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Advancing Health in America

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August 28, 2025

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

Submitted Electronically

Re: Medicare and Medicaid Programs; Calendar Year 2026 Home Health Prospective Payment System (HH PPS) Rate Update; Requirements for the HH Quality Reporting Program and the HH Value-Based Purchasing Expanded Model; Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Competitive Bidding Program Updates; DMEPOS Accreditation Requirements; Provider Enrollment; and Other Medicare and Medicaid Policies
90 Fed. Reg. 29,108 (July 2, 2025).

Dear Administrator Oz:

On behalf of our nearly 5,000 member hospitals, health systems and other health care organizations, including approximately 1,000 hospital-based home health (HH) agencies, 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 Center for Medicare & Medicaid Service's (CMS') calendar year (CY) 2026 HH prospective payment system (PPS) proposed rule.

The AHA is very concerned about CMS' proposed budget neutrality reductions to the HH base payment rate, which, at a combined -8.4%, are staggering. This magnitude of cuts would compound ongoing access challenges for beneficiaries needing HH care and potentially also disrupt operations for acute care and other hospitals. As explained further below, HH agencies are key partners to hospitals in Medicare beneficiaries' recoveries, and they help ensure patients can receive the right care in the most appropriate setting. Hospitals rely on HH agencies for safe and timely discharge of patients and to avoid extended hospital stays. **We urge the agency to suspend its proposed cuts and take steps to ensure HH agencies receive**

adequate and timely payment updates that enable them to continue to care for Medicare beneficiaries.

HH AGENCY PAYMENT UPDATES

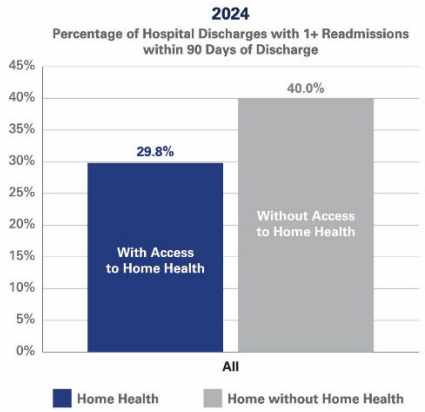
HH agencies are an essential part of the Medicare care continuum. However, CMS' market basket forecasting has underpaid HH providers to the tune of nearly $1 billion annually in recent years, and the productivity adjustment has reduced that figure even more. In addition, the budget neutrality adjustments previously applied and now further proposed by CMS would curtail the ability of HH agencies to meet the demands of patients. Further, Medicare Advantage (MA) prior authorization practices are delaying hospital discharges, causing capacity issues for acute care hospitals.

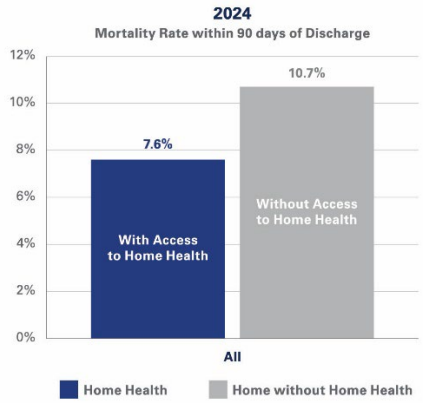
For these reasons, the AHA urges CMS to take steps to ensure access for patients and avoid further strain on hospitals and the entire care continuum. Specifically, the AHA recommends that CMS:

- **Reassess and refine the HH market-basket construction and forecasting approach, including independent review of IGI's methodology and greater transparency of key inputs.**
- **Re-examine the magnitude of the productivity adjustment and its impact on Medicare payments.**
- **Suspend Patient-Driven Grouping Model (PDGM) budget neutrality reductions until CMS can reevaluate its methodology and more appropriately account for expected changes in payment that are not due to provider behavior.**
- **Address the harmful practices of MA plans that restrict acute care hospital capacity and delay access to timely post-acute care.**

HH Agencies' Role in the Continuum of Care. HH agencies enable hospitalized beneficiaries to return home and still receive medically necessary skilled nursing, therapy and other services. This reduces pressure on hospitals and institutional post-acute settings, avoids readmissions, keeps costs down and, most importantly, keeps beneficiaries healthy on the road to recovery. Indeed, nearly 1 in 5 acute care hospital beneficiaries are discharged to HH.

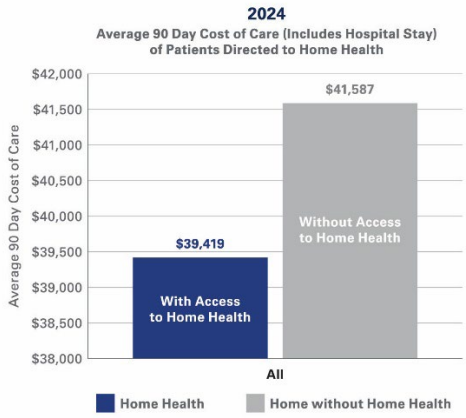
There is robust evidence that timely HH care improves outcomes and reduces downstream costs. An analysis of 2024 Medicare claims by CareJourney by Arcadia shows that among patients referred to HH, those who did not receive HH services had a significantly higher readmission risk than referred patients who did receive care (see figure below). In addition, as shown below, patients referred to and receiving HH care had a 41% lower mortality rate within 90 days of discharge than those who were referred but did not receive care.





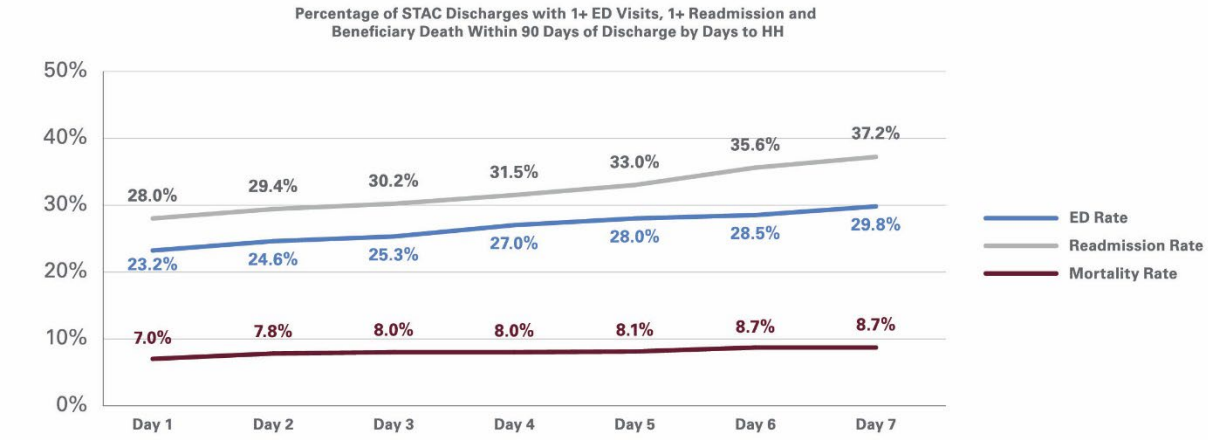
Source: CareJourney by Arcadia. Analysis of 2024 inpatient claim files.

Beyond better outcomes, beneficiaries receiving HH also had a lower 90-day cost of care compared with referred patients who did not receive HH, even when including the payments for the HH episode(s) of care (see figure below).



Source: CareJourney by Arcadia. Analysis of 2024 inpatient claim files.

The timeliness of receiving such care is crucial to these outcomes. For HH agency beneficiaries, the emergency department visit rate, readmission rate and mortality rate all increase the longer a beneficiary must wait to initiate the HH care following discharge from the hospital.



Source: CareJourney by Arcadia. Analysis of 2024 inpatient claim files.

Clearly, HH agencies continue to be a critical tool for the Medicare program to ensure that hospitalized patients can return home safely and minimize complications following their hospitalization and costly follow-up care.

Financial and Operational Pressures on HH Agencies. Health care providers, including HH agencies, continue to face serious inflationary pressures. 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] While HH agencies are not hospitals, they utilize much of the same clinical and nonclinical staff as hospitals, including nurses, therapists, nurse aides and others. A large portion of this growth is attributable to increased labor costs, which make up 75% of the share of services provided by HH agencies, according to CMS. Indeed, an analysis by the AHA found that hospital employee compensation grew by 45% from 2014 to 2023.[2] The AHA has also found that advertised salaries for nurses have risen 26.6% in the last four years.[3]

Another strain on providers is increasing drug and supply costs. A recent report from the Department of Health and Human Services (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.[4] Adding to this uncertainty providers face is the threat of

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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. Changes in the List Prices of Prescription Drugs, 2017-2023. (October 2023) (https://aspe.hhs.gov/reports/changes-list-prices-prescription-drugs).

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. A recent survey showed that 82% of health care experts expect tariff-related expenses to raise hospital costs by at least 15%.[5]

In addition to direct costs of care, HH agencies have also faced rising administrative costs. For example, most MA plans require prior authorization for HH agency care. As such, HH agencies 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.[6] The findings prompted the OIG to initiate another investigation focused specifically on MA practices for access to post-acute care.[7] MA plans do not reimburse for costs due to delays and added administrative costs, which instead must be absorbed by providers as they continue to care for a rising proportion of MA patients.

These increasing costs for clinicians, personnel, drugs, and other critical supplies and services have put a strain on the entire health care continuum. They have also forced providers to divert funds that could have been invested in patient care, new technologies and other potential efficiencies. These are yet more reasons why, as discussed more below, the AHA is very concerned about the inadequate market basket update, productivity adjustment, and budget neutrality cut proposed by CMS. These issues are exacerbating strain on providers and threatening the continuum of care.

Market Basket Forecasting Has Fallen Short. Since CY 2021, CMS' market-basket forecasts for HH agencies and other providers have underforecast actual market-basket growth.

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

[6] 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/

[7] 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

Table 1: HH Market Basket Updates, CYs 2021-2025

Year	CY 2021	CY 2022	CY 2023	CY 2024	CY 2025	Total (Compounded)
Market Basket Update in Final Rule	2.3%	3.1%	4.1%	3.3%	3.2%	17.0%
Actual/Updated Market Basket Forecast	3.0%	5.7%	4.8%	4.0%	3.5%	22.3%
Difference in Net Market Basket Update and Actual Increase	**-0.7%**	**-2.6%**	**-0.7%**	**-0.7%**	**-0.3%**	**-5.1%**

These missed forecasts have a significant and permanent impact on HH agencies and the patients they care for. At current levels, this cumulative underpayment of 5.1 percentage points totals approximately $900 million annually. Further, as CMS knows, these forecasting shortfalls translate into permanent reductions because future rates build on the current base. Combined with the proposed cuts discussed below, the strain on providers is severely compounded.

While forecasts will never be perfect, they have been more balanced in the past. 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.[8] By design, the ECI cannot capture changes in costs driven by shifts between different categories of labor; CMS itself has recognized this shortcoming.[9] Yet, one major labor market change over the last several years has been increased utilization of contract labor. Therefore, the ECI may not be adequately capturing employment and labor cost growth.

For these reasons, the AHA recommends CMS reassess and refine the HH market-basket construction and forecasting approach, including independent review of IGI's methodology and greater transparency of key inputs. The AHA continues to stand ready to work with CMS to examine the market basket compensation indices and proxies to improve the accuracy of these.

[8] 86 Fed. Reg. 25401. "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." (May 10, 2021).
[9] 86 Fed. Reg. 25421. 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." (May 10, 2021).

The Productivity Adjustment Further Exacerbates Underpayments. Under the Affordable Care Act, the HH agency payment update is reduced annually by a productivity factor, which is equal to the 10-year moving average of changes in the annual economy-wide, private nonfarm business total factor productivity (TFP).[10] For CY 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 health care 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 it cannot do this. For example, by focusing only on private businesses, this measure excludes nonprofit and government businesses. **Thus, this measure is not an appropriate or reliable predictor of productivity for the health care field. 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 health care 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 physical products, measuring these outputs is relatively straightforward and often standardized. However, health care quantity and prices do not operate in this way. For example, quantities such as HH episodes are not necessarily an appropriate output measure; such a measure may actually be more reflective of the disease burden of a community. More volume — thus more quantity — does not equate to more productivity in the same manner as it does for private nonfarm businesses.

In addition, health care 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 health care reimbursement is through fixed payments. Hospitals and health systems 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 health care sector when the same output function does not apply.

Second, the TFP does not reflect unique challenges that prevent health care providers from achieving productivity improvements consistent with those in the broader economy. Specifically, the private nonfarm business sector encompasses a broad range of

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

industries with stable and predictable production processes. In contrast, health care providers operate in a complex environment characterized by unpredictable patient volumes, rising input costs and varying acuity levels, not to mention natural disasters and pandemics. Health care providers also face heavy regulatory burdens beyond those of other industries. Private nonfarm businesses rarely have such onerous challenges and requirements.

Third, the health care field is different from private nonfarm businesses because the services they provide 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. Health care providers are, in this way, more similar to fields like education and social assistance. These industries all experience lower TFP 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 sectors, according to the Bureau of Labor Statistics.

In fact, CMS itself has acknowledged that health care providers are unable to achieve the same productivity gains as the general economy over the long run. Specifically, it found that providers can only achieve a productivity gain that is one-third of the gains seen in the private nonfarm business sector.[11] Thus, using the private nonfarm business sector TFP to adjust the market basket 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, for HH agencies, the CY 2025 cut was 0.5%, but this year CMS proposes a cut of 0.8%. The 10-year moving average methodology should smooth fluctuations from one year to the next. Instead, moving from CY 2025 to CY 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, but it appears that the updated 10-year moving average periods used for the CY 2026 proposed rule exclude a period of low-TFP growth in 2016. We do not understand this exclusion 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, IGI forecasted the 10-year moving average growth of the productivity factor to be -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 market basket by changes in economy-wide productivity.[12] Simply put, the agency applies the productivity factor only

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

[12] 85 Fed. Reg. 58,797 (Sep 18, 2020).

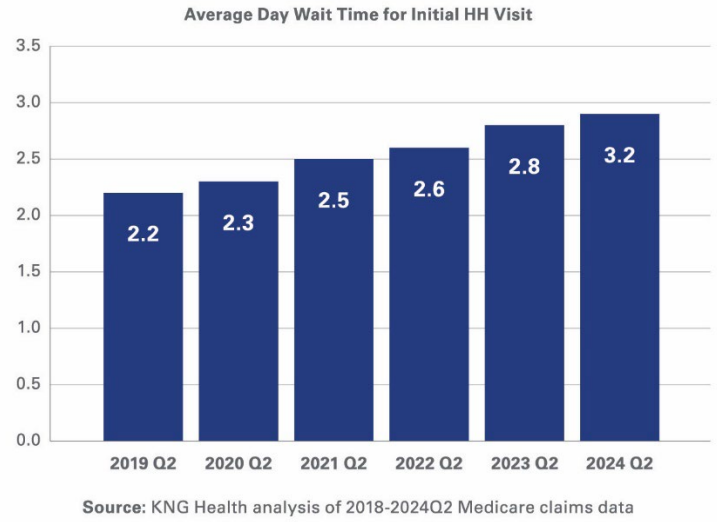
when it cuts Medicare spending. However, the cumulative, compounding effect of these reductions year-over-year and the asymmetric treatment of declines in economy-wide productivity led to an increasing gap between payments and the cost of providing services, leaving providers progressively underfunded, 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 health care field is not appropriate, and in an economy marked by great uncertainty due to tariffs and demand and supply shocks, the calculation generates significant departures from economic reality.

Proposed Budget Neutrality Adjustments Will Severely Hamper HH Operations. CMS is again proposing permanent reductions to correct for what it says are both past and ongoing overpayments due to the implementation of the PDGM. In addition to prospectively correcting the base payment rate, CMS is now also proposing to implement a temporary recapture of past overpayments. Specifically, CMS — for the first time — is proposing a 3.7% permanent reduction and a 5.0% temporary adjustment to the HH base payment rate. This would reduce payments by about $1.5 billion in CY 2026. These payments would be on top of the approximately 13% in reductions the agency has already made to the base payment rate since 2020.

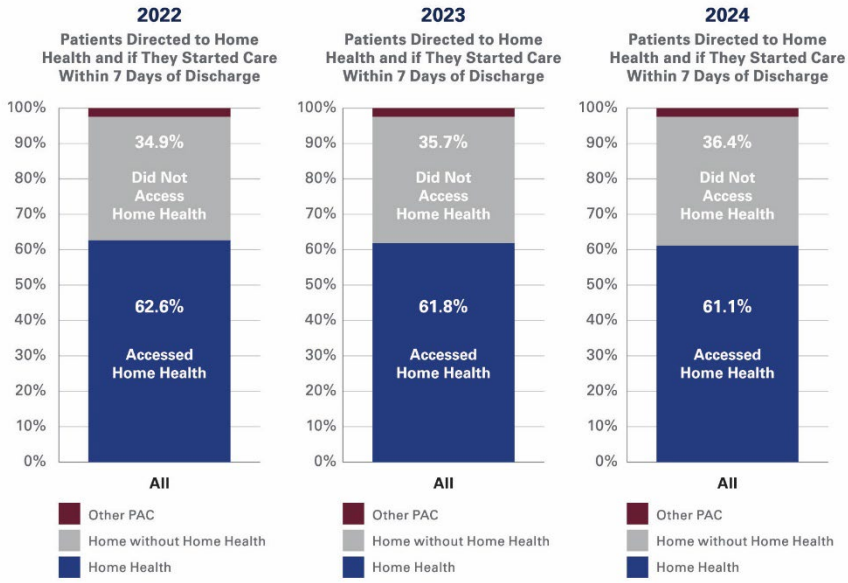
First, the AHA reiterates its opposition to CMS' approach to applying PDGM budget neutrality adjustments. While we will not repeat them in full in this letter, the AHA's detailed objections can be found in prior years' comment letters. In summary, we continue to believe the adjustments are based on a flawed methodology that does not accurately account for shifts in care delivery and utilization under the new payment system and does not accurately compare hypothetical payments under the old payment system to those under PDGM. The methodology is also inconsistent with how CMS applied similar behavioral adjustments in the skilled nursing facility PPS for implementation of the Patient Driven Payment Model. The result is that CMS overestimates the difference in overall spending between the old and new payment systems, leading to much higher than appropriate budget neutrality adjustments.

Evidence of patient access challenges due to all the above cited issues, including past budget neutrality cuts, is already apparent. An analysis of Medicare claims data shows that wait times to initiate HH access have been increasing steadily since 2019 (as shown below).



Source: KNG Health analysis of 2018-2024Q2 Medicare claims data

In fact, as shown below, more than 36% of beneficiaries referred to HH did not access it within seven days. This figure has been steadily increasing since 2022 (see figure below).



Source: CareJourney by Arcadia. Analysis of 2022-2024 inpatient claim files filtered for acute care hospital claims.

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Further, Medicare Payment Advisory Commission (MedPAC) analysis also shows less utilization of HH services. Its July 2025 data book showed that the share of Fee-for-Service (FFS) Medicare beneficiaries utilizing HH was down 2.3%, and HH episodes of care per beneficiary were down 1.8%. Further, MedPAC's most recent analysis of FFS

Medicare margins showed a year-over-year decrease of at least 2 percentage points for all agency types. Even more concerning, MedPAC recently found that hospital-based HH agencies had a FFS Medicare margin of *negative 17%.*

CMS' payment reductions are affecting not only HH agencies and their patients but also acute care hospitals. As HH agencies struggle with diminished capacity, hospitals in turn have fewer options for post-acute discharges. This leaves hospitals holding patients who are clinically ready to leave, driving up costs while limiting available beds for new admissions. AHA members report that finding HH placement for patients is becoming increasingly difficult. **For these reasons, the AHA urges CMS to suspend further PDGM behavioral reductions until CMS can reevaluate its methodology and more appropriately account for expected changes in payment that are not due to provider behavior.**

The challenge of discharging patients to post-acute care also is magnified by the practices of some MA plans. While Original Medicare beneficiaries do not require prior authorization for HH services, most MA plans do require such authorization. This is burdensome for the hospital, requiring staff time that could otherwise be dedicated to patient care, and often takes up to three days to receive a response. These delays further extend the length of stay of patients, compounding the issue of patient boarding. Indeed, a recent report from the University of Chicago found that MA beneficiaries have consistently longer hospital lengths of stay prior to discharge to post-acute care compared to Original Medicare beneficiaries, and the length of stay has been rising for these patients. For discharges to HH, the length of stay has increased by more than 20%.[13] This issue combines with lagging market basket updates, productivity reductions and behavioral adjustments to seriously strain hospital throughput of patients. **Therefore, as the AHA has previously requested, we implore CMS to address the harmful practices of MA plans that further restrict acute care hospital capacity and delay access to timely post-acute care.**

PROPOSED CHANGES TO THE FACE-TO-FACE ENCOUNTER POLICY

CMS is proposing to change the face-to-face visit requirement for HH services to allow physicians to perform the required face-to-face encounter regardless of whether they are the certifying practitioner or whether they cared for the patient in the hospital or other facility. This change would provide needed flexibility for providers and help prevent delays in beneficiaries receiving needed care. Therefore, the AHA thanks CMS for this proposal and supports its finalization.

[13] https://strengthenhealthcare.org/key-takeaways-norc-report-on-analysis-of-post-acute-care-discharges-among-medicare-beneficiaries-2018-2022/

HH QUALITY REPORTING PROGRAM

As mandated by the Social Security Act, HH agencies receiving Medicare payments have been required to collect and submit patient assessment data using the Outcome and Assessment Information Set (OASIS) since 1999 and to participate in the HH Quality Reporting Program (QRP) since 2007. The Improving Medicare Post-Acute Care Transformation (IMPACT) Act required that, starting CY 2020, providers must report standardized patient assessment data elements (SPADEs) as part of the HH QRP. Failure to comply with these requirements results in a 2-percentage-point reduction to the HH agencies' annual market-basket update.

Proposed Removal of Four Social Determinants of Health SPADEs. With a stated purpose of reducing administrative burden, CMS proposes to remove four SPADEs it adopted in the CY 2025 HH 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 HH 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 HH agencies 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 OASIS 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 OASIS, 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 OASIS items, 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 OASIS 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. Finally, CMS has already finalized the removal of these items from the patient assessment tools used in the other post-acute care settings, and thus it would be consistent to finalize their removal from OASIS as well. For these reasons, the AHA supports the removal of these four SPADEs from the HH QRP.

Proposed Removal of COVID-19 Vaccine: Percent of Patients/Residents Who Are Up to Date Measure. CMS proposes to remove this measure from the HH QRP beginning with the CY 2026 program. The measure was originally adopted in the CY 2024 HH PPS final rule. Citing the conclusion of the public health emergency for COVID-19, declining numbers of COVID-19 cases and deaths, and the continued costs

to providers of reporting this measure, CMS believes the measure is no longer necessary and removing it would reduce the burden to HH agencies.

The AHA again appreciates CMS' approach to achieving a balance between burden and value in quality measurement programs. The level of administrative effort and resources needed to collect and report the vaccination measure is impractical and untenable. The definition of "up to date" can and has changed based on updates to guidance from the Centers for Disease Control and Prevention (CDC). Practically speaking, this means that a patient who counted as up to date during one reporting period may no longer be up to date in the next. Furthermore, the CDC's current vaccination guidance suggests that some individuals with certain risk factors should consider receiving an additional booster dose. Yet, HH agencies usually do not have routine access to data to know which of their health care personnel may need an additional booster. In short, the resources needed to collect data under the CDC's current definitions may outweigh the measure's 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.

Proposed Revisions to HHCAHPS Survey and Measures. CMS proposes implementing a revised and shortened version of the HHCAHPS survey and accompanying measures beginning with the April 2026 sample month. Revisions include the removal of several questions that relate to topics CMS has deemed of less importance as well as minor text changes to selected existing questions to help clarify the question or response options. In addition, CMS proposes to update adjustments based on the mode through which the survey was completed to account for differences in ratings. **The AHA appreciates and supports CMS' efforts to refine and modernize the HHCAHPS to improve the usefulness of data gleaned from the survey and reduce the burden to patients. We recommend that CMS further pursue revisions to the survey, specifically by considering the addition of a web-based mode of administration.** The latter has been investigated and added in other settings that use the CAHPS surveys and CMS has found improvements in response rates as a result.

Proposed Changes to the Reconsideration Process. CMS proposes two changes to the HH QRP reconsideration process that permit HH agencies to appeal a CMS initial determination of noncompliance with reporting or other programmatic requirements. First, CMS proposes to allow HH agencies 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 HH agencies to file reconsideration requests.** We are encouraged that CMS has adopted similar policies for its other quality reporting and value programs in recent rulemaking.

Second, CMS proposes to clarify that it will reverse a finding of noncompliance with the HH QRP only if CMS determines that the HH agency was in full compliance with the 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.**

Request for Information: Shortening Data Submission Timelines. CMS seeks input on decreasing the amount of time that HH agencies have to submit quarterly quality measure and SPADE data to CMS. The agency notes that it is concerned that the time between data collection and measure reporting is too long at nine months; the agency believes that the primary driver of this lag is that the deadline for HH agencies to submit data to CMS is four and a half months after a quarter closes. CMS seeks input on potentially requiring that quality and SPADE data be submitted 45 days after the close of a quarter instead. The agency believes this would result in more timely publicly reported data on HH agency 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 HH agencies to submit QRP data and meet all program administrative requirements. Home health agencies 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 HH QRP measures can take time, including time after patients' encounters with the care team have concluded. Once the patient assessment and medical records are complete, HH agencies 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 HH QRP policy requires HH agencies 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 HH agencies need to ensure their data reporting complies with CMS requirements and could lead to processing errors that ultimately result in HH agencies losing 2.0% of their market basket updates for being out of compliance with program requirements.

We encourage CMS to continue engaging the HH and post-acute field in general in further analysis of the time frames for collecting and submitting QRP data. CMS could consider conducting quantitative and qualitative studies of the QRP reporting process with a representative sample of facilities. The agency could also solicit further input from facilities on what time frame would strike the best balance of feasibility and timeliness.

Request for Information: Digital Quality Measurement. CMS seeks input on how to advance the uptake of digital quality measures in the HH QRP. CMS is particularly interested in the extent to which HH agencies are using application programming interfaces (APIs) 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 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 inpatient psychiatric facilities 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 enough 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 should 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 are not accomplished by flipping a switch; painstaking and thoughtful groundwork is needed 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 a robust technology infrastructure. The AHA and our members are excited to work with CMS to build the agency’s digital quality measurement enterprise, and we would be happy to collaborate on more specific plans for the future.

HOME HEALTH VALUE-BASED PURCHASING (VBP) PROGRAM

The HH VBP model was adopted as a demonstration in the CY 2016 HH PPS final rule. In the CY 2022 HH PPS final rule, CMS finalized the expansion of the model nationwide beginning Jan. 1, 2022, and has adopted additional measures for use in the program each year since.

Proposed Adoption of Medicare Spending Per Beneficiary Post-Acute Care (MSPB-PAC) Measure. CMS proposes to add this claims-based measure to the HH VBP measure set starting in CY 2026. MSPB-PAC assesses Medicare spending for Part A and B services clinically related to HH services during an episode of care relative to the Medicare spending for other HH agencies and is based on two years of data.

The AHA urges caution in the adoption of the MSPB-PAC measure into the HH VBP. While the measure has been used in the HH QRP and other post-acute care settings since 2017, continued analysis demonstrates that "…if the measure is unreliable, as is often true for low-volume providers, it cannot distinguish 'good' from 'poor' performance" (Garrett, et. Al., 2021).[14] We acknowledge that CMS has attempted to account for the challenges of calculating performance for low-volume providers by aggregating two years of data to inform this measure and through its small- and large-volume cohort methodologies. However, because performance on the measure is tied to payment adjustments in the HH VBP program, the measures used therein should be as reliable as possible in differentiating levels of performance. Aggregating data across multiple years to glean enough volume for statistical reliability can dilute findings and make it difficult for HH agencies to identify areas for improvement. Thus, we request that CMS provide modeled estimates of the impact using this measure in the VBP might have on payment adjustments, particularly for the small-volume cohort.

Proposed Adoption of OASIS-based Function Measures. CMS proposes to add three measures informed by OASIS assessment data to the HH VBP measure set starting in CY 2026. They include Improvement in Bathing (M1830), Improvement in Upper Body Dressing (M1810) and Improvement in Lower Body Dressing (M1820). **The AHA supports the inclusion of the OASIS-based function measures instead of the recently adopted Discharge (DC) Function measure.** The DC Function measure was adopted in QRPs across post-acute care settings, but we have voiced concern about the cross-setting applicability of the measure considering the different patient populations served. The M18XX items proposed for inclusion for the HH VBP measure set are more appropriate for use than the DC Function measure. These items do not include specific assessments of bathing and dressing, which are particularly important for patients receiving HH services. We appreciate that CMS understands the

[14] Garrett B, Carter C, Wissoker D. Evaluation of the Reliability of Medicare Spending Per Beneficiary for Post-Acute Care. Med Care. 2021 Aug 1;59(8):721-726. doi: 10.1097/MLR.0000000000001560. PMID: 33935252.

importance of using measures that address outcomes specifically important to HH patients in the HH VBP 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: Assessment of Productivity Adjustments and Applicability to the Hospital Sector*

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]

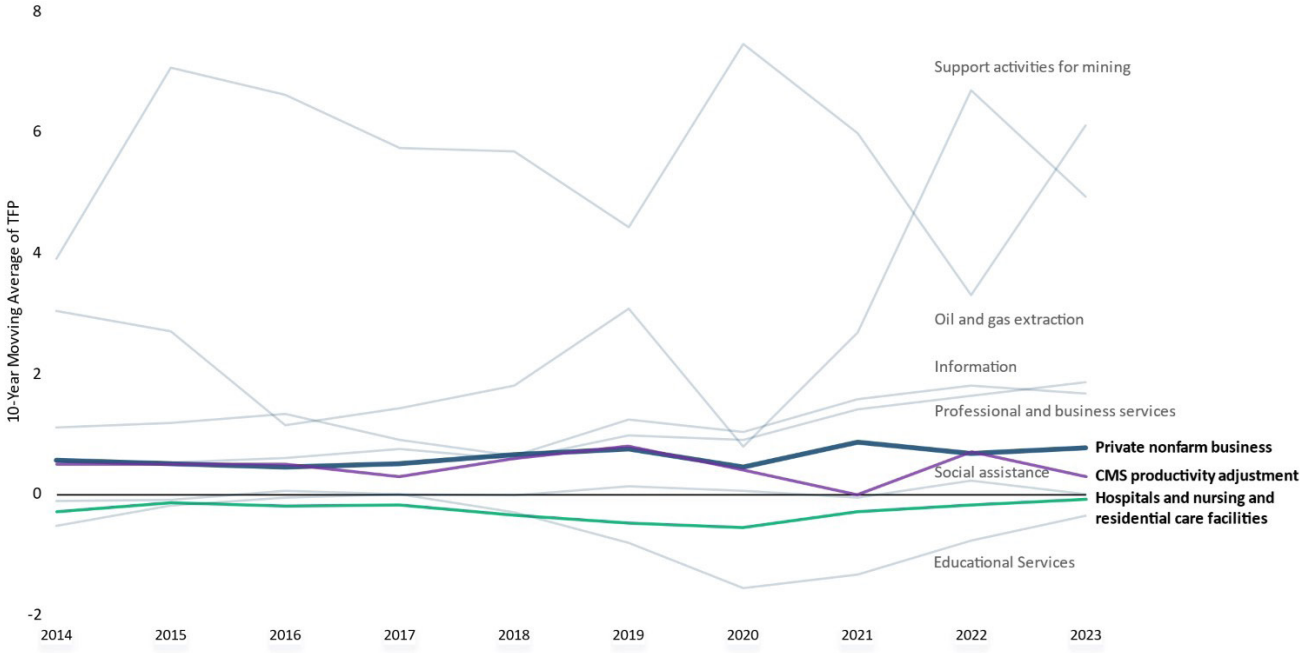
Hospitals encounter substantial regulatory requirements unique to the healthcare sector. Hospitals must then bear the cost to maintain compliance with these regulations. Government-set reimbursement rates have not kept pace with inflation, covering only 83 cents for every dollar hospitals spent in 2023.[10]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