legitimate-medical-claims).

health care experts expect tariff-related expenses to raise hospital costs by at least 15%.[9]

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 IRFs, to divert funds that could have been invested in patient care, new technologies and other potential efficiencies, making all the more concerning the inadequate market basket updates provided by CMS. In addition, as discussed more below, this has heightened the harm caused by the productivity adjustment as hospitals are unable to keep up with efficiencies that could be realized with less financial strain.

Market Basket Forecasts Continue to Underestimate Actual Market Basket Growth

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

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

	FY 2021	FY 2022	FY 2023	FY 2024	FY 2025	Total (Compounded)
Market Basket Update in Final Rule	2.4%	2.6%	4.2%	3.6%	3.5%	17.4%
Actual/Updated Market Basket Forecast	2.8%	5.3%	4.8%	3.8%	3.6%	22.0%
Difference in Net Market Basket Update and Actual Increase	**-0.4%**	**-2.7%**	**-0.6%**	**-0.2%**	**-0.1%**	**-4.6%**

These missed forecasts have a significant and permanent impact on IRFs and the patients they care for. At current levels, this cumulative underpayment of 4.6 percentage points totals approximately $450 million annually. Further, 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 IRFs and will continue to compound.

[9] https://www.beckershospitalreview.com/supply-chain/hospital-finance-supply-leaders-predict-15-increase-in-tariff-related-costs/

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 comment letters, one such factor may be CMS' use of the Employment Cost Index (ECI) to measure changes in labor compensation in the market basket.[10] By design, the ECI cannot capture changes in costs driven by shifts between different categories of labor; CMS itself has recognized this shortcoming.[11] Yet, one major labor market change over the last several years has been increased utilization of contract labor. Therefore, the 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.

The Productivity Adjustment Further Exacerbates Underpayments

Under the Affordable Care Act, the IRF 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).[12] 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 nonprofit 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 reexamine 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

[10] 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."
[11] 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."
[12] CMS. (February 2016). Hospital Multifactor Productivity: An Updated Presentation of Two Methodologies (https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/ReportsTrustFunds/Downloads/ProductivityMemo2016.pdf).

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; it may actually 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 IRF PPS; 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, which often lock in rates for several years. Thus, 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 the unique 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. Private nonfarm businesses rarely have such onerous challenges and requirements.

Third, 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 long been 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.[13] Thus, using the private nonfarm business sector TFP to adjust the market basket is inappropriate.

Additionally, it is puzzling to see how an indicator based on a 10-year moving average could yield such an increase in 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 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.[14] 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 of 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.

HIGH-COST OUTLIER PAYMENTS

AHA supports CMS' policy of setting outlier payments at 3% of total payments. Indeed, an outlier policy is an important part of a payment system, particularly for patients, as it ensures providers are not unduly penalized for caring for the most extremely ill. However, there are improvements that could minimize volatility in the outlier threshold and improve predictability for providers. Although this year's proposed change to the

[13] Centers for Medicare and Medicaid Services. (February 2016). Hospital Multifactor Productivity: An Updated Presentation of Two Methodologies (https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/ReportsTrustFunds/Downloads/ProductivityMemo2016.pdf).
[14] 85 Fed. Reg. 58797 (Sept. 18, 2020).

threshold is about 6%, in recent years, changes have been as high as 32%. AHA, therefore, recommends that CMS explore changes to its methodology**.** For example, CMS could use a three-year rolling average methodology in setting its outlier threshold. AHA would be happy to work with CMS to explore changes that would fairly and consistently reimburse IRFs for outlier cases.

WAGE INDEX POLICIES

CMS proposes to continue to use the most recent labor market areas issued by the Office of Management and Budget in the July 2023 Bulletin No. 23-01. In addition, it would continue applying a 5% year-to-year cap on any reductions in an individual IRF's wage index. **The AHA continues to support both of these policies. However, we also urge CMS to implement them in a non-budget-neutral manner.** As explained above, IRFs, like other hospitals, continue to face financial strain due to rising costs and lagging payment updates. The cumulative effect of these budget neutrality reductions, which last year was more than three-quarters of a percent for wage and labor changes, compounds the lagging payment rates for hospitals.

IRF QUALITY REPORTING PROGRAM

As mandated by the Affordable Care Act, IRFs receiving Medicare payments have been required to participate in the IRF Quality Reporting Program (QRP) since 2014. The Improving Medicare Post-Acute Care Transformation (IMPACT) Act requires that, starting FY 2019, providers must report standardized patient assessment data elements (SPADEs) as part of the IRF QRP. Failure to comply with these requirements results in a 2 percentage point reduction to the IRF's annual market basket update.

Proposed Removal of Four Social Determinants of Health (SDOH) SPADEs. With a stated purpose of reducing administrative burden to IRFs, CMS proposes to remove four SPADEs it adopted in the FY 2025 IRF PPS final rule that are focused on living situation, food security and utilities. The AHA 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 SPADEs from the IRF QRP. In general, streamlining the number of measures and reporting requirements in federal QRPs can help providers focus their resources on high-priority topics of national importance while freeing up resources to help IRFs address the quality issues that matter most to their patients.

In addition, the AHA has noted that these SPADEs were being implemented in a manner discordant with the rest of the IRF Patient-Assessment Instrument (IRF-PAI) that could lead to difficulty in obtaining accurate information from patients. For example, the food security questions ask patients to rate the frequency of food shortages using a three-point scale, whereas other questions on the IRF-PAI, such as the resident mood (PHQ-9 tool), behavioral symptoms and daily preferences items, use a four-point scale to determine frequency. These discrepancies might make it difficult for staff to administer the SPADEs and given the inconsistency with the scales used in other IRF-

PAI items, it may lead to confusion for staff and patients alike. In addition, there is no skip logic included for these questions as there is for other IRF-PAI items. If a patient reports that they do not have a stable place to live in response to the living situation item, it seems inappropriate to subsequently ask them about their utility difficulties. For these reasons, the AHA supports the removal of these four SPADEs from the IRF QRP.

Proposed Removal of Two COVID-19 Vaccination Measures. For the FY 2026 IRF QRP, CMS proposes to remove two COVID-19 vaccination measures — one focused on patients and the other on health care personnel (HCP). CMS believes removing these two measures would reduce the burden to IRFs and that they are no longer necessary, given the conclusion of the COVID-19 PHE.

The AHA again appreciates CMS' approach to achieving a balance between burden and value in quality measurement programs and especially applauds CMS' proposal to sunset the COVID-19 vaccination coverage among HCP measure. While IRFs continue to support efforts to vaccinate health care workers for COVID-19 in a manner consistent with federal guidelines, the COVID-19 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 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. IRFs 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, IRFs 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, IRFs usually do not have routine access to data to know which of their HCPs may need an additional booster. In short, the resource intensiveness of collecting data under 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.

Reconsideration Process. CMS proposes two changes to the IRF QRP reconsideration process that permit IRFs to appeal a CMS initial determination of noncompliance with reporting or other programmatic requirements. First, CMS proposes to allow IRFs to request an extension to file a request for reconsideration in the event the organization experiences an extraordinary circumstance (e.g., natural disaster) that overlaps with the deadline for filing a reconsideration request. **The AHA supports this**

proposal and thanks CMS for recognizing that extraordinary circumstances may inhibit the ability of IRFs to file reconsideration requests. We encourage CMS to consider adopting similar policies for its other quality reporting and value programs.

Second, CMS proposes to clarify that it would reverse a finding of noncompliance with the IRF QRP only if CMS determines that the IRF was in full compliance with the IRF QRP requirements for the applicable program year, including, when relevant, following CMS' established policies for requesting and receiving an extraordinary circumstance exception from reporting. **The AHA supports this proposal.**

RFI: Advancing Digital Quality Measurement. In the proposed rule, CMS seeks input on how to advance the uptake of digital quality measures in the IRF QRP. CMS is particularly interested in the extent to which IRFs are using application programming interfaces based on the Fast Healthcare Interoperability Resource (FHIR) standard to support any data reporting or exchange functions.

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. It also could enable more automated sharing of data with CMS in the long term. However, we encourage CMS to hone its approach to digital quality measurement by clearly defining the goals and expectations for providers and considering the specific needs and capabilities of post-acute care providers and their patients.

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 information technology (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, long-term care and post-acute care providers were not eligible for the EHR Incentive Programs (now known as the Promoting Interoperability Program) under the Act. In its 2019 RFI that accompanied the Interoperability and Patient Access proposed rule, CMS largely attributed the slower 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 post-acute care is heterogeneous. Many providers have been able to successfully incorporate health IT with higher levels of sophistication, including certified EHR technology (CEHRT). However, others are using technologies with fewer capabilities for digital exchange. Post-acute care providers also experience significant shortages of health IT professionals, raising concerns about whether there would be a sufficient number of health IT professionals to implement new requirements for post-acute providers.

Because of these challenges, any approach to digital quality measurement in post-acute

care will have to be nuanced and gradual. We encourage CMS to consider developing a "glide path" for post-acute care 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, personnel and physical investments — that can support highly technical requirements. Standards and other requirements must be clear and accessible to providers with limited technology infrastructure, enabling them to work toward future interoperability rather than be discouraged and overwhelmed by the complexity and cost. 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: IRF QRP Data Submission Timelines. CMS seeks input on decreasing the amount of time that IRFs have to submit quarterly quality measure and SPADE data to CMS. Currently, IRFs have four and a half months after a quarter closes to submit data to CMS. CMS seeks input on potentially requiring that quality and SPADE data be submitted 45 days after the close of a quarter. The agency believes this would result in timelier publicly reported data on the performance of IRFs.

The AHA appreciates CMS' goal of improving the timeliness of publicly reported data. At the same time, we are not confident that a 45-day window is sufficient for IRFs to submit QRP data and meet all program administrative requirements. IRFs work to ensure that clinical documentation and processing are done accurately and expeditiously. At the same time, finalizing medical records and other data that form the basis of the IRF QRP measures can take time, including time after a patient's encounters with the care team have concluded. Once the patient assessment and medical records are complete, IRFs must then aggregate data and package it in a manner that aligns with CMS reporting requirements. This packaging step is vital and has no room for error. That is because the IRF QRP policy requires IRFs to meet *all* administrative and reporting requirements to be in full compliance. The AHA is concerned that a 45-day timeframe would overly compress the amount of time that IRFs need to ensure their data reporting complies with CMS requirements and could lead to processing errors that ultimately result in IRFs losing 2.0% of their market basket updates for being out of compliance with program requirements.

We encourage CMS to continue engaging the IRF field in further analysis of the timeframes for collecting and submitting IRF data. CMS could consider conducting quantitative and qualitative studies of the IRF reporting process with a representative sample of facilities. The agency could also solicit further input from facilities on what timeframe would strike the best balance of feasibility and timeliness.

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 an RFI available 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 AHA is responding to the RFI directly through the provided site and looks forward to continuing to work with the administration on the much-needed effort to reduce regulatory red tape so America's hospitals and health systems can best support the health of their communities. However, for your consideration, we also wish to call CMS' attention to a previous set of deregulation requests that we have provided to the administration. Among these is the burdensome IRF Review Choice Demonstration (RCD), which unnecessarily subjects IRFs in selected states to 100% pre- or post-claim review. Based on data to date from the program, it appears to be doing little to achieve its stated purpose while forcing providers to undergo a time and resource-intensive process. We urge CMS to rescind these and other burdensome program requirements that do not provide value to patients, providers, or the Medicare program.

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We appreciate your consideration of these issues. Please contact me if you have questions or feel free to have a member of your team contact Jonathan Gold, AHA's senior associate director for policy, at (202) 626-2368 or jgold@aha.org.

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 serve that belong to the Medicare program, but also because private insurers typically base their reimbursement rates off of a proportion of

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 non-farm 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)

YEAR	FINAL RULE PAYMENT UPDATES	MARKET BASKET INCREASE	PRODUCTIVITY ADJUSTMENT	OTHER LEGAL ADJUSTMENTS
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

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 non-business 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 3.8[7] 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]

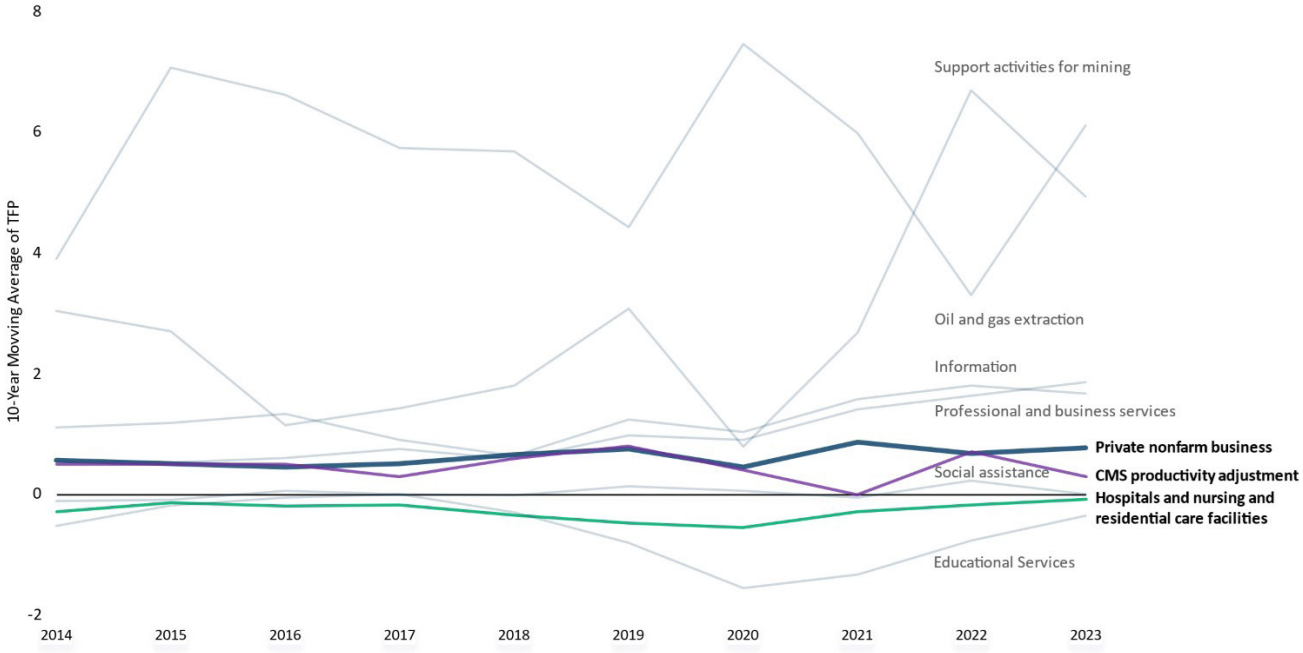
Hospitals encounter substantial regulatory requirements unique to the healthcare sector. Hospitals must then bear the cost to maintain compliance with these regulations. Government-set reimbursement rates have not kept pace with inflation, covering only 83 cents for every dollar hospitals spent in 2023.[10] 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 Commission[12], 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 for-profit hospitals[13]. Some belong to large health systems, while others are independent community hospitals. Safety-net hospitals focus on low-income, uninsured, or Medicaid-heavy 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 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 (2014-2023) ranged from 1.9 to 4.9. Given their higher-than-average 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 outputs[15] (described further below). The hospitals and nursing and residential care facilities (NAICS 622-623) subsector[16] 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: 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.

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 10-year 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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