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Advancing Health in America

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June 10, 2025

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

RE: CMS-1833-P, 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, (Vol. 90, No. 82), April 30, 2025.

Dear Administrator Oz:

On behalf of our nearly 5,000 member hospitals, health systems and other health care organizations, our clinician partners — including more than 270,000 affiliated physicians, 2 million nurses and other caregivers — and the 43,000 health care leaders who belong to our professional membership groups, the American Hospital Association (AHA) appreciates the opportunity to comment on the Centers for Medicare & Medicaid Services (CMS) hospital inpatient prospective payment system (PPS) proposed rule for fiscal year (FY) 2026. We are submitting separate comments on the agency's proposed changes to the long-term care hospital PPS and Transforming Episode Accountability Model.

Hospitals are the backbone of America's healthcare system, providing essential, life-saving care 24/7 to millions of people each year. They serve as critical centers for emergency response, specialized treatment, and chronic disease management, while also acting as major employers and economic engines within their communities. As communities across the country face demand for health services, it is essential that Medicare payment policies support the sustainability and availability of these providers.

To that end, we support several of the inpatient PPS proposed rule provisions, including the proposed increase in disproportionate share hospital (DSH) payments. We also appreciate the agency's interest in deregulatory activities in the Medicare program and

have submitted our comments through the request for information website. We also support several aspects of CMS' quality-related proposals, including CMS' recognition of the importance of striking an appropriate balance of burden and value in quality measurement programs and the removal of certain quality measures in the quality reporting programs.

At the same time, we continue to have strong concerns about the proposed payment updates. The proposed net payment update of 2.4% is simply inadequate given the unrelenting financial headwinds faced by hospitals and health systems. We are particularly concerned with the inappropriately large productivity cut that is being proposed. We urge the agency to re-examine the magnitude of this adjustment and its impact on Medicare payments.

Finally, we have concerns over the agency's proposal to include Medicare Advantage patients in the Hospital Readmissions Reduction Program. Specifically, we are concerned that by including MA patients in calculating readmissions penalties, CMS effectively would be holding hospitals accountable for excessive and inappropriate coverage delays and denials on the part of MA plans.

We appreciate your consideration of these issues. Our detailed comments are attached. Please contact me if you have questions or feel free to have a member of your team contact Shannon Wu, AHA's director for payment policy, at (202) 626-2963 or swu@aha.org.

Sincerely,

/s/

Ashley Thompson
Senior Vice President
Public Policy Analysis and Development

Attachment: Hospital Inpatient Prospective Payment System

American Hospital Association
Detailed Comments on the Inpatient Prospective Payment System Proposed Rule for Fiscal Year 2026

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INPATIENT PPS PAYMENT UPDATE

The AHA remains concerned about inaccurate and inadequate market basket updates. In recent years, the market basket forecasts utilized by CMS have consistently under forecast actual market basket growth. In addition, the actual market basket growth has fallen short of or has failed to exceed general inflation, despite well-documented medical inflation that surpasses that of the rest of the economy. **Especially combined with the productivity adjustment, which is inappropriate for application to the hospital field, Medicare's payment updates to hospitals have become increasingly deficient. As such, we ask CMS to use its "special exceptions and adjustments" authority to eliminate the productivity cut for FY 2026.**

Hospitals and Health Systems Continue to Face High Rates of Inflation

Hospitals and health systems continue to face serious inflationary pressures. As detailed in our comments on the FY 2025 inpatient PPS proposed rule, unprecedented levels of inflation have raised labor, drug, supply and other costs. A recent report from the AHA found that in 2024 alone, hospital expenses grew by 5.1%.[1] A large portion of this growth is attributable to increased labor costs, which make up nearly two-thirds of the inpatient PPS market basket, according to CMS itself. Indeed, an analysis by AHA found that hospital employee compensation grew by 45% between 2014 and 2023.[2] 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]

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 hospitals and health systems as they care for patients with a wide range of complex medical conditions.

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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 Drug Shortages (June 2023) (https://news.ashp.org/-/media/assets/drug-shortages/docs/ASHP-2023-Drug-Shortages-Survey-Report.pdf).

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 authorizations. As such, hospitals and health systems spend substantial amounts of time and resources navigating the prior authorization process. A 2021 study by McKinsey estimated that hospitals spent $10 billion annually dealing with insurer prior authorizations.[7] Additionally, a 2023 study by Premier found that hospitals are spending just under $20 billion annually appealing denials — more than half of which was wasted on claims that should have been paid out at the time of submission.[8] Notably, many of these denials were ultimately overturned as noted above. In fact, a study by the HHS Office of Inspector General (OIG) found that 75% of care denials were subsequently overturned.[9] Making matters worse, MA plans paid hospitals less than 90% of Medicare rates despite costing taxpayers substantially more than traditional Medicare in 2023.[10,11] MA plans do not reimburse these costs, which instead must be absorbed by hospitals and health systems as they continue to care for a rising proportion of MA patients.

In addition, other economic headwinds are creating uncertainty. Despite ongoing efforts to build the domestic supply chain, the U.S. health care system relies significantly on international sources for many drugs, devices and other supplies needed to both care for patients and protect our health care workers. Tariffs, as well as any reaction of the countries on whom such tariffs are imposed, could reduce the availability of these life-saving items in the U.S. As we have detailed in our feedback regarding tariffs related to pharmaceutical and medical devices, the AHA is concerned about the potential for tariffs to raise the costs of delivering care. Indeed, a recent survey showed 82% of health care experts expect tariff-related expenses to raise hospital costs by at least 15%.[12]

These escalating costs for clinicians, personnel, drugs, and other essentials have put a strain on the entire health care continuum. It has also forced hospitals and health systems

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[7] McKinsey & Company. (2021). Administrative Simplification: How to Save a Quarter-Trillion Dollars in US Healthcare. https://www.mckinsey.com/~/media/mckinsey/industries/healthcare%20systems%20and%20services/our%20insights/administrative%20simplification%20how%20to%20save%20a%20quarter%20trillion%20dollars%20in%20us%20healthcare/administrative-simplification-how-to-save-a-quarter-trillion-dollars-in-us-healthcare.pdf

[8] Premier. (2024). Trend Alert: Private Payers Retain Profits by Refusing or Delaying Legitimate Medical Claims. https://premierinc.com/newsroom/blog/trend-alert-private-payers-retain-profits-by-refusing-or-delaying-legitimate-medical-claims

[9] DHHS OIG. (2023). High Rates of Prior Authorization Denials by Some Plans and Limited State Oversight Raise Concerns About Access to Care in Medicaid Managed Care. https://oig.hhs.gov/oei/reports/OEI-09-19-00350.pdf

[10] MedPAC (2021). MedPAC Report to Congress. https://www.medpac.gov/wp-content/uploads/import_data/scrape_files/docs/default-source/reports/mar21_medpac_report_to_the_congress_sec.pdf#page=401

[11] Ensemble Health Partners. (2023). The Real Cost of Medicare Advantage Plan Success. https://www.ensemblehp.com/blog/the-real-cost-of-medicare-advantage-plan-success/

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

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 more concerning.

Market Basket Forecasts Continue to Underestimate Actual Market Basket Growth

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

Table 1: Inpatient PPS Market Basket Updates, FY 2021 through FY 2025

Year	FY 2021	FY 2022	FY 2023	FY 2024	FY 2025	Total (Compounded)
Market Basket Update in Final Rule	2.4%	2.7%	4.1%	3.3%	3.4%	16.9%
Actual/Updated Market Basket Forecast	3.0%	5.7%	4.8%	3.6%	3.4%	22.2%
Difference in Net Market Basket Update and Actual Increase	**-0.6%**	**-3.0%**	**-0.7%**	**-0.3%**	**0.0%**	**-5.3%**

These missed forecasts have a significant and permanent impact on hospitals and health systems and the patients they care for. At current levels, this compounded underpayment of 5.3 percentage points totals approximately $6.5 billion 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 inpatient PPS and will continue to compound.

Indeed, these trends have continued and exacerbated Medicare's underpayments to the hospital field. The Medicare Payment Advisory Commission (MedPAC) projects that 2025 Medicare margins *will be less than negative 13%*, resulting in more than *20 straight years* of Medicare paying below costs.[13] Even among relatively efficient hospitals, the median Medicare margin will remain about *negative* 2%. The AHA's own analysis showed that Medicare underpayments reached $100 billion in 2023.[14] **This cannot be sustained.**

[13] MedPAC. (2025). https://www.medpac.gov/wp-content/uploads/2025/03/Mar25_Ch3_MedPAC_Report_To_Congress_SEC.pdf
[14] AHA. The Cost of Caring: Challenges Facing America's Hospitals in 2025 (April 2025) (https://www.aha.org/costsofcaring).

Therefore, we urge CMS to focus on appropriately accounting for recent and future trends in inflationary pressures and cost increases in the hospital payment update, which is essential to ensure that Medicare payments for acute care services more accurately reflect the cost of providing hospital care.

While forecasts will never be perfect, in the past, they have been more balanced. The AHA remains concerned that there is a more systemic issue with IGI's forecasting that biases towards under-forecasting growth. Indeed, as AHA noted in prior comment letters, one such factor may be CMS' use of the Employment Cost Index (ECI) to measure changes in labor compensation in the market basket.[15] By design, the ECI cannot capture changes in costs driven by shifts between different categories of labor; CMS itself has recognized this shortcoming.[16] Yet, one major labor market change over the last several years has been increased utilization in 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.**

Productivity

Under the Affordable Care Act, the inpatient 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).[17] 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 the appendix, it is well proven by the economic literature that the hospital and health care field cannot do this.** For example, by focusing only on private businesses, this measure excludes non-profit and government businesses, which account for more than 60% of hospitals and health systems. Thus, this measure is not an appropriate or reliable predictor of productivity for the hospital field. **As such, we ask CMS to use its "special exceptions and adjustments" authority to eliminate the productivity cut for FY 2026.**

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[15] 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."

[16] 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."

[17] 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

First, measures of productivity contained in the private nonfarm business TFP are not appropriate measures of productivity for the hospital field. Outputs in the TFP are measured as a function of the total quantity and prices of the goods and services produced in private nonfarm businesses. For sectors that sell tangible, physical products, measuring these outputs is relatively straightforward and often standardized. However, hospital quantity and prices do not operate in this way. For example, hospital quantity, such as volume of visits or procedures, is not necessarily an appropriate output measure; 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; unlike those of private nonfarm businesses. This is because much of hospitals and health systems' reimbursement is through fixed payments, such as through the inpatient PPS. Moreover, for commercially-insured patients, hospital rates are determined through negotiations, which often lock in the payment rate 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 specific challenges that prevent hospitals from achieving productivity improvements consistent with those in the broader economy. Specifically, the private nonfarm business sector encompasses a broad range of industries with stable and predictable production processes. In contrast, hospitals operate in a complex environment characterized by unpredictable patient volumes, rising input costs, and varying acuity levels, not to mention natural disasters and pandemics. Hospitals also face heavy regulatory burdens beyond those of other industries. For example, hospitals face unique fixed costs such as requirements to keep emergency departments open 24/7 so that patients can seek care at all times. Private nonfarm businesses rarely have such onerous challenges and requirements.

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

In fact, CMS itself has acknowledged that hospitals are unable to achieve the same productivity gains as the general economy over the long run. Specifically, it found that hospitals can only achieve a productivity gain that is one-third of the gains

seen in the private nonfarm business sector.[18] Thus, using the private nonfarm business sector TFP to adjust the market basket inappropriately exacerbates Medicare's chronic underpayments to hospitals, which we discussed in greater detail above.

Additionally, it is puzzling to see how an indicator based on a 10-year moving average could yield a near doubling of the productivity cut in a single year. Specifically, the FY 2025 cut was 0.5%, but this year CMS proposes a cut of 0.8%. In moving from one year to the next in calculating a 10-year moving average, one only changes a single one of the 10 years; as such, this methodology should smooth fluctuations to a very large degree. Instead, in moving from FY 2025 to FY 2026, we see the productivity cut increase by 60%. Unfortunately, the AHA is unable to fully analyze these projections due to a lack of transparency from CMS. That said, it appears that the updated 10-year moving average periods used for the FY 2026 proposed rule exclude a period of low-TFP growth in 2016. We do not understand why this would be and are concerned it has artificially and inappropriately increased the productivity adjustment

Finally, we find it particularly troubling that the productivity adjustment is used only when it *decreases* Medicare payments. For example, in FY 2021, the 10-year moving average growth of the productivity factor forecasted by IGI was -0.1%. CMS acknowledged that subtracting a negative growth factor from the hospital market basket would have *increased* it by 0.1 percentage points. However, the agency set the productivity factor at 0, stating that it is required to reduce, not increase, the hospital market basket by changes in economy-wide productivity.[19] Simply put, the agency applies the productivity factor only when it cuts Medicare spending. However, the cumulative, compounding of effect of these reductions year-over-year, and the asymmetric treatment of declines in economy-wide productivity led to an increasing gap between payments and the cost of providing services, leaving hospitals increasingly underfunded, as discussed above.

Given all of the above, the AHA continues to have deep concerns about the proposed productivity cut, particularly given the extreme pressures in which hospitals and health systems continue to operate, which we also detailed in length in our 2023 and 2024 letters. Applying the private nonfarm business TFP to the hospital field is not appropriate, and in an economy marked by great uncertainty due to tariffs and demand and supply shocks, it generates significant departures from economic reality.

MEDICARE DISPROPORTIONATE SHARE HOSPITAL PAYMENT

Under the DSH program, hospitals receive 25% of the Medicare DSH funds they would have received under the former statutory formula (described as "empirically justified" DSH

[18] Centers for Medicare and Medicaid Services. (February 2016). Hospital Multifactor Productivity: An Updated Presentation of Two Methodologies. https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/ReportsTrustFunds/Downloads/ProductivityMemo2016.pdf
[19] 85 Fed. Reg. 58797 (Sep 18, 2020).

payments). The remaining 75% flows into a separate funding pool for DSH hospitals. This pool is reduced as the percentage of uninsured declines and is distributed based on the proportion of total uncompensated care each Medicare DSH hospital provides.

Transparency Related to DSH Calculations

The AHA remains concerned about CMS' sustained lack of transparency about how it and the Office of the Actuary (OACT) are calculating DSH payments. As we have previously commented, we urge the agency to disclose the OACT information that we outline below in advance of publication of the final rule and permit further comment on it. Moreover, we urge the agency to disclose such information in its inpatient PPS proposed rule each year in the future.

Factor 1

Factor 1 is the estimate of what total DSH payments would have been under the former statutory formula. In estimating Factor 1, CMS used a variety of data inputs, including discharge numbers, case-mix and other components that impact Medicare DSH. In this rule, CMS included a table detailing the factors applied for FYs 2023 through 2026 to estimate Factor 1.[20] Additionally, CMS published a DSH supplemental data file, where the same table is displayed.[21] However, the data inputs did not match[22] and the AHA was limited in its ability to comment on this discrepancy, given the lack of detail that CMS has provided for each component that impacts Medicare DSH payments. **We appreciated that CMS issued a correction notice to fix this discrepancy before the final rule. Given the administration's interest in transparency, we urge the agency to detail its calculations. Specifically, we would appreciate it if the agency would publish a detailed methodology of its calculations that specifies how all the components contribute, as well as their estimates from year to year, so that stakeholders can comment sufficiently on the issue.**

Additionally, the AHA would appreciate seeing detailed calculations of the discharge estimates in the inpatient PPS proposed rule each year going forward so that we have sufficient information to evaluate the impact on fee for service (FFS) inpatient hospital payments and provide feedback to the agency on how growth in MA is affecting the development of FFS rates over time. The growth of MA has led to frustrations around, for example, prior authorization requirements placed by plans, which often negatively impact patients and providers alike.[23] As such, there are questions about

[20] 90 Fed. Reg. 18257 (Apr 30, 2025).
[21] https://www.cms.gov/medicare/payment/prospective-payment-systems/acute-inpatient-pps/fy-2026-ipps-proposed-rule-home-page
[22] Specifically, the proposed FY 2026 estimated DSH payment is stated as "15.682 billion" in the rule but as "15.791 billion" in the supplemental data file.
[23] https://www.nytimes.com/2024/03/24/opinion/prior-authorization-medical-care.html; https://www.nbcnews.com/health/rejecting-claims-medicare-advantage-rural-hospitals-rcna121012; https://www.npr.org/sections/health-shots/2023/10/17/1205941901/medicare-advantage-rural-hospitals;

the sustainability of MA growth and its impact on inpatient hospital payments, and in particular, on those hospitals that serve a disproportionate share of lower-income beneficiaries. The AHA welcomes the opportunity to work with CMS in examining the impacts of MA enrollment on FFS inpatient hospital payments.

Factor 2

CMS establishes Factor 2 in the calculation of uncompensated care DSH payments as one minus the percent change in the percent of uninsured individuals, determined by comparing the percent of the individuals who were uninsured in 2013 and the percent of individuals who were uninsured in the most recent period for which data is available. In the FY 2025 final rule, CMS used an uninsured rate of 7.6% for FY 2025. In this rule, CMS proposes to use an uninsured rate of 8.5% for FY 2026. **Given potential, proposed and realized Medicaid and enhanced Affordable Care Act premium tax credit policy changes expected this year, we believe we will see an even *larger increase* in the number of uninsured in FY 2026.**

To determine uninsured rates, OACT uses projections from the latest National Health Expenditure Accounts (NHEA) historical data, which account for expected changes in enrollment across several categories of insurance coverage, including Medicaid. OACT projects enrollment and spending trends for the coming 10-year period; the most recent projections are for 2023 through 2032 and use NHEA historical data through 2022. CMS states that the projected increase in the rate of the uninsured reflects the net result of multiple trends across various categories of insurance. For example, the agency says it reflects the expiration of enhanced marketplace subsidies, with projected enrollment in direct-purchase plans to fall by 7.3 million in 2026.[24] However, CMS further states that there are expected gains in both employer-sponsored insurance and Medicaid in 2026, with a projected increase of 1.3 million in the Medicaid program.

Yet, recent CBO estimates of the One Big Beautiful Bill Act, as passed by the House of Representatives on May 22, 2025, estimate that almost 11 million will become uninsured if the bill passes as written, with an additional 5.1 million individuals are at risk of becoming uninsured at the end of the year if the enhanced premium tax credits expire.[25] Other policies may also affect the rate of the uninsured, including CMS' proposed rules regarding marketplace program integrity and affordability that could take effect in 2026. The agency itself estimates that between 750,000 to 2 million consumers could lose their coverage under these rules.[26] This would be contrary to CMS' estimate of the uninsured rate. In such a climate of continued turbulent coverage losses, we urge CMS to carefully consider its reliance on current data sources and methodologies to estimate the uninsured rate.

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https://www.beckershospitalreview.com/finance/nearly-half-of-health-systems-are-considering-dropping-ma-plans.html

[24] https://www.cms.gov/files/document/certification-rates-uninsured-fy-2026-proposed-rule.pdf

[25] https://www.cbo.gov/system/files/2025-06/Wyden-Pallone-Neal_Letter_6-4-25.pdf

[26] https://www.aha.org/lettercomment/2025-04-11-aha-comments-cms-marketplace-integrity-and-affordability-rule

Data and projections that worked when coverage levels were more stable may no longer be adequate during these times of turmoil. **As such, we continue to believe that the uninsured rate will be higher than OACT's estimate of 8.5% in FY 2026.**

Finally, CMS also does not publish its Factor 2 methodology, which severely limits the AHA's ability to sufficiently comment on this issue. Specifically, the agency has not published the details of its methodology and how it incorporates NHEA projections, despite stakeholders, including the AHA, consistently voicing their concerns. The AHA is unable to replicate CMS' methodology to project the uninsured rate to understand how policies may affect these projections. As such, we urge CMS to not only publish a detailed methodology on the Factor 2 calculation and how it uses and incorporates NHEA projections but also to use real-world data from key stakeholders and researchers to arrive at a more appropriate uninsured estimate.

Use of Worksheet S-10 Data

CMS proposes to use three years of audited data to determine uncompensated care payments in FY 2026. Specifically, the agency proposes to use the three-year average of uncompensated care from the three most recent FYs for which audited data are available.

The AHA has a longstanding position supporting the use of audited S-10 data to promote accuracy and consistency. We continue to believe that audited data and, by extension, ongoing refinements to the audit process, result in data that are most appropriate for use in Medicare DSH payments. In addition, three-year averages help to reduce year-to-year fluctuations, providing more predictability and stability for hospitals. **We, therefore, support CMS' proposal to use the three most recent FYs of S-10 data to determine each Medicare DSH hospital's share of uncompensated care in FY 2026.**

We also support the following DSH proposals:

- Newly Merged Hospitals. CMS proposes to continue its policy to treat hospitals that merge after the development of the final rule as new hospitals. Specifically, the newly merged hospital's (i.e., the surviving hospital's) current cost report would be used to determine the hospital's DSH payment. CMS also proposes to continue its policy that interim uncompensated care payments for the newly merged hospital would be based only on the data for the surviving hospital's CMS Certification Number available at the time of the development of the final rule. CMS would then determine the final DSH payment for the newly merged hospital during the FY 2026 cost report settlement.
- New Hospitals. CMS proposes to continue its policy for new hospitals. Specifically, for newly established hospitals, the hospital's Medicare Administrative Contractor (MAC) would make a final determination concerning whether the hospital is eligible to receive Medicare DSH payments at cost report settlement.

NURSING ALLIED HEALTH EDUCATION PAYMENTS

Medicare makes payment for its share of a hospital's reasonable cost for approved nursing and allied health education (NAHE) programs operated by the hospital. These payments play a critical part in training the next generation of health providers.

In this rule, CMS addresses how to calculate the net costs of NAHE that hospitals are allowed to claim for pass-through payment after a court ruling. It proposes that the net cost of approved educational activities should be calculated by deducting the revenues that a provider receives from tuition and student fees from the provider's total allowable educational costs that are directly related to approved educational activities. Specifically, CMS is proposing a modification to ensure that revenues received from tuition, student fees, textbooks purchased for resale, and other revenue from or on behalf of students are subtracted *before* completing the indirect cost allocation, rather than *after*. In effect, this could result in circumstances where revenue from or on behalf of students reduces direct nursing and allied health education costs to zero, and there would be no indirect costs to allocate. As such, providers could no longer receive NAHE payments, without which they may be forced to close such programs. This is especially alarming as many organizations around the country are experiencing healthcare staffing shortages. **We urge CMS to reconsider its proposal such that it can better support education activities to train the next generation of nurses and various allied health professionals.**

AREA WAGE INDEX

Permanent Cap on Wage Index Decreases

In the FY 2024 rule, CMS finalized a policy to apply a 5% cap on all wage index decreases, regardless of the reason, in a budget-neutral manner; it proposes to continue this policy for FY 2026. **The AHA appreciates CMS' recognition that significant year-to-year changes in the wage index can occur due to external factors beyond a hospital's control. While we support this policy that would increase the predictability of inpatient PPS payments, we continue to urge CMS to apply this policy in a non-budget-neutral manner.**

Low-wage Hospital Policy

Beginning in FY 2020, CMS finalized a policy to increase wage index values for low-wage hospitals. This was done in a budget-neutral manner through an adjustment applied to the standardized amounts for all hospitals. Specifically, the agency increased the wage index for hospitals with a wage index value below the 25th percentile by half the difference between their otherwise applicable wage index value and the 25th percentile wage index value across all hospitals for that year. While this policy had been originally scheduled to expire after FY 2023, CMS indicated that it had been unable to disentangle the effects of the COVID-19 pandemic and the low-wage index policy to determine whether the policy has successfully resulted in hospitals raising wages to get a higher wage index. Therefore,

in the FY 2025 proposed rule, the agency proposed to extend the policy and related budget neutrality adjustment for at least three more years.

However, in the FY 2025 final rule, CMS noted that the policy had become the subject of litigation. Specifically, on July 23, 2024, the Court of Appeals for the D.C. Circuit held that the secretary lacked authority to adopt the policy and that it, and its related budget neutrality adjustments, must be vacated. As a result of this court decision, the agency discontinued the low-wage index policy and its related budget neutrality factor for FY 2025. It also implemented a non-budget-neutral transition policy for hospitals impacted by the discontinuation, which capped wage index decreases at 5%. However, the agency did not indicate if and how it would address the policy for FYs 2026 and beyond.

In this rule, CMS is proposing to discontinue the low-wage policy for FY 2026 and beyond. Additionally, the agency is proposing to implement a budget-neutral policy to help hospitals significantly impacted by the policy removal. For these hospitals, if the proposed FY 2026 wage index decreased by more than 9.75% compared to their FY 2024 wage index, the decrease would be capped at 9.75% in a budget-neutral manner. We believe that CMS is not bound by statute to make its proposed FY 2026 transition policy budget-neutral. We appreciate that the agency's FY 2025 transition policy was implemented in a non-budget-neutral manner, and we maintain that the FY 2026 transition policy should also be implemented in a non-budget-neutral manner. Indeed, reducing the standardized amount for all PPS hospitals intensifies historical Medicare underpayment. **As such, the AHA urges CMS to implement the FY 2026 low-wage hospital transition policy in a non-budget-neutral manner.**

Imputed Rural Floor Calculation

As required by law, CMS proposes to continue the minimum area wage index for hospitals in all-urban states, known as an "imputed rural floor," for FY 2026. This policy applies to states that have no rural hospitals or no rural areas to set a rural floor wage index for those states. Also, as required by law, CMS proposes to apply this policy in a non-budget-neutral manner. **We support this proposal.**

RURAL HOSPITAL PROVISIONS

Low-volume Adjustment and Medicare-dependent Hospital Program

The Full-Year Continuing Appropriations and Extensions Act, 2025, extended the low-volume hospital qualifying criteria and payment adjustment (LVA) and Medicare-dependent Hospital (MDH) Program under the inpatient PPS through Sept. 30, 2025. However, as it currently stands, beginning on Oct. 1, 2025, the LVA would revert to statutory requirements that were in effect prior to FY 2011. Similarly, beginning Oct. 1, 2025, the MDH program would expire. **The AHA supports congressional action that would make permanent the enhanced LVA so that hospitals can continue to qualify for and be paid under the current enhanced method. We also support congressional action to**

make permanent the MDH program, with an additional base year available to calculate MDH payments, which would provide more flexibility for these hospitals to provide the best care possible for their patients and communities. Finally, we urge CMS to expeditiously process claims and provide instructions to MACs during program extensions, especially in instances when extensions are made retroactively. Seamless transition of programmatic support is a crucial lifeline for rural providers.

Hospitals Applying for Rural Referral Center Status

One way in which a hospital can qualify for rural referral status is based on a combination of discharge volume and case-mix criteria, in comparison to other providers in the hospital's region. CMS proposes to use FY 2024 data to calculate case-mix criteria and FY 2023 cost report data to calculate discharge volume. **We support the use of this data.**

Rural Community Hospital Demonstration Program

The Rural Community Hospital Demonstration allows rural hospitals with fewer than 51 acute care beds to test the feasibility of cost-based reimbursement. Last year, CMS solicited 10 additional qualifying hospitals to participate. However, the original authorizing legislation, section 410A of the Medicare Modernization Act, requires that CMS conduct this demonstration in states with low population densities, as determined by the secretary. Therefore, the agency only accepted applications to its solicitation from hospitals in the 20 least densely populated states, according to data for 2020 from the U.S. Census Bureau.[27] CMS did not accept applications from hospitals located in other states or in the U.S. territories.

CMS stated that hospitals not selected for the 10 slots will be placed on a waitlist. When a participating hospital voluntarily terminates from the demonstration, CMS will utilize this waitlist to fill any vacant spots. Waitlist placement will be based on an applicant's overall score, meaning those with higher scores will be placed at the top of the waitlist. **We urge CMS to accept applications from hospitals in other states and consider them for the program and for the waitlist if there is a vacancy not otherwise able to be filled. The demonstration program provides a critical path for rural hospitals to seek additional ways to remain financially viable for their communities.**

CHANGES TO MS-DRG CLASSIFICATIONS

Broadly, the AHA supports CMS' proposed changes within the Medicare Severity Diagnosis-Related Group (MS-DRG) classifications section. We agree with most proposals given the data, the ICD-10-CM/PCS codes, and the information provided. However, we request that CMS consider the exceptions detailed below.

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[27] These states are Alaska, Arizona, Arkansas, Colorado, Idaho, Iowa, Kansas, Maine, Mississippi, Montana, Nebraska, Nevada, New Mexico, North Dakota, Oklahoma, Oregon, South Dakota, Utah, Vermont and Wyoming.

First, the AHA thanks CMS for continuing to provide test versions of files and software applications needed to assess proposed MS-DRG Classification Changes more thoroughly. Specifically, we thank CMS for providing Version 43 (V43) of the ICD-10 MS-DRG Grouper Software, the draft V43 of the ICD-10 MS-DRG Definitions Manual, the draft V43 of the Definitions Manual for Medicare Code Edits, and the supplemental mapping files in Tables 6P.1a and 6P.1b, which include the FY 2025 and FY 2026 ICD-10-CM diagnosis codes and ICD-10-PCS procedure codes associated with this proposed rule.

However, the updated test software and a current batch GROUPER are needed. The updated test software provided with a batch GROUPER would allow hospitals to analyze the operational and monetary impact of proposed changes more thoroughly via a batch versus an individual case review. As such, consistent with our prior comments, we request that CMS offer a batch GROUPER option associated with future rulemaking.

FY 2026 MS-DRG Updates

For this FY 2026 inpatient PPS proposed rule, we acknowledge that CMS' MS-DRG analysis was based on ICD-10 claims data from the September 2024 update of the FY 2024 MedPAR file, which contains hospital bills received from Oct. 1, 2023, through Sept. 30, 2024, i.e., the "September 2024 update of the FY 2024 MedPAR file."

The following are the AHA's concerns to the proposed changes for CMS' review and consideration in the FY 2026 inpatient PPS final rule.

MDC 01 (Diseases and Disorders of the Nervous System): Logic for MS-DRGs 023 Through 027

We agree with most CMS proposals associated with the logic updates for MS-DRGs 23-27, with one proposed consideration below.

- During CMS' analysis, CMS incorporated a review of MS-DRGs 20-22 logic. CMS acknowledged that the GROUPER logic for MS-DRGs 20-22 contains a list of procedure codes describing intracranial vascular procedures captured under a logic list referred to as "Intracranial Vascular Procedures" and a list of diagnosis codes describing a diagnosis of hemorrhage captured under a logic list referred to as "Hemorrhage Principal Diagnosis."
- As discovered during CMS' analysis, CMS noted that codes describing intracranial vascular procedures and diagnosis codes describing a diagnosis of intracranial hemorrhage were excluded inadvertently from the logic list for MS-DRGs 20-22.
- We agree with CMS' proposal to move the ICD-10-CM and ICD-10-PCS codes currently included in the "Intracranial Vascular Procedures" and "Hemorrhage Principal Diagnosis" logic lists to the logic lists for MS-DRGs 20-22 to align better clinically.

- We agree with CMS' proposal to add fifty-seven procedure codes to the "Intracranial Vascular Procedures" and sixty-six diagnosis codes to the "Hemorrhage Principal Diagnosis" logic lists for MS-DRGs 20-22:
    - **However, we are unclear on the rationale for not including ICD-10-PCS code 057L0DZ (Dilation of Intracranial Vein with Intraluminal Device, Open Approach) to the MS-DRG 20-22 logic.**
    - Within Table 6P.2c for MS-DRGs 20-22 and the ICD-10-CM/PCS MS-DRG V43 Definitions Manual, ICD-10-PCS codes are included in the updated logic for MS-DRGs 20-22:
        - 057L3DZ (Dilation of Intracranial Vein with Intraluminal Device, Percutaneous Approach) and
        - 057L4DZ (Dilation of Intracranial Vein with Intraluminal Device, Percutaneous Endoscopic Approach)
    - **CMS' insight would help us understand the rationale for including or excluding 057L0DZ in the updated MS-DRG 20-22 logic. If applicable, we request that CMS consider adding ICD-10-PCS code 057L0DZ to the MS-DRG 20-22 logic.**

MDC 01 (Diseases and Disorders of the Nervous System): Hypertensive Encephalopathy

CMS included a proposal in this rule to delete MS-DRGs 077, 078 and 079 (Hypertensive Encephalopathy with major complication or comorbidity (MCC), with complication or comorbidity (CC), and without CC/MCC, respectively). We support this proposal based on CMS' data analysis, which indicates a general decline in the number of cases reporting hypertensive encephalopathy as a principal diagnosis in these MS-DRGs over the past five years.

The AHA supports CMS' proposed reassignment of ICD-10-CM code I67.4 to MS-DRGs 070, 071 and 072 and changing their titles to "Other Cerebrovascular Disorders with MCC, with CC, and without CC/MCC, respectively."

CMS reviewed the ICD-10-CM Tabular List of Diseases and Injuries and instructional notes as part of the analysis to determine whether to propose the deletion of MS-DRGs 077, 078 and 079. CMS also commented on the sequencing of ICD-10-CM codes I16.1 (Hypertensive emergency) and I67.4 (Hypertensive encephalopathy).

We agree with CMS that:

- Per ICD-10-CM Official Guidelines for Coding and Reporting, "certain conditions have both an underlying etiology and multiple body system manifestations due to the underlying etiology."
- That "for such conditions the ICD-10-CM has a coding convention that requires the underlying condition be sequenced first, followed by the manifestation."

- That “wherever such a combination exists and there is a ‘use additional code’ note at the etiology code, and a ‘code first’ note at the manifestation code, these instructional notes indicate the proper sequencing order of the codes, etiology followed by manifestation.”

However, we disagree with CMS that given no ‘code first’ note appears at ICD-10-CM diagnosis code I67.4 (Hypertensive encephalopathy) in the ICD-10-CM Tabular List of Diseases and Injuries, the sequencing depends on the circumstances of the encounter, when there is supporting provider documentation of hypertensive emergency and hypertensive encephalopathy.

The instructional note “use additional code,” as in the case of hypertensive emergency (I16.1) effective FY 2025 in the Tabular list, provides the sequencing instruction for ICD-10-CM code I16.1, i.e., sequence I16.1 before I67.4. **We request CMS’ clarification for ICD-10-CM code I16.1 and I67.4 sequencing, as this differs from the coding convention regarding the "use additional code" instructional note.**

MDC 05 (Diseases and Disorders of the Circulatory System): Endovascular Aneurysm Repair (EVAR) with Iliac Branch Procedures

Cases reporting endovascular repair of abdominal aortic aneurysms (AAA) that extend into at least one iliac artery to preserve blood flow to the iliac arteries are technically more challenging and require more resources. CMS’ analysis supports this in that EVAR procedures using an AAA endoprosthesis with an iliac branch endoprosthesis (IBE) utilize greater resources compared to cases reported using standard EVAR using an AAA endoprosthesis. CMS proposes to create a new base MS-DRG 213 (Endovascular Abdominal Aorta and Iliac Branch Procedures) to address this.

We agree with CMS that patients with EVAR procedures using an AAA endoprosthesis with an iliac branch endoprosthesis (IBE) are a more complex population to treat, contributing to increased resource utilization. And we agree with CMS’ analysis that a new MS-DRG is warranted to distinguish the higher resource utilization between the standard EVAR to treat an AAA and an EVAR to treat an AAA that extends into the iliac artery.

Cases reporting a combination of these procedure codes using an AAA endoprosthesis with IBE for the endovascular treatment of aortoiliac and iliac artery aneurysms are currently assigned to MS-DRGs 268 and 269 (Aortic and Heart Assist Procedures Except Pulsation Balloon with MCC and without MCC, respectively).

Table 5 associated with this proposed rule indicates that the MS-DRG weight for the proposed new MS-DRG 213 is lower than MS-DRG 268 and higher than MS-DRG 269. In a table within this section of the proposed rule, while case volume was lower, the average length of stay (ALOS) was higher in cases reporting an EVAR using an AAA endoprosthesis with an IBE (MS-DRG 268) and had higher average costs as compared to cases reporting a standard EVAR with AAA endoprosthesis only (MS-DRG 269).

We acknowledge that to create CC subgroups, five criteria must be met for the base MS-DRG to be split (or subdivided) by a CC subgroup. **These five criteria were not met to subdivide the proposed new MS-DRG 213 further. However, given that CMS' data supports that patients who have EVAR procedures using an AAA endoprosthesis with an IBE are a more complex population to treat and contribute to increased resource utilization, we request that CMS reconsider the weight of new MS-DRG 213 to capture overall resource utilization for these procedures better — reference excerpt from Table 5 and the additional table from CMS' analysis comparing cases with and without IBE in MS-DRGs 268 and 269 below.**

TABLE 5.—LIST OF MEDICARE SEVERITY DIAGNOSIS-RELATED GROUPS (MS-DRGS), RELATIVE WEIGHTING FACTORS, AND GEOMETRIC AND ARITHMETIC MEAN LENGTH OF STAY—FY 2026 Proposed Rule						
MS-DRG	MDC	TYPE	MS-DRG Title	Weights	Geometric mean LOS	Arithmetic mean LOS
213	05	SURG	ENDOVASCULAR ABDOMINAL AORTA WITH ILIAC BRANCH PROCEDURES	5.7834	1.7	2.9
268	05	SURG	AORTIC AND HEART ASSIST PROCEDURES EXCEPT PULSATION BALLOON WITH MCC	6.9027	6.0	9.1
269	05	SURG	AORTIC AND HEART ASSIST PROCEDURES EXCEPT PULSATION BALLOON WITHOUT MCC	4.2850	1.5	2.0

MS-DRG	Number of Cases	Average Length of Stay	Average Costs
MS-DRG 268 – All cases	2,519	9.1	$62,984
MS-DRG 268 – Cases reporting standard EVAR using an AAA endoprosthesis	1,500	7.4	$63,877
MS-DRG 268 – Cases reporting EVAR using an AAA endoprosthesis with an IBE	193	8.2	$68,145
MS-DRG 269 – All cases	10,108	2.0	$39,165
MS-DRG 269 – Cases reporting standard EVAR using an AAA endoprosthesis	8,655	1.8	$38,562
MS-DRG 269 – Cases reporting EVAR using an AAA endoprosthesis with an IBE	871	1.8	$48,159

Proposed Additions and Deletions to the Diagnosis Code Severity Levels

Table 6A (New Diagnosis Codes) associated with this proposed rule provides the severity level designations for these new codes. We agree with the assigned designations for all new diagnosis codes for FY 2026, except for the new diagnosis codes for hyperoxaluria. We agree with CMS' proposal to designate the three hyperoxaluria codes in the table below as CCs. However, the other four hyperoxaluria codes are proposed as non-CCs. **Acknowledging that these all specify distinct types of hyperoxaluria, we ask that CMS consider if the other four diagnosis codes in the table below that are not currently proposed as a designated CC should be designated as such. We welcome clinical insight and rationale as well.**

TABLE 6A - NEW DIAGNOSIS CODES		
Diagnosis Code	Description	CC
E72.530	Primary hyperoxaluria, type 1	C
E72.538	Other specified primary hyperoxaluria	C
E72.539	Primary hyperoxaluria, unspecified	C
E72.540	Dietary hyperoxaluria	N
E72.541	Enteric hyperoxaluria	N
E72.548	Other secondary hyperoxaluria	N
E72.549	Secondary hyperoxaluria, unspecified	N

NEW TECHNOLOGY ADD-ON PAYMENTS

We generally agree with the proposed ICD-10-CM/PCS codes to identify the FY 2026 proposed new technologies for which CMS specifically sought input.

We recognize that new technology add-on payments (NTAPs) intend to consider the costs of new medical services and technologies under the hospital inpatient PPS by providing additional payments for eligible cases until CMS has sufficient data for MS-DRG rate setting. These payments are not budget-neutral, and NTAP eligibility may extend for up to three years after the point at which data begin to become available. After that point, payments for these technologies are incorporated into the existing payment system to maintain budget neutrality compared to the inpatient PPS without them included.

We acknowledge the importance of having efficient processes to help ensure the reporting and capture of these new technologies within hospital organizations. In addition to the 26 new technologies for which CMS proposes to continue making new technology add-on payments for FY 2026, there are 43 new NTAP proposals for FY 2026. With 43 new NTAP proposals, the ICD-10-CM and/or ICD-10-PCS codes or combinations of codes proposed to identify these new technologies also increased. Many of these new technologies are part of hospital organizations' day-to-day inpatient ICD-10-CM/PCS coding and reporting processes. However, others involve items that are not routinely part of these processes, such as medication administration.

To ensure overall NTAP capture, hospital organizations often must build and maintain additional internal edits, which can be a cumbersome administrative process. **In the spirit of the Medicare Deregulation Request for Information (RFI) associated with this rule, we request that CMS consider creating a Technical Expert Panel (TEP) to explore alternative processes to capture the provision of new technologies that could be less administratively burdensome. The AHA would welcome the opportunity to work with and provide input to such a TEP.**

PROMOTING INTEROPERABILITY PROGRAM FOR HOSPITALS

The Promoting Interoperability program is CMS' statutorily required program intended to encourage adoption and use of certified electronic health record (EHR) technology.

Hospitals must meet the Promoting Interoperability requirements to avoid a reduction of three-quarters of their annual market basket update.

Reporting Period. For the CY 2026 reporting / FY 2028 payment years, CMS proposes to retain a reporting period of any continuous 180-day period within the calendar year. CMS believes this reporting timeframe provides stability to hospitals while the agency continues to consider longer reporting periods for future program years. **The AHA appreciates CMS maintaining stability in the reporting period for the Promoting Interoperability program. We believe further lengthening the reporting period could pose significant challenges to the field.**

CMS has previously established reporting periods of less than a full calendar year in recognition that EHRs are far from static tools. EHRs are continually undergoing software upgrades, system downtime, expansions to other sites with the system, and a variety of other improvement and maintenance activities. When CMS makes changes to the requirements of the Promoting Interoperability program, these changes affect *all* the thousands of hospitals required to participate in the program. Yet, to make the changes and upgrades needed to comply with the Promoting Interoperability program requirements, hospitals are drawing on the same EHR vendors simultaneously, and the capacity of those vendors is finite. That is why hospitals have frequently chosen reporting periods later in the year. In some cases, their vendors are simply not available to perform the needed work because they are working with multiple other facilities. Hospitals also need sufficient time for testing and implementation, which is necessary to identify and resolve problems with the software and provide essential training to end users. Ultimately, these activities are crucial to ensuring EHRs do not inadvertently compromise the safe delivery of care.

We urge CMS to carefully consider these issues in assessing any future expansion of the Promoting Interoperability program requirements, including lengthening the reporting period.

Safety Assurance Factors for EHR Resilience (SAFER) Measure. In the FY 2022 inpatient PPS final rule, CMS added the SAFER Guide measure to the Protect Patient Health Information objective of the Promoting Interoperability program. Developed by the Assistant Secretary for Technology Policy/Office of the National Coordinator for Health Information Technology (ASTP), the SAFER assessment includes nine guides that ask hospitals to assess the safety and effectiveness of their EHR implementation, proactively identify potential vulnerabilities and adopt a “culture of safety” with respect to the use of EHRs in their organizations. Beginning with the CY 2024 reporting period, CMS has required hospitals to attest “yes” to whether they conducted an annual assessment using all nine SAFER guides. In early 2025, ASTP updated SAFER guides covering eight areas instead of nine. As a result, beginning with the CY 2026 reporting / FY 2028 payment year, CMS proposes to modify the SAFER guideline measure to require that hospitals conduct the annual SAFER Guides self-assessments and attest a “yes” response accounting for the completion of the self-assessment for all eight of the updated SAFER guides.

The AHA continues to urge CMS not to require hospitals to attest "yes" to completing the SAFER Guides annually. We note the considerable length of each of the eight guides, and the level of administrative effort required to complete them, especially for CAHs and other hospitals with fewer resources. Furthermore, we believe the requirement to complete the SAFER guide assessment likely overlaps with the Security Risk Analysis measure with the same Promoting Interoperability Program objective, especially since CMS has proposed to expand the security risk assessment measure to include security risk management.

Lastly, the concept of requiring hospitals to attest "yes" on this or any other promoting interoperability measure is not consistent with the program's design. When CMS adopted a performance-based scoring approach for the program, the agency's goal was to provide differential rewards based on how hospitals perform to incentivize the adoption of a particular practice. Performance-based scoring was never intended to create an across-the-board requirement for all participants in the program; yet this is precisely what CMS' proposal would do.

At the same time, we appreciate CMS' focus on ensuring the safety of the implementation and use of EHR technology. We believe these efforts can be most effectively advanced through the dissemination of more modernized approaches and guidelines to EHR safety, and not necessarily through the use of a measure in a promoting interoperability program.

Security Risk Analysis Measure. The security risk analysis measure is a longstanding part of the Protect Patient Health Information program objective and aligns with the HIPAA Security Rule. To date, hospitals have been required to attest "yes" to conducting a security risk analysis that conforms with the broad requirements of the HIPAA security rule. Beginning with the CY 2026 reporting / FY 2028 payment year, CMS proposes to expand the measure to attest yes to conducting both security risk analysis and security risk management. **The AHA does not object to this proposal as conducting security risk management aligns with expectations under HIPAA.** At the same time, as described in the previous section of this letter, we continue to have misgivings about requiring "yes" attestations in the Promoting Interoperability program to receive full scoring credit.

New Optional Bonus Measure. In the proposed rule, CMS expresses its interest in using the Trusted Exchange Framework and Common Agreement (TEFCA) to promote greater exchange of data between hospitals and public health agencies. As a result, beginning with the CY 2026 reporting / FY 2028 payment period, the agency proposes to add an optional bonus measure under the Public Health and Clinical Data Exchange objective for data exchange to occur with a public health agency using the Trusted Exchange Framework and Common Agreement® (TEFCA), beginning with the EHR reporting period in CY 2026.

The AHA supports this proposal. However, we are uncertain as to how many hospitals and CAHs will benefit from the bonus points in the measure. As a general matter, the AHA appreciates CMS' interest in modernizing approaches to exchanging data

between hospitals and public health agencies. The use of the TEFCA framework may help to create a foundation for strengthened data exchange. However, the TEFCA framework is an inherently bi-directional framework that requires a range of stakeholders — hospitals, public health agencies, health information networks and EHR vendors — to both participate and have the technical capabilities to support data exchange. Hospitals have shared with the AHA that their public health agencies often have underdeveloped technological infrastructure and limited staffing capabilities to build more robust and technically sophisticated approaches to data exchange.

For these reasons, we encourage CMS to assess hospital and health system experiences with adopting this measure to inform future policy development efforts. This would help the agency ascertain barriers to TEFCA participation and the speed at which to adopt any additional TEFCA-related measures in the Promoting Interoperability Program.

Requests for Information. CMS seeks input on several potential future policy changes to the Promoting Interoperability Program. First, CMS asks for input on whether to change the query of prescription drug monitoring programs (PDMP) measure from a “yes/no” attestation to a performance-based measure reflecting the proportion of all schedule II drugs electronically prescribed with an accompanying query of a PDMP for prescription history, with a numerator and denominator reflecting the frequency of PDMP queries.

As a general matter, the AHA appreciates the potential value of expanding the PDMP measure to include all schedule II drugs — including non-opioid drugs — given that such drugs are sometimes subject to abuse. At the same time, there is significant variation across states in what non-opioid data are captured in PDMP, some of which stems from differences in state-level requirements around what drugs should be included. In addition, there remains variation in the technical capabilities for state-level PDMPs to integrate data with health care providers. As a result, we are concerned that moving to a performance-based measure too expeditiously would result in differential performance for hospitals based on factors beyond their control. **We encourage CMS to further work with hospitals, state public health agencies, EHR vendors and other vendors to identify barriers to standardizing and broadening PDMP data before seeking to convert the PDMP measure into a performance-based measure.**

Second, CMS asks for input on using more performance-based measures in the Promoting Interoperability Program, especially in the public health and information exchange objective. The AHA appreciates the value of strengthening data exchange with public health agencies. However, as noted above in our comments on the new optional TEFCA measure, there is significant variation in technical capabilities across public health agencies that would influence the ability for hospitals to exchange data with them. These variations likely will grow even wider given the funding challenges that many public health agencies are experiencing. Furthermore, as noted in the RFI, the standards for data exchange with public agencies remain a patchwork. Adopting a performance-based approach to the public health and clinical data exchange objective too expeditiously could hold hospitals accountable for issues that are not fully within their control. ven if CMS were

to adopt exemptions for those hospitals whose state agencies may not yet have technical capabilities, we fear that CMS will be creating an unlevel playing field in which some hospitals are held to a higher standard — and have a higher risk for a payment reduction from performance-based thresholds — than others. **For these reasons, we urge CMS to prioritize the further development of the infrastructure to support data exchange with public health agencies, including exploration of the technical standards that would be most feasible for hospitals and agencies to adopt**.

HOSPITAL INPATIENT QUALITY REPORTING PROGRAM

The inpatient quality reporting (IQR) program is CMS' pay-for-reporting program in which hospitals must submit measures and meet other administrative requirements to avoid a payment reduction equal to one quarter of the annual market basket update. CMS proposes to remove four measures while modifying four other measures.

Measure Removals. With a stated purpose of reducing regulatory burden to hospitals, CMS proposes to remove the following four measures from the IQR effective with the CY 2024 reporting / FY 2026 payment periods:

- COVID-19 vaccination coverage among health care personnel.
- Hospital commitment to health equity structural measure.
- Screening for social drivers of health.
- Screen positive rate for social drivers of health.

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

The AHA especially applauds CMS' proposal to sunset the COVID-19 vaccination coverage among HCP measure. While hospitals continue to support efforts to vaccinate health care workers for COVID-19 in a manner consistent with federal guidelines, the COVID-19 public health emergency (PHE) concluded in May 2023. Since then, the level of administrative effort and resources needed to collect and report the health care personnel COVID-19 vaccination measure has become impractical and untenable. In 2023, the Centers for Disease Control and Prevention (CDC) and CMS shifted the measure definition to measure the proportion of health care personnel who are "up to date" on COVID-19 vaccinations. The measure collection protocol uses a reference period for

determining up-to-date vaccination status that changes every quarter. Practically speaking, this means that an HCP who counted as “up to date” during one quarter may no longer be up to date in the next quarter. Hospitals are also asked to take into consideration any recent positive COVID-19 tests, which would affect the timing of when an HCP should receive a vaccine. To collect and report the measure, hospitals must conduct near-continuous tracking of each employee’s vaccination status, including obtaining documentation of either the vaccination, a recent COVID-19 test or an exemption.

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

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

Measure Modifications.
Removal of COVID-19 Exclusion for Multiple Claims-based Measures. For multiple IQR measures, CMS proposes to remove its previously adopted exclusion for patients with a principal or secondary diagnosis of COVID-19 coded as present on admission on index claims. This change would affect measure calculations beginning with the FY 2027 IQR program year. CMS states that since the end of the COVID-19 PHE, there has been a significant decline in the number of patients excluded from the measures under this criterion. **The AHA supports this proposal.**

Total Hip/Knee Arthroplasty (THA/TKA) Complications and Ischemic Stroke Mortality. For these two IQR measures, CMS proposes three methodology changes that, taken together, CMS believes would improve reliability and meaningfulness. First, CMS proposes to update the risk adjustment approach for each measure by using individual ICD-10-CM codes instead of the current hierarchical condition category (HCC) approach. The agency believes the individual ICD-10-CM codes will improve the accuracy of measure calculations. **The AHA supports this proposal.**

Secondly, CMS would incorporate MA patients into the calculation of performance. As a result of this change, CMS believes it would have sufficient measure volumes to shorten the data reporting period used to calculate performance without reducing measure reliability. Thus, CMS also proposes to shorten the measure reporting period from three years to two years. **While the AHA appreciates the intent of this proposal, we believe additional work is necessary before CMS adopts this approach in the IQR and other hospital programs.**

The AHA agrees that MA penetration rates have increased across the country. We appreciate that CMS' intent in including MA patients in calculating performance is to ensure the measures reflect the experiences of the Medicare patient population more broadly. We also agree in concept with shortening the data reporting period to enable more timely information on hospital performance.

However, we are concerned that these measures — which are designed to encompass post-hospital-discharge outcomes — may be influenced by the adverse practices of MA plans to delay and deny access to post-acute care. Access to post-acute care is often a key determinant in outcomes such as readmissions, mortality and complications. Yet, as has been well documented by providers as well as by the Department of Health and Human Services Office of Inspector General and congressional investigations, MA plans often place restrictions on post-acute care.[28] The prior authorization process used by MA plans places a significant administrative burden on both acute-care hospitals and post-acute care providers. Perhaps more importantly, it is directly harmful to Medicare beneficiaries — at best delaying their care and at worst outright denying medically necessary treatment.

Despite steps taken by CMS in recent years, providers have seen little meaningful change in MA plan behavior and no increased post-acute care access for beneficiaries. Additionally, post-acute care providers still face challenges with MA plans listing them within their networks. For these reasons, we are concerned that those hospitals that care for larger proportions of MA patients could perform worse on the measures through no fault of their own. This situation would be especially problematic given that both these measures likely would be used in calculating the Hospital Overall Star Ratings. In addition, the THA/TKA complication measure would be used in the Hospital Value-Based Purchasing (HVBP) program.

At the same time, we recognize the potential value of measures that could more fully reflect performance among the Medicare population. For this reason, we encourage CMS to conduct further analysis of the variation in performance across these measures between Medicare fee-for-service and MA patients. We also encourage

[28] HHS, Office of Inspector General (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/oei/reports/OEI-09-18-00260.pdf), and https://www.hsgac.senate.gov/wp-content/uploads/2024.10.17-PSI-Majority-Staff-Report-on-MedicareAdvantage.pdf

CMS to provide confidential feedback reports on their performance so that hospitals can better understand performance differences.

Hybrid Hospital-wide Readmission and Mortality Measures. These two measures are "hybrid" measures that combine CMS claims data with EHR-derived data that hospitals collect and submit to CMS. The data hospitals submit include "core clinical data elements" (CCDEs) that reflect certain patient vital signs and laboratory values, along with "linking variables" to help match the data hospitals submit to CMS claims data. In the CY 2025 outpatient PPS final rule, CMS delayed the mandatory reporting of the measures, making data submission optional for the reporting periods of July 1, 2023-June 30, 2024 (FY 2026 payment) and July 1, 2024-June 30, 2025 (FY 2027 payment). CMS made this change in light of significant concerns raised by AHA and other stakeholders about the ability for hospitals to report the data as CMS intended.

Since then, CMS indicates it has continued to assess potential changes to the hybrid measures to determine how it could make reporting more feasible. The agency believes that its previously adopted completeness standards for CCDEs and linking variables of 90% and 95%, respectively, could be prohibitively high for hospitals to meet at this time. CMS also believes that allowing for some limited missing data values in hospital submissions would enable more hospitals to meet data completeness thresholds without degrading measure reliability. As a result, beginning with data reported for the performance period of July 1, 2025, through June 30, 2026, (FY 2028 payment), CMS proposes to lower the measure data completeness thresholds for core clinical data elements and linking variables to 70%. In addition, CMS would allow for up to two missing vital signs and lab values within the CCDEs.

The AHA thanks CMS for its responsiveness in addressing concerns about the hybrid readmissions and mortality measures. However, we recommend that CMS adopt one more year of voluntary reporting to fully ensure the feasibility of these proposed changes. In concept, we agree that lowering the data completeness thresholds and allowing for missing data should improve the ability for hospitals to meet CMS requirements. At the same time, it is important to note that the completeness thresholds were not the only issue that hospitals experienced in reporting the measures. Hospitals participating in voluntary reporting have shared that some patients may have been included or excluded from the measure calculation inappropriately, which could be a function of the approach that CMS uses to match hospital-submitted data with Medicare claims. It is possible that as hospitals gain experience with the measure through voluntary reporting and CMS further refines measure specifications and reporting guidance, this issue may diminish. An additional year of voluntary reporting could help CMS further ensure that the measures are working as intended.

RFI: New Measure Concepts for the IQR. In the proposed rule, CMS seeks ideas for tools and measures assessing two topics — well-being and nutrition. On the nutrition measure, CMS notes the IQR already includes the malnutrition composite measure of the

Electronic Clinical Quality Measure (eCQM) and seeks further ideas on measures that assess optimal nutrition and preventive care.

The AHA appreciates CMS' focus on whole-person care and on improving the health of all Americans. At the same, it is important to note that hospitals alone cannot address the broader challenges of nutrition and well-being. Indeed, making progress requires collaboration and resources from public and private sector partners. Hospitals and health systems often play a key convening role for these partners who have implemented innovative strategies ranging from school-based mental health clinics to food pantries and other health promoting activities. In some communities, public and private sector partners are willing, able and have the resources to bring to bear to address these challenges, but this is not the case everywhere. Yet, quality measurement programs like the IQR are inherently designed to assess the performance of hospitals and health systems alone. As CMS continues to explore measures of well-being and nutrition, we caution the agency against adopting measures that are scoped so broadly that they end up reflecting differences in the availability of community resources rather than true hospital performance.

HOSPITAL VALUE-BASED PURCHASING

The Affordable Care Act mandated that CMS implement the HVBP program, which ties a portion of hospital payment to selected measures of the quality, safety and cost of hospital care. CMS funds the program by reducing base operating DRG payment amounts to participating hospitals by 2% to create a pool of funds to pay back to hospitals based on their measure performance. Hospitals may earn back some, all or more than the 2% withhold based on their measure performance. By statute, the program must be budget neutral — that is, the entire pool of dollars must be paid back to hospitals, and CMS may not hold back any portion of it to achieve savings to the Medicare program.

Health Equity Adjustment. Beginning with the FY 2026 HVBP program, CMS proposes to remove the health equity adjustment from the HVBP scoring methodology. The health equity adjustment would have awarded bonus points to hospitals based on a combination of quality performance and the proportion of dual-eligible patients cared for by hospitals. CMS believes that the removal of the adjustment would simplify program scoring and "provide clearer incentives to hospitals as they seek to improve the quality of care for all patients."

The AHA shares CMS' goal of improving the quality of care for all patients. As CMS removes the HVBP health equity adjustment, we encourage the agency to continue assessing ways to account for the complex interplay between provider performance and community-level factors. The AHA has advocated that quality measurement programs include mechanisms to account for non-medical risk factors on outcomes such as readmissions and mortality. While the quality of hospital-level care is an important determinant of performance, patient outcomes can also be influenced by poverty; a lack of primary care, home health and rehabilitation services in the community; a dearth of

transportation options that enable patients to go to follow up appointments; and challenges adhering to dietary restrictions or health promoting activities. Failure to account for these factors in quality measurement and value programs can inadvertently penalize providers that care for large numbers of patients facing these challenges.

We encourage CMS to consider the administration's approaches in this space in other programs. For example, as part of the Transforming Episode Accountability Model, CMS has recently proposed a new beneficiary-economic risk adjustment variable in determining model participant performance. While the AHA believes CMS should provide additional transparency and details around the methodology, CMS could consider adapting this approach to the HVBP program and other value programs in which performance depends heavily on post-discharge outcomes influenced by community-level factors.

Measure Modifications. For the FY 2027 HVBP, CMS proposes to adopt the same modifications to the THA/TKA complication measure that it proposed for the IQR. **The AHA supports CMS' proposal to modify the risk adjustment approach for the THA/TKA measure to use ICD-10-CM codes rather than HCCs. However, we urge CMS not to finalize its proposal to include MA patients in the measure calculation at this time.** We refer CMS to the IQR section of this letter for further information.

CMS also proposes to remove the exclusion for COVID-19 patients from the THA/TKA measure, as well as the five 30-day mortality measures (pneumonia, heart failure, acute myocardial infarction, chronic obstructive pulmonary disease, coronary artery bypass graft) that are used in the HVBP. **The AHA supports this proposal.**

Lastly, for the HVBP health care-associated infection (HAI) measures, CMS proposes to use a standard patient population baseline year of 2022 for calculating HAI measures. Given the HVBP's staggered timelines for baseline and performance periods, the new HAI baseline will not affect HVBP payments until FY 2029. **The AHA supports this proposal.**

HOSPITAL-ACQUIRED CONDITION REDUCTION PROGRAM

The Hospital-acquired Condition (HAC) Reduction Program imposes a 1% reduction on all Medicare inpatient payments for hospitals in the top (i.e., worst-performing) quartile of risk-adjusted national HAC rates. The HAC rates are calculated using five HAI measures and a claims-based patient safety indicator composite measure.

Similar to the HVBP program, CMS proposes to use a new standard patient population baseline of 2022 in calculating performance on the HAC Reduction Program's HAI measures. **The AHA supports this proposal.**

Extraordinary Circumstances Exception (ECE) Policy. For approximately a decade, CMS has had an ECE policy across its hospital quality reporting and value programs that enables the agency to grant reporting exceptions in the event of natural disasters, systemic problems with data collection systems and other extenuating circumstances that

either affect hospitals' ability to submit data or significantly distort measure performance for reasons beyond hospitals' control. CMS proposes several changes to the ECE policy.

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

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

The AHA does not, however, support CMS' proposal to shorten the timeframe for requesting an ECE. In the proposed rule, CMS states that shortening the timeframe to request an exception would better align the hospital ECE policy with other CMS systems implementation requirements across all quality reporting programs. While this might be true for some — but certainly not all — quality reporting programs, we believe a 90-day window to request an ECE is necessary given the increasing frequency of, and devastation caused by, storms, cyberattacks and other emergencies. In the early days and weeks following these types of extraordinary events, hospitals and other health care settings often struggle just to stay operational and care for their patients and communities. Requiring hospitals to prioritize paperwork over patients just to get a one-time exception to reporting seems counter to the intended goals of the CMS quality reporting and value programs. We fear such a change to the process of requesting an ECE would divert critical staff at a time when they are needed most. **For these reasons, we urge CMS to retain its current policy and allow hospitals to request an ECE for up to 90 days following a disaster or other extraordinary event.**

HOSPITAL READMISSIONS REDUCTION PROGRAM

The Hospital Readmissions and Reduction Program (HRRP) imposes penalties of up to 3% of base inpatient PPS payments for having "excess" readmission rates for selected conditions when compared to expected rates. CMS uses six Medicare claims-based readmission measures to assess performance in the program — acute myocardial

infarction (AMI), heart failure (HF), pneumonia (PN), chronic obstructive pulmonary disease (COPD), isolated coronary artery bypass grafts (CABG), and elective THA/TKA.

Inclusion of MA. Beginning with the FY 2027 HRRP program year, CMS proposes to include MA patients in the calculation of all six measures used in the program. CMS also proposes to shorten the performance period from three years to two years because it believes the inclusion of MA patients would improve measure reliability sufficiently to do so. For example, FY 2027 HRRP penalties would be based on performance from July 1, 2023, through June 30, 2025.

Certainly, the AHA agrees that national MA enrollment rates have increased significantly. We appreciate that CMS' intent in including MA patients in calculating performance is to ensure the measures reflect the quality of care for the Medicare patient population more broadly. We also agree in concept that increasing the measure denominator volumes can improve measure reliability, and that a shorter data reporting period could enable CMS to share more timely information on hospital performance with hospitals and the public.

However, the AHA does not believe these potential benefits outweigh the significant financial and reputational harms these changes could do to hospitals. Specifically, we are concerned that by including MA patients in calculating readmissions penalties, CMS effectively would be holding hospitals accountable for excessive and inappropriate coverage delays and denials on the part of MA plans. In addition, CMS' proposed approach to calculating payment penalties lacks clarity and transparency. For these reasons, the AHA urges CMS not to adopt its proposal to include MA patients in calculating HRRP measure performance and payment penalty amounts.

Timely access to post-acute care is often a key determinant in ensuring patients do not need to return to the hospital. Hospitals and post-acute care providers have collaborated on many strategies to reduce readmissions, including optimizing discharge instructions, virtual visits from hospitals to post-acute facilities to discuss strategies for proactively managing higher complexity patients and remote patient monitoring approaches.[29] To realize the benefits of these innovations, a patient for whom post-acute care is indicated should receive it as quickly as possible when they leave the hospital.

Unfortunately, as has been well documented by providers as well as by the Department of Health and Human Services Office of Inspector General and congressional investigations, MA plans often place restrictions on post-acute care.[30] The prior authorization process used by MA plans places a significant administrative burden on both acute-care hospitals and post-acute care providers. Perhaps more importantly, it is directly harmful to Medicare

[29] Examples of innovative work in this space were recently covered in Modern Healthcare. See Diane Eastabrook, "How provider collaborations are cutting hospital readmissions." *Modern Healthcare.* May 30, 2025.

[30] https://www.hsgac.senate.gov/wp-content/uploads/2024.10.17-PSI-Majority-Staff-Report-on-MedicareAdvantage.pdf

beneficiaries — at best delaying their care and at worst outright denying medically necessary treatment. Despite important steps taken by CMS in recent years to strengthen the oversight of MA plans' use of prior authorizations, providers have seen little meaningful change in MA plan behavior and no increased access for beneficiaries. Additionally, post-acute care providers still face challenges with MA plans listing them within their networks.

For these reasons, we are concerned that those hospitals that care for larger proportions of MA patients could perform worse in the HRRP because of decisions by the MA plan to deny needed care, and not because of the quality of care hospitals deliver. This situation could be especially problematic given that there remains variation in MA participation nationally. While it is true that in 2024, MA covered approximately 50% of Medicare beneficiaries, 21 states and the District of Columbia had MA rates under 50%, and 14 states had enrollment rates under 40%.[31] For a pay-for-performance program like the HRRP to work fairly, hospitals must be assured that the performance to which their payment is tied is truly their own, and not disproportionately influenced by factors beyond their control.

Indeed, the limited data provided by CMS in the proposed rule would seem to bear out the AHA's concern that the inclusion of MA could serve to worsen hospital performance and increase penalties. The agency estimates that the proportion of hospitals receiving the readmissions penalty would increase from 82% to 84%, and that aggregate penalties would increase from $316 million to $361 million in FY 2027. In addition, the updated technical specifications for the six readmission measures show that readmission performance is much more likely to change as the proportion of MA patients hospitals treat increases. Table 2 below clearly shows that significant proportions of hospitals would experience changes in the readmission performance stemming from the inclusion of MA patients. On each measure, approximately half or more of hospitals would experience a change in their readmission performance quintile. For example, 56% of hospitals would change performance quintiles on the COPD readmissions measure. Furthermore, hospitals appear to be even more likely to change performance if they treat higher proportions of MA patients. For example, for hospitals with the highest percentages of MA admissions, 69.3% would see a change in their HF readmission rate, and 68% would see a change in their COPD readmission rate.

Table 2: Percentages of Hospitals That Would Shift Readmissions Measure Performance Quintiles

	AMI	HF	PN	COPD	THA/TKA	CABG
Overall	52.5	54.4	50	56	47.7	53
By MA Admission Percentage						
0-34.4%	43.3	37.8	35.1	46.9	27	41.3

[31] See https://www.kff.org/medicare/issue-brief/medicare-advantage-in-2024-enrollment-update-and-key-trends/

34.4%-44.0%	46.5	52.2	47.7	47.9	43.6	53.6
44.0%-51.0%	54.3	56	51.3	57.8	54.6	56.4
51.8%-59.9%	60.4	56.4	55.9	59.2	50.2	59.1
60.0%+	58.1	69.3	59.9	68.1	63.2	54.5

Adapted from CMS 2024 Condition- and Procedure-Specific Readmission Measures Supplemental Methodology Report, Tables 4.1.8, 4.2.8, 4.3.8, 4.4.8, 4.5.8, 4.6.8

The AHA's ability to fully assess the impact of CMS' proposed changes also is limited by a lack of sufficient data provided by CMS to replicate their analyses, and confusing terms used to describe the methodology changes. To replicate CMS' impact estimates, hospitals would need access to MA encounter data that CMS does not provide in the proposed rule. Furthermore, to calculate a combined rate, CMS would blend the MA encounter file that plans report with hospital-submitted information only claims. We note that some hospital types — especially those that receive DSH payments or graduate medical education payments — are required to submit information-only claims. This could have the effect of skewing which hospitals will have the most MA beneficiaries attributed to them. CMS' own impact analysis in the proposed rule seems to suggest that both teaching hospitals and DSH hospitals would experience increases in the readmissions penalties when MA patients are included.

Notwithstanding the incomplete data CMS provided in the proposed rule, the AHA worked with the firm McDermott, Will & Emery (M+) to simulate some of the potential impacts of CMS' changes. **The results of this analysis confirm our concern that adding MA patients generally serves to increase payment penalties, even when hospitals' underlying performance does not change.** This is likely due to the design of the readmissions penalty formula.

The HRRP is intended to calculate CMS' "aggregate payments" for "excess readmissions," and the resulting payment penalty is capped at 3% of base inpatient PPS payments. To calculate the payment penalty, CMS first calculates risk-adjusted excess readmission ratios (ERR) for each of the six measures in the program for which hospitals have enough data to be scored. CMS then multiples the ERRs by DRG ratios that represent the fraction of total base operating DRG payments each of the six clinical areas comprises.[32]

The M+ analysis used the ERRs, hospital characteristics and neutrality multipliers from the FY 2025 inpatient PPS final rule supplemental readmissions data table, along with MA "shadow claims" from MedPAR in FYs 2021-2023 to recreate the DRG payment ratios.[33] The lack of data from CMS meant that M+ could not recalculate

[32] CMS also uses a statutorily required "neutrality modifier" reflecting the use of peer grouping by dual-eligible status. The neutrality modifier ensures that CMS does not penalize hospitals more than if the peer groups did not exist.

[33] These shadow claims were also compared to hospital cost report data (specifically, Worksheet S-3, Part 1, Column 12, Line 2, "Enter the title XVIII Medicare Advantage (MA) discharges"). The overall match in MA

risk-adjusted ERRs to reflect CMS' inclusion of MA patients or CMS' proposed risk adjustment changes. However, their analysis allowed for isolating the impact of changing one key aspect of the methodology — the DRG ratios. The M+ analysis modeled two key scenarios. Scenario 1 uses FY 2025 ERRs, a three-year performance period, but adds MA patients to the calculation of DRG ratios. Scenario 2 also keeps the ERRs at FY 2025 levels, but consistent with CMS' proposed changes, reduces the performance period used to calculate the DRG ratios from three years to two years.

In both scenarios, simply including MA patients in the DRG ratios calculation increases readmissions penalties. Scenario 1 increased HRRP penalties by $41 million, while Scenario 2 increased penalties by $46 million compared to using FFS only data (Table 3 below). These increases largely stem from increasing the penalties to those hospitals that would have otherwise been penalized using FFS data only. In Scenario 1, $40.6 million of the $41 million increase in penalties comes from hospitals already receiving a penalty using FFS data only.

Table 3: M+ Analysis of Impact of Including MA Patients in HRRP Penalty Calculations

		M+ Model	CMS
Baseline — FFS Only	Number of HRRP Eligible Hospitals	2,858	2,828
	Number of Penalized Hospitals	2,400	2,342
	Penalty as % of Base Operating Payments	0.45%	0.42%
	Aggregate Penalty Amount	$329,431,356	$316,131,336
Scenario 1 — MA+FFS DRG Ratios, 3-year Performance Period	Number of HRRP Eligible Hospitals	2,893	2,868
	Number of Penalized Hospitals	2,491	2,417
	Penalty as % of Base Operating Payments	0.49%	0.46%
	Aggregate Penalty Amount	$370,410,789	$357,264,092
Scenario 2 — MA+FFS DRG Ratios, 2-year	Number of HRRP Eligible Hospitals	2,854	2,868
	Number of Penalized Hospitals	2,410	2,417

claim counts was very close — 100% in FY 2021 and 96% in FYs 2022 and 2023. In addition, 85% of hospitals in the shadow claims files had MA case counts within 10% of what was recorded in the cost report.

Performance Period	Penalty as % of Base Operating Payments	0.50%	0.46%
	Aggregate Penalty Amount	$375,446,551	$357,264,092

The AHA believes that including MA patients in the DRG ratio calculation has the effect of broadening the potential penalty base. Put in the context of the HRRP payment penalty calculation, the fraction of base operating payments covered by the six readmissions conditions increases when a larger number of patients are included in it. As a result, the payment estimates for excess readmissions also goes up.

However, the AHA believes the inclusion of MA patients in the DRG ratio is inconsistent with the broader design of the HRRP. Indeed, the HRRP expressly applies penalties as a percentage of base operating payments under the inpatient PPS. Indeed, the calculation of aggregate payments called for in regulation and statute uses base operating DRG payments. Yet, by including MA plans in the DRG ratio, CMS is also effectively assuming there is nothing different about MA from traditional Medicare. Hospitals are paid differently under such plans, and as described above, MA also behave differently by restricting access to post-acute care. **If CMS is intent on including MA patients, we recommend the agency calculate DRG ratios using FFS data only and include MA patients only in calculating measure performance (i.e., in the determination of ERRs).**

Certainly, the AHA continues to recognize the potential value of measures that could more fully reflect performance among the Medicare population. However, unless and until more is done to rein in MA plans' unreasonable denials of post-acute care, and CMS can provide greater transparency, we believe it would be inappropriate and counterproductive to include MA patients in calculating readmissions performance.

Other Readmission Measure Changes. Similar to proposals in its other hospital quality reporting and value programs, CMS proposes to remove the COVID-19 exclusions. CMS would also modify the risk adjustment methodology for all six measures to use ICD-10 codes instead of HCCs. **The AHA supports these proposals.**

RFI: DIGITAL QUALITY MEASUREMENT

In the proposed rule, CMS seeks feedback on ways to continue advancing the adoption of digital quality measures (dQMs) that maximize the use of EHR-based data. The agency states it intends to begin converting its existing eCQMs to use Health Level 7 Fast Healthcare Interoperability Resources (FHIR) standards. The agency asks for input on a wide range of questions, including the pace of conversion and adoption into programs.

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 is more flexible than many other available frameworks. At the same time, transitioning to only FHIR-based dQMs in CMS quality measurement programs will prove to be a staggeringly complex task. As CMS has correctly surmised in the proposed rule, some eCQMs will be more complex to convert into FHIR-based dQMs than others. It is difficult to predict how long such a conversion might take or whether it will be feasible for all eCQMs.

As CMS continues its digital quality measurement work, the AHA offers several overarching recommendations. **First, while FHIR-based reporting holds promise, CMS' overarching goal for its quality measurement programs should remain as measuring the highest priority opportunities to improve care.** In other words, CMS' pursuit of adopting particular reporting standards should not come at the expense of ensuring the measures are a meaningful reflection of quality and provide usable information to hospitals to improve care.

Second, we urge CMS not to set an arbitrary date for converting all existing eCQMs into FHIR-based dQMs. As noted above, we do not expect that every eCQM will be as ready to convert to FHIR-based standards as others. The pace of conversion should be based on the results of field testing and feasibility studies rather than an arbitrary deadline.

Lastly, we support CMS' concept of allowing for transitional reporting options as it brings FHIR-based dQMs into the program. At the same time, this approach could introduce some complexity into publicly reporting rates. As we understand it, CMS would allow for up to two years of reporting using either existing eCQM reporting standards or new FHIR-based standards to give hospitals the chance to test FHIR-based standards before being required to use them to submit data. We appreciate CMS' sensitivity to the need for ramp-up time for hospitals. Indeed, we would expect that hospitals may need to implement workflow changes and EHR system upgrades to accommodate FHIR-based reporting, both of which take time and resources. However, we encourage CMS to assess the extent to which the availability of two sets of reporting standards for a single measure could introduce variation into measure performance rates. To the extent that variation is large, the agency may need to consider peer grouping approaches for public reporting — one for traditional eCQMs and the other for FHIR-based standards — to ensure that hospitals are being compared fairly. This issue could be especially important for applications such as Hospital Star Ratings or any pay-for-performance programs.

RFI: REGULATORY RELIEF

On Jan. 31, 2025, President Trump issued Executive Order 14192, "Unleashing Prosperity Through Deregulation," which states the administration's policy to significantly reduce the private expenditures required to comply with federal regulations. Accordingly, CMS is soliciting public input on approaches and opportunities to streamline regulations and

reduce administrative burdens on providers, suppliers, beneficiaries and other interested parties participating in the Medicare program. The agency has made available an RFI at https://www.cms.gov/medicare-regulatory-relief-rfi.

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

The 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's attention to a previous set of deregulation requests that we have provided to the administration. These actions include, for example:

- Making all Center for Medicare and Medicaid models voluntary, specifically the Transforming Episode Accountability Model, and repealing the mandatory Increasing Organ Transplant Access Model and Inpatient Rehabilitation Facility Review Choice Demonstration.
- Standardizing more insurance-related administrative transactions, starting with operationalizing the Interoperability and Prior Authorization Final Rule to establish standard electronic prior authorization processes in MA, the Health Insurance Marketplaces and Medicaid.
- Repealing outdated COVID-19 reporting mandates.
- Replacing the sepsis bundle measure with a measure of sepsis outcomes.
- Eliminating duplicative "look back" validation surveys of accrediting organizations and permanently adopting concurrent validation surveys.
- Resuming conducting low-risk complaint surveys virtually.
- Removing telehealth originating site restrictions within the Medicare program to enable patients to receive telehealth in their homes.
- Removing telehealth geographic site restrictions within the Medicare program to enable beneficiaries in non-rural areas to have the same access to virtual care as those in rural areas.
- Removing the in-person visit requirements for behavioral health telehealth, which are unnecessary, adds a barrier to access and creates a disparity between physical and mental health services.
- Removing requirements that require hospice recertification to be completed in person to allow for hospice recertification to be completed via telehealth.
- Streamlining care plan documentation requirements.

- Eliminating the telehealth physician home address reporting requirement, which is currently under waiver.
- Eliminating certain nurse practitioner and other advanced practice practitioner limitations.
- Removing requirements that outpatient physical therapy plans of care be signed off by a physician or non-physician practitioner every 90 days.

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]

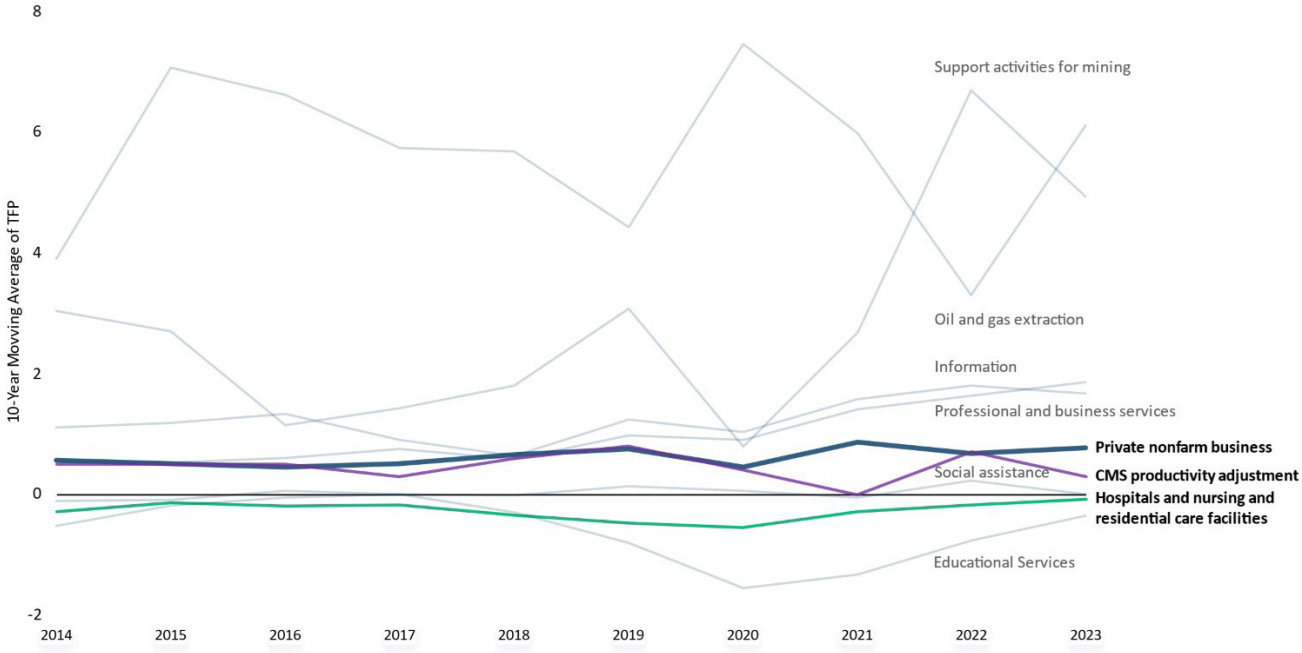
Hospitals encounter substantial regulatory requirements unique to the healthcare sector. Hospitals must then bear the cost to maintain compliance with these regulations. Government-set reimbursement rates have not kept pace with inflation, covering only 83 cents for every dollar hospitals spent in 2023.[10]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