



Charles N. Kahn III
President and CEO

June 9, 2025

Via electronic submission at <http://www.regulations.gov>

The Honorable Mehmet Oz, MD
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Hubert H. Humphrey Building
200 Independence Avenue SW
Washington, DC 20201

RE: Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long Term Care Hospital Prospective Payment System and Policy Changes and Fiscal Year 2026 Rates; Requirements for Quality Programs; and Other Policy Changes (CMS-1833-P)

Dear Dr. Oz:

The Federation of American Hospitals (FAH) is the national representative of more than 1,000 leading tax-paying hospitals and health systems throughout the United States. FAH members provide patients and communities with access to high-quality, affordable care in both urban and rural areas across 46 states, plus Washington, DC and Puerto Rico. Our members include teaching, acute, inpatient rehabilitation, behavioral health, and long-term care hospitals and provide a wide range of inpatient, ambulatory, post-acute, emergency, childrens', and cancer services.

The FAH appreciates the opportunity to submit comments to Centers for Medicare & Medicaid Services (CMS) about the above-referenced Proposed Rule for the IPPS and LTCH-PPS, published in the Federal Register (90 Fed. Reg. 18002) on April 30, 2025. This letter will detail the FAH's comments on the IPPS, LTCH-PPS, Transforming Episode Accountability Model (TEAM) and quality reporting and value-based payment programs and related requests for information. The FAH will submit a separate letter outlining our response to the CMS request for information on deregulation, specifically addressing the questions outlined in the Executive Order issued on January 31, 2025, entitled "Unleashing Prosperity Through Deregulation."

EXECUTIVE SUMMARY

IPPS Market Basket Update

The FAH requests CMS adopt a one-time forecast error adjustment to the FY 2026 IPPS operating update based on the forecast shortfalls in the hospital market basket in FY 2021 through FY 2024. We also note that CMS itself acknowledges that the total factor productivity adjustment applied to the update is more than hospitals can realize.

The market basket is intended to capture inflationary changes in labor and other costs that a hospital will encounter on a year-by-year basis when updating payment rates. As has been clear from the FY 2021 through FY 2024 data, the market basket forecast significantly understated the actual increase in hospital costs by a combined 4.6 percentage points due to an unprecedented confluence of circumstances during the COVID-19 PHE. **The FAH requests that, in recognition of this unique and extraordinary situation, CMS apply a positive adjustment of 4.6 percentage points to the IPPS update taking into account the combined forecast error previously not adjusted for the years FY 2021 through FY 2024. If CMS were to adopt the FAH's recommendation, the update would be the market basket of 3.2 percent plus 4.6 percentage points for forecast error correction less 0.8 percentage points for productivity or a net 7.0 percent.**

In addition, the FAH maintains that the standardized amount improperly continues the adjustments adopted under section 7(b)(1)(B) of Pub. L. No. 110-90. The FAH strongly urges CMS to eliminate this error for FY 2026 with a positive 0.9412% adjustment.

Disproportionate Share Hospital Payments

In recent years, the FAH has expressed significant concerns with declining uncompensated care (UC-DSH) payments. From FY 2023 to FY 2025, UC-DSH payments declined by over \$1.1 billion despite a growing uninsured rate. For FY 2026, however, CMS proposes reversing this trend of declining UC-DSH payments, reflecting the estimated growth in empirically justified Medicare DSH and the increasing uninsured rate. **The FAH strongly supports these UC-DSH estimates as consistent with hospitals' current expectations for FY 2026 and urges CMS to finalize these estimates with any upward adjustments as appropriate based on other policy developments that may increase the number of uninsured before the rule is finalized.**

In addition, the FAH is concerned that pending regulatory and legislative proposals may increase the uninsured rate and the associated Factor 2 calculation for FY 2026. For example, CMS estimated that the March 19, 2025 Marketplace Integrity and Affordability proposed rule would reduce enrollment during calendar year 2026 by between 750,000 to 2 million.¹ Likewise, pending reconciliation legislation is expected to increase the uninsured rate significantly. **These proposed regulatory and legislative changes became likely after the NHEA projections**

¹ 90 Fed. Reg.13,032, 13025 tbl. 16-17 (March 19, 2025).

were certified by OACT for this proposed rule, and the FAH strongly urges CMS and the OACT to broaden their data sources to more fully reflect current estimates of the uninsured rate in FY 2026 in light of proposed regulatory and legislative changes including shifting market conditions.

Finally, the FAH is concerned that the per-discharge amount of interim UC-DSH payments continues to be understated due to the impact of older data that overestimates discharges in the coming fiscal year. Therefore, **the FAH opposes the proposed use of the three-year average discharge volume to calculate interim UC-DSH payments and urges CMS to instead reasonably project discharges for purposes of calculating interim UC-DSH payments.**

Transforming Episode Accountability Model (TEAM)

CMS proposes to proceed with national, mandatory testing of the Transforming Episode Accountability Model (TEAM). The FAH continues to strongly oppose mandatory provider participation in any Centers for Medicare and Medicaid Innovation (CMMI) testing. The FAH has repeatedly expressed significant legal and policy concerns with mandatory CMMI models and has urged HHS to ensure that CMMI acts only within its designated authority to test voluntary alternative payment models.

LTCH Market Basket Update

Similar to the IPPS market basket, data for LTCHs show that CMS has understated the LTCH market basket by a combined 4.3 percentage points for FY 2021 – FY 2024. **The FAH requests that CMS also provide for a forecast error adjustment for the combined understatement of the FY 2021 through FY 2024 LTCH market baskets when updating the FY 2025 LTCH rates. Adopting this one-time forecast error adjustment to address the exception and unprecedented circumstances surrounding the COVID-19 PHE would make the LTCH PPS update equal to 3.4 percent plus 4.3 percentage points for forecast error less 0.8 percentage points for total factor productivity or a net 6.9 percent.**

LTCH High-Cost Outliers

CMS did not propose any policy changes or temporary adjustments to its methodology for setting the LTCH high-cost outlier (HCO) fixed-loss amount. **The FAH urges CMS not to finalize the proposed HCO fixed-loss amount of \$91,247 because it will further destabilize the LTCH PPS and harm Medicare beneficiaries, LTCHs, and hospitals that refer patients to LTCHs.** Rather, CMS should return to the market basket-based charge inflation factor methodology that CMS historically used to determine the LTCH PPS fixed-loss amount.

If CMS does not return to the market basket-based charge inflation factor methodology recommended above, the FAH requests that CMS adopt the two-year transition approach it considered for FY 2025 to mitigate the substantial increase in the HCO fixed loss threshold. This approach will support LTCHs and ensure that such a significant

increase does not accelerate financial strain on LTCHs – ensuring access to Medicare beneficiaries that need access to long term acute care hospital services.

Quality Reporting

The FAH continues to strongly oppose the mandatory implementation of the Total Hip Arthroplasty/Total Knee Arthroplasty (THA/TKA) Patient-Reported Outcome-Based Performance Measure (PRO-PM) as finalized for the FY 2026 payment determination. CMS has proceeded with requiring hospitals to collect resource-intensive, pre- and post-operative patient-reported data under a timeline and methodology that are misaligned with the realities of clinical operations. Hospitals face persistent challenges in capturing baseline responses before surgery, engaging patients post-discharge, and navigating survey submission requirements amid staffing and platform constraints. The rigid 50% response rate is especially burdensome to hospitals, particularly small, rural, and low-volume hospitals and fails to adjust for differences in surgical care settings and patient follow-up capacity. **The FAH urges CMS to rescind any associated penalties for FY 2026 and develop a more flexible, risk-adjusted approach that reflects diverse hospital structures and workflows.**

In parallel, CMS' proposals to integrate Medicare Advantage (MA) beneficiary data into all Hospital Readmissions Reduction Program (HRRP) measures, shift the risk adjustment model from Hierarchical Condition Categories (HCCs) to individual ICD-10 codes, and reduce the HRRP performance period from three years to two represent a sweeping and untested redesign of foundational quality programs. These changes would significantly alter hospital penalty exposure without adequate transparency, impact modeling, or data reliability safeguards. Integrating data from MA plans, which operate under an upside-only Star Ratings framework and often apply their own readmission denial practices, into a punitive, provider-facing program like HRRP is methodologically unsound and creates inequitable accountability. Further, CMS' reliance on MA encounter data, often incomplete or manipulated through downstream vendors, raises serious concerns about the validity of resulting performance scores. Simultaneously implementing a shift in risk adjustment methodology and a shortened performance window only magnifies data volatility and confusion.

For these reasons, **the FAH does not support the mandatory reporting of the THA/TKA PRO-PM and strongly opposes the proposed HRRP changes, including the addition of MA data to any measures in HRRP or HVBP, the replacement of HCC-based risk adjustment with ICD-10 codes, and the reduction of the performance period to two years.** These proposals, individually and collectively, represent a rush toward overhauling key Medicare quality programs without adequate attention to operational feasibility, efficiency, or program alignment. The FAH urges CMS to provide transparent impact data and pursue a phased approach that protects the integrity of hospital performance measurement and supports continued quality improvement.

* * *

The FAH appreciates the opportunity to offer comments on the FY 2026 IPPS and LTCH-PPS Proposed Rule. Our detailed comments are included in the following pages in Appendix A of our letter and further supported by a WPA Report attached as Appendix B and an

FTI Report attached as Appendix C. If you have any questions or would like to discuss further, please do not hesitate to contact me or a member of my staff at (202) 624-1500.

Sincerely,

A handwritten signature in black ink, appearing to read "A. M. ...". The signature is fluid and cursive, with a large initial letter and a long, sweeping tail.

APPENDIX A:
FAH Detailed Comments on FY 2026 IPPS/LTCH PPS Proposed Rule (CMS-1833-P)

MS-DRG Classifications and Relative Weights

II.C. Proposed Changes to Specific MS-DRG Classifications

The FAH generally supports the proposed changes recommended for MS-DRG and/or ICD-10 code classification changes for FY 2026 except for the items to follow.

II.C.1.b Basis for Proposed FY2026 MS-DRG Updates

For FY 2026, CMS provided a test version of ICD-10 MS-DRG GROUPER Software, Version 43 along with conversion files to assist with analysis. The FAH appreciates the public availability of the V43 draft GROUPER. The FAH, however, encountered inconsistencies when grouping two of the new MS-DRGs (MS-DRG 403 and 404) using the V43 draft GROUPER, which is further detailed in the comments on Part II.C.5 of the Proposed Rule, below.

In addition, without a Batch x/OS version of the Grouper, we were unable to undertake a broader and more meaningful analysis of larger batches of data to determine whether these inconsistencies were confined to these two new MS-DRGs or identify any other areas of inconsistency with the GROUPER in a timely manner. Although this grouper appears to allow for a case-by-case analysis and a minimal batch analysis, it does not allow providers the opportunity to assess a large batch analysis. It would be more beneficial to have a Batch z/OS version of the test grouper. The FAH therefore requests that CMS make public a Batch z/OS version of the test GROUPER for all future rulemaking.

II.C.3. MDC 01 (Disease and Disorders of the Nervous System)

II.C.3.b. Hypertensive Encephalopathy

CMS proposes to delete MS-DRGs 077, 078, and 079 (Hypertensive Encephalopathy with MCC, with CC, and without CC/MCC, respectively) based on CMS' data analysis that 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.

Additionally, CMS proposes reassigning ICD-10-CM code I67.4 to MS-DRGs 070, 071, and 072, and changing the title of these MS-DRGs to "Other Cerebrovascular Disorders with MCC, with CC, and without CC/MCC, respectively." The FAH agrees with the proposal to delete MS-DRGs 77, 78, 79 as well as the reassignment of the code I67.4 to MS-DRGs 070, 071 and 072 with revisions in titles based on the declining volume.

The Proposed Rule also sets forth CMS' review of the ICD-10-CM Tabular List of Diseases and Injuries, including a new instructional note diagnosis code I16.1, effective for FY 2025. Because the FY2025 instruction note is not included in the FY 2024 data, we question the discussion and interpretation of the instructional notes in the Proposed Rule. The FAH believes

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data analytics should be performed based on the coding guidelines/instructional notes that were relevant for the timeframe of the data analysis.

II.C.4. MDC 05 (Diseases and Disorders of the Circulatory System)

II.C.4.a Endovascular Aneurysm Repair (EVAR) with Iliac Branch Procedures

For FY 2026, CMS has proposed to create new base MS-DRG 213 (Endovascular Abdominal Aorta and Iliac Branch Procedures). In the Proposed Rule, CMS reports the outcome of its review and concludes as follows:

The findings suggest that the cases reporting EVAR using [abdominal aortic aneurysm (AAA)] endoprosthesis with an [iliac branch endoprosthesis (IBE)] utilize greater resources compared to the cases reporting standard EVAR using an AAA endoprosthesis. We agree that the patients who had aortoiliac and iliac aneurysms are more complex population to treat, contributing to increased resource utilization.

Based on our review and analysis of the cases reporting standard EVAR using an AAA endoprosthesis compared to the cases reporting EVAR using an AAA endoprosthesis with an IBE to treat aortoiliac and iliac artery aneurysms in MS-DRGs 268 and 269, we believe new MS-DRGs are warranted to differentiate the utilization of resources between standard EVAR to treat AAA and EVAR to treat AAA extending into the iliac artery.

Table 5 of the Proposed Rule sets forth the following proposed weights for the three MS-DRGs for FY 2026:

MS-DRG	MS-DRG Title	Weights	Weights - 10% Cap Applied	Geometric mean LOS	Arithmetic mean LOS
213	ENDOASCULAR ABDOMINAL AORTA WITH ILIAC BRANCH PROCEDURES	5.7834	5.7834	1.7	2.9
268	AORTIC AND HEART ASSIST PROCEDURES EXCEPT PULSATION BALLOON WITH MCC	6.9027	6.9027	6.0	9.1
269	AORTIC AND HEART ASSIST PROCEDURES EXCEPT PULSATION BALLOON WITHOUT MCC	4.2850	4.2850	1.5	2.0

The FAH supports the creation of new MS-DRG 213 and agrees with the analysis that there is more complexity and resources associated with cases reporting EVAR using an AAA endoprosthesis with an IBE as compared to those without an IBE. With the understanding that CMS recognizes the additional resource utilization, the FAH requests additional information as to why the weight for the new MS-DRG is lower than the weight for MS-DRG 268. With this proposal, cases that have been recognized as more complex with increased resource utilization will receive a lower relative weight with proposed MS-DRG 213 (proposed weight of 5.7834) as

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compared to those EVAR cases that will continue to be assigned to MS-DRG 268 (proposed weight of 6.9027), even when the same major complication or comorbidity is present.

II.C.5. MDC 08 Diseases and Disorders of the Musculoskeletal System and Connective Tissue

II.C.5.a. Hip or Knee Procedures with Periprosthetic Joint Infection (PJI)

CMS received a request to reassign cases reporting a hip or knee procedure with a principal diagnosis of periprosthetic joint infection (PJI) from the lower severity level “without CC/MCC” MS-DRGs to higher severity level “with CC” MS-DRG when there is no other major complication or comorbidity (MCC) or complication or comorbidity (CC) reported.

CMS analyzed data for cases reporting a principal diagnosis of PJI with a hip or knee procedure. The list of diagnosis codes analyzed to identify a PJI is reported in Table 6P.6a of the proposed rule and as follows:

ICD-10-CM-Diagnosis Code	Description
T84.51XA	Infection and inflammatory reaction due to internal right hip prosthesis, initial encounter
T84.52XA	Infection and inflammatory reaction due to internal left hip prosthesis, initial encounter
T84.53XA	Infection and inflammatory reaction due to internal right knee prosthesis, initial encounter
T84.54XA	Infection and inflammatory reaction due to internal right knee prosthesis, initial encounter

The analysis included MS-DRGs 463, 464, 465, 466, 467, 468, 474, 475, 476, 480, 481, 482, 485, 486, and 487, and CMS’ findings are noted in the following table:

MS-DRG	Description	Number of cases	Average length of stay	Average costs
463	All cases	3,909	14.2	\$45,233
	Cases with principal diagnosis of PJI with hip or knee procedure	804	13.9	\$50,127
464	All cases	5,775	7.3	\$26,757
	Cases with principal diagnosis of PJI with hip or knee procedure	1,358	7.7	\$32,474
465	All cases	1,496	3.0	\$16,794
	Cases with principal diagnosis of PJI with hip or knee procedure	237	4.3	\$22,689
466	All cases	4,282	9.0	\$43,314
	Cases with principal diagnosis of PJI with hip or knee procedure	460	11.2	\$40,433
467	All cases	17,682	4.1	\$30,612
	Cases with principal diagnosis of PJI with hip or knee procedure	947	6.5	\$28,505
468	All cases	12,986	1.8	\$24,921
	Cases with principal diagnosis of PJI with hip or knee procedure	160	4	\$23,978
474	All cases	2,417	12.2	\$35,707

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MS-DRG	Description	Number of cases	Average length of stay	Average costs
	Cases with principal diagnosis of PJI with hip or knee procedure	112	13.6	\$47,240
475	All cases	2,634	7.3	\$19,577
	Cases with principal diagnosis of PJI with hip or knee procedure	166	7	\$20,739
476	All cases	322	3.5	\$10,454
	Cases with principal diagnosis of PJI with hip or knee procedure	27	4.1	\$14,101
480	All cases	26,238	7.3	\$26,430
	Cases with principal diagnosis of PJI with hip or knee procedure	136	11.7	\$38,407
481	All cases	62,141	4.9	\$19,153
	Cases with principal diagnosis of PJI with hip or knee procedure	234	7.4	\$24,138
482	All cases	13,842	3.5	\$14,886
	Cases with principal diagnosis of PJI with hip or knee procedure	30	4.6	\$19,122
485	All cases	1,297	9.5	\$29,761
	Cases with principal diagnosis of PJI with hip or knee procedure	521	9.6	\$31,779
486	All cases	2,574	6.0	\$19,679
	Cases with principal diagnosis of PJI with hip or knee procedure	985	5.8	\$21,376
487	All cases	632	4.1	\$14,615
	Cases with principal diagnosis of PJI with hip or knee procedure	194	4	\$16,616

CMS noted that the findings reporting “PJI with a hip or knee procedure in MS-DRGs 466, 467, and 468 have a slightly longer average length of stay and lower average costs compared to the average length of stay and average costs of all the cases in their respective MS-DRGs. Therefore, because the resource utilization of these cases is generally comparable to all the cases in their respective MS-DRGs, we believe the cases reporting a PJI in MS-DRGs 466, 467, 468 appear to be grouping appropriately in their current MS-DRG assignment.” *The FAH notes that the sum of cases included within MS-DRGs 466 (460 cases), 467 (947 cases), 468 (160 cases) provided by CMS was 1,567 cases.*

Based on this analysis, CMS proposes to create new MS-DRGs for cases reporting PJI with a hip or knee procedure in MS-DRGs 463, 464, 465, 474, 476, 480, 481 and 482. CMS indicates that MS-DRGs 466, 467, 468, 485, 486, and 487 were not included in the shifting cases based on the analysis of average length of stay and charges. As a result of the analysis, new MS-DRGs 403 and 404 (Hip or Knee procedures with Principal Diagnosis of Periprosthetic Joint Infection with MCC and without MCC, respectively) are proposed for FY 2026.

The FAH reviewed CMS’ analysis reported in the Proposed Rule and the accompanying AOR/BOR File that shows the MS-DRG shifts between the V42.1 GROUPER and V43 draft GROUPER and also reviewed the differences in case volume between the MS-DRGs that were analyzed for the new MS-DRGs 403 and 404. This is a multiple page report that has been summarized in a single, condensed table below. It was challenging to understand the rationale for some of the MS-DRG volume shifts when comparing this report of outcomes with the Proposed Rule. The data reflected the declining volume in MS-DRGs 463, 464, 465, 474, 475, 476, 480, 481, and 482 as CMS outlined in the review as they are now within MS-DRGs 403 and 404. CMS analysis excluded MS-DRGs 485, 486, and 487 and these also reflected as CMS

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outlined in the rule with zero cases shifting. However, the AOR/BOR File still shows declines for MS-DRGs 466 (-243 cases), 467 (-406 cases), 468 (-48 cases) which total to -699 cases. As noted, CMS excluded MS-DRGs 466, 467, and 468 as they felt they were appropriately grouping in their current MS-DRG assignment within the proposed rule.

The FAH reviewed the list of procedures included within 6P.6a for the new MS-DRGs 403 and 404 as well as the list of procedures included in the V43 DRG Definition Manual for MS-DRGs 466, 467, and 468 and noted overlap of approximately 52 procedure codes. For example, procedure code 0SRB0EZ is included in both lists. The FAH recognizes that logically the surgical hierarchy would result in the MS-DRG 403 or 404 being assigned over MS-DRGs 466 through 468. The FAH is concerned that over 699 of the 1,567 cases within these three MS-DRGs will shift into the new MS-DRG and that this shift is neither acknowledged nor explained in the Proposed Rule. The Proposed Rule specifically outlines that cases in MS-DRGs 466 through 468 are appropriately grouped; however more than 44% of them will be reassigned to MS-DRGs 403 or 404. The FAH believes these shifts should have been included within the Proposed Rule and explained for data transparency. The lack of detail in the Proposed Rule makes it unclear if the cases shifted because of the code overlap or because of an opportunity with the V43 draft GROUPER.

The FAH requests an explanation with the data for why there is a decline in these three MS-DRGs within this report. As it appears that the V43 grouper and this report, does not reflect what is outlined in the Proposed Rule for which MS-DRGs with procedure and diagnoses from 6P.6a will shift into new MS-DRGs 403 and 404.

V42 DRG	V42 Weig	V43 DRGs	V43 DRGs Desc	V43 Weigh	CMS Data V42 10/1/23 - 9/30/24	CMS V43 Data 10/1/23 - 9/30/24	Difference in Cases V43-4
		403	HIP OR KNEE PROCEDURES WITH PRINCIPAL DIAGNOSIS OF PERIPROSTHETIC JOINT INFECTION WITH MCC	5.7946		1250	
		404	HIP OR KNEE PROCEDURES WITH PRINCIPAL DIAGNOSIS OF PERIPROSTHETIC JOINT INFECTION WITHOUT MCC	3.1898		2397	
463	5.401	463	WOUND DEBRIDEMENT AND SKIN GRAFT EXCEPT HAND FOR MUSCULOSKELETAL AND CONNECTIVE TISSUE DISOR	5.1998	4211	3477	-734
464	2.9486	464	WOUND DEBRIDEMENT AND SKIN GRAFT EXCEPT HAND FOR MUSCULOSKELETAL AND CONNECTIVE TISSUE DISOR	2.9052	6156	4952	-1204
465	1.7361	465	WOUND DEBRIDEMENT AND SKIN GRAFT EXCEPT HAND FOR MUSCULOSKELETAL AND CONNECTIVE TISSUE DISOR	1.7301	1580	1355	-225
466	5.0946	466	REVISION OF HIP OR KNEE REPLACEMENT WITH MCC	5.1427	4574	4331	-243
467	3.4252	467	REVISION OF HIP OR KNEE REPLACEMENT WITH CC	3.5342	18959	18553	-406
468	2.6233	468	REVISION OF HIP OR KNEE REPLACEMENT WITHOUT CC/MCC	2.7811	13789	13741	-48
474	4.4847	474	AMPUTATION FOR MUSCULOSKELETAL SYSTEM AND CONNECTIVE TISSUE DISORDERS WITH MCC	4.2234	2606	2491	-115
475	2.1573	475	AMPUTATION FOR MUSCULOSKELETAL SYSTEM AND CONNECTIVE TISSUE DISORDERS WITH CC	2.2474	2834	2655	-179
476	1.1631	476	AMPUTATION FOR MUSCULOSKELETAL SYSTEM AND CONNECTIVE TISSUE DISORDERS WITHOUT CC/MCC	1.1412	347	319	-28
480	2.941	480	HIP AND FEMUR PROCEDURES EXCEPT MAJOR JOINT WITH MCC	2.9622	27820	27678	-142
481	2.0749	481	HIP AND FEMUR PROCEDURES EXCEPT MAJOR JOINT WITH CC	2.1196	65807	65556	-251
482	1.5864	482	HIP AND FEMUR PROCEDURES EXCEPT MAJOR JOINT WITHOUT CC/MCC	1.6368	14643	14612	-31
485	3.2193	485	KNEE PROCEDURES WITH PRINCIPAL DIAGNOSIS OF INFECTION WITH MCC	3.229	1364	1364	0
486	2.1209	486	KNEE PROCEDURES WITH PRINCIPAL DIAGNOSIS OF INFECTION WITH CC	2.1176	2751	2751	0
487	1.5802	487	KNEE PROCEDURES WITH PRINCIPAL DIAGNOSIS OF INFECTION WITHOUT CC/MCC	1.5736	666	666	0

While researching the unexplained decline with MS-DRGs 466, 467, and 468, the FAH utilized test V43 of the draft GROUPER to validate MS-DRG assignment and discovered what appeared to be inconsistencies with the calculation of MS-DRGs 403 and 404. This was a very labor-intensive process in light of the version of the public grouper. (See comments in response to Part II.C.1.b of the Proposed Rule, above.) The brief table below shows an example of 8 cases, each of which included procedure codes (highlighted in yellow) listed in Table 6P.6a of the Proposed Rule. Based on this, it would appear that all 8 cases should be assigned to MS-DRG 403 or 404; however, only half of them are so assigned in the V43 draft GROUPER. Four of the cases went to the new MS-DRGs and four of the cases stayed within current MS-DRGs 463 or 464. MS-DRGs 403 and 404 are noted to be higher in the surgical hierarchy than MS-

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DRGs 463 and 464. The FAH requests an explanation on the accuracy of the V43 draft GROUPER as well as the impact on the AOR/BOR File.

	Change MSDRG	V42	V43	PDX	SDX	Px 1	Px 2	Px 3	Px 4	Px 5
1	Yes	464	404	T8453XA	I5032	0SBC0ZZ	0SPC09Z	0SUC09Z	05HC33Z	
2	Yes	465	404	T8454XA		0SBD0ZZ	0SPD09Z	0SUD09Z	0SHC33Z	
3	Yes	464	404	T8451XA	I5032	0SP90JZ	0SH908Z			
4	Yes	464	404	T8454XA	I5032	0SPD09Z	0SUU09Z			
5	No	464	464	T8453XA	I5032	0KNS0ZZ	0HRKX74	0JBN0ZZ	0SPC0JZ	0SPT0JZ
6	No	463	463	T8454XA	A419	0DJ08ZZ	0JBP0ZZ	0SPD0JZ	0SRD0J9	05HY33Z
7	No	464	464	T8453XA	E871	0SGC0JZ	0HRKX74	0SPC0JZ	0SRC0J9	0SHC08Z
8	No	463	463	T8453XA	A408	0JBR0ZZ	0SPC0JZ	0SRC0J9	0QBM3ZX	02HV33Z

The FAH supports the creation of MS-DRGs 403 and 404; however, request transparency in the data with explanations involving the MS-DRGs regrouping to the new MS-DRG as well as the accuracy of the V43 groupings included within the draft GROUPER and the AOR/BOR File. If these are not accurate, the FAH requests an immediate release of an addendum to the AOR/BOR report and the corrected proposed V43 grouper. For future rulemaking, we ask that CMS consider that any shifts in volume that result from new, deleted and revised MS-DRG logic include the insight, rationale and transparency within the proposed IPPS rule.

II.C.8. Proposed Changes to MS-DRG Diagnosis Codes for FY2026

II.C.8.c. Proposed Additions and Deletions to the Diagnosis Severity Levels for FY2026

CMS proposes a number of additions and deletions to the diagnosis code MCC severity levels list and to the diagnosis code CC severity list for FY 2026. These tables provide additional specificity for the diagnosis of hyperoxaluria. Three of the new hyperoxaluria diagnosis codes have been designated with complication or comorbid condition (CC) (E72.530, E72.538, and E72.539), but the remaining four hyperoxaluria codes are not so designated (E72.540, E72.541, E72.548, and E72.549). Each hyperoxaluria type involves the excessive excretion of oxalate in urine that can lead to kidney stones. The FAH requests that all seven hyperoxaluria types be considered for CC designation.

Diagnosis Code	Description	CC	MDC	MS-DRG
E72.530	Primary hyperoxaluria, type 1	C	10	642
E72.538	Other specified primary hyperoxaluria	C	10	642
E72.539	Primary hyperoxaluria, unspecified	C	10	642
E72.540	Dietary hyperoxaluria	N	11	695, 696
E72.541	Enteric hyperoxaluria	N	11	695, 696
E72.548	Other secondary hyperoxaluria	N	11	695, 696
E72.549	Secondary hyperoxaluria, unspecified	N	11	695, 696

II.E. Add-On Payments for New Services and Technologies for FY 2026

The FAH supports CMS proposal of new technology add-on payments for 14 technologies under the traditional pathway and 29 additional technologies under the alternative pathway. We appreciate and support CMS continuing support of 26 previously approved technologies for add-on payments.

II.E.5.c BREYANZI[®]

CMS requested public comment on the use of a specific list of ICD-10-CM codes provided by the applicant to identify the indication of relapsed or refractory (R/R) small lymphocytic leukemia (SLL) or chronic lymphocytic leukemia (CLL) for the purposes of the new NTAP, if approved for BREYANZI[®]. The proposed diagnosis codes are as follows:

ICD-10-CM Code	Description
C83.00	Small cell B-cell lymphoma, unspecified site.
C83.01	Small cell B-cell lymphoma, lymph nodes of head, face, and neck.
C83.02	Small cell B-cell lymphoma, intrathoracic lymph nodes.
C83.03	Small cell B-cell lymphoma, intra-abdominal lymph nodes.
C83.04	Small cell B-cell lymphoma, lymph nodes of axilla and upper limb.
C83.05	Small cell B-cell lymphoma, lymph nodes of inguinal region and lower limb.
C83.06	Small cell B-cell lymphoma, intrapelvic lymph nodes.
C83.07	Small cell B-cell lymphoma, spleen.
C83.08	Small cell B-cell lymphoma, lymph nodes of multiple sites.
C83.09	Small cell B-cell lymphoma, extranodal and solid organ sites.
C91.10	Chronic lymphocytic leukemia of B-cell type not having achieved remission.
C91.12	Chronic lymphocytic leukemia of B-cell type in relapse.

The FAH agrees that the provided codes properly identify the R/R SLL/CLL indication, but urges CMS to consider the following additional diagnosis codes that also identify the indication of R/R SLL/CLL:

- C91.Z0 Other lymphoid leukemia not having achieved remission
- C91.Z2 Other lymphoid leukemia, in relapse
- C91.90 Lymphoid leukemia, unspecified not having achieved remission
- C91.92 Lymphoid leukemia, unspecified, in relapse

II.E.6.a.12. iFuseTORQ TNT Implant System

CMS is proposing to approve new technology add-on payments for the iFuse TORQ TNT[™] Implant System when used for fracture fixation of pelvis, including acute, nonacute and nontraumatic fractures and sacroiliac joint fusion for sacroiliac joint dysfunction including sacroiliac joint disruption and degenerative sacroiliitis. CMS requested public comments on the exclusion of cases reporting these ICD-10-PCS procedure codes in combination with procedure codes that identify use of the iFuse TORQ TNT[™] Implant System for augmenting immobilization and stabilization of the sacroiliac joint in skeletally mature patients undergoing

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sacroiliac fixation as part of a lumbar or thoracolumbar fusion, which would not be eligible for new technology add-on payments, if approved. The procedure codes were included within CMS table 10.

The FAH requests that CMS consider whether there is potential for a multiple level fusion that would involve the sacroiliac fusion using the iFuse TORQ TNT™ Implant System simultaneously with lumbar or thoracolumbar fusion that does not use this implant system. It would be inappropriate to exclude such cases from new technology add-on payments simply because the patient is receiving two levels of fusion in the same surgical encounter.

Market Basket Update

VI.B.1. Proposed FY 2026 Inpatient Hospital Update

CMS proposes a market basket update of 3.2 percent for FY 2026. This market basket update is a product of CMS’ reliance on historical data to forecast FY 2026 hospital operating costs using a hospital market basket that reflects rebasing and revising from a 2018 to a 2023 base year. However, the revised market basket continues to exclude profoundly aberrant and historic economic forces that fueled rapid cost increases for goods and services that understated the market basket between FY 2021 and FY 2024. Beginning with FY 2021, CMS provided for a market basket update below the actual rate of increase annually through FY 2024 as shown in the below table²:

IPPS Market Basket	FY 2021	FY 2022	FY 2023	FY 2024
Forecast Used in the Update	2.4	2.7	4.1	3.3
Actual Based on Later Utilization	3.0	5.7	4.8	3.6
Difference	-0.6	-3.0	-0.7	-0.3

The combined reduction in the hospital update due to forecast error for these four years was 4.6 percentage points. This means hospital payments are understated by this amount absent CMS doing a one-time forecast error correction adjustment to bring hospital rates in line with inflation during these years.

In addition, CMS has proposed reducing the proposed market basket update of 3.2 percent by 0.8 percentage points for productivity. This productivity adjustment contemplates improbable and overstated gains in productivity for the hospital sector as noted by the CMS Office of the Actuary (OACT) itself and detailed below.

² Office of the Actuary, 4th quarter 2024 release of the market basket information with historical data through the 3rd quarter of 2024 (<https://www.cms.gov/research-statistics-data-and-systems/statistics-trends-and-reports/medicareprogramratesstats/marketbasketdata>) for the actual update based on later utilization.

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Considering the foregoing, **the FAH urges CMS to do a one-time adjustment to the FY 2026 hospital market basket update methodology to account for the combined 4.6 percentage point understatement of inflation in the FY 2021 to FY 2024 market baskets.**

Background

Under section 1886(b)(3)(B)(iii) of the Act, CMS is required to update hospital rates based on:

the percentage, estimated by the Secretary before the beginning of the...fiscal year, by which the cost [of] ... inpatient hospital services...will exceed the cost...for the preceding 12-month cost reporting period or fiscal year.

The update is subject to the productivity adjustment and further adjustments for hospitals that fail to submit quality information and/or are not meaningful EHR users.³ CMS is proposing to use a hospital market basket of 3.2 percent to update inpatient hospital rates for FY 2026. This market basket is based on the forecast of CMS' contractor, IHS Global Insight, Inc. (IGI). IGI's fourth quarter 2024 forecast (with historical data through the third quarter of 2024) for the hospital market basket is 3.2 percent. IGI's fourth quarter 2024 forecast of productivity is 0.8 percent.

The proposed rule indicates that CMS' forecast of the FY 2026 hospital market basket and the offset for productivity will be updated if more recent data become available before the final rule. If CMS follows past practice, this will mean that the FY 2026 final rule update will be based on IGI's second quarter 2025 forecast of the FY 2026 hospital market basket with historical data through the first quarter of 2025.

The FAH strongly urges CMS to use the later data on the market basket increase for FY 2026 as it has in past years and to further adjust its estimate to account for forecast error in the FY 2021 through FY 2024 hospital market basket update which understated the actual rate of inflation by a combined 4.6 percentage points. In three of these four years, the magnitude of the difference between the market basket and the actual rate of increase exceeded 0.5 percentage points—the same threshold that the SNF PPS uses for determining when to apply a forecast error correction.⁴ Upward pressure on hospital costs occurring throughout the pandemic and other global economic developments has not been fully reflected in the updates that hospitals have received dating back to FY 2021.

³ Social Security Act § 1886(b)(3)(B)(i)(XX), (vii), (ix), (xi).

⁴ 90 Fed. Reg. 18593. For SNF, CMS forecasted an FY 2024 market basket of 3.0 while the actual increase was 3.6 percent. As 3.6 percent exceed the 0.5 percentage point threshold for a forecast error correction, CMS is proposing to apply a +0.6 percentage point adjustment to the SNF update for forecast error correction.

CMS' Understatement of Prior Year Hospital Inflation

In our public comments on the FY 2023 IPPS proposed rule,⁵ the FAH provided several sources of data showing that hospitals' projected rate of increase would far exceed the proposed FY 2023 forecast of the market basket.⁶ Ultimately, CMS' forecasts of the market basket during a time of high inflation and economic instability understated the actual rate of increase as borne out by CMS' own data.

Comparing CMS' forecast of the market basket to the actual market basket based on later data between FY 2021 and FY 2024 shows that CMS has understated the market basket by a combined 4.6 percentage points for FY 2021 through FY 2024.

One reason that CMS understated the market basket data in these years is that its data reflected lower increases in staffing costs compared to what hospitals were experiencing using contract labor. Hospitals confronted worrying shortages of hospital workers during the COVID-19 pandemic, necessitating an outsized reliance on contract staff – particularly travel nurses – to meet patient demand. In 2019, hospitals spent a median of 4.7 percent of their total nurse labor expenses for contract travel nurses, which skyrocketed to a median of 38.6 percent in January 2022. A quarter of hospitals – those who have had to rely disproportionately on contract travel nurses in order to serve their communities during a global pandemic – saw their costs for contract travel nurses account for over 50 percent of their total nurse labor expenses.⁷ However, the Bureau of Labor Statistics' (BLS) Employment Cost Index (ECI) only captured the salary increases associated with employed staff, and thus wholly failed to capture the extraordinary growth in labor costs associated with hospitals' necessary reliance on nursing personnel that are contracted through staffing agencies during a time of labor supply shortages.

This discrepancy explains why the ECI data was so divergent at the time from that being reported to Premier Inc (PINC) AI™. As we noted in our public comments on the FY 2023 IPPS proposed rule, the FAH and the American Hospital Association (AHA) provided a report from FTI Consulting that likewise recognized that hospital use of contracted staff increased markedly since 2019. According to FTI:

[H]ospitals face more competition than ever from travel and temporary nurse staffing firms that are attracting a greater share of the workforce with higher pay and more generous benefits, a trend driving up hospital labor costs. The cost of contract labor relative to total labor expenses increased five-fold in 2022

⁵ Available at <https://assets.fah.org/uploads/2022/06/FY2023-IPPS-FAH-061722.pdf>.

⁶ These data came from the KaufmanHall, National Hospital Flash Report, p.4 (Jan. 2021) (https://www.kaufmanhall.com/sites/default/files/2021-01/nationalhospitalflashreport_jan.-2021_final.pdf) and Premier, Inc. (PINC) AI™ Data: CMS Data Underestimates Hospital Labor Spending (Apr. 12, 2022) (<https://premierinc.com/newsroom/blog/pinc-ai-data-cms-data-underestimates-hospital-labor-spending>) and demonstrated that the latest data that CMS used for the market basket seriously underestimated cost increases hospitals were experiencing using other data sources.

⁷ Advisory Board, "Charted: The 4 factors increasing hospital expenditures," *available at* <https://www.advisory.com/daily-briefing/2022/04/28/hospital-expenses>.

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compared to 2019, primarily due to the need to replace departing staff nurses with travel or agency nurses. Median wages for contract nurses reached triple the median wages of employed nurses in March 2022.⁸

In an analysis undertaken by the FAH and AHA and provided to CMS in the FY 2024 IPPS proposed rule comment period, we found contract labor use and general workforce composition will not likely revert to its earlier levels.⁹ This report relies on many of the sources we provided in our FY 2023 IPPS proposed rule comments documenting that the ECI does not account for contract labor being a higher proportion of total hospital costs. While stability in the economy has appeared to result in less forecast error as we move away from the pandemic years, FAH remains concerned that a larger portion of hospital labor costs—contract labor—is not accounted for by the ECI.

For the FY 2024 IPPS, the FAH suggested that CMS use the Employer Costs for Employee Compensation (ECEC) that may be better and timelier in accounting for growth in hospital compensation costs than the ECI. CMS declined to use the ECEC as an alternative to the ECI.¹⁰ While we understand CMS' decision to reject using the ECEC, the problem remains that a larger share of hospital labor cost increases are not accounted for by the hospital market basket. We look forward to proposals or ideas from CMS on how to better account for hospital contract labor costs in the market basket as it has rejected alternatives suggested by the FAH.

The market basket is intended to capture changes in labor and other costs that a hospital will encounter on a year-by-year basis when updating payment rates. As has been clear from the FY 2021 through FY 2024 data, the market basket update significantly understated the actual increase in hospital costs by a combined 4.6 percentage points supporting our request for a one-time adjustment for forecast error. **The FAH once again requests that CMS revisit the market basket shortfall between FY 2021 and FY 2024 and apply a one-time forecast error adjustment to the FY 2026 update.**

Productivity

Pursuant to section 1886(b)(3)(B)(xi)(II) of the Act, the Secretary reduces the IPPS market basket increase by the “10-year moving average of changes in annual economy-wide private nonfarm business multi-factor productivity (as produced by the Secretary for the 10-year period ending with the applicable fiscal year).” The theory behind the offset for economy wide total productivity is that the hospital sector should be able to realize the same productivity gains as the general economy.

⁸ FTI Consulting, Report: Assessing the Adequacy of Proposed Updates to the Hospital Inpatient Prospective Payment System, page 4, available at <https://assets.fah.org/uploads/2022/06/FY2023-IPPS-FAH-061722.pdf>.

⁹ Federation of American Hospitals and the American Hospital Association, Hospital Employment Cost Index Undermeasures Labor Cost Growth in Recent Years, page 4, available at <https://assets.fah.org/uploads/2023/06/FAH-IPPS-2024-Comment-Final-06092023-with-Attachments.pdf>.

¹⁰ 88 Fed. Reg. 59032.

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However, CMS actuaries also take issue with the assumption that hospitals can recognize the same kinds of productivity gains as the general economy. In a memorandum dated June 2, 2022, OACT stated: “over the period 1990-2019, the average growth rate of hospital [total factor productivity (TFP)] using the two methodologies ranges from 0.2 percent to 0.5 percent, compared to the average growth of private nonfarm business TFP of 0.8 percent.” The memorandum also indicates that an assumed future rate of hospital industry productivity growth of 0.4 percent per year remains reasonable compared to an assumed rate of productivity growth in the private nonfarm business sector of 1.0 percent.¹¹

The FAH shares OACT’s skepticism regarding the offset to the hospital market basket for the 10-year average in economy-wide nonfarm productivity. One reason that hospitals may not be able to realize the same growth in general economy wide productivity is that hospital services are highly labor intensive. As labor represents nearly 70 percent of the index, hospitals have little opportunity to obtain productivity gains from non-labor inputs as may be occurring in other industries that are less labor intensive. The June 2025 report from FTI (Appendix C) likewise concludes that the productivity adjustment “overestimates achievable improvements in efficiency, worsening hospitals’ financial pressures.”¹²

The FAH understands that CMS is required by law to adjust the IPPS market basket update for productivity. However, the FAH asks CMS to consider that the adjustment for productivity reduces the update below what even OACT says is reasonable for hospitals to achieve when deciding on our request to make an adjustment for forecast error as detailed below. Furthermore, the FAH asks that CMS urge Congress to modify section 1886(b)(3)(B)(xi)(II) of the Act to focus on adjustments based on productivity changes in the hospital sector rather than in the private nonfarm business.

There are two other issues of concern to the FAH with the productivity offset. First, CMS has applied the productivity adjustment exclusively to restrict the increase in Medicare payments. In the one year (FY 2021) where productivity in the non-farm business section did not improve and measured TFP declined, CMS set the productivity adjustment to 0 rather than increasing payments. 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, to the detriment of the communities they serve.

CMS addressed this issue in a final rule in FY 2021 without an opportunity for public comment. In the FY 2021 IPPS final rule, CMS indicated that IGI’s June 2020 estimate of 10-year productivity would be -0.1 percent. CMS indicated:

¹¹ Paul Spitalnic, Stephen Heffler, Bridget Dickensheets and Mollie Knight, “Hospital Multifactor Productivity: An Update Presentation of Two Methodologies Using Data through 2019,” *available at* <https://www.cms.gov/files/document/productivity-memo.pdf>.

¹² FTI, Assessment of Productivity Adjustments for the Hospital Inpatient Prospective Payment System and Applicability to the Hospital Sector (June 2025).

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...under section 1886(b)(3)(B)(xi)(I) of the Act, the Secretary is required to reduce (not increase) the hospital market basket percentage increase by changes in economy-wide productivity. Accordingly, we are applying a 0.0 MFP adjustment to the FY 2021 market basket percentage increase.

While CMS section 1886(b)(3)(B)(xi)(I) of the Act states that “such percentage increase shall be reduced by the productivity adjustment” it does not follow that the statute necessarily requires that the productivity adjustment be a subtraction from the otherwise applicable update. Reducing the otherwise applicable update by a negative number would be an addition to the update.

In other statutory contexts, Congress has specified if the addition or subtraction of a variable may be overridden. For instance, under section 1833(i)(2)(C)(ii) of the Act, Congress specified “the increase under this subparagraph shall be reduced (but not below zero) by 2.0 percentage points.” Under section 1886(h)(2)(D)(iv)(II) of the Act, Congress specified application of an update to some per resident amounts shall be equal to the consumer price index “reduced (but not below zero) by 2 percentage points. If Congress meant that the productivity adjustment is zero if it’s not positive, Congress could have specified that in subclause (II) but did not. Therefore, it is the FAH’s contention that CMS should have increased the update in FY 2021 for productivity rather than applying no adjustment.

Second, the FAH is concerned that CMS’ methodology for computing the productivity adjustment results in excessive variability from one fiscal year to the next, reducing predictability and further straining hospital resources. CMS does not explain the large increase in the productivity adjustment in the FY 2026 IPPS proposed rule. The updated 10-year moving average period used for the FY 2026 IPPS proposed rule excludes a period of low TFP growth that was included in the relevant period for FY 2025. As explained in the June 2025 report from FTI (Appendix C), while this may partially explain the increase, with all else being equal, this would produce a small increase in the productivity adjustment.

However, the productivity growth during the projection period implied by the FY 2026 IPPS proposed rule is substantially higher than the projected growth implied by the 2025 IPPS proposed rule, which appears to be the key factor driving a large increase in the computed productivity adjustment. CMS does not provide any explanation for this update to the projections, which contradicts the consensus that the near-term economic outlook has worsened, particularly considering the economic uncertainties associated with high tariffs being threatened or imposed on imported goods. This issue is not isolated to the FY 2026 proposed rule: As explained in the June 2025 report from FTI (Appendix C), the projections used for the later quarters of the 10-year moving average appear to vary dramatically as they are updated for each successive payment year.

In addition, the implied projected growth rates for a given projection period do not track the observed data over time, suggesting substantial forecast error. The implied projections for several periods are outside the historical range for recent TFP growth, even when disregarding projections made during the COVID-19 public health emergency. Given the current uncertainty regarding near-term economic conditions, forecasting even for the short-term can be especially

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challenging and lead to volatility in the TFP and inaccurate estimates that generate unjustified cuts to hospital payments.

One-Time Adjustment for FY 2021 through FY 2024 Forecast Error

As indicated above, the hospital update from FY 2021 through FY 2024 understated the actual rate of inflation as measured by the hospital market basket by a combined 4.6 percentage points. This understatement of the market basket results in a permanent reduction to hospital rates below the rate of inflation unless adjusted for in a future rate update. In the FY 2023 IPPS final rule, CMS indicates that “an important goal of a PPS is predictability” and that “due to the uncertainty regarding future price trends, forecast errors can be both positive and negative.”¹³

The FAH agrees that predictability in the future rate updates is a worthwhile goal of a prospective payment system. However, we also believe the large understatements of past year rates must be corrected in the future to prevent what has already been chronic Medicare underpayment reported by the Medicare Payment Advisory Commission (MedPAC) from becoming even worse. MedPAC, March 2025 Report states:

FFS Medicare payments continued to be lower than hospitals’ costs in 2023: Excluding relief funds, hospitals’ FFS Medicare margin was –13 percent, and the median FFS Medicare margin was –2 percent for relatively efficient hospitals.¹⁴

MedPAC’s March 2025 Report finds negative hospital Medicare margins, and OACT’s own analysis suggesting the productivity offset is higher than can be realized by hospitals. Further, CMS should have increased the FY 2021 IPPS update by 0.1 percentage point considering the negative productivity estimate for that year and the strong possibility that productivity is overstated in the projection period for the FY 2026 during a period economic uncertainty considering tariffs and other economic factors.

Therefore, the FAH requests that CMS apply a positive adjustment of 4.6 percentage points to the IPPS update addressing the combined forecast error for the years FY 2021 through FY 2024. If CMS were to adopt the FAH’s recommendation, the update would be the market basket of 3.2 percent plus 4.6 percentage points for forecast error correction less 0.8 percentage points for productivity or 7.0 percent. This could be implemented for FY 202 or transitioned over a two or three year period.

Rebasing and Revising the Hospital Market Basket and Labor Share

Section 404 of the Medicare Modernization Act requires the Secretary of Health and Human Services to establish a frequency for revising the hospital market basket weights, including the labor share more frequently than once every 5 years. The law further required

¹³ 89 Fed. Reg. 69434.

¹⁴ MedPAC, Report to Congress: Medicare Payment Policy Chapter 3, page 68 (March 13, 2025), available at https://www.medpac.gov/wp-content/uploads/2025/03/Mar25_MedPAC_Report_To_Congress_SEC.pdf.

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CMS to provide an explanation of its reasons for determining the frequency for rebasing and revising the hospital market basket in the IPPs rule.

In the FY 2006 IPPS rule, CMS provided a detailed explanation of the options it considered for rebasing and revising the hospital market basket more frequently than every 5 years. Public commenters generally agreed that the hospital market basket did not need to be updated more frequently than every 5 years. CMS agreed with commenters that revising the hospital market basket more frequently than every 5 years is unnecessary. However, CMS adopted a policy to rebase and revise the hospital market basket every 4 years as the MMA required the market basket to be revised more frequently than every 5 years.

The FAH has examined how the labor share has changed every four years since CMS adopted this schedule for rebasing and revising of the market basket:

IPPS Rule Date	Base Year	Old Labor Share	New Labor Share	Change
08/12/2005 (70 Fed. Reg. 47393)	2002	71.1%	69.7%	-1.4%
08/27/2009 (74 Fed. Reg. 43856)	2006	69.7%	68.8%	-0.9%
08/19/2013 (78 Fed. Reg. 50596)	2010	68.8%	69.6%	0.8%
08/14/2017 (78 Fed. Reg. 50596)	2014	69.6%	68.3%	-1.3%
08/13/2021 (86 Fed. Reg. 45194)	2018	68.3%	67.6%	-0.7%
04/30/2025 (Proposed Rule) (90 Fed. Reg. 18246)	2023	67.6%	66.0% (proposed)	-1.6%

As these data illustrate, the labor-related share has consistently declined—with one exception—in each rebasing since 2005. In that time, the labor-related share declined from 71.1 percent to a proposed 66.0 percent, a decline of more than 5 percentage points. This decline reduces payments to hospitals with wage index values over 1.0, and therefore must be budget neutralized with a positive adjustment. In establishing the wage index budget neutrality adjustment, however, CMS does not separately show the budget neutrality adjustment from the change to the labor-related share in the IPPS rule. **The FAH requests CMS explain how it applies budget neutrality for a reduction to the labor-related share and show the related adjustment to the standardized amount as it does for all budget neutral provisions.**

Does CMS first apply budget neutrality as a change to the national labor-related share including hospitals with a wage index less than 1.0 and then apply the 62 percent labor-related share without budget neutrality? If so, **the FAH requests CMS apply an alternative methodology that ensures that the decrease in payments for high-wage hospitals requires a positive budget neutrality adjustment to the standardized amount.**

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CMS' proposal to decrease the labor-share yet again but this time by 1.6 percentage points is inconsistent with our members' experience. As noted previously, hospital labor costs increased significantly more than other hospital costs during and after the COVID-19 pandemic, making it unlikely that hospital labor costs as a share of total costs could be declining in this period. Most of the increase in costs is being driven by contractor labor being used to address chronic nursing shortages during COVID-19 PHE.

However, according to Table IV-07 of the proposed rule, the largest factor in the decreasing labor-related share is due to employee benefits (1.2 percentage points). While it is possible that employee benefits are decreasing as a share of total costs as hospitals are more reliant on contracted labor, this reduction should be more than offset by contract labor. CMS indicates that contract labor costs are included in the "Professional Fees: Labor-Related" category through a complex methodology that allocates a portion of home office costs to this cost center. While this cost category's weight is increasing from 8.6 percent to 10.0 percent, a portion of this increase in costs is due to professional fees (advertising, legal services, accounting and auditing, engineering and management consulting) while the remainder are home office costs and contract labor. Given that contract labor has substituted for employed labor in recent years and accelerated with the COVID-19 PHE, our expectation would be that any decrease in labor costs for employee benefits would be more than offset by the increased costs for contract labor. **The FAH requests that CMS reexamine its methodology for allocating home office costs to contract labor to ensure that it is appropriately resulting in an increase that offsets the decline in employee benefits as contract labor now represents a significantly higher share of total hospital labor costs.**

The Proposed Rule Would Unlawfully Continue to Apply Adjustments Under TMA § 7(b)(1)(B) in FY 2026

The Proposed Rule, like the IPPS/LTCH Final Rules for FY 2024 and FY 2025, would continue a series of adjustments under section 7(b)(1)(B) of the TMA, Abstinence Education, and QI Program Extension Act of 2007, Pub. L. No. 110-90 as amended¹⁵ ("TMA"), totaling negative 0.9412 percent. These section 7(b)(1)(B) adjustments, however, are expired by the plain text of the statute, making their proposed continuation in FFY 2024 and subsequent years unlawful. The Proposed Rule, however, does not make mention of section 7(b) of the TMA and fails to provide any rationale or legal basis for effectively making the net adjustments under section 7(b)(1)(B) permanent. **The FAH strongly urges CMS to eliminate this error for FY 2026 with a positive 0.9412% adjustment to the standardized amount, which would eliminate the remaining adjustment under section 7(b)(1)(B) of the TMA and effectuate their statutory expiration.**

Beginning with FY 2014,¹⁶ CMS has made the following adjustments under section

¹⁵ Section 7 of the TMA was amended by the American Taxpayer Relief Act of 2012, Pub. L. No. 112-240, § 631(b) ("ATRA") in 2013, by Medicare Access and CHIP Reauthorization Act of 2015, Pub. L. No. 114-10, § 414 ("MACRA") in 2015, and by the 21st Century Cures Act, Pub. L. No. 114-255, § 15005 in 2016.

¹⁶ Under section 7(b)(1)(B)(i), CMS also adopted a -2.9% adjustment in FY 2011 and then retained that adjustment in FY 2012. 76 Fed. Reg. 51,475, 51,497 (Aug. 18, 2011). In recognition of the TMA's prohibition on

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7(b)(1)(B)(ii) and (iii) of the TMA:

FY	Adjustment	Cumulative Adjustment
2014	-0.8%	-0.8%
2015	-0.8%	-1.6%
2016	-0.8%	-2.4%
2017	-1.5%	-3.9%
2018	+0.4588%	-3.4412%
2019	+0.5%	-2.9412%
2020	+0.5%	-2.4412%
2021	+0.5%	-1.9412%
2022	+0.5%	-1.4412%
2023	+0.5%	-0.9412%

The FY 2014 through FY 2017 adjustments were made under section 7(b)(1)(B)(ii) of the amended TMA, followed by the adjustments for 2018 through 2023, which were made under amended section 7(b)(1)(B)(iii) of the TMA. *See* 82 Fed. Reg. 37,990, 38,008–009 (Aug. 14, 2017); 87 Fed. Reg. 48,780, 48,799–48,800 (Aug. 10, 2022). All of these adjustments, both positive and negative, are adjustments under section 7(b)(1)(B) of the TMA, and thus are all subject to section 7(b)(4), which prohibits continuing any section 7(b)(1)(B) adjustments into years beyond FY 2023.

TMA § 7(b)(4) provides that “[n]othing in this section shall be construed as providing authority to apply the adjustment under paragraph (1)(B) other than for discharges occurring during fiscal years 2010, 2011, 2012, 2014, 2015, 2016, and 2017 and each succeeding fiscal year *through fiscal year 2023*” (emphasis added). This language makes clear that **CMS must fully eliminate the payment adjustment under section 7(b)(1)(B) for any year not listed in section 7(b)(4)**. And, in fact, that is precisely what CMS did in the FY 2013 Final Rule by fully eliminating the section 7(b)(1)(B) adjustment at that time with a one-time positive 2.9% adjustment. 77 Fed. Reg. at 53,276.

As illustrated in the above table, the series of negative and positive adjustments made under TMA section 7(b)(1)(B) between FYs 2014 and 2023 have produced a cumulative, net adjustment of negative 0.9412%. As such, in order to comply with Congress’ mandate that the adjustment under section 7(b)(1)(B) not apply to any year after FY 2023, CMS was required to fully eliminate this remaining section 7(b)(1)(B) adjustment with a one-time, offsetting positive adjustment of 0.9412% for FY 2024. CMS, however, failed to do so in FY 2024, and the standardized amount for FY 2024 remains impermissibly reduced by the section 7(b)(1)(B) adjustments. In response to comments on this issue, in the FY 2024 IPPS/LTCH Final Rule, CMS focused on its authority to adopt and apply the adjustments under section 7(b)(1)(B)(ii) and (iii) of the TMA in past fiscal years. 15 88 Fed. Reg. 58,640, 58,654 (Aug. 28, 2023). But, the

continuing to apply these adjustments in FY 2013, the adjustments were fully reversed in FY 2013 with a +2.9% adjustment, thereby returning the standardized amount “to the appropriate baseline.” 77 Fed. Reg. 53,257, 53,276 (Aug. 31, 2012).

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FY 2024 IPPS/LTCH Final Rule failed to discuss or give any meaning to Congress' clear and unequivocal prohibition under section 7(b)(4) on applying any of these section 7(b)(1)(B) adjustments to discharges after FY 2023 and Congress' prohibition in section 7(b)(2) on the inclusion of an adjustment under section 7(b)(1)(B) "in the determination of the standardized amounts for discharges occurring in a subsequent year." Put simply, Congress' instruction to adopt and apply the adjustments under section 7(b)(1)(B)(ii) and (iii) in FY 2014 through 2023 does not authorize the continuation of these adjustments in FY 2024 and subsequent years, and such a continuation is expressly prohibited under section 7(b)(2) and (4) of the TMA. And the Proposed Rule, if finalized, would continue this error in FY 2026 by again continuing the adjustments adopted under section 7(b)(1)(B) as permanent reductions to the standardized amount.

The FY 2024 and FY 2025 IPPS/LTCH Final Rules and the FY 2026 Proposed Rule provide no rationale for diverging from CMS' established approach to eliminating section 7(b)(1)(B) adjustments to comply with section 7(b)(4) of the TMA with a one-time offsetting restoration to the standardized amount. Nor does either rulemaking cite to any authority for making the section 7(b)(1)(B) adjustments permanent. In light of the foregoing concerns and express limitations on CMS' authority, **the FAH urges CMS to end the erroneous continuation of the statutorily expired section 7(b)(1)(B) adjustments in FY 2026 with a one-time, offsetting positive adjustment of 0.9412%.**

VI.G Nursing and Allied Health Education

Reasonable Cost Payment for Nursing and Allied Health Education Programs (§ 413.85 and § 413.87)

Hospitals may receive reasonable cost payment for Medicare's share of a hospital's costs for provider operated nursing and allied health education payments. 42 CFR §413.85(d)(2)(i) indicates that:

The net cost of approved educational activities is determined by deducting the revenues that a provider receives from tuition and student fees from the provider's total allowable educational costs

Under 42 CFR §413.24, hospitals allocate indirect costs to each direct cost center through the step-down method:

Step-down method. This method recognizes that services furnished by certain nonrevenue-producing departments or centers are utilized by certain other nonrevenue-producing centers as well as by the revenue-producing centers. All costs of nonrevenue-producing centers are allocated to all centers that they serve, regardless of whether or not these centers produce revenue.¹⁷

¹⁷ 42 CFR §413.24(d)(1).

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On November 17, 2017, CMS issued Transmittal 12, which contained updates to the hospital cost report instructions at CMS–2552–10, Pub. 15– 2, chapter 40.¹⁸ CMS advised hospitals that revenues from tuition and student fees should be subtracted from the costs of nursing and allied health education prior to allocating indirect costs. However, several hospitals objected to this instruction as being inconsistent with 42 CFR §413.85(d)(2)(i)

On February 9, 2024, the U.S. District Court for the District of Columbia (D.C.) issued a decision involving five plaintiff hospitals. The providers disputed the order of operations for determining “net costs” under 42 CFR 413.85(d)(2)(i). The providers disagreed with the instructions in Transmittal 12 arguing that the offsets for revenue from tuition and student fees should be made after indirect costs are allocated. The providers argued the regulations require that indirect costs be included as part of a provider’s total allowable educational costs before tuition and student fees are offset, and the change to the cost reporting instructions in 2017 was a change in policy that conflicts with the regulations. The District Court sided with the providers indicating that the regulations are consistent with the providers’ interpretation of the regulations. The Court wrote: “The hospitals are right, and it is not even close.”¹⁹

CMS is proposing to modify 42 CFR §413.85(d)(2)(i) in response to the District Court’s decision. Under CMS’ proposal, 42 CFR §413.85(d)(2)(i) would be explicit that tuition, student fees, textbooks purchased for resale and other revenue from or on behalf of students is subtracted before completing the indirect cost allocation. The new policy would be effective for cost reporting periods beginning on or after October 1, 2025.

CMS indicates that its policy could result in no indirect costs being allocated to the nursing and allied health education cost center. If this occurs, CMS will allow a hospital to seek permission from their MAC to employ a different indirect cost allocation method in accordance with Publication 15-1, Provider Reimbursement Manual (PRM), chapter 23, section 2313. CMS indicates that this alternative indirect cost allocation could mitigate the reduction in reasonable cost payment associated with its proposal.

Under this alternative allocation, CMS indicates that only those indirect costs that are directly related to the operation of approved educational activities under 42 CFR §413.85 could be allocated to the nursing the allied health education cost center. Examples of these costs would be costs the hospital would not have in the absence of an educational program such as for “nursing supervisors who oversee floor nurses and student nurses” or costs that benefit the hospital as a whole (e.g., admissions or patient registration) and would also exclude the costs of a related organization (such as a home office).²⁰

¹⁸ Medicare, Provider Reimbursement Manual, Part 2, Provider Cost Reporting Forms and Instructions, Chapter 40, Form CMS 2552-10.

¹⁹ *Mercy Health—St. Vincent Medical Center LLC d/b/a Mercy St. Vincent Medical Center, et al., v. Xavier Becerra*, Case No. 22–cv–3578 (TNM)).

²⁰ 90 Fed. Reg. 18281.

CMS' Proposal is Counter to the Purpose of the Indirect Cost Allocation

The FAH opposes CMS' proposal to change the order of operations for the indirect cost allocation. CMS' proposal conflicts with the purpose of the indirect cost allocation. The indirect cost allocation assigns administrative and general costs that support the entire institution to each direct cost center on the Medicare cost report. Direct costs are specific to the production of specific services within the hospital—such as the costs of paying teachers, classroom and clinical instruction directly associated with the operation of the educational program. Conversely, indirect costs cannot be attributed to a specific product or service yet are necessary for the overall operation of the hospital.

As indicated above 42 CFR §413.24 authorizes use of the step-down process for allocating indirect costs to each of the direct cost centers. Using the step-down process, indirect costs are allocated to each direct cost center in relationship to how that direct cost center is supported by administrative and general costs. CMS' longstanding policy has recognized the step-down method of apportioning indirect costs under 42 CFR §413.24:

This allocation method has been longstanding and recognizes that a revenue producing cost center like nursing and allied health education is supported by administrative and general expenses of the hospital such as utilities, rent, administrative salaries, and depreciation as noted in CMS' cost finding principles:

For the purpose of proper matching of revenue and expenses, the cost of the revenue-producing centers should include both its direct expenses and its proportionate share of the costs of each nonrevenue-producing center (indirect costs) based on the amount of services received.²¹

By using direct expenses in the step-down method, the nursing and allied health education cost center draws “a proportionate share” of indirect expenses that are supporting the hospital's nursing and allied health education activities. If CMS finalizes its proposal, the relationship between a direct cost center and the indirect costs necessary to support that direct cost center will be distorted. The nursing and allied health education cost center will receive less than its share of the allocation of indirect costs than are being used to support the department.

CMS' Alternative Proposal will Disallow All Indirect Costs and Even Some Direct Costs

For an indirect cost to be allocated to the nursing and allied education cost center, the proposed rule indicates that its costs must be “directly attributable” to the operation of an approved educational activity. However, this proposal is also fundamentally inconsistent with the purpose of the indirect cost allocation. To be considered an indirect cost, the cost *cannot* be attributed to any individual cost center. If a cost can be attributed to an individual cost center, it is, by definition, a direct cost, not an indirect cost. Under CMS' proposal, no indirect costs could be attributed to the nursing and allied health education cost center as there could be no indirect costs that are directly attributable to the nursing and allied health education cost center.

²¹ PRM 15-1, chapter 23, section 2306.

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CMS' examples of indirect costs are very troubling. For instance, CMS indicates that the costs of nursing supervisors are costs the hospital would have in the absence of the nursing education program and are therefore non-allowable indirect costs. However, these costs are direct costs that are allowable nursing and allied health education costs under current policy. In a final rule published on January 12, 2001, CMS indicated that the portion of a nursing supervisor's compensation associated with training a student nurse is currently a *direct* cost and allowable for the purposes of reasonable cost payment if that cost is an incremental cost the hospital would have from operating and nursing and allied health education program.²² CMS' proposed rule suggests any costs associated with a nursing supervisor is an unallowable indirect cost which would be a change in policy as that cost is currently an allowable direct cost.

The FAH argues that these costs are analogous to the cost of a teaching physician supervising a medical resident. In a September 29, 1989 *Federal Register* notice, CMS indicated:

The allowable costs of these activities include the direct costs of salaries and fringe benefits of interns and residents, *salaries attributable to the supervisory time of teaching physicians*, other teachers' salaries, and the indirect costs (that is, institutional overhead, for example, employee health and welfare benefits) that are appropriately allocated to the particular medical education cost center.²³ (italics added).

Prior to the per resident methodology, 42 CFR §413.85 governed medical education as well as nursing and allied health education further supporting our conclusion that the portion of compensation of a nursing supervisor associated with the educational program would be an allowable direct cost.

The above quote also makes clear that “indirect costs” (including “institutional overhead”) are costs that may be allocated to the educational program and there is no exclusion for indirect costs that benefit the hospital as a whole. **For these reasons, the FAH opposes CMS' alternative allocation of indirect costs to only allow those costs “directly related to the operation of specific approved programs.”**²⁴

Costs of a Related Organization

42 CFR §413.85(d)(2)(ii) indicates that the cost of a related organization such as a home office would not be an allowable cost. CMS reiterates this policy in the proposed rule. **The FAH requests that CMS change this policy and allow costs of a related organization as indirect costs where the related organization is not a college or university.** In the January 12, 2001 final rule, CMS indicates that the concern motivating the disallowance of related party

²² 66 Fed. Reg. 3369. CMS indicates that the incremental costs of a floor nurse supervising a student would be considered a direct allowable cost associated with the provider-operated nursing education program.

²³ 54 Fed. Reg. 40286

²⁴ Quoting CMS' proposed rule at 82 Fed. Reg. 18281 (bold not in the original)

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costs track to the original statute creating Medicare: “it was not intended that Medicare should pay for increased costs resulting from a redistribution of cost from educational institutions to providers.”²⁵

However, long-standing CMS policy has recognized the legitimacy of related organization cost when those costs are home office costs that are not associated with an educational institution. For instance, Publication 15-2, PRM Chapter 40, section 4017 states:

Cost applicable to home office costs, services, facilities, and supplies furnished by organizations related to you by common ownership or control are includable in your allowable cost at the cost to the related organizations. However, such cost must not exceed the amount a prudent and cost-conscious buyer pays for comparable services, facilities, or supplies that are purchased elsewhere.²⁶

The PRM recognizes that the costs of a home office are legitimate costs to a hospital if those costs are not inflated in the transaction. There is no risk of redistribution of costs from an educational institution to a hospital when the related party is only providing necessary hospital services and not supporting an educational infrastructure. In these circumstances, the related organization is a home office or other related organization with the sole purpose of furnishing allowable cost services to a hospital or another hospital in its network.

The FAH opposes CMS’ proposed changes because it would unfairly penalize hospitals that receive reasonable cost payment for nursing and allied health education. As structured, even with the alternative allocation of indirect costs, CMS’ proposed changes would preclude any indirect costs from being allocated to the nursing and allied health education cost center. Further, the FAH requests that CMS reverse its disallowance of related party costs for provider-operated nursing and allied health education programs if the related party is not an educational institution.

Outlier Payments FY 2026

Addendum II.A.4.i. Proposed Outlier Payments

For FY 2026, CMS has proposed that a case will be eligible for a high-cost outlier payment when the cost of the case exceeds the sum of the prospective payment rate for the MS-DRG plus any IME, empirically justified Medicare DSH payments, estimated uncompensated care payment, and any add-on payments for new technology, plus the proposed fixed loss threshold of \$44,305. The proposed threshold represents a slight reduction to the inflated and unreasonable threshold for FY 2025, but it remains significantly elevated over the level at which CMS set the threshold before the COVID-19 public health emergency.

²⁵ 66 Fed. Reg. 3359

²⁶ Publication 15-2, PRM Chapter 40, section 4017

Continuation of Methodological Changes Adopted for FY 2020, with Modified Calculation of Estimated Reconciliation of Outlier Payments

CMS proposes to again use the same basic methodology to calculate the fixed loss threshold as it has since FY 2014, applying methodological refinements that were first applied in the FY 2020 IPPS rulemaking.

Projecting Outlier Reconciliation. First, CMS proposes to again account for outlier reconciliation in the FY 2026 outlier threshold calculation. The FAH has repeatedly requested that CMS release information on the outlier reconciliation process and data showing the amounts recovered so that it can evaluate the impact of the reconciliation process on the outlier threshold, and we again commend CMS for proposing to continue addressing the impact of outlier reconciliation in setting the FY 2026 fixed-loss threshold. Using the FY 2020 cost report data and provider specific file (PSF) values and applying the new outlier reconciliation criteria set forth in CR 13566 produced a percentage of operating outlier reconciliation dollars to total Federal operating payments that is a positive value (+0.1%). Watson Policy Analysis (WPA) matched CMS' calculation of a positive 0.1% reconciliation factor. Using this positive value, however, would have the effect of an increase to the outlier payment threshold for the first time since CMS incorporated a reconciliation adjustment into its outlier methodology. CMS concluded that "this positive value may be an anomaly and may not be an accurate predictor of outlier reconciliations for FY 2026." 90 Fed. Reg. at 18,432. Therefore, CMS proposes to hold the data constant from the FY 2025 IPPS/LTCH final rule, using the ratio of negative 0.04% of total operating outlier reconciliation dollars to total Federal operating payments (based on FY 2019 cost reports and PSF data). The FAH supports this proposal to avoid improperly inflating the outlier payment threshold based on anomalies in the FY 2020 data, but continues to object to CMS' application of the new reconciliation criteria in CR 13566 without first going through notice and comment rulemaking.

Projecting Charge Inflation. Second, the Proposed Rule charge inflation factor calculation conceptually mirrors the method CMS adopted in the FY 2020 final rule, relying on charge data from the most recent publicly available MedPAR files to compute the one-year charge inflation factor. For the Proposed Rule, CMS used the December 2023 MedPAR file of FY 2023 charge data and the December 2024 MedPAR file of FY 2024 charge data to compute the proposed charge inflation factor; and for the FY 2026 final rule, CMS proposes using the more recent MedPAR files from March 2024 for the FY 2023 time period and March 2025 for the FY 2024 time period. With this data, CMS has computed a proposed one-year charge inflation factor of 5.440 percent and has converted that into a proposed two-year charge-inflation-factor of 11.18 percent. However, unlike with the LTCH PPS high-cost outlier threshold (LTCH threshold), CMS does not propose to apply any trims to the charge data in the FYs 2023 and 2024 MedPAR data files. Specifically, for the LTCH threshold, CMS has appropriately proposed "to remove all claims from providers whose growth in average charges was a statistical outlier." 90 Fed. Reg. at 18,451. CMS explained, "We remove these statistical outliers prior to calculating the charge inflation factor because we believe they may represent aberrations in the data that would distort the measure of average charge growth." *Id.* Yet CMS has failed to articulate any principled basis not to apply similar trims to the charge inflation data used to set the IPPS outlier threshold. If not removed from the IPPS charge inflation data, the statistical outliers "will distort the measure of average charge growth" for IPPS hospitals. We therefore urge CMS to apply such trims when computing

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the final charge inflation factor. We also continue to believe that CMS should disclose all aspects of its edits to the most current data used for the Proposed Rule and commit to the same process and methods when it recalculates the threshold for purposes of the final rule. Additionally, CMS should commit to making public the data files it uses for the final rule, including all edits and calculations, when it publishes the final rule.

Projecting CCRs. Third, the Proposed Rule applies the same method, first adopted in the FY 2014 IPPS Rule, to project the change in CCRs. For FY 2026, CMS has proposed comparing the CCRs in the December 2023 update of the PSF to the CCRs in the December 2024 update of the PSF and has computed a proposed one-year national operating CCR adjustment factor of 0.970113. The final CCR adjustment factors for FYs 2013 through 2024 have consistently been below 1.0,²⁷ and the proposed one-year national operating CCR adjustment factor for FY 2026 is consistent with this historic experience.

Extreme Charge Cases Significantly Skew the Fixed Loss Threshold

As we have in past years, the FAH also asks CMS to consider whether it is appropriate to include extreme cases when calculating the fixed-loss threshold. The fixed-loss threshold has doubled between FY 2016 and FY 2025, and most of that increase occurred over just three years, from FY 2022 to FY 2025. WPA conducted various examinations and probing of data to understand the factors that drove these significant increases to the fixed-loss threshold, and observed that the inclusion of extreme cases in the calculation of the threshold, the rate of which are increasing over time, significantly impacts CMS' determination of the fixed-loss threshold.²⁸

In the IPPS rate-setting process for the MS-DRG relative weights, statistical outliers (*i.e.*, extreme cases) are generally removed from calculations on the basis that they improperly skew those calculations. In calculating the outlier threshold, however, those statistical outliers are not excluded from the calculation. To observe the impact of these statistical outliers on the calculation of the threshold, WPA calculated how the proposed FY 2025 threshold would differ after the removal of cases that had total charges above particular trim points. The results of WPA's analysis are included in the tables below:

²⁷ For FY 2025, CMS finalized a positive national operating CCR adjustment factor despite the FAH's and others' concerns that the positive national operating CCR adjustment factor was unreasonable and the product of skewed data reflecting costs incurred during the peak inflationary period in 2022 and early 2023.

²⁸ See WPA Report at p. 8. The tables from the WPA report have been reproduced here with minor editing for formatting purposes.

FY 2026 Proposed Rule Table

Scenario	Cases Remaining	Removed Cases	FLT	Percentage of Cases Removed
Base (No Trim)	6,693,693	0	\$44,515	0.00%
Trim at: \$4,000,000	6,693,197	496	\$42,380	0.01%
Trim at: \$3,750,000	6,693,102	591	\$42,153	0.01%
Trim at: \$3,500,000	6,692,940	753	\$41,812	0.01%
Trim at: \$3,250,000	6,692,719	974	\$41,358	0.01%
Trim at: \$3,000,000	6,692,443	1,250	\$40,820	0.02%
Trim at: \$2,750,000	6,692,039	1,654	\$40,173	0.02%
Trim at: \$2,500,000	6,691,637	2,056	\$39,580	0.03%
Trim at: \$2,250,000	6,690,954	2,739	\$38,820	0.04%
Trim at: \$2,000,000	6,689,925	3,768	\$37,863	0.06%
Trim at: \$1,750,000	6,668,594	5,099	\$36,831	0.08%
Trim at: \$1,500,000	6,686,458	7,235	\$35,495	0.11%
Trim at: \$1,250,000	6,682,645	11,048	\$33,790	0.17%
Trim at: \$1,000,000	6,674,514	19,179	\$31,350	0.29%
Trim at: \$750,000	6,655,302	38,391	\$27,905	0.57%
Trim at: \$500,000	6,594,701	98,992	\$22,400	1.48%
Trim at: \$250,000	6,279,559	414,134	\$13,162	6.19%

The FY 2026 table illustrates that the removal of a relatively small number of extremely high cost (using total charges as a proxy for cost) cases from the calculation significantly decreases the threshold. For example, removing all cases with total charges above \$2,000,000 (3,768 cases) lowers the threshold over \$6,600. Removing all cases at certain other thresholds, lower than \$2,000,000, but still high enough to be considered extreme high-cost cases, drives the threshold down even further. For example, removing all cases with total charges above \$1,000,000 (19,179 cases) drives the threshold down over \$13,000, and removing all cases with charges above \$500,000 (98,992 cases) drives the threshold down over \$22,000.

Furthermore, these high charge cases are increasing quickly over time, but still represent a very small percentage of total cases. To demonstrate this trend of an increase in extremely high charge cases, WPA created the following table illustrating the number of cases with covered charges above \$1.5 million for each of the past several years:²⁹

²⁹ See WPA Report at p. 9.

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Year	Number of Cases Over \$1.5 million in Covered Charges	Percentage of Total Cases	Number of Unique Providers
2011	926	0.0088%	272
2012	994	0.0098%	272
2013	1,092	0.0111%	283
2014	1,329	0.0141%	306
2015	1,539	0.0161%	320
2016	1,733	0.0185%	334
2017	2,291	0.0250%	403
2018	2,650	0.0286%	398
2019	3,128	0.0348%	441
2020	3,666	0.0474%	474
2021	4,719	0.0650%	530
2022	5,482	0.0803%	594
2023	6,620	0.0980%	607
2024	7,340	0.1095%	607

If this trend continues (that is, if the number (and proportion) of extreme cases continues to increase each year), the impact of this population of cases on the threshold will likewise increase. Thus, it is imperative that CMS carefully consider what is causing this trend, whether the inclusion of these cases in the calculation of the threshold is appropriate, or whether a separate outlier mechanism should apply to these cases that more closely hews outlier payments to marginal costs.

The FAH urges CMS to carefully study this problem as it pertains to outlier payment policy. Not only is this consistent with the calculation process used for IPPS rate setting generally, but it will also produce a threshold that more accurately reflects the universe of cases.

Using the Most Recent Data to Calculate the Threshold

We also note that with each IPPS rulemaking for more than a decade (with the exception of FYs 2022 and 2024), the final fixed-loss threshold established by CMS has consistently been lower than the threshold set forth in the proposed rule, and the variance between the proposed and final thresholds has generally exceeded 4 percent. The table below derived from WPA Report at p.6 shows this trend of regular, significant variances between proposed and final fixed-loss thresholds:

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FY	Proposed	Final	Variance	% of Variance
2009	\$ 21,025	\$ 20,045	\$ (980)	-4.66%
2010	\$ 24,240	\$ 23,140	\$ (1,100)	-4.54%
2011	\$ 24,165	\$ 23,075	\$ (1,090)	-4.51%
2012	\$ 23,375	\$ 22,385	\$ (990)	-4.24%
2013	\$ 23,630	\$ 21,821	\$ (1,809)	-7.66%
2014	\$ 24,140	\$ 21,748	\$ (2,392)	-9.90%
2015	\$ 25,799	\$ 24,626	\$ (1,173)	-4.55%
2016	\$ 24,485	\$ 22,544	\$ (1,941)	-7.93%
2017	\$ 23,681	\$ 23,573	\$ (108)	-0.46%
2018	\$ 26,713	\$ 26,537	\$ (176)	-0.66%
2019	\$ 27,545	\$ 25,769	\$ (1,776)	-6.45%
2020	\$ 26,994	\$ 26,552	\$ (521)	-1.93%
2021	\$ 30,006	\$ 29,064	\$ (942)	-3.31%
2022	\$ 30,967	\$ 30,988	\$ 21	0.07%
2023	\$ 43,214	\$ 38,859	\$ (4,355)	-11.21%
2024	\$ 40,732	\$ 42,750	\$ 2,018	4.95%
2025	\$ 49,237	\$ 46,217	\$ (3,020)	-6.13%
2026	\$ 44,305			

Although the FAH can only speculate as to why this drop in the threshold occurs, the FAH believes the decline is most likely due to the use of updated CCRs and/or additional/other data in calculating the final threshold. This again emphasizes that CMS must ordinarily use the most recent data to appropriately calculate the outlier threshold.

With regard to the current rulemaking, WPA was able to replicate the threshold within 0.5%. Thus, we have high confidence that WPA understands CMS’ methodology and has accurately modeled that methodology.

FY 2026 Outlier: Conclusion

The FAH is not proposing a threshold for FY 2026. While we have confidence in the work of WPA, its work is dependent on large number of variables in the outlier calculation. We also note that the impact of the inclusion of extreme cases in the calculation of the fixed loss threshold is significant and we urge CMS to carefully study this trend and whether outlier payment policy should be adjusted so that it is fair to all hospitals that fund outlier payments. Finally, we recognize that with the release of the MedPAR final data with additional claims, which will lead to new weights being calculated, and with updated cost to charge ratios, it is appropriate to recalculate the fixed loss threshold from the data that will be released with the final rule.

Area Wage Index

III.F.7. Proposed Transition for the Discontinuation of the Low Wage Index Hospital Policy

The FAH supports CMS’ proposal to adopt a narrow transitional exception to the calculation of FY 2026 IPPS payments for low wage index hospitals significantly impacted by the discontinuation of the low wage index hospital policy, but strongly urges CMS to forego the proposed, unlawful budget neutrality adjustment and to instead continue implementing the transition in a non-budget neutral manner. As CMS notes, temporary transition policies ensure that the effects of payment policy changes (here, the elimination of the low wage index hospital policy) are phased in, thus mitigating short-term instability and payment fluctuations that negatively impact hospitals and promoting the principles of certainty and predictability under prospective payment systems.

For FY 2020, CMS adopted a low-wage index policy where it increased wage index values below the 25th percentile by one-half the difference between the hospital’s otherwise applicable wage index and the 25th percentile wage index value. CMS applied a budget neutrality adjustment for the low wage index policy such that increasing the wage index for the affected hospitals did not increase Medicare spending.³⁰ This low wage index hospital policy and associated budget neutrality adjustment remained in place through FY 2024 and was the subject of litigation, including in *Bridgeport Hospital v. Becerra*. On July 23, 2024, the Court of Appeals for the D.C. Circuit held that the Secretary lacked authority under section 1886(d)(3)(E) of the Act or under the adjustments language of section 1886(d)(5)(I)(i) of the Act to adopt the low wage index hospital and that the policy and related budget neutrality adjustment must be vacated.³¹ Then, on December 11, 2024, the Court of Appeals for the Ninth Circuit similarly held CMS lacked statutory authority to implement the policy and that vacatur should be awarded.³²

On October 3, 2024, CMS published an interim final rule with comment (IFC) in the *Federal Register* revising its previously announced FY 2025 IPPS policies and rates. In the IFC, CMS recalculated the IPPS hospital wage index to remove the low wage index hospital policy for FY 2025 and remove the low wage index budget neutrality factor from the FY 2025 standardized amounts.³³

For FY 2026, CMS proposes to continue a transition policy it first implemented in the IFC for FY 2025. In the FY 2023 IPPS rule, CMS adopted a 5-percent cap on year-to-year decreases in each hospital’s wage index value regardless of the circumstances causing the decline. For FY2025 CMS limited the decrease in the wage index value for hospitals that no longer benefit from the low wage index hospital policy to 5 percent, consistent with past practice to address significant changes to payment policies and the wage index cap policy at 42 C.F.R.

³⁰ 84 Fed. Reg. 42,325.

³¹ *Bridgeport Hosp.*, 108 F.4th 882, 887–91 & n.6 (D.C. Cir. 2024).

³² *Kaweah Delta Health Care District v. Becerra*, 123 F.4th 939 (9th Cir. 2024).

³³ 89 Fed. Reg. 80,405.

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§ 412.64(h)(7). The transitional policy proposed for FY 2026 would limit wage index reductions between FY 2024 and FY 2026 to 9.75% for hospitals significantly impacted by the discontinuation of the low wage index hospital policy. The FAH supports this continued transitional policy, and appreciates CMS' attention to the difficulties faced by hospitals that are significantly impacted by discontinuation of the low wage index hospital policy.

The FAH, however, urges CMS to apply this transitional exception without any budget neutrality adjustment, consistent with its practice in FY 2025. As CMS concedes, section 1886(d)(5)(I)(i) of the Act does not require budget neutrality for these “adjustments.”³⁴ In fact, as the FAH has emphasized in past comments, CMS does not have authority under subsection (d)(5)(I)(i) or otherwise to reduce IPPS payments for purposes of budget neutrality. Subsection (d)(5)(I) restricts the Secretary's authority to adopt budget neutrality adjustments to only adjustments for transfer cases, and budget neutrality is neither required nor authorized in other circumstances. Clause (i) of § 1395ww(d)(5)(I) authorizes the Secretary to “provide by regulation for such other exceptions and adjustments to such payment amounts under this subsection as the Secretary deems appropriate.” No budget neutrality authority is included under this clause. Rather, Congress adopted clause (ii) at CMS' express request in order to provide limited authority for a budget neutrality adjustment only when CMS makes an adjustment under clause (i) for transfer cases. This clause states:

In making adjustments under clause (i) for transfer cases . . . the Secretary may make adjustments...to assure that the aggregate payments made under this subsection for such fiscal year are not greater or lesser than those that would have otherwise been made in such fiscal year.

Because the statute explicitly restricts the Secretary's authority to adopt budget neutrality adjustments in connection with adjustments for transfer cases, budget neutrality is neither required nor authorized in other circumstances. For this reason, CMS' transitional policy may properly be adopted as an adjustment under 42 U.S.C. § 1395ww(d)(5)(I)(i) but may not be implemented in a budget neutral manner. **Accordingly, the FAH urges CMS to remove the Proposed Rule's budget neutrality adjustment to the IPPS standardized amounts for the transitional policy.**

Disproportionate Share Hospital Payments

IV.E. Uncompensated Care Payments

In recent years, the FAH has had significant concerns with declining uncompensated care (UC-DSH) payments. From FY 2023 to FY 2025, UC-DSH payments declined by over \$1.1 billion despite a growing uninsured rate. Against this backdrop, hospitals have faced Medicare payments that are lower than hospitals' costs. According to MedPAC's March 2025 Report to

³⁴ 90 Fed. Reg. 18,234.

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Congress, without relief funds, hospitals' Medicare margin was negative 13 percent, and the median margin was negative 2 percent for relatively efficient hospitals.³⁵

For FY 2026, however, CMS proposes reversing this trend of declining UC-DSH payments, reflecting the estimated growth in empirically justified Medicare DSH and the high uninsured rate. **The FAH strongly supports these UC-DSH estimates as consistent with hospitals' current expectations for FY 2026, and urges CMS to finalize these estimates with any upward adjustments as appropriate based on developments before the rule is finalized.**

IV.E.2 Calculation of Proposed Factor 2 for FY 2026

Factor 2 of the UC-DSH calculation adjusts Factor 1 for the change in the number of uninsured individuals in the United States since 2013, the last year before the Patient Protection and Affordable Care Act's (ACA) coverage expansion. The higher the uninsured rate, the larger the aggregate dollar amount of UC-DSH payments that are distributed to IPPS hospitals under Factor 3. Because Factor 2 turns exclusively on the uninsured rate, it is critical that CMS' estimate accurately accounts for significant factors that are expected to fuel the uninsured rate. For FY 2026, the FAH is concerned that the expiration of enhanced premium tax credits and other legislative and regulatory proposals will reduce coverage in ways that must ultimately be captured in the final Factor 2 estimates.

Under current law, the ACA enhanced premium tax credits (EPTCs) will expire on December 31, 2025. We are deeply concerned with the anticipated reduction in coverage and access to care if EPTCs are not extended and believe that the Making America Healthy Again movement begins with access to health care coverage -from preventive care to specialized chronic disease services. We therefore continue to urge CMS and the Administration to support extending the EPTCs to maintain health care access and affordability across the country. If, however, EPTCs expire, the Congressional Budget Office (CBO) estimates that the number of uninsured will rise by 2.2 million in 2026 and by 3.7 million in 2027, with an average increase of 3.8 million annually between 2026 and 2034.³⁶

In addition, the FAH is concerned that pending regulatory and legislative proposals may increase the uninsured rate and the associated Factor 2 calculation for FY 2026. For example, CMS estimated that the March 19, 2025 Marketplace Integrity and Affordability proposed rule would reduce enrollment during calendar year 2026 by between 750,000 to 2 million.³⁷ CMS' intention to implement this rule is clear in the draft final rule is already under review for release by the Office of Management and Budget. Likewise, pending reconciliation legislation is expected to increase the uninsured rate. **These proposed regulatory and legislative changes were released dafter the NHEA projections were certified by OACT for this proposed rule, and the FAH strongly urges CMS and the OACT to broaden their data sources to more**

³⁵ MedPAC, Report to Congress: Medicare Payment Policy Chapter 3, page 68 (March 13, 2025), available at https://www.medpac.gov/wp-content/uploads/2025/03/Mar25_MedPAC_Report_To_Congress_SEC.pdf.

³⁶ Congressional Budget Office, Letter to Chairman Arrington and Chairman Smith Concerning Premium Tax Credits, <https://www.cbo.gov/system/files/2024-12/59230-ARPA.pdf>.

³⁷ 90 Fed. Reg. 13,032, 13025 tbl. 16-17 (March 19, 2025).

fully reflect current estimates of the uninsured rate in FY 2026 in light of proposed legal changes as well as shifting market conditions.

We note that the Factor 2 estimates have significant impacts on the UC-DSH funding available to support critical hospital services to the uninsured and underinsured. For example, even acknowledging an additional 0.5 percentage point of growth in the uninsured rate in FY 2026 (9 percent uninsured, reflecting a projection of approximately 1.87 million additional uninsured individuals), would increase the proposed UC-DSH pool by approximately \$421 million above CMS' proposal.

IV.D.3(d) Per Discharge Amount of Interim Uncompensated Care Payments

The FAH is concerned that the per-discharge amount of interim UC-DSH payments continues to be understated due to the impact of older data that overestimates discharges in the coming fiscal year. The FAH believes it is inconsistent to project falling discharges for purposes of the Factor 1 calculation (thereby reducing the UC-DSH pool) but not similarly assume falling discharges for purposes of projecting the discharges used to calculate the per-discharge amount (thereby reducing interim UC-DSH payments). The overestimation of discharges depresses interim UC-DSH payments, creating cash flow issues for hospitals, and inadequate interim payments compromise the UC-DSH program's effectiveness in supporting hospital care for uninsured and underinsured patients. Therefore, **the FAH opposes the proposed use of the three-year average discharge volume to calculate interim UC-DSH payments and urges CMS to instead reasonably project discharges for purposes of calculating interim UC-DSH payments.**

A discharge projection methodology that better reflects the anticipated volume of discharges in FY 2026 would improve the effectiveness of the UC-DSH program and reduce overreliance on the reconciliation process for UC-DSH payments. This could be achieved by using the national discharge trends and projections used in Factor 1 to produce a national adjustment factor. This national adjustment factor could then be applied to trend each hospital's three-year average of historical discharges forward and better project anticipated FY 2026 discharges. Meanwhile, hospitals that are experiencing discharge growth despite national trends, could make use of the voluntary process finalized in the FY 2021 IPPS/TCH PPS final rule and request a lower per-discharge interim UC-DSH payment amount. This approach would reduce the national burden of understated interim UC-DSH payments while minimizing the extent to which outlier hospitals receive overstated interim UC-DSH payments.

Long Term Care Hospital (LTCH) PoliciesIX.C.2 Proposed FY 2026 LTCH PPS Standard Federal Payment Rate Annual Market Basket Update

CMS is proposing an annual update to the LTCH PPS standard federal payment rate of 2.6 percent that is equal to the LTCH market basket of 3.4 percent less 0.8 percentage points for productivity. For LTCHs failing to submit data to the LTCH Quality Reporting Program (QRP), the annual update would be further reduced by 2.0 percentage points. All the same issues stated

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above for IPPS hospitals would also apply to the LTCH market basket. Below is a table that compares the LTCH update to the LTCH market basket based on later data since FY 2021:

LTCH Market Basket	FY 2021	FY 2022	FY 2023	FY 2024
Forecast Used in the Update	2.3	2.6	4.1	3.5
Actual Based on Later Utilization	2.6	5.1	5.1	4.0
Difference	-0.3	-2.5	-1.0	-0.5

Like the IPPS market basket, these data show that CMS has understated the LTCH market basket by a combined 4.3 percentage points for FY 2021 – FY 2024.

As we requested for the FY 2026 IPPS operating update, **the FAH requests that CMS also provide for a forecast error adjustment for the combined understatement of the FY 2021 through FY 2024 LTCH market baskets when updating the FY 2026 LTCH rates. Adopting our suggestion would make the market basket equal to 3.4 percent plus 4.3 percentage points for forecast error less 0.8 percentage points for productivity or 6.9 percent.**

As we described in our comments on the IPPS update, the FAH is further concerned that the LTCH update for FY 2026 includes a reduction for non-farm productivity of 0.8 percent. While the annual productivity offset is based on a provision of the ACA and is required by law, the FAH urges CMS to consider the appropriateness of this reduction when deciding whether to incorporate a forecast error adjustment to the FY 2026 LTCH PPS update based on the understatement of the LTCH PPS market basket baskets from FY 2021 to FY 2024 of 4.3 percentage points.

LTCH High-Cost Outlier (HCO) Fixed-Loss Amount

Under the LTCH PPS, Medicare makes additional payments for HCO cases that have extraordinarily high costs relative to the costs of most discharges. CMS sets a threshold each year at the maximum loss that an LTCH can incur under the LTCH PPS for a case with unusually high costs before the LTCH receives these additional payments. Since FY 2018, CMS has set the HCO fixed-loss amount so that HCO payments will equal 7.975 percent of total LTCH PPS payments, as required by section 15004 of the 21st Century Cures Act.

Based on the current fixed-loss amount of \$77,048, CMS estimates that outlier payments in FY 2025 will equal 8.2 percent of total LTCH PPS standard Federal rate payments. CMS is proposing to increase the HCO fixed-loss amount for FY 2026 standard Federal payment rate cases to \$91,247 to ensure that estimated HCO payments will be 7.975% of total LTCH PPS standard Federal rate payments in FY 2026. Estimated total HCO payments are projected to decrease by approximately 0.22 percentage points from FY 2025 to FY 2026 under this proposal.

CMS did not propose any policy changes or temporary adjustments to its methodology for setting the HCO fixed-loss amount. **The FAH urges CMS not to finalize the proposed HCO fixed-loss amount of \$91,247 because it will further destabilize the LTCH PPS and harm Medicare beneficiaries, LTCHs, and hospitals that refer patients to LTCHs.** Rather,

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CMS should return to the market basket-based charge inflation factor methodology that CMS historically used to determine the LTCH PPS fixed-loss amount. Using this methodology, the fixed-loss amount for FY 2026 should be approximately \$51,000. In addition, CMS should cap the fixed-loss amount at this number going forward, with no budget neutrality adjustment for any amount that is calculated above the cap, until CMS implements a permanent solution to the spiraling fixed-loss amount.

Alternatively, CMS could use a transitional approach. For FY 2025, CMS solicited comments on an alternative approach for determining the fixed-loss amount. Under the alternative approach, CMS considered averaging the FY 2024 fixed-loss amount and the proposed FY 2025 fixed-loss amount based on the 7.975 percent statutory target. The result would have been an alternative fixed-loss amount of \$75,397 (*i.e.*, $(\$59,873 + \$90,921) / 2$).

This alternative was intended to provide a 1-year transition to the full increase in the fixed-loss amount. While HCO payments would have equaled 9.5 percent of estimated FY 2025 LTCH PPS standard Federal rate payments using the FY 2025 proposed rule data and would therefore increase aggregate LTCH PPS payments by \$39 million, CMS said that it would not apply a budget neutrality adjustment to offset the increased payments from this alternative approach because the LTCH PPS budget neutrality requirement only applies to the first year of the implementation of the LTCH PPS (*i.e.*, FY 2003). CMS did not implement this approach because updated data used in the final rule reduced the outlier threshold to \$77,048.

The LTCH HCO fixed loss amount has increased substantially over the last two years from \$38,518 in FY 2023 to \$59,873 in FY 2024 and \$77,048 in FY 2025 and CMS proposes a further increase to \$91,247. The increases respectively in these years have been 55 percent and 29 percent with a further increase of 18 percent projected for FY 2026. If finalized, the increase in the LTCH HCO fixed loss threshold will be \$52,729 over three years—an increase of 137 percent over just three years.

While CMS did not propose any intervention to mitigate another large increase in the LTCH HCO fixed loss amount, the averaging processing CMS considered for FY 2025 was welcomed even if not ultimately adopted. **If CMS does not return to the market basket-based charge inflation factor methodology recommended above, the FAH requests that CMS adopt the transition approach it considered for FY 2025 and other longer-term solutions to mitigate the substantial increases occurring annually to the LTCH HCO fixed loss threshold.** This approach will support LTCHs and ensure that such a significant increase does not accelerate financial strain on LTCHs – ensuring access to Medicare beneficiaries that need access to long term acute care hospital services.

Finally, the FAH continues to urge CMS to rescind its April 2024 outlier reconciliation transmittal (CR 13566) because it made changes to substantive legal standards governing payment for services that can only be made using notice-and-comment rulemaking procedures, and it will further reduce HCO payments to LTCHs at cost report settlement. This transmittal is inconsistent with the requirements of notice-and-comment rulemaking in section 1871 of the Social Security Act, and it is also a prime candidate for rescission in furtherance of President Trump's deregulation Executive Orders 14192 and 14219. If CMS does not retract this transmittal, then CMS must account for the increase in LTCH outlier reconciliation recoupments

when calculating the HCO fixed-loss amount for the LTCH PPS, in the same manner that CMS currently accounts for IPPS outlier reconciliation recoupments when setting the IPPS outlier fixed-loss threshold.

Hospital Quality and Value-Based Payment Programs

Total Hip/Total Knee Arthroplasty PRO-PM – Implementation Challenges and Request for Relief

In the Calendar Year (CY) 2022 rulemaking cycle, CMS finalized the implementation of the Total Hip Arthroplasty/Total Knee Arthroplasty (THA/TKA) Patient-Reported Outcome-Based Performance Measure (PRO-PM), with mandatory reporting beginning July 1, 2024, for the FY 2026 payment determination. The FAH cautioned CMS against moving too quickly to mandatory reporting for this complex and resource-intensive measure. Those concerns have been borne out, as hospitals now face significant operational and technical barriers in collecting and submitting the required patient-reported data.

Hospitals report persistent challenges in capturing baseline responses before surgery, maintaining patient engagement post-discharge, and managing data submission logistics through third-party platforms amid constrained staff capacity. A further complication is that many orthopedic clinics already use validated instruments such as the Hip disability and Osteoarthritis Outcome Score (HOOS) and Knee injury and Osteoarthritis Outcome Score (KOOS) in their routine workflows. These existing physician-led surveys may confuse patients, fragment the data collection process, and compete with hospitals' efforts to meet CMS' survey protocols, undermining the likelihood of achieving the required 50% response rate.

The 50% response rate threshold is particularly burdensome for small, rural, low-volume orthopedic programs. The measure's methodology does not sufficiently adjust for case volume variation or the risk of nonresponse bias. It fails to account for the fragmented nature of surgical care delivery between hospitals and outpatient clinics. While the FAH supports the broader goal of incorporating patient-reported outcomes into quality measurement, the current implementation timeline and requirements are misaligned with on-the-ground realities.

The FAH urges CMS to rescind any associated penalties for FY 2026 and develop a more flexible, risk-adjusted approach that reflects diverse hospital structures and workflows. CMS demonstrated appropriate flexibility in the past by removing penalties associated with the Hybrid Hospital-Wide All-Cause Readmission measure due to similar data collection and implementation challenges. A comparable approach is warranted here to recognize the good-faith efforts of hospitals working to comply.

Finally, the FAH reiterates its call for CMS to revise the 50% response rate requirement. This rigid threshold does not reflect real-world patient engagement patterns, even when hospitals undertake robust outreach strategies. We recommend CMS adopt a more flexible and equitable approach, such as incorporating a minimum case threshold or permitting stratified reporting, to ensure the measure yields valid and meaningful comparisons across diverse hospital settings.

VI. K. Hospital Readmissions Reduction Program (HRRP) Updates and Changes

Proposal to Integrate Medicare Advantage (MA) Beneficiaries into the Cohorts of the Hospital Readmissions Reduction Program Measure Set Beginning with the FY 2027 Program Year

CMS proposes to integrate Medicare Advantage (MA) beneficiaries and reduce the performance period from three to two years, from July 1, 2023, through June 30, 2025, which is associated with the FY 2027 program year, into all the readmission measures. CMS also proposes a technical change involving updating the risk adjustment model to use individual ICD-10 codes instead of Hierarchical Condition Categories (HCCs). CMS states that this change is considered non-substantive and would improve the performance of the risk adjustment models for condition- and procedure-specific mortality and complication measures.

The FAH urges CMS to delay the proposed timeline and instead pursue a phased implementation. While each of these proposed changes may have individual merit, they represent a substantial shift in program design, and CMS has not sufficiently analyzed or disclosed the impact of these changes individually or in combination. Hospitals cannot meaningfully evaluate or comment on the proposals without access to clear, hospital-specific data showing how each change would affect their performance and penalty exposure. **The FAH strongly recommends CMS release hospital-level and aggregate impact analyses for each proposal and the combined effect before proceeding to final rulemaking.**

Inappropriate Integration of MA Data into Legacy Medicare Penalty Programs

The integration of MA beneficiary data into the HRRP measure set is fundamentally flawed and risks creating a distorted and inequitable penalty structure for hospitals. Traditional Medicare uses a narrowly defined, condition-specific penalty program to incentivize hospitals to reduce readmissions, applying financial withholds tied to clinically validated cohorts. In contrast, the MA program uses an *All-Cause Readmissions* measure to determine plan Star Ratings—an *upside-only* system in which MA plans face no financial loss for poor performance, only the potential for increased bonuses.

These are two entirely different accountability structures: one imposes penalties on hospitals, while the other rewards health plans. Blending data from a provider-facing penalty system with data from a plan-based reward system is methodologically inappropriate and misaligned. It is not equitable to subject hospitals to penalties based on data derived from a system where plans are not similarly accountable.

Moreover, many MA plans already apply their own readmission penalty programs to support their Star Ratings performance, often denying payment for any readmission within 30 days of discharge, including those involving observation stays. Simultaneously, these same plans rely on the IPPS MS-DRG payment structure, which incorporates reductions tied to HRRP performance. This dual approach creates a scenario, where hospitals are penalized through MA plan readmission denials by the insurer *and further reduced* CMS payments based on readmission measures.

CMS should not permit this. If an MA plan intends to maintain its internal readmission penalties, it should be prohibited from applying IPPS payment structures that penalize hospitals

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for the same metric. Alternatively, if the MA plan wishes to rely on IPPS-based hospital reimbursement, it should be required to eliminate its proprietary readmission penalty programs.

Data Source Integrity and Transparency

The FAH is deeply concerned by CMS' anticipated reliance on MA encounter data rather than paid claims to calculate hospital performance scores and opposes the proposed change to include MA data in the HRRP. CMS has not clarified whether a given claim included in the dataset was paid, denied, or denied for administrative versus clinical reasons. Many MA plans employ automated processes that deny readmissions solely based on proximity to the original discharge date, without regard for clinical necessity. This practice undermines the integrity of any readmissions data derived from MA encounter submissions.

Additionally, denied claims with clinical relevance may not appear in encounter data unless they support risk adjustment. Plans may selectively report such claims for their benefit while omitting them from reporting mechanisms affecting hospital penalties. CMS must clarify which data elements it intends to use and whether hospital readmission scores under HRRP will be accompanied by plan-specific subsets or flags.

Further complicating matters, MA plans often delegate claims processing to downstream entities, creating risks for inaccurate data transfer, inconsistent file submissions, and unclear accountability. These inconsistencies directly affect hospital performance scores under HRRP and the Hospital Value-Based Purchasing (HVBP) program. CMS must require attestation of data accuracy from MA plans and establish a transparent process to address disputes when hospitals are held responsible for errors beyond their control.

Impact on Sepsis and Mortality Measures under HVBP

In the HVBP program, similar concerns apply. Many of the same MS-DRGs implicated in HRRP are also used in HVBP's mortality and complication measures, including the sepsis measure. Hospitals are incentivized to implement early recognition protocols for sepsis and can be rewarded for strong performance. However, MA plans often deny or down-code sepsis-related admissions, citing non-standardized criteria or inconsistent definitions.

This practice creates a troubling contradiction: hospitals may be penalized or denied reimbursement under MA contracts while being judged by CMS for performance on the same clinical episodes. It is unclear how CMS plans to reconcile conflicting interpretations of care delivery or ensure that encounter data reflect the full scope and clinical integrity of a hospital's interventions.

Risk Adjustment Shift to ICD-10 and Data Volatility

The FAH also strongly opposes the shift from HCCs to ICD-10 codes. This change is not a minor technical refinement. It marks a foundational departure from the risk adjustment methodology currently in use across multiple CMS programs, including the CMMI TEAM model, which continues to rely on HCCs. Hospitals have made significant investments to support accurate HCC coding and reporting as part of quality and compliance operations. Abruptly shifting to ICD-10 codes without adequate transition time, training, or validation creates substantial operational risk and threatens the continuity of data integrity. Implementing

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this change alongside other significant updates, including adding MA beneficiaries and the shortened performance period, exacerbates the hospital burden and introduces uncertainty that may undermine quality improvement efforts.

The FAH also opposes the proposed reduction in the HRRP performance period from three years to two. This policy was originally used in the early years of the HRRP and was found to produce volatile results. The shift to a three-year period was made to improve reliability and predictability in performance assessments. CMS has not provided evidence that the concerns previously associated with two-year periods have been resolved, nor has it demonstrated that measure reliability will be preserved under the proposed timeframe.

These proposals collectively reflect a broader pattern of CMS implementing significant programmatic changes too rapidly and without sufficient transparency. We urge CMS to delay finalizing these changes until hospitals and other stakeholders can thoroughly assess their implications. A staggered approach, supported by clear impact modeling and appropriate alignment with other CMS initiatives, will better serve hospitals and the beneficiaries they care for.

VI.L. Hospital Value-Based Purchasing (HVBP) Program

Proposed Measure Updates to the Hospital-Level Risk-Standardized Complication Rate (RSCR) Following Elective Primary Total Hip Arthroplasty (THA) and/or Total Knee Arthroplasty (TKA)

CMS proposes significant updates to the Hospital-level Risk-Standardized Complication Rate (RSCR) Following Elective Primary Total Hip Arthroplasty (THA) and/or Total Knee Arthroplasty (TKA), also known as the COMP-HIP-KNEE measure, starting with the FY 2033 program year (contingent on its adoption in the Inpatient Quality Reporting Program). Specifically, they propose to include MA beneficiaries and reduce the performance period from three to two years.

The FAH reiterates the concerns outlined in our comments on the proposed HRRP changes. We recommend that implementation of each is phased-in to allow hospitals to isolate the impact of each change. We also strongly urge CMS to share hospital-specific reports showing how each change would shift individual facility performance before finalizing the updates. Hospitals should be aware of the potential impact to ensure that the results can effectively drive quality improvement.

In addition, the FAH is deeply concerned that the recommendation by the Endorsement & Maintenance (E&M) Committee to remove endorsement was overturned on appeal. We support the committee's reasoning for withdrawing endorsement—particularly their concerns regarding the differences in patient populations between inpatient and outpatient settings, as well as the insufficient approach to adjusting performance for low-volume facilities. It is imperative that CMS promptly address these issues to ensure the measure yields accurate and valid representations of hospital care. Until these concerns are resolved, performance scores derived from the measure should not be used for payment purposes.

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Technical Updates to the Specifications of the COMP-HIP-KNEE Measure to Update the Risk Adjustment Model Beginning with the FY 2027 Program Year

CMS plans on making what it calls a “non-substantive” change to update the risk adjustment model to use individual ICD-10 codes instead of HCC for risk adjustment. As we outline in our comments in the HRRP section, the FAH views this proposed technical update as a significant change and urges CMS to propose a roll-out plan that hospitals can comment on to help determine if changes are warranted and if so, the order in which the changes should be made.

Technical Update to the Five National Healthcare Safety Network (NHSN) Healthcare-Associated Infection (HAI) Measures

CMS proposes to use the 2015 data to determine performance standards and report measure scores until FY 2029. From FY 2029 onward, the program will switch to using the new 2022 data for these calculations.

The FAH requests that CMS release the new 2022 data immediately as it would allow hospitals to prepare for the revised performance standards. We believe that this transparency is essential to enable groups to continue in their efforts to reduce HAIs and improve patient care.

VI.M. Hospital-Acquired Conditions (HAC) Reduction Program Updates and Changes

Technical Update to CDC’s NHSN Healthcare-Associated Infection Measures for the HAC Reduction Program

CMS proposes updates to the population data used to calculate the standardized infection ratio (SIR) for the CDC’s NHSN measures, specifically they would use the 2015 data to determine performance standards and report measure scores until FY 2029. From FY 2029 onward, the program would switch to using the new 2022 data for these calculations.

The FAH reiterates our request that CMS release the new 2022 data immediately as it would allow hospitals to prepare for the revised performance standards. We believe that this transparency is essential to enable groups to continue in their efforts to reduce HAIs and improve patient care.

X.B. Toward Digital Quality Measurement in CMS Quality Programs – Request for Information

CMS provides a request for information (RFI) with updates on their progress in the transition to digital quality measurement (dQM) and seeks input as they continue their path forward in the dQM transition. In this RFI, they solicit comments on the anticipated approach to the use of Health Level Seven® (HL7®) Fast Healthcare Interoperability Resources® (FHIR®) in electronic clinical quality measure (eCQM) reporting.

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The FAH and our members support the transition to digital data as we believe that it will reduce the burden of data collection and enable the capture of information that is essential at the point of care. However, as evidenced by the recent challenges encountered by hospitals to report the hybrid measures, the field is not yet ready to rapidly move to dQMs, and CMS must ensure that most hospitals are able to participate in the move to FHIR eQMs followed by FHIR dQMs before anything is finalized through rulemaking.

Hospitals currently struggle to implement the existing Clinical Quality Language (CQL) based eQMs, including identifying individuals with sufficient expertise to program the system to integrate the changes, and ensure that the resulting data are clinically valid and consistently extracted. We shared several of these examples during last year's rulemaking and continue to identify areas where additional processes and integrations must be completed. For example, disparate systems such as for obstetrics or radiology still exist, which increases the complexity of integrating then extracting data from EHRs. While shifting to a new data standard (FHIR) may ultimately advance the field, this process must be completed in a way that allows hospitals of all sizes and settings to successfully participate.

The FAH encourages CMS to establish a clear glide path that outlines the essential steps, stakeholders, and milestones required for successful implementation. This should include a detailed timeline specifying when critical actions will be completed, along with the necessary deliverables and readiness criteria to ensure the field is adequately prepared to advance to each subsequent phase. For instance, the timeline could indicate when technical specifications for FHIR-based reporting will be released, allowing vendors sufficient time to incorporate them into their systems, and when these specifications will be integrated into certification requirements.

Simultaneously, CMS should develop the internal infrastructure needed to receive data via FHIR-based application programming interfaces (APIs) and provide guidance and educational resources to support hospitals during this transition. Once CMS confirms that vendors are certified and capable of supporting FHIR-based reporting—and that CMS itself is ready to accept the data—it should establish a reasonable timeframe for hospitals to begin submitting these measures, which we believe will take more than the proposed two years. Hospitals must budget, train, and create processes for each eQOM implementation and a two-year timeline will not be sufficient, particularly if hospitals are required to implement multiple measures at one time.

Within this timeline, we also urge CMS to enable widespread testing across multiple vendors and systems to ensure that the required data can be collected. We are especially concerned that small and/or rural hospitals will need additional time and potentially funding to support these changes. The current approach of testing in two or three EHRs primarily within academic medical centers or health systems is insufficient and real-world testing that represents the facilities across the United States will be critical.

The FAH and our members support this shift but caution CMS on moving too quickly without the needed infrastructure and resources in place. We offer our assistance in advising on this glidepath and associated steps and milestones as CMS moves toward digital measurement.

X.C. Hospital Inpatient Quality Reporting (IQR) Program

Measure Concepts Under Consideration for Future Years in the Hospital IQR Program– Request for Information (RFI): Well-Being and Nutrition

CMS requests feedback on well-being and nutrition measures for the upcoming years in the Hospital IQR Program.

The FAH agrees that these topics are very important to address; however, we do not believe that developing and implementing hospital-level quality measures would prove to be effective. We encourage CMS to consider quality measures for these areas in other clinical settings where providers can effectively address any gaps. Quality measures should be actionable for the providers and settings to which they are applied, and, in this instance, we do not believe that these topics lend themselves to attribution in the inpatient setting.

Proposed Modification of the Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate Following Acute Ischemic Stroke Hospitalization Measure Beginning with the FY 2027 Payment Determination

Similar to other updates proposed for HRRP and HACRP, CMS proposes modifications to the stroke mortality measure, starting with the FY 2027 program year. The updates to the measure include:

- Expanding to include Medicare Advantage (MA) patients
- Reducing the performance period from three years to two years
- Updating the risk adjustment model to use individual ICD-10 codes instead of HCCs
- Removing the exclusion of patients with a secondary diagnosis code of COVID-19 coded as POA on the index admission claim.

While the FAH has no concerns with the removal of the COVID-19 exclusion from these measures, we reiterate our concerns on the timing of the inclusion of MA patients, decrease in the performance period, and updating of the risk model. These changes must be implemented in phases to allow hospitals to understand the potential impact to their performance scores and enable them to continue to drive quality improvement to their patients.

Proposed Modification to the Hospital-Level, Risk-Standardized Complication Rate Following Elective Primary Total Hip Arthroplasty (THA) and/or Total Knee Arthroplasty (TKA) Measure Beginning with the FY 2027 Payment Determination

CMS' proposed updates to this measure are outlined under the Hospital VBP section. CMS would begin to report this revised measure for the FY 2027 payment determination. The FAH reiterates our concerns regarding the proposed approach of implementing all the changes at the same time, while also not yet addressing the significant concerns raised during the most recent E&M committee review. We urge CMS to consider our comments prior to finalizing these changes.

Proposed Removals in the Hospital IQR Program Measure Set

CMS proposes removing the following measures from the program:

- Hospital Commitment to Health Equity measure beginning with the CY 2024 reporting period/FY 2026 payment determination.
- COVID-19 Vaccination Coverage among Healthcare Personnel measure beginning with the CY 2024 reporting period/FY 2026 payment determination.
- Screening for Social Drivers of Health measure beginning with the CY 2024 reporting period/FY 2026 payment determination.
- Screen Positive Rate for Social Drivers of Health measure beginning with the CY 2024 reporting period/FY 2026 payment determination.

All four measures are proposed to be removed because the burden of data collection may outweigh the benefits. **The FAH supports the removal of these measures and encourages CMS to consider additional removal of the Healthcare Personnel Influenza Vaccination measure as we do not believe that the burden of data collection outweighs the benefits for that measure.**

Furthermore, we strongly encourage CMS to consider removing the Patient-Reported Outcome-based Performance Measure (PRO-PM) Following an Elective Primary Total Hip Arthroplasty (THA) and/or Total Knee Arthroplasty (TKA) (THA/TKA PRO-PM) from the program as it is extremely costly and burdensome to administer and collect the required surveys and track patients for more than a year. Hospitals continue to struggle to collect the required minimum set of data and surveys. For example, it is extremely difficult to get reliable phone numbers and emails for patients, and the 50% collection requirement is next to impossible to achieve. The current data collection approach also does not consider the challenges that facilities within a rural community encounter since it is likely that surveys must be collected via land line phones as reliable internet and cell service may not be available. These hospitals must incur additional costs and the burden to be compliant with the minimum requirements increases significantly.

Additional workflows must be designed and integrated that add to the clinical team's responsibilities such as manually confirming that a patient has completed the surveys needed prior to surgery and if not, ensuring that they administer what is missing before surgery begins. One hospital reported that each survey administration costs approximately \$40 using a third-party vendor since current staffing cannot support this additional work. These administration costs are just the beginning since there are additional expenses and staffing needed to complete the follow-up required for the measure.

Most importantly, hospitals report that there is limited to no opportunity to improve patient experience and outcomes for these two surgeries using this measure since feedback on performance cannot be provided quickly and hospitals are unable to leverage the results to drive quality improvements in a timely way.

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Proposed Modification to the Reporting of the Hybrid Hospital-Wide All-Cause Readmission (HWR) and Hybrid Hospital-Wide All-Cause Risk Standardized Mortality (HWM) Measures: Decrease of the Hybrid Measures CCDE and Linking Variable Submission Thresholds Beginning with the FY 2028 Payment Determination

CMS proposes reducing these submission thresholds to at least 70 percent for both measures and allowing up to two missing laboratory results and up to two missing vital signs. Hospitals not meeting these criteria would face a payment reduction.

The FAH appreciates CMS' recognition of the need to reduce the required thresholds for the data elements derived from EHRs. Hospitals continue to work with vendors and staff to ensure that the data used are reliable and valid. We encourage CMS to monitor the hospitals' ability to collect and report these data and continue to refine the measure specifications to align with clinical workflows.

X.F. Medicare Promoting Interoperability Program

The FAH appreciates CMS' continued efforts to evolve the Medicare Promoting Interoperability Program in ways that promote data exchange, patient safety, and improved public health infrastructure. While we support the overall direction of CMS' proposals, we urge the agency to maintain a flexible and readiness-based approach, particularly for hospitals operating with constrained IT and staffing resources. As outlined below, several of CMS' proposals would benefit from phased implementation, more tailored expectations, or alignment with previously established federal timelines and capabilities.

Security Risk Analysis and Management

The FAH supports CMS' proposal to require eligible hospitals to attest to having conducted a security risk analysis and to having undertaken corresponding security risk management activities beginning with the calendar year (CY) 2026 electronic health record (EHR) reporting period. This proposal aligns with the HIPAA Security Rule and reflects the best current practices in hospital cybersecurity. To support consistent implementation, we recommend that CMS provide guidance modeled after the Office for Civil Rights' documentation expectations under its "Recognized Security Practices" standard, which encourages hospitals to demonstrate active mitigation steps alongside risk assessments.

SAFER Guides Measure

While the FAH supports the goal of enhancing EHR safety, we urge CMS to reconsider the proposed requirement for annual attestation of completion of all eight Safety Assurance Factors for EHR Resilience (SAFER) Guides. Many of the domains addressed in the SAFER Guides—such as contingency planning, patient identification, and alerting mechanisms—are already covered under the security risk analysis and through ONC-certified EHR functionalities.

Requiring annual attestation to all guides introduces substantial administrative burden, especially for hospitals in rural or resource-constrained settings, without a strong evidence

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linking the process to improved safety outcomes. We recommend that CMS either make the SAFER attestation optional or allow hospitals to demonstrate compliance through alternative, nationally recognized safety evaluations. Additionally, CMS should clarify what documentation will be expected in the case of audit and whether EHR vendors may share accountability for SAFER-related implementation where relevant configuration and interoperability components are vendor-managed.

Public Health and Clinical Data Exchange: TEFCA Bonus Measure

The FAH appreciates CMS' proposal to introduce a Trusted Exchange Framework and Common Agreement (TEFCA)-based bonus measure as a forward-looking strategy to promote public health data interoperability. While we agree with CMS' vision, we caution that readiness across hospitals, public health agencies, and Qualified Health Information Networks (QHINs) remains uneven. Because TEFCA relies on multilateral participation across the data exchange ecosystem, it cannot yet function as a viable national reporting mechanism. The FAH recommends that CMS publish a TEFCA readiness framework, including benchmarks for public health agency onboarding, QHIN participation, and EHR vendor integration. CMS should continue to treat TEFCA participation as optional and ensure that hospitals lacking access to a functioning QHIN or TEFCA-enabled registry are not penalized under the Promoting Interoperability Program.

Request for Information: Public Health and Clinical Data Exchange Objective – Performance-Based Measures and Data Quality

CMS has requested public comments on the potential development of performance-based measures that assess the quality of public health and clinical data exchange. Specifically, CMS seeks input on possible measures, the standardization of definitions for completeness, timeliness, and validity, existing tools or benchmarks that may be applicable, and any additional policy or operational considerations relevant to such work.

The FAH appreciates this opportunity to respond. We support enhancing the quality and utility of public health reporting but believe that foundational challenges must be addressed before implementing such measures. Many hospitals face persistent difficulties with HL7 data mapping, registry access, and interoperability due to variation in state and local public health infrastructures. These gaps would likely result in significant reporting inconsistencies if CMS were to implement quality measures at this time.

We recommend that CMS initiate voluntary pilots and explore existing data evaluation frameworks, such as the Patient Information Quality Improvement (PIQI) Framework, which evaluates accuracy, completeness, and timeliness using provider-submitted clinical data.³⁸ We recommend that CMS prioritize resolving the challenges mentioned above to avoid placing undue burden on healthcare providers. Introducing additional requirements before establishing robust quality standards would be premature.

³⁸ Chute, Christopher G., et al. "Secondary Use of Clinical Data: Review of the Literature and Recommendations." *Journal of the American Medical Informatics Association*, vol. 17, no. 4, 2010, pp. 144–150.

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Furthermore, we urge CMS to avoid duplicative reporting obligations between the Promoting Interoperability Program, the Hospital Inpatient Quality Reporting Program, and the Merit-Based Incentive Payment System. To ensure provider success, public health data quality measures must be actionable, aligned across programs, and introduced with infrastructure support and educational resources.

Overview of Scoring Methodology for the EHR Reporting Period in CY 2026

We believe requiring a passing score above 70 could pose challenges for smaller hospital systems, particularly those not part of a national health information exchange (HIE) and cannot attain the full 30 points for the Health Information Exchange Objective. These hospitals may lack the necessary resources to connect to a national HIE, unlike larger hospital systems. For smaller, independent hospitals, the associated costs may outweigh the benefits of larger health systems.

We propose gradually increasing the passing score in 5–10-point increments over several reporting years. This will better position eligible hospitals and healthcare providers more generally to allocate the time and resources required to maintain compliance, thus reducing the overall burden. We want CMS to emphasize innovation more within the program objectives. This could be accomplished by introducing new measures to the program under a menu section, as was available under previous iterations, enabling eligible hospitals to attest to measures strategically aligned with their other goals and prove their value through some level of organic adoption. We also want to understand how electronic prior authorization will be integrated into the proposed scoring methodology. The IPPS proposed rule does not mention electronic prior authorization requirements, though they directly impact the Promoting Interoperability Program by incorporating a new measure beginning in CY 2027.

Request for Information: Prescription Drug Monitoring Program (PDMP) Measure Expansion

CMS also issued a request for feedback on whether to expand the current Prescription Drug Monitoring Program (PDMP) measure to include all Schedule II controlled substances, rather than limiting it to opioids. CMS specifically asks for comment on the clinical appropriateness of such an expansion, the operational feasibility of querying for all Schedule II drugs within clinical workflows, and the expected challenges or benefits of this policy change.

The FAH supports the intent of PDMP utilization to enhance patient safety and reduce medication misuse, but we strongly caution against expanding the current measure until systemic access and interoperability challenges are resolved. Hospitals in many states still operate under legal and technical barriers that limit direct access to PDMP systems or preclude role-based querying by pharmacists and clinical support staff. In many settings, PDMPs are not integrated into EHR workflows, requiring clinicians to exit and re-enter platforms to retrieve controlled substance histories—disrupting patient care and increasing administrative burden.

We believe that such a measure should remain voluntary until consistent access and integration standards are established nationwide. We also recommend that CMS clarify how

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attestation should be handled in team-based models where non-prescribing clinicians query the PDMP, and whether CMS expects full EHR integration to be in place to satisfy this requirement. Expanding the PDMP measure without addressing these operational realities would disproportionately affect hospitals that are technically or legally constrained and may result in lower compliance despite high intent.

Electronic Prior Authorization Readiness

The FAH supports CMS' broader goal of advancing electronic prior authorization (ePA) as a key step in streamlining administrative processes and improving care coordination. However, we reiterate that hospitals cannot comply with ePA expectations until payers and health IT vendors have fully implemented the necessary FHIR-based application programming interfaces and met ONC Health IT Certification requirements. In prior comments on CMS' interoperability and ePA rulemaking, the FAH urged the agency to adopt a phased approach that delays provider-side requirements until the payer ecosystem and EHR vendor infrastructure are certified and functional.

We encourage CMS to align ePA implementation timelines with ONC's Health IT Certification Program and to allow at least twelve months of operational lead time for hospitals to configure, test, and deploy certified workflows. We also recommend that CMS explore financial and technical support mechanisms for smaller or rural hospitals to help address the resource-intensive nature of implementation. A readiness-based approach supported by technical validation, stakeholder education, and field testing is essential to a successful national rollout.

The FAH supports the strategic direction of the Medicare Promoting Interoperability Program and shares CMS' goals of improving health IT safety, data quality, and public health interoperability. However, these reforms must be implemented in a way that acknowledges the realities of current infrastructure gaps and workforce limitations. A phased, voluntary, and readiness-based approach—grounded in real-world testing and stakeholder collaboration—will ensure the success of these important policy goals.

Transforming Episode Accountability Model (TEAM)

CMS Lacks the Authority to Mandate Provider Participation in CMMI Models

CMS proposes to proceed with national, mandatory testing of the Transforming Episode Accountability Model (TEAM). The FAH continues to strongly oppose mandatory provider participation in any Centers for Medicare and Medicaid Innovation (CMMI) testing. The FAH has repeatedly expressed significant legal and policy concerns with mandatory CMMI models and has urged HHS to ensure that CMMI acts only within its designated authority to test voluntary alternative payment models. These objections to mandatory demonstrations are particularly acute with respect to the TEAM testing in light of its extraordinarily wide proposed breadth—both in terms of the proportion of subsection (d) hospitals that will be mandated to participate and in terms of the proportion of surgical encounters that fall within the five surgical episode categories.

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Mandatory provider and supplier participation in CMMI models affects an impermissible mandatory change to the Medicare program and runs counter to both the letter and spirit of the law that established the CMMI. CMMI’s demonstration authority is limited to the testing models under section 1115A and the making of recommendations to Congress, but Congress reserved for itself the authority to make permanent or mandatory changes to the Medicare program and the IPPS through legislation.

CMS nonetheless proposes to proceed with TEAM, a five-year “mandatory model that will be tested under the authority of section 1115A of the Act.”³⁹ Case law, however, confirms that CMS’ assertion of authority under section 1115A to mandate a demonstration model is misplaced. In recent years, courts have continued to make clear that constitutional limits inform the scope of agency authority. In particular, grants of authority to agencies must be narrowly construed and delegations of broad authority should not be presumed to exist. For example, the Supreme Court has been explicit that agencies must have clear Congressional authorization to exercise extraordinary regulatory authority.⁴⁰ “Agencies have only those powers given to them by Congress, and ‘enabling legislation’ is generally not an ‘open book to which the agency [may] add pages and change the plot line.’”⁴¹ As such, Congress does not typically use “modest words,” “vague terms,” “subtle devices,” or “oblique or elliptical language” to empower an agency to make a fundamental change to a statutory scheme.⁴²

Mandating provider participation in TEAM (and other CMMI models) transforms the methodology through which providers receive Medicare payments from the statutorily mandated, predictable prospective payment system to interim, uncertain payments, and potentially recoupable losses. No such authorization exists or should be presumed to exist here—Congress has not included in the authorizing statute any statements indicating that it intended to and actually did delegate its lawmaking role to CMS to require providers to accept this different, unpredictable payment scheme in lieu of full IPPS payments for these services. Rather, § 1115A(g) indicates Congress reserved the authority to adopt such fundamental alterations for itself.

Notably, were Congress to have clearly articulated such a broad delegation of authority to CMS to alter the Medicare reimbursement scheme (again, it has not), it would need to provide intelligible principles defining the scope of its delegated authority to ensure such a delegation to the agency was constitutionally sound. This is especially true because Congress precluded administrative or judicial review of a substantial number of matters of CMMI demonstration authority under section 1115A(d)(2) to permit the testing of models.

³⁹ 90 Fed. Reg. 18,007.

⁴⁰ *W. Virginia v. Env’t Prot. Agency*, 597 U.S. 697, 732 (2022).

⁴¹ *Id.* at 723.

⁴² *Id.* (citing *Whitman v. American Trucking Assns., Inc.*, 531 U.S. 457, 468 (2001); *MCI Telecommunications Corp. v. American Telephone & Telegraph Co.*, 512 U.S. 218, 229 (1994)). *See also Biden v. Nebraska*, 143 S. Ct. 2355, 2372–75 (2023) (Congress did not provide “clear congressional authorization” for the Secretary to act in ways that would in effect fundamentally revise the statutory scheme).

Separately, requiring Medicare providers to participate in TEAM Track 2 or 3, which require participants to be held financially accountable if spending on specified episodes of care exceeds the model's reconciliation target price, means that Medicare providers will be required to furnish medically necessary services to Medicare beneficiaries without payment. CMS has previously taken the position that mandatory demonstrations with two-sided risk do not reduce guaranteed Medicare benefits because model participants are required to provide medically necessary covered services even if such services are not separately payable.⁴³ However, this approach fails to justly compensate Medicare providers for the use of their services by Medicare beneficiaries in violation of the Fifth Amendment of the United States Constitution and the Medicare Act.

In sum, the mandatory TEAM demonstration is an overreach of agency authority that contradicts the statutory mandate of section 1115A and raises concerns about impermissible delegation of lawmaking authority to the executive branch and unjust compensation for services provided to Medicare beneficiaries. These concerns are particularly acute in light of the extraordinary breadth of the proposed demonstration: Approximately 25 percent of eligible CBSAs would be selected and all subsection (d) hospitals within selected CBSAs would be required to participate in all five episode-based payment models that are part of the TEAM demonstration. **Because section 1115A does not authorize mandatory payment demonstrations, we strongly oppose the implementation of the TEAM demonstration as proposed. Instead, we urge CMS to ensure that all CMMI models are voluntary and designed to test—at an appropriate scale—alternative payment models.**

XI.A. Proposed Changes to TEAM

While CMS has proposed a series of modifications to the TEAM model in this rulemaking cycle, several of the changes do not sufficiently address the ongoing operational and financial burdens that hospitals will face under this expansive, mandatory payment demonstration. For example, the proposed addition of the *Information Transfer PRO-PM* to the TEAM quality measure set in performance years 3 through 5 raises significant concerns. This measure, which is already included under the Hospital Outpatient Quality Reporting Program (OQR), imposes duplicative burdens and fails to reflect actionable or clinically meaningful information in the context of a surgical episode-based payment model. The Information Transfer PRO-PM is inherently subjective, functioning more as an opinion survey than a robust quality metric. Coupling this measure with the existing THA/TKA PRO-PM within TEAM, despite the lack of comparative benchmarks or prior performance experience, which places hospitals at considerable disadvantage and risks penalizing them based on unreliable or incomplete data.

The FAH strongly opposes the inclusion of either PRO-PM in the TEAM model. The resource demands and technical difficulties associated with these measures are well-documented. Hospitals must submit a minimum of 300 survey responses under the Information Transfer PRO-

⁴³ *E.g.*, 85 Fed. Reg. 61,114, 61,141 (Sep. 29, 2020) (noting that the proposed model would not result in a reduction of guaranteed Medicare benefits because participants are required to continue to make medically necessary covered services available to beneficiaries to the extent required by law.”)

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PM, an arbitrary threshold that becomes untenable for lower-volume sites. For hospitals with fewer than 300 qualifying episodes, CMS effectively expects a 100% response rate—an unrealistic standard given challenges such as unreliable patient contact information, inconsistent internet access in rural areas, and limited clinical bandwidth to oversee preoperative survey compliance. Additionally, hospitals continue to report that follow-up survey tracking for the THA/TKA PRO-PM is operationally complex and financially burdensome, with one system estimating administration costs at \$40 per survey. The cumulative cost—including staffing, vendor fees, and data management infrastructure—is not sustainable. Critically, these measures do not provide timely or actionable insights to drive improvements in patient experience or clinical quality.

We are further concerned by the proposed methodology for calculating target prices and the divergence introduced between prospective and final reconciliation methods. Specifically, CMS proposes a linear regression model using additional trend years (2020 and 2021) to establish the prospective trend factor for preliminary target prices, while retaining a different method for computing final reconciliation. This bifurcation creates unnecessary complexity and fosters uncertainty for providers. The use of COVID-era data to inform prospective trends may produce skewed results due to the atypical utilization patterns during those years. The FAH urges CMS to retain the prospective trend factor methodology finalized in the FY 2025 rule and avoid introducing a moving target that jeopardizes hospitals' ability to reasonably forecast financial exposure.

The rule also fails to sufficiently address hospitals with low surgical episode volumes. We urge CMS to exclude from reconciliation any surgical episode category for which a hospital does not have at least 72 qualifying episodes over the three-year baseline (equivalent to two procedures per month). For hospitals that do not meet this threshold in any of the five TEAM surgical categories, we recommend excluding the facility from participation in the TEAM model altogether for that performance year. Such a policy would recognize the reality that meaningful intervention and investment in episodic care management is economically impractical when volume is low, and risk is disproportionately high.

The FAH also reiterates its objection to the requirement that hospitals ensure primary care provider (PCP) follow-up is included in discharge instructions under TEAM. For surgical episodes, specialist follow-up is often more appropriate and clinically relevant. Imposing this requirement as a blanket rule undercuts surgical best practices and fragments postoperative care planning.

These concerns are amplified by our overarching objections to the mandatory nature of TEAM. We continue to believe that the scope and scale of the TEAM model do not constitute a “test” within the bounds of Section 1115A. The affected provider base is far too large, and the magnitude of financial risk imposed—particularly through required downside risk, mandatory participation in Tracks 2 and 3, and CMS' unilateral discounting of target prices—resembles a de facto payment policy rather than a demonstration project. We reiterate our strong opposition to CMS' designation of hospitals as sole risk-bearing entities, to mandatory beneficiary notifications triggered by DRG categorization prior to final discharge, and to CMS' guarantee of

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Medicare savings through price reductions, which functions more as a fee cut than as a value-based incentive.

We urge CMS to substantially scale back or suspend implementation of TEAM as currently proposed. At a minimum, the model should be voluntary and redesigned to reflect true pilot testing principles—limited in scope, appropriately risk-adjusted, and responsive to the operational capabilities of diverse hospital types and sizes.

APPENDIX B:
Watson Policy Analysis of FY 2026 Outlier Payments

Summary of research modeling
FY 2026 Proposed Inpatient Prospective Payment System

Outlier Payments

Date: June 2, 2025

Introduction

Watson Policy Analysis (WPA) was asked to analyze issues and replicate outlier payments from the Centers for Medicare & Medicaid Services (CMS) Fiscal Year (FY) 2026 Inpatient Prospective Payment System (IPPS) proposed rule. In short, this outlier policy sets forth a set of rules whereby CMS provides payment to inpatient hospitals for a portion of their high cost inpatient cases once particular thresholds are met. CMS describes its methodology and logic starting on page 18430 of the Federal Register.¹ We attempted to replicate the CMS logic and then compared our results and made a variety of adjustments to assess the impact of using different parameters. This report summarizes our findings.

Summary

A summary of findings is as follows:

- WPA was able to come very close to the CMS calculation of the Fixed Loss Threshold (FLT) (within 0.5%).
- WPA replicated other factors that went into the payment calculation.
- WPA was able to replicate the CMS calculation of the necessary adjustment for the target percentage based on the outlier reconciliations reported in the cost reports.
- WPA was able to come close to the estimate of charge inflation.

Background on outlier payments

In the IPPS program, CMS has established the concept of “outliers” to be high cost cases which are paid an additional amount so that providers’ potential losses are limited. When the estimated costs of a case exceed the payment for the case, plus a threshold, CMS will generally pay 80% of the costs that exceed the payment plus the threshold. CMS pays 90% for discharges assigned to one of the “burn” diagnosis related groups (DRGs).

This threshold is known as the “fixed loss threshold” (FLT) and is set prospectively with each rule based on a target that operating outlier payments will be 5.1% of total operating payments, including outliers. This target is determined by simulations of expected payments.

¹ "Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long Term Care Hospital Prospective Payment System and Proposed Policy Changes and Fiscal Year 2026 Rates; Quality Programs Requirements; and Other Policy Changes". Published in Federal Register, Vol 90, No. 82, April 30, 2025

Background from CMS on outlier payments can be found at:
<http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/outlier.html>

Additional detail is provided by CMS each year in the IPPS rule.

Analysis 1: Replication of the CMS estimated FY 2026 outlier payment from the FY 2026 IPPS proposed rule

WPA estimated payments, including outlier payments from the FY 2024 Proposed Medicare Provider Analysis and Review (MedPAR) Proposed File, following the methodology set forth in various IPPS rules. In modeling payments, WPA used information from the following data sources:

- MedPAR FY 2026 proposed file: contains inpatient hospital claims from FY 2023 that were used by CMS to model proposed FY 2025 payments,
- Table 5 – Weight file: contains the proposed weights for FY 2026,
- Impact file: contains hospital specific characteristics and payment factors,
- DSH Supplemental File: contains uncompensated care per claim payment amounts for providers,
- The FY2026 Proposed IPPS rule, in particular information on cost and charge inflation factors, and
- Inpatient Provider of Services File: contains provider specific information.
- Hospital Cost Reporting Information System (HCRIS) data containing cost reports from providers. This information was used to calculate the adjustment to the outlier target based on the historical outlier reconciliation.

In addition, other factors such as charge inflation, CCR adjustment factors, and standardized payment amounts from the proposed rule were used.

Complete payments were calculated including operating, capital, disproportionate share hospital (DSH), indirect medical education (IME), uncompensated care, etc. for each case, following the CMS methodology. The CMS methodology excludes sole community hospitals, hospitals that have become Critical Access Hospitals (CAHs), and Maryland hospitals.

Please note that the FLT will adjust with the release of the final rule and associated files, in addition to the recalculated weights.

Analysis 2: Comparison of Cost-to-Charge ratios from the FY 2026 proposed rule Impact file and the Inpatient Provider Specific File

As part of the analysis, we compared the CCRs included in the impact file (used in modeling the FLT) with the CCRs from the Provider Specific File (PSF). CMS used the same CCRs both in the proposed blended methodology and in the alternative methodology.

For the modeling using the FY 2024 data, used the December 2024 release of the PSF file. Comparing the 3,108 providers listed in the impact file and the December 2024 PSF file, we had a match rate of 96.49% (2,999 providers).

Using this data, the average difference in operating CCRs between the impact file and the PSF file (weighted by discharges) was -0.087% when all providers were used, and -4.524% when just providers with differences were used.

For the modeling using the FY 2024 data, used the March 2025 release of the PSF file. Comparing the 3,108 providers listed in the impact file and the March 2025 PSF file, we had a match rate of 71.847% (2,233 providers).

Using this data, the average difference in operating CCRs between the impact file and the PSF file (weighted by discharges) was 0.247% when all providers were used, and -0.779% when just providers with differences were used.

The table of matching statistics reported nearly nine years ago in a report from The Moran Company – “Modeling Fiscal Year 2015 Inpatient Prospective Payment System Outlier Payments” dated June 23, 2014, and then updated with WPA calculated data is as follows:

IPPS Rule for FY	Matching Rate Between Impact file and Most recent PSF CCRs	Average Percent Difference Between the Impact File and Most Recent PSF Operating CCR of the Same Hospital (weighted By Discharges)
Final 2010*	93.2%	0.4%
Final 2011*	96.4%	0.1%
Final 2012 - Dec 2010 Update	96.9%	0.2%
Final 2012 - March 2011 Update	65.3%	1.6%
Final 2013	92.1%	0.0%
Final 2014	97.2%	-0.1%
Proposed 2015 - Dec 2015 Update	98.8%	-2.7%
Proposed 2015 - March 2015 Update	64.8%	1.0%
Proposed 2016 - Dec 2015 Update	89.6%	-0.02%
Proposed 2016 - March 2015 Update	61.6%	0.19%
Proposed 2017 - Dec 2016 Update	94.16%	-0.014%
Proposed 2017 - March 2017 Update	65.70%	0.236%
Proposed 2018 – December 2017 update	94.33%	-0.017%
Proposed 2018 – March 2018 update	67.33%	-0.342%
Proposed 2019 – December 2018 update	97.33%	-0.002%
Proposed 2019 – March 2018 update	67.69%	0.240%
Proposed 2020 – December 2018 update	97.49%	-0.027%
Proposed 2020 – March 2019 update	70.12%	0.209%
Proposed 2021 – December 2020 update	97.49%	-0.027%
Proposed 2021 – March 2020 update	70.12%	0.209%
Proposed 2022 – December 2019 update	96.35%	-0.648%
Proposed 2022 – March 2020 update	68.49%	-0.208%

Proposed 2023 – December 2021 update	75.23%	0.119%
Proposed 2023 – March 2022 update	78.59%	0.001%
Proposed 2024 – December 2022 update	96.34%	0.001%
Proposed 2024 – March 2023 update	73.40%	-0.002%
Proposed 2025 – December 2023 update	93.86%	-0.035%
Proposed 2025 – March 2024 update	72.30%	-0.722%

* Vaida Health Data Consulting, Modeling FY 2013 IPPS Outlier Payment. June 11, 2012

Note that WPA developed new programs to analyze the data, so there may be differences with the previous analyses by The Moran Company and Vaida Health Consulting. However, the matching percentage calculated by WPA is within a similar matching percentage as that calculated by the Moran Company. In addition, the average difference in operating CCR is much smaller.

Analysis 3: Fixed Loss Threshold over time

From examining the fixed loss threshold in proposed rules and final rules, there is a pattern of the fixed loss threshold declining. The following table shows the fixed loss thresholds for recent years.

FY	Final	Proposed	Variance	% of Variance
2009	\$ 20,045	\$ 21,025	\$ (980)	-4.66%
2010	\$ 23,140	\$ 24,240	\$ (1,100)	-4.54%
2011	\$ 23,075	\$ 24,165	\$ (1,090)	-4.51%
2012	\$ 22,385	\$ 23,375	\$ (990)	-4.24%
2013	\$ 21,821	\$ 23,630	\$ (1,809)	-7.66%
2014	\$ 21,748	\$ 24,140	\$ (2,392)	-9.90%
2015	\$ 24,626	\$ 25,799	\$ (1,173)	-4.55%
2016	\$ 22,544	\$ 24,485	\$ (1,941)	-7.93%
2017	\$ 23,573	\$ 23,681	\$ (108)	-0.46%
2018	\$ 26,537	\$ 26,713	\$ (176)	-0.66%
2019	\$ 25,769	\$ 27,545	\$ (1,776)	-6.45%
2020	\$ 26,552	\$ 26,994	\$ (521)	-1.93%
2021	\$ 29,064	\$ 30,006	\$ (942)	-3.31%
2022	\$ 30,988	\$ 30,967	\$ 21	0.07%
2023	\$ 38,859	\$ 43,214	\$ (4,355)	-11.21%
2024	\$ 42,750	\$ 40,732	\$ 2,018	4.95%
2025	\$ 46,217	\$ 49,237	\$ (3,020)	-6.13%
2026		\$44,305		

Note: FY 2023 is based on the proposed blended weight for weighting. Final rule FLT is also blended. Methodology for FY2023 final rule FLT is different than the proposed rule due to the blending, so change from proposed to final should be viewed with caution and not a standard change.

Note: FY 2024 reverted back to not using blended weight or FLT.

Note: FY 2025 Final is as published in the FY 2025 Interim Final Rule with Comment (IFC) version.

Analysis 4: Outlier Reconciliation

In the FY2020 IPPS rule, CMS finalized a new methodology to adjust the outlier target percentage to account for outlier reconciliation. For the FY 2026 rule, CMS is continuing to implement the updated methodology finalized in the FY2025 Final IPPS rule. This updated methodology accounts for the new criteria put forth in Change Request (CR) 13566 issued in 2024. The CR instructs MACs to expand the criteria for cost reports that can be considered for outlier reconciliation. Instead of needing a discrepancy of +/- 10 “percentage points” between the actual operating CCR and the operating CCR used for outlier payment during the same time period, the new criterion is +/- 20 “percent”. This change results in more hospitals being evaluated for outlier reconciliation.

WPA was successful in replicating the CMS calculations given the logic described. WPA matched their rounded calculation of +0.1% when using the FY 2020 cost report data released with the December 2024 update of HCRIS and the CMS issued Public Use File for the imputed

amounts calculated from data supplied by the MACs. Unrounded, CMS computed 0.095654 while WPA calculated unrounded results of: 0.0966319. The difference is due to slight difference in the estimated Federal Operating payment, while matching exactly on the outlier reconciliation amount.

Given CMS's interpretation of this as an "... an anomaly and may not be an accurate predictor of outlier reconciliations..." (Federal Register Vol. 90, No 82, P. 18432), CMS is proposing to continue to use the threshold from the FY2025 Final IPPS rule.

The March 2024 release of HCRIS, the March 2024 update to the Provider Specific File, and presumably updated data from the MACs will be used in the final rule. As WPA does not have access to the data feed from the MACs, we cannot estimate the final rule results at this time.

Analysis 5: Explorations on high charge cases

As evidenced in Analysis 3, the Fixed Loss Threshold has been adjusting over time, generally increasing. In response to this, WPA conducted various examinations and probing of the data and other issues that may relate to the Fixed Loss Threshold.

No single, definitive, cause for the increase was identified. However, one intriguing finding of this research was:

- a) The impact of "extreme" cases on the Fixed Loss Threshold; and
- b) The increase in the rate of "extreme" cases.

In the IPPS rate-setting process, statistical outliers – extreme cases – generally are removed from the calculations during the normal methodology. However, these cases are left in during the calculation of the Fixed Loss Threshold.

To examine this issue, WPA tested trimming out cases with covered charges greater than particular thresholds. This removed the case if the covered charges were greater than a threshold.

The following table shows the results at different trim points when using the proposed blended weights data.

Scenario	Cases remaining	Removed cases	FLT	Percentage of cases removed
Base	6,693,693	0	\$44,515	0.00%
Trim at: 4,000,000	6,693,197	496	\$42,380	0.01%
Trim at: 3,750,000	6,693,102	591	\$42,153	0.01%
Trim at: 3,500,000	6,692,940	753	\$41,812	0.01%
Trim at: 3,250,000	6,692,719	974	\$41,358	0.01%
Trim at: 3,000,000	6,692,443	1,250	\$40,820	0.02%
Trim at: 2,750,000	6,692,039	1,654	\$40,173	0.02%
Trim at: 2,500,000	6,691,637	2,056	\$39,580	0.03%
Trim at: 2,250,000	6,690,954	2,739	\$38,820	0.04%
Trim at: 2,000,000	6,689,925	3,768	\$37,863	0.06%
Trim at: 1,750,000	6,668,594	5,099	\$36,831	0.08%
Trim at: 1,500,000	6,686,458	7,235	\$35,495	0.11%
Trim at: 1,250,000	6,682,645	11,048	\$33,790	0.17%
Trim at: 1,000,000	6,674,514	19,179	\$31,350	0.29%
Trim at: 750,000	6,655,302	38,391	\$27,905	0.57%
Trim at: 500,000	6,594,701	98,992	\$22,400	1.48%
Trim at: 250,000	6,279,559	414,134	\$13,162	6.19%

Removing a relatively small number of cases can have the impact of shifting the Fixed Loss Threshold potentially thousands of dollars.

As was noted in previous years, the number and proportion of very high charge cases (defined here as having *covered charges* greater than \$1.5 million) have been increasing over time. In the FY2024 data, this trend continued. (Note: The FY2023 data has been updated to final rule data.)

Year	Number of cases over \$1.5 million	Percentage of total cases	Number of unique providers
2011	926	0.0088%	272
2012	994	0.0098%	272
2013	1,092	0.0111%	283
2014	1,329	0.0141%	306
2015	1,539	0.0161%	320
2016	1,733	0.0185%	334
2017	2,291	0.0250%	403
2018	2,650	0.0286%	398
2019	3,128	0.0348%	441
2020	3,666	0.0474%	474
2021	4,719	0.0650%	530
2022	5,482	0.0803%	594
2023	6,620	0.0980%	607
2024	7,340	0.1095%	607

APPENDIX C:
FTI Report, 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

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 productivity and efficiency gains in the general economy, and is applied to reduce the annual market basket update. In FY 2025, the finalized productivity adjustment was 0.5 percentage points. For FY2026, the proposed productivity adjustment is 0.8 percentage points, thereby reducing the market basket update increase of 3.2% to 2.4%. Table 1 summarizes the historical market basket, productivity adjustments and other legal adjustments that are applied to obtain the final operating payments rates from FY2014 through the proposed rates in FY2026.

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

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

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

Industry-specific challenges prevent hospitals from achieving productivity improvements in inpatient care consistent and concurrent with the private nonfarm business sector

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

Multiple studies indicate that hospital sector productivity falls below the general productivity gains of the general economy. The 10-year average of published BLS TFP growth for the private nonfarm

sector is 0.8 for the 10-year period of 2015 – 2024. CMS' own estimates of hospital TFP conclude that at least through 2019, hospital TFP growth remained below BLS estimates of the private nonfarm business TFP growth. CMS used two methodologies to compute hospital TFP and found that average growth rate of hospital TFP ranged from 0.2 to 0.5 percent, compared to the average growth of private nonfarm business TFP of 0.8 percent.⁸ In the 2021 Trustees Report, it was assumed that hospitals could achieve productivity gains of 0.4 percent year over year in the long run.⁹

Hospitals encounter substantial regulatory requirements unique to the healthcare sector. Hospitals must then bear the cost to maintain compliance with these regulations. Government-set reimbursement rates have not kept pace with inflation, covering only 83 cents for every dollar hospitals spent in 2023.¹⁰ Hospitals also face requirements to keep emergency departments open, such as the Emergency Medical Treatment and Labor Act (“EMTALA”)¹¹, which requires hospitals to provide stabilizing treatment regardless of patients' ability to pay, or to provide an appropriate transfer. Hospitals must also meet certain accreditation requirements, such as through The Joint Commission¹², which requires hospitals to meet certain quality standards and to undergo on-site survey inspections as a condition for participating in the Medicare program. There are also a variety of other legal requirements to maintain patient confidentiality, infection control protocols, and medication management systems to prevent errors that all add to the operational costs of running a hospital and require significant investment that does not necessarily contribute directly to productivity.

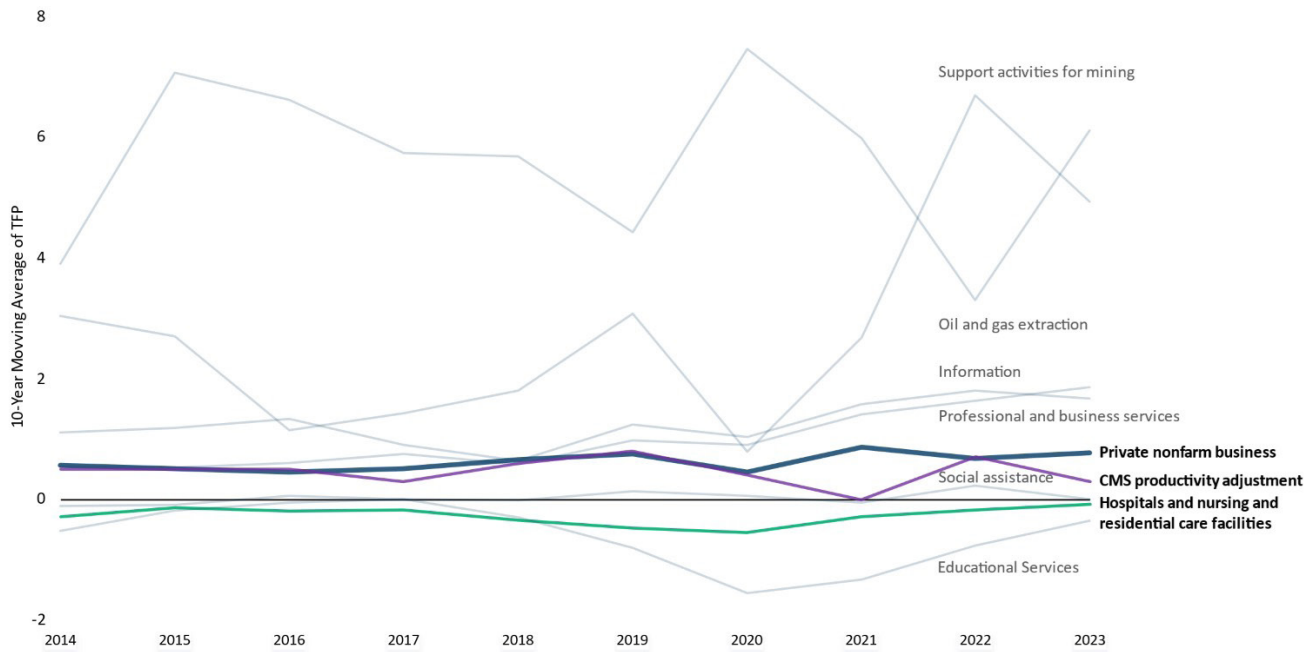
Hospitals vary widely across a range of characteristics, with each institution structured to address the unique healthcare needs of their local communities. They differ by ownership: 14.7% are public hospitals, 49.2% are private, non-profit hospitals and 36.1% are private for-profit hospitals¹³. Some 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 outputs¹⁵ (described further below). The hospitals and nursing and residential care facilities (NAICS 622-623) subsector¹⁶ had an average TFP of -0.1, Educational services (NAICS 61) sector had an average TFP of -0.4, and Social assistance (NAICS 624) had an average TFP of -0.1 over the same period.

Figure 1: 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 among 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 unwarrantedly 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 achievable 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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