June 10, 2025

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

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

Dear Administrator Oz:

On behalf of the Arizona Hospital and Healthcare Association (AzHHA) and our more than 80 hospitals, healthcare and affiliated health system members, we are pleased to present CMS with the following comments on the Centers for Medicare & Medicaid Services' (CMS') fiscal year (FY) 2026 LTCH prospective payment system (PPS) proposed rule. [1] We are submitting separate comments on the rule's inpatient PPS.

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

Unfortunately, Medicare payment dynamics and related factors have caused a contraction of the LTCH field. This not only limits the ability of certain high-need patients from receiving care at an LTCH, but also strains the entire continuum of care as acute-care hospitals and other providers must find ways to care for these patients. This rule has several proposals that will

[1] Since AzHHA agrees with the recommendations made by the American Hospital Association (AHA), our letter largely reflects language used by the AHA.

exacerbate the ongoing difficulties within the LTCH field, particularly the large proposed increase in the high-cost outlier threshold. Our detailed comments follow.

PROPOSED FY 2026 LTCH PPS PAYMENT UPDATES

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

Impact of Inflation and Dual-Rate Payment System on LTCHs

The combination of rising costs due to inflation and the novel dual-rate payment system imposed on LTCHs has challenged the LTCH field, with many hospitals unable to continue to operate under the pressures created by the confluence of these factors. Indeed, more than 100 LTCHs have closed since 2016 when the dual-rate payment system went into effect, accounting for nearly a quarter of all LTCHs. In Arizona, while other types of hospitals are increasing, we are seeing the closure of LTCHs. In the past decade, Arizona has gone from having eight LTCHs to six, despite a rapidly increasing population. This loss of important hospital capacity has and will continue to strain the continuum of care for upstream acute-care hospitals and other providers.

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

Hospitals Continue to Face High Rates of Inflation. Hospitals, including LTCHs, continue to face serious inflationary pressures, including unprecedented levels of inflation have raised labor, drug, supply and other costs. A recent report from the American Hospital Association (AHA) found that in 2024 alone, hospital expenses grew by 5.1%.[2] A large portion of this is growth is attributable to increased labor costs, which make up nearly three-quarters of the LTCH market basket, according to CMS itself. Another analysis by AHA found that hospital employee

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

compensation grew by 45% from 2014 to 2023.[3] However, the net market basket update to the LTCH PPS (market basket minus productivity), provided for only a 23.7% increase during this time. AHA has also found that advertised salaries for nurses have risen 26.6% in the last four years.[4] Such labor-related inflation has been driven in large part by a severe workforce shortage, which the Department of Health and Human Services (HHS) says will persist well into the future.[5] These shortages and rising costs significantly impact LTCHs due to the high acuity, complex nature, and labor-intensive treatments required by their patients.

In addition to labor costs, increasing drug and supply costs have also strained hospital finances. A recent report from HHS found that prices for nearly 2,000 drugs increased an average of 15.2% from 2017 through 2023, notably faster than the rate of general inflation.[6] Further, the American Society of Health System Pharmacists has found that numerous drug shortages are having a critically negative impact on hospital operations. This has a substantial impact on LTCHs as they care for patients with multiple comorbidities and who require extended hospitalizations.

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

Adding to the uncertainty facing providers is the threat of increased tariffs across many sectors, including those essential to the health care system. Despite ongoing efforts to build the domestic supply chain, the U.S. health care system relies significantly on international sources for many drugs, devices and other supplies needed to both care for patients and protect our health care workers. Tariffs, as well as any reaction by the countries on which such tariffs are imposed, could reduce the availability of these lifesaving items in the U.S. Indeed, a

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[3] AHA. America's Hospitals and Health Systems Continue to Face Escalating Operational Costs and Economic Pressures as They Care for Patients and Communities (April 2024) (https://www.aha.org/system/files/media/file/2024/05/Americas-Hospitals-and-Health-Systems-Continue-to-Face-Escalating-Operational-Costs-and-Economic-Pressures.pdf).

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

[5] ASPE Office of Health Policy. *Impact of the COVID-19 Pandemic on the Hospital and Outpatient Clinician Workforce*, HP-2022-13 at 1 (May 3, 2022).

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

[7] HHS OIG. Some Medicare Advantage Organization Denials of Prior Authorization Requests Raise Concerns About Beneficiary Access to Medically Necessary Care; (April 2022) (https://oig.hhs.gov/reports/all/2022/some-medicare-advantage-organization-denials-of-prior-authorization-requests-raise-concerns-about-beneficiary-access-to-medically-necessary-care/).

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

recent survey found 82% of health care experts expect tariff-related expenses to raise hospital costs by at least 15%.[9]

These escalating costs for clinicians, personnel, drugs and other essentials have put a strain on the entire health care continuum. Rising costs also have forced hospitals, including LTCHs, to divert funds that could have been invested in patient care, new technologies and other potential efficiencies, making the inadequate market basket updates provided by CMS even more concerning. In addition, as discussed more below, hospitals are unable to keep up with efficiencies that could be realized with less financial strain, heightening the harm caused by the productivity adjustment.

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

Market Basket Forecasts Continue to Underestimate Actual Market Basket Growth

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

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

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

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

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

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

	FY 2021	FY 2022	FY 2023	FY 2024	FY 2025	Total (Cumulative)
Market Basket Update in Final Rule	2.3%	2.6%	4.1%	3.5%	3.5%	17.0%
Actual/Updated Market Basket	2.8%	5.5%	4.8%	3.7%	3.6%	22.1%
Difference in Net Market Basket Update and Actual Increase	**-0.5%**	**-2.9%**	**-0.7%**	**-0.2%**	**-0.1%**	**-5.1%**

These missed forecasts have a significant and permanent impact on LTCHs and the patients they care for. At current levels, this cumulative underpayment of 5.1 percentage points totals approximately *$130 million annually*. Further, as CMS knows, future updates are based on current payment levels; therefore, absent action from CMS, these missed forecasts are permanently established in the standard payment rate for LTCHs and will continue to compound.

The Productivity Adjustment Further Exacerbates Underpayments

Under the Affordable Care Act, the LTCH PPS payment update is reduced annually by a productivity factor, which is equal to the 10-year moving average of changes in the annual economy-wide, private nonfarm business total factor productivity (TFP).[13] For FY 2026, CMS proposes a productivity cut of 0.8 percentage points.

The use of the private nonfarm business TFP is meant to capture gains from new technologies, economies of scale, business acumen, managerial skills and changes in production. **Thus, this measure effectively assumes the hospital field can mirror productivity gains achieved by private nonfarm businesses. However, as we discuss in more detail below and in the appendix, it is well proven by the economic literature that the hospital and health care field cannot do this.** For example, by focusing only on private businesses, this measure excludes nonprofit and government businesses, which account for more than 60% of hospitals and health systems. Thus, this measure is not an appropriate or reliable predictor of productivity for the hospital field. **As such, we ask CMS to re-examine the magnitude of this adjustment and its impact on Medicare payments.**

First, outputs in the TFP are measured as a function of the total quantity and prices of the goods and services produced in private nonfarm businesses. For sectors that sell tangible,

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

physical products, measuring these outputs is relatively straightforward and often standardized. However, hospital quantity and prices do not operate in this way. For example, hospital quantity, such as volume of visits or procedures, is not necessarily an appropriate output measure; it may actually be more reflective of the disease burden of a community. More hospital volume — thus more quantity — does not equate to more productivity in the same manner as it does for private nonfarm businesses.

In addition, hospital prices per unit of service often cannot be adjusted in response to changes in demand or quality; those of private nonfarm businesses can be. This is because much of hospitals' and health systems' reimbursement is through fixed payments, such as through the LTCH PPS; they cannot alter their prices in the same manner that private nonfarm businesses can. This is similarly true for their payments from private insurance. Hospitals and health systems do not set their rates. Instead, prices for commercially insured patients are determined through negotiations, which often lock in rates for several years. Thus, it makes relatively little sense to apply a TFP output function of quantity and prices that is experienced in the private sector to the hospital sector when the same output function does not apply.

Second, the TFP does not reflect the unique challenges that prevent hospitals from achieving productivity improvements consistent with those in the broader economy. Specifically, the private nonfarm business sector encompasses a broad range of industries with stable and predictable production processes. In contrast, hospitals operate in a complex environment characterized by unpredictable patient volumes, rising input costs and varying acuity levels, not to mention natural disasters and pandemics. Hospitals also face heavy regulatory burdens beyond those of other industries. Private nonfarm businesses rarely have such onerous regulatory challenges and requirements.

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

In fact, CMS itself has acknowledged that hospitals are unable to achieve the same productivity gains as the general economy over the long run. Specifically, it found that hospitals can only achieve a productivity gain that is one-third of the gains seen in the private nonfarm business sector.[14] Thus, using the private nonfarm business sector TFP to adjust the market basket inappropriately exacerbates Medicare's chronic underpayments to LTCHs.

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

Additionally, it is puzzling to see how an indicator based on a 10-year moving average could yield such an increase to the productivity cut in a single year. Specifically, the FY 2025 cut was 0.5%, but this year CMS proposes a cut of 0.8%. In moving from one year to the next in calculating a 10-year moving average, one only changes a single one of the 10 years; as such, this methodology should smooth fluctuations to a very large degree. Instead, in moving from FY 2025 to FY 2026, we see the productivity cut increase by 60%.

Finally, we find it particularly troubling that the productivity adjustment is used only when it *decreases* Medicare payments. For example, in FY 2021, the 10-year moving average growth of the productivity factor forecasted by IGI was -0.1%. CMS acknowledged that subtracting a negative growth factor from the hospital market basket would have *increased* it by 0.1 percentage points. However, the agency set the productivity factor at 0, stating that it is required to reduce, not increase, the hospital market basket by changes in economy-wide productivity.[15] Simply put, the agency applies the productivity factor only when it cuts Medicare spending. However, the cumulative, compounding of effect of these reductions year-over-year, and the asymmetric treatment of declines in economy-wide productivity led to an increasing gap between payments and the cost of providing services, leaving hospitals increasingly underfunded, as discussed above.

Given all of the above, AzHHA continues to have deep concerns about the proposed productivity cut, particularly given the extreme pressures under which health care providers continue to operate. Applying the private nonfarm business TFP to the hospital field is not appropriate, and in an economy marked by great uncertainty due to tariffs and supply-and-demand shocks, it generates significant departures from economic reality.

Proposed High-Cost Outlier Fixed-Loss Amount

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

While AzHHA agrees with the stated purpose of the HCO policy, which is to "reduce the financial losses that would otherwise be incurred by hospitals when treating patients who require more costly care and, therefore, reduce the incentives to underserve these patients."[16] However, it is not reasonable to conclude that a hospital losing more than $91,000 on a patient would effectively accomplish this goal. On the contrary, it will likely cost prohibitive for some

[15] 85 Fed. Reg. 58797 (Sep 18, 2020).
[16] Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System Policy Changes and Fiscal Year 2016 Rates; 80 Fed. Reg. 49325, 49,617 (Aug. 17, 2015).

hospitals to continue to care for these patients. This underpayment seriously threatens access for the sickest of sick Medicare beneficiaries — those requiring long stays in LTCHs.

AzHHA also agrees with the recommendations offered in the American Hospital Association comment letter, including 1) utilizing a market basket-based methodology, 2)implementing a permanent cap on increases to the FLA, 3) implementing an extended transition for the FLA, and 4) rescinding Transmittal 12594.

LTCH QUALITY REPORTING PROGRAM

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

Proposed Removal of Four Social Determinants of Health (SDOH) SPADEs.

With a stated purpose of reducing administrative burden to LTCHs, CMS proposes to remove four SPADEs it adopted in the FY 2025 LTCH PPS final rule that are focused on living situation, food security and utilities. AzHHA appreciates CMS' recognition of the importance of striking an appropriate balance of burden and value in quality measurement programs and supports the removal of these four SPADEs from the LTCH QRP. In general, streamlining the number of measures and reporting requirements in federal QRPs can help providers focus their resources on high priority topics of national importance while freeing up resources to help LTCHs address the quality issues that matter most to their patients.

Modification of Percent of Patients/Residents Up to Date with COVID-19 Vaccination.

CMS proposes to modify this measure by excluding patients who expire during their LTCH stay. The change is being proposed in response to stakeholder feedback noting that collecting accurate information on vaccination from this patient population is often impossible.

While AzHHA supports this proposal, we also encourage CMS to consider phasing out the measure from the LTCH QRP entirely. The COVID-19 public health emergency concluded in May 2023, raising questions about whether the level of administrative effort required to collect and report this measure exceeds its value in improving outcomes. Furthermore, as we noted in our 2023 letter to CMS when this measure was first proposed for the LTCH QRP, we do not believe the conceptual design of the measure is a good match for the LTCH setting. The decision of whether to offer a COVID-19 vaccination during hospitalization should be informed by the clinical judgment of the patient's care team. At times, clinicians may determine that a patient's needs are best served by deferring COVID-19 vaccination. For example, a patient may have had a recent COVID-19 infection and not be appropriate to vaccinate. Or a patient may have a condition that could be exacerbated by a vaccine side effect such as fever. In addition,

ascertaining accurate vaccination status—which is critical to determining whether to offer a vaccine or not—is a particular challenge among LTCH patients who may have received care from multiple proximal providers. Even without these challenges, however, patients/residents always preserve the right to decline vaccination. Yet, patients exercising this right would be treated as poor performance for the LTCH. For these reasons, we encourage CMS to consider removing this measure from future LTCH QRP program years.

Thank you for the opportunity to comment on this rulemaking. Please feel free to contact me with any questions.

Sincerely,

Director of Financial Policy and Reimbursement, AzHHA

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