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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

Submitted Electronically

Re: Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Policy Changes and Fiscal Year 2026 Rates; Requirements for Quality Programs; and Other Policy Changes; 90 Fed. Reg. 18,002 (April 30, 2025).

Dear Administrator Oz:

On behalf of our nearly 5,000 member hospitals, health systems and other health care organizations, including approximately 230 long-term care hospitals (LTCHs), our clinician partners — 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') fiscal year (FY) 2026 LTCH prospective payment system (PPS) proposed rule. We are submitting separate comments on the rule's inpatient PPS and Transforming Episode Accountability Model proposals.

LTCHs care for some of the most complex and severely ill Medicare beneficiaries. As CMS points out in this rule, more than 90 percent of Medicare patients are dependent on a ventilator when arriving at an LTCH, have spent three or more days in an intensive care unit (ICU), or both. These patients have high rates of complex wounds, chronic illness, and other factors that make the LTCH patient population a uniquely resource-intensive group. For this reason, LTCHs maintain a deeply specialized expertise that enables them to care for these patients and maximize their chances of recovery. Indeed, many acute-care hospitals rely on LTCHs as partners to care for patients with these specific high-acuity needs by transferring them to LTCHs.

Unfortunately, and as explained further in this letter, Medicare payment dynamics and related factors have caused a contraction of the LTCH field. This not only limits the ability of certain high-need patients from receiving care at an LTCH, but also strains the entire continuum of care as acute-care hospitals and other providers must find ways to care for these patients. This rule has several proposals that will exacerbate the ongoing difficulties within the LTCH field, particularly the large proposed increase in the high-cost outlier threshold. The AHA offers numerous recommendations to mitigate these effects, and we urge CMS to adopt them in the final rule.

While we have concerns about the payment updates for this proposed rule, the AHA appreciates 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 LTCH 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.

PROPOSED FY 2026 LTCH PPS PAYMENT UPDATES

CMS proposes a market basket update of 3.4%, reduced by a productivity adjustment of 0.8 percentage points, resulting in a net market basket update of 2.6% for FY 2026. However, as discussed further below, overall payments to LTCHs would again be reduced year-over-year due to an increase in the high-cost outlier (HCO) fixed-loss amount (FLA). The AHA is deeply concerned about the additional fiscal stress this will place on the LTCH field, which provides critical care to extremely ill Medicare beneficiaries in communities throughout the country. **The inadequate market basket updates, including the misguided productivity adjustment, combined with the untenable rise in the HCO FLA, threaten to lead to further closures in a field that has already seen the number of LTCHs decrease by 25% over the last 10 years. As such, we urge CMS to re-examine the magnitude of the productivity adjustment and its impact on Medicare payments.**

Impact of Inflation and Dual-rate Payment System on LTCHs

The combination of rising costs due to inflation and the novel dual-rate payment system imposed on LTCHs has challenged the LTCH field, with many hospitals unable to continue to operate under the pressures created by the confluence of these factors. Indeed, more than 100 LTCHs have closed since 2016 when the dual-rate payment system went into effect, accounting for nearly a quarter of all LTCHs. This loss of important hospital capacity has and will continue to strain the continuum of care for both

upstream acute-care hospitals and other providers. Compounding this situation is that CMS has under-forecasted the LTCH market basket for the past five years, resulting in a cumulative underpayment of approximately $133 million annually. In addition, the productivity adjustment further reduces LTCH payments, despite the inability of hospitals to match economy-wide productivity due to the nature of their services. **We therefore urge CMS to take action as outlined below to increase reimbursement for LTCHs, avoid further closures in the field and help maintain access to this critical care for Medicare beneficiaries.**

Hospitals Continue to Face High Rates of Inflation. Hospitals, including LTCHs, continue to face serious inflationary pressures. As detailed in our comments on the FY 2025 LTCH 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 is growth is attributable to increased labor costs, which make up nearly three-quarters of the LTCH 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 LTCH 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 significantly impact LTCHs due to the high acuity, complex nature, and labor-intensive treatments required by their patients.

In addition to labor costs, 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 LTCHs as they care for patients with multiple comorbidities and who require extended hospitalizations.

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[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).
[5] ASPE. Changes in the List Prices of Prescription Drugs, 2017-2023. (Oct. 2023). (https://aspe.hhs.gov/reports/changes-list-prices-prescription-drugs)
[6] American Society of Health-System Pharmacists. Severity and Impact of Current

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 LTCH admissions. As such, hospitals spend substantial amounts of time and resources navigating the prior authorization process. A study by the HHS Office of Inspector General (OIG) found many of these post-acute care prior authorization requests were being denied inappropriately and, as a result, providers 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 regarding 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 LTCHs as they continue to care for a rising proportion of MA patients.

Adding to the uncertainty facing providers is 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 both care for patients and protect our health care workers. Tariffs, as well as any reaction by the countries on which 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 found 82% of 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 essentials have put a strain on the entire health care continuum. Rising costs also have forced hospitals, including LTCHs, to divert funds that could have been invested in patient care, new technologies and other potential efficiencies, making the inadequate market basket updates provided by CMS even more concerning. In addition, as discussed more below, hospitals are unable to keep up with efficiencies that could be realized with less financial strain, heightening the harm caused by the productivity adjustment.

The Dual-Rate Payment System Has Driven Up Patient Acuity and Costs. As a result of the dual-rate payment system, the LTCH field has undergone drastic changes

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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) (premierinc.com/newsroom/blog/trend-alert-private-payers-retain-profits-by-refusing-or-delaying-legitimate-medical-claims).

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

over the last decade.[10] In addition to the closure of nearly a quarter of all LTCHs, there has been a corresponding sharp decrease in patient volume, consolidation of cases into a small number of diagnosis-related groups (DRGs) and an overall higher acuity patient pool. In fact, since the implementation of the dual-rate payment system in FY 2016, the number of standard-rate LTCH cases has fallen by over 40%, from about 74,000 in FY 2016 to about 42,000 in FY 2024, and decreased by approximately 70% from the peak number of cases under the legacy payment system. In addition, the remaining patient pool is notably more acute and costly to treat and has been consolidated into a relatively small number of LTCH PPS DRGs.[11,12] Within these DRGs, there is great variation in patient severity and therefore in actual cost, and thus more cases are qualifying for HCO payments to compensate for lack of precision in the DRGs, as discussed more below.

While standard rate case volume has declined, approximately 10 percent of all Medicare LTCH discharges nationally are paid the inpatient PPS-equivalent rate, and these cases are substantially underpaid. A prior AHA analysis showed that reimbursement for these cases totaled only 46% of the cost of care.[13] This underpayment is due to the fact that while the patients may not have had a three-day ICU stay or required long-term ventilation to qualify them for the standard rate, they nonetheless required long-term hospitalization and complex care. Of inpatient PPS claims with three days or more in the ICU, the average length of stay (ALOS) was approximately *four* days. However, the ALOS for inpatient PPS-equivalent cases in LTCHs was *23* days. Further, only 16% of inpatient PPS claims had patients with five or more complications or comorbidities or major complications or comorbidities, while 41% fell in that category for LTCH inpatient PPS-equivalent cases.

These market dynamics have put severe stress on the LTCH field. From FY 2011 through FY 2013, LTCHs' aggregate average Medicare margin ranged from 6.6% to 7.4%.[14] However, from FY 2017 through FY 2019, that margin fell substantially, ranging from -0.5% to -2.2%.[15] Despite the continued closure of LTCHs, those that remain open continued to have negative Medicare margins, with MedPAC finding a FY 2022 Medicare margin of -1.3%, despite a waiver of the dual-rate payment system during this

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[10] https://www.aha.org/white-papers/2023-12-29-white-paper-medicares-ltch-outlier-policy-needs-reforms-protect-extremely-ill-beneficiaries

[11] These values are calculated using CMS' LTCH PPS impact files for the FY 2018 final rule (which uses the FY 2016 MedPAR file) and the FY 2026 proposed rule (which uses the FY 2024 MedPAR file).

[12] https://www.aha.org/white-papers/2023-12-29-white-paper-medicares-ltch-outlier-policy-needs-reforms-protect-extremely-ill-beneficiaries

[13] https://www.aha.org/system/files/media/file/2019/06/aha-cms-long-term-care-proposed-rule-fy2020-6-21-2019_0.pdf

[14] MedPAC, March 2015 Report to Congress, Ch. 11, pg. 275, https://www.medpac.gov/wp-content/uploads/import_data/scrape_files/docs/default-source/reports/chapter-11-long-term-care-hospital-services-march-2015-report-.pdf.

[15] MedPAC March 2022 Report to Congress Chapter 11, pg. 351, https://www.medpac.gov/wp-content/uploads/2022/03/Mar22_MedPAC_ReportToCongress_Ch10_SEC.pdf.

time due to the COVID-19 public health emergency.[16] With the discontinuation of the public health emergency waivers, margins have continued to drop, precipitating further contraction in the field.

Market Basket Forecasts Continue to Underestimate Actual Market Basket Growth

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

Table 1: LTCH 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	2.3%	2.6%	4.1%	3.5%	3.5%	17.0%
Actual/Updated Market Basket	2.8%	5.5%	4.8%	3.7%	3.6%	22.1%
Difference in Net Market Basket Update and Actual Increase	**-0.5%**	**-2.9%**	**-0.7%**	**-0.2%**	**-0.1%**	**-5.1%**

These missed forecasts have a significant and permanent impact on LTCHs and the patients they care for. At current levels, this cumulative underpayment of 5.1 percentage points totals approximately *$130 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 LTCHs and will continue to compound.

While forecasts will never be perfect, they have been more balanced in the past. The AHA is concerned that there is a more systemic issue with IHS Global's forecasting that biases towards under-forecasting growth. Indeed, as AHA noted in prior comment letters, one such factor may be the use of the Employment Cost Index (ECI) to measure changes in labor compensation in the market basket.[17] By design, the ECI cannot capture changes in costs driven by shifts between different categories of labor; CMS

[16] MedPAC, Health Care Spending and the Medicare Program, Chapter 8, pg. 122 (July 2024) (https://www.medpac.gov/wp-content/uploads/2024/07/July2024_MedPAC_DataBook_SEC.pdf).
[17] 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."

itself has recognized this shortcoming.[18] 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 LTCH 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).[19] 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 re-examine the magnitude of this adjustment and its impact on Medicare payments.**

First, 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; 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 LTCH PPS; they cannot alter their prices in the same

[18] 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."
[19] 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

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 regulatory 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.[20] Thus, using the private nonfarm business sector TFP to adjust the market basket inappropriately exacerbates Medicare's chronic underpayments to LTCHs.

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

[20] 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

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.[21] Simply put, the agency applies the productivity factor only when it cuts Medicare spending. However, the cumulative, compounding 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 under which health care providers 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 supply-and-demand shocks, it generates significant departures from economic reality.

Proposed High-Cost Outlier Fixed-Loss Amount

For FY 2026, CMS is proposing to increase the high-cost outlier (HCO) fixed-loss amount (FLA) from $77,048 to $91,247, an 18% increase. This is staggering in light of the fact that the FLA has already increased by more than 300% since FY 2016. While CMS recognizes the magnitude in the increase in the proposed rule, it does not propose any alternative approaches that could help yield a more reasonable figure. **The AHA continues to be seriously troubled by the increase in the FLA and urges CMS to take action in the final rule, as recommended below, to avoid disruptions to care.**

The AHA agrees with the stated purpose of the HCO policy, which is to "reduce the financial losses that would otherwise be incurred by hospitals when treating patients who require more costly care and, therefore, reduce the incentives to underserve these patients."[22] However, it is not reasonable to conclude that a hospital losing more than

[21] 85 Fed. Reg. 58797 (Sep 18, 2020).
[22] Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System Policy Changes and Fiscal Year 2016 Rates; 80 Fed. Reg. 49325, 49,617 (Aug. 17, 2015).

$91,000 on a patient would effectively accomplish this goal.[23] On the contrary, it will likely be cost-prohibitive for some hospitals to continue to care for these patients. This underpayment seriously threatens access for the sickest of sick Medicare beneficiaries — those requiring long stays in LTCHs.

The AHA detailed the underlying causes and the impacts of the rising FLA in our recent white paper. To summarize, LTCH volume has dropped severely since the implementation of the dual-rate payment system. In accordance with this volume decrease, the acuity of cases has increased, making the average case more costly. Therefore, a much higher proportion of total cases (and thus payments) are high-cost patients that qualify for HCO payments. However, in an effort to continue targeting paying 7.975% of total payments as outliers, CMS has continually raised the FLA. In addition to increasing the losses that must be incurred for HCO cases, this has resulted in more cases that once would have qualified for an HCO payment now not qualifying. Thus, LTCHs must now absorb additional losses for both 1) cases that would have previously qualified for HCO payment with a lower FLA but no longer do, and 2) cases that do qualify for HCO payment, but require LTCHs to absorb a much higher loss due to the increased FLA.

These phenomena are not surprising to providers who cautioned that the dual-rate payment system would have such an effect. Indeed, in the FY 2016 and 2017 rulemakings, CMS noted increases in the FLA and said it believed that it was due to the new dual-rate payment system. [24] However, it stated that it "expect[s] annual changes to the fixed-loss amount to generally stabilize as experience is gained under the new dual rate LTCH PPS payment structure."[25] However, that stabilization clearly never materialized.

AHA offers a series of recommendations below that we implore CMS to adopt. Keeping the FLA to a reasonable level will help ensure that the HCO policy serves its intended purpose. As such, it will also help ensure that access for the sickest, most severely ill patients is not disrupted.

Recommendation No. 1: Utilize a Market-Basket-Based Methodology.[26] Until FY 2022, CMS calculated the FLA by forecasting growth in charges using the market basket for LTCHs. It did this because indexing the charge growth to market basket growth helped ensure the FLA grew consistent with payment. In addition, the market basket was a reasonable proxy for growth in charges. However, in FY 2022 the agency began utilizing a methodology that forecasts growth in charges using claims data. When CMS

[23] The loss is further exacerbated by the fact that Medicare pays only 80% of the difference between the estimated cost of the case and the FLA, and not the entire difference.
[24] FY 2016 IPPS/LTCH PPS Final Rule, 80 Fed. Reg. 49326, 49621 (Aug. 17, 2015).
[25] FY 2017 IPPS/LTCH PPS Final Rule, 81 Fed. Reg. 56762, 57305 (Aug. 22, 2016).
[26] CMS can implement any of these recommendations in a non-budget neutral manner. AS CMS noted in its FY 2025 rulemaking, it believes the budget neutrality requirement for the LTCH PPS HCO policy "applies only to the first year of the implementation of the LTCH PPS (that is, FY 2003)."

made the change, the field warned it would lead to volatility, and indeed, these concerns have borne out.

Due to the instability the current methodology creates, the AHA encourages CMS to revert to its previous, market-basket-based methodology for forecasting charges as part of its HCO methodology**.** The AHA has replicated CMS' previous methodology, applied it to recent claims data and determined this would result in a FLA amount of approximately $51,000 for FY 2026. While still a more than 200% increase over FY 2016 levels, it nonetheless would better serve the aim of the HCO policy and help ensure access to care.

Recommendation No. 2: Implement a Permanent Annual Cap on Increases to the FLA. As CMS has recognized, stability and predictability are essential for providers. For example, in its FY 2023 rulemaking, CMS proposed and finalized a permanent 10-percent cap on any decreases to weights for MS-DRGs. The agency stated that such a cap was appropriate "in order to promote predictability and stability in hospital payments and to mitigate the financial impacts of significant fluctuations in the weights. That is, by smoothing year-to-year changes in the MS-DRG relative weights, this proposed policy would provide greater predictability to hospitals, allowing time to adjust to significant changes to relative weight."[27] Similarly, CMS also finalized a permanent cap of 5% for any changes to LTCHs' wage index from year to year. In finalizing that policy, CMS stated this policy "would provide greater predictability to LTCHs. That is, the policy would smooth year-to-year changes in LTCHs' wage indexes and provide for increased predictability in their wage index and thus their LTCH PPS payments."[28] As such, we urge CMS to adopt a cap on any year-to-year changes in the FLA in order to help provide similar stability and predictability.

Recommendation No. 3: Implement an Extended Transition for the FLA. In last year's rulemaking, CMS proposed a transition policy for the FLA that would have phased in the FLA increase over two years. Specifically, CMS stated that "as an alternative to our proposed fixed-loss threshold, using the broad authority conferred upon the Secretary under section 307(b)(1) of the BIPA to make 'adjustment' to 'outliers' under the LTCH prospective payment system, we considered proposing to establish the FY 2025 fixed-loss amount as an average of the FY 2024 fixed-loss amount ($59,873) and our modelled FY 2025 fixed-loss amount ($90,921)".[29] The AHA agrees that phasing in any increases over multiple years would provide additional stability for providers and encourages CMS to consider a transition over several years. Such an approach may be

[27] Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Proposed Policy Changes and Fiscal Year 2023 Rates; 87 Fed. Reg. 28,108, 28,202 (May 10, 2022) (https://www.federalregister.gov/documents/2022/05/10/2022-08268/medicare-program-hospital-inpatient-prospective-payment-systems-for-acute-care-hospitals-and-the).
[28] *Ibid*. at 28,685
[29] Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Proposed Policy Changes and Fiscal Year 2025 Rates; 89 Fed. Reg. 35,934, 36,644 (May 2, 202)

especially prudent at a time of continued economic uncertainty. For example, rising labor costs and the potential for tariffs and other changes may create instability in charges that would be best addressed over several years to allow for short-term aberrations to correct.

Recommendation No. 4: Transmittal 12594 Should Be Rescinded and Reconciliation Should Be Incorporated into Outlier Projections. On April 26, 2024, CMS issued Transmittal 12594 regarding outlier reconciliation under the inpatient PPS and LTCH PPS.[30] In this transmittal, CMS changed the threshold and criteria for a facility to qualify for outlier reconciliation. As CMS knows, this will subject many additional facilities to the reconciliation process. This is concerning because it will create significant administrative burden, further financially strain LTCHs, and further underpay HCO cases.

The cost report reconciliation process is already backlogged and takes several years to complete. Hospitals must wait several years for Medicare contractors to complete the process. In the interim, hospitals are denied the ability to appeal and must forgo any funds owed to them. Hospitals must also dedicate resources to working through the process with contractors. Expanding this process to additional hospitals – as this transmittal does – is inconsistent with CMS' and HHS' desire to repeal unnecessarily burdensome and costly rules. It also will further strain LTCHs that are already taking deep losses on their outlier cases.

In addition to its costly and burdensome nature, CMS does not account for this reconciliation process in determining total outlier payments. Specifically, while CMS targets paying outliers as 7.975% of total payments, it does not account for payments that would later be reconciled and recouped by CMS as part of this process. This is contrary to what CMS does in other payment systems, where it does factor in funds that will later be recouped through reconciliation. Indeed, in this proposed rule, CMS discusses its outlier reconciliation process for the inpatient PPS, and the agency's proposed approach for accounting for additional reconciliation that would take place due to this new transmittal and criteria. However, no such process has been adopted for LTCHs. Therefore, it can be inferred CMS will ultimately be underpaying outliers by an even greater magnitude once it completes reconciliation under this expanded criteria that involves more hospitals.

The AHA urges CMS to rescind this transmittal, at least in so far as it applies to LTCHs, due to the difficulties facing this field and due to the fact CMS has failed to account for this expanded reconciliation process in its outlier calculations. As an alternative, and at a minimum, CMS should account for recouped outlier funds in determining outlier thresholds as it does for other payment systems such as the inpatient PPS.

LTCH QUALITY REPORTING PROGRAM

[30] https://www.cms.gov/files/document/r12594cp.pdf

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

Proposed Removal of Four Social Determinants of Health (SDOH) SPADEs. With a stated purpose of reducing administrative burden to LTCHs, CMS proposes to remove four SPADEs it adopted in the FY 2025 LTCH 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 LTCH 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 LTCHs 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 LTCH Continuity Assessment Record and Evaluation (CARE) Data Set (LCDS), which 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 LCDS, 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 LCDS 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 LCDS 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 LTCH QRP.

Modification of Percent of Patients/Residents Up to Date with COVID-19 Vaccination. CMS proposes to modify this measure by excluding patients who expire during their LTCH stay. The change is being proposed in response to stakeholder feedback, noting that collecting accurate information on vaccination from this patient population is often impossible.

While the AHA supports this proposal, we also encourage CMS to consider phasing out the measure from the LTCH QRP entirely. The COVID-19 public health emergency concluded in May 2023, raising questions about whether the level of administrative effort required to collect and report this measure exceeds its value in improving outcomes. Furthermore, as we noted in our 2023 letter to CMS when this measure was first proposed for the LTCH QRP, we do not believe the conceptual

design of the measure is a good match for the LTCH setting. The decision of whether to offer a COVID-19 vaccination during hospitalization should be informed by the clinical judgment of the patient's care team. At times, clinicians may determine that a patient's needs are best served by deferring COVID-19 vaccination. For example, a patient may have had a recent COVID-19 infection and not be appropriate to vaccinate. Or a patient may have a condition that could be exacerbated by a vaccine side effect, such as fever. In addition, ascertaining accurate vaccination status — which is critical to determining whether to offer a vaccine or not — is a particular challenge among LTCH patients who may have received care from multiple proximal providers. Even without these challenges, however, patients/residents always preserve the right to decline vaccination. Yet, patients exercising this right would be treated as poor performance for the LTCH. For these reasons, we encourage CMS to consider removing this measure from future LTCH QRP program years.

Reconsideration Process. CMS proposes two changes to the LTCH QRP reconsideration process that permit LTCHs to appeal a CMS initial determination of noncompliance with reporting or other programmatic requirements. First, CMS proposes allowing LTCHs 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 LTCHs 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 LTCH QRP only if CMS determines that the LTCH was in full compliance with the LTCH 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 LTCH QRP. CMS is particularly interested in the extent to which LTCHs 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 to 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 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 Program (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 as straightforward as 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: LTCH QRP Data Submission Timelines. CMS seeks input on decreasing the amount of time that LTCHs have to submit quarterly quality measure and SPADE data to CMS. Currently, LTCHs 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 LTCHs' performance.

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 LTCHs to submit QRP data and meet all program administrative requirements. LTCHs 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 LTCH 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, LTCHs 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 LTCH QRP policy requires LTCHs 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 LTCHs need to ensure their data reporting complies with CMS requirements and could lead to processing errors that ultimately result in LTCHs losing 2.0% of their market basket updates for being out of compliance with program requirements.

We encourage CMS to continue engaging the LTCH field in further analysis of the timeframes for collecting and submitting LTCH data. CMS could consider conducting quantitative and qualitative studies of the LTCH 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 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' attention to a previous set of deregulation requests that we have provided to the administration. These actions include, for example, removing outdated measure and

data, and reporting requirements for LTCHs carried over from the COVID-19 pandemic. This includes health care personnel vaccination measures and weekly reporting of respiratory illness data. Eliminating this reporting would reduce costs in the health care system and enable providers to spend more time with their patients.

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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]

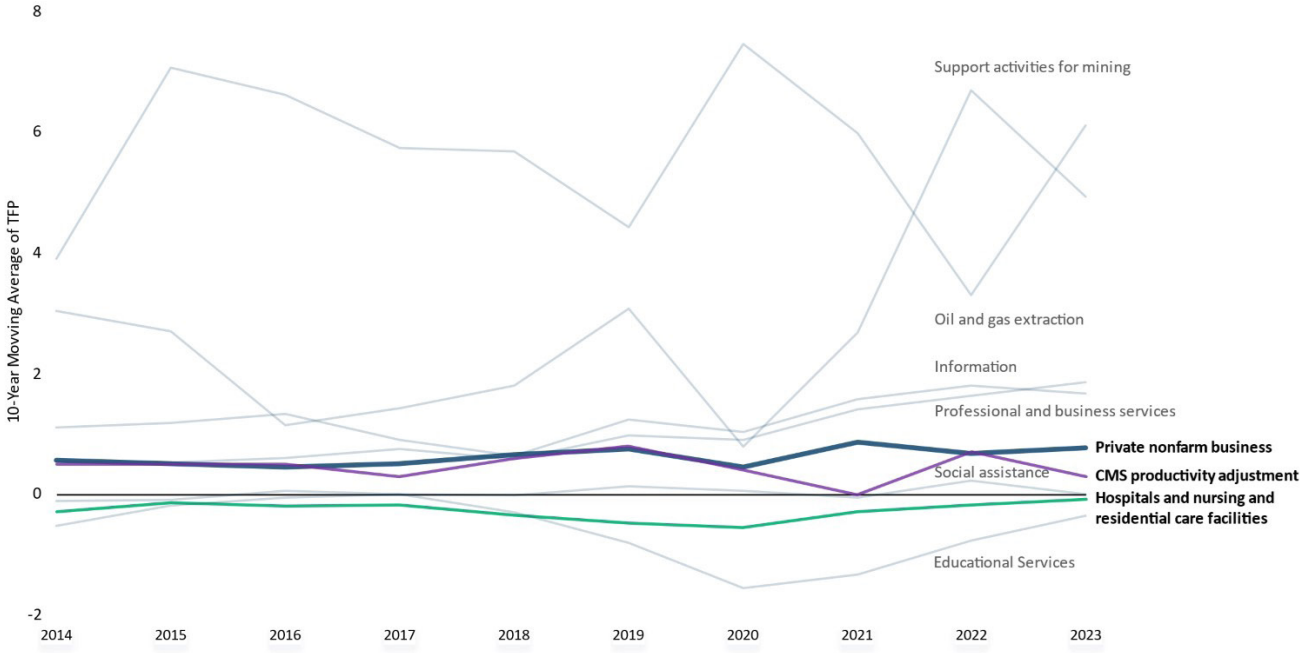
Hospitals encounter substantial regulatory requirements unique to the healthcare sector. Hospitals must then bear the cost to maintain compliance with these regulations. Government-set reimbursement rates have not kept pace with inflation, covering only 83 cents for every dollar hospitals spent in 2023.[10] 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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