June 10, 2025

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

RE: CMS-1833-P, Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long Term Care Hospital Prospective Payment System and Policy Changes and Fiscal Year 2026 Rates; Requirements for Quality Programs; and Other Policy Changes, (Vol. 90, No. 82), April 30, 2025.

Dear Administrator Oz:

On behalf of 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 Fiscal Year 2026 hospital inpatient prospective payment system (PPS) proposed rule.[1] We are submitting separate comments on the rule's LTCH PPS.[2]

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

To that end, we support several of the inpatient PPS proposed rule provisions, including the proposed increase in disproportionate share hospital (DSH) payments. We also appreciate the agency's interest in deregulatory activities in the Medicare program. At the same time, we continue to have strong concerns about the proposed payment updates. The proposed net payment update of 2.4% is simply inadequate given the unrelenting financial headwinds faced by hospitals and health systems. We are particularly concerned with the inappropriately large

[1] Since AzHHA agrees with the recommendations made by the American Hospital Association (AHA), our letter largely reflects language used by the AHA.
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productivity cut that is being proposed. We urge the agency to re-examine the magnitude of this adjustment and its impact on Medicare payments. More specific comments are below.

INPATIENT PPS PAYMENT UPDATE

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

Hospitals and Health Systems Continue to Face High Rates of Inflation

Hospitals and health systems continue to face serious inflationary pressures. 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%.[3] A large portion of this growth is attributable to increased labor costs, which, according to CMS, make up nearly two-thirds of the inpatient PPS market basket. An analysis by AHA found that hospital employee compensation grew by 45% between 2014 and 2023.[4] AHA has also found that advertised salaries for nurses have risen 26.6% in the last four years.[5] 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.[6]

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.[7] Further, the American Society of Health System Pharmacists has found that numerous drug shortages are having a critically negative impact on hospital operations.[8] This has a substantial impact on hospitals and health systems as they care for patients with a wide range of complex medical conditions.

In addition to direct costs of care, hospitals have also faced rising administrative costs. For example, the vast majority of Medicare Advantage (MA) plans require prior authorizations. As

[3] AHA. The Cost of Caring: Challenges Facing America's Hospitals in 2025 (April 2025) (https://www.aha.org/costsofcaring).
[4] 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).
[5] AHA; The Cost of Caring: Challenges Facing America's Hospitals in 2025 (April 2025) (https://www.aha.org/costsofcaring).
[6] 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).
[7] ASPE. Changes in the List Prices of Prescription Drugs, 2017-2023. (Oct. 2023). (https://aspe.hhs.gov/reports/changes-list-prices-prescription-drugs)
[8] American Society of Health-System Pharmacists. Severity and Impact of Current Drug Shortages (June 2023) (https://news.ashp.org/-/media/assets/drug-shortages/docs/ASHP-2023-Drug-Shortages-Survey-Report.pdf).

such, hospitals and health systems spend substantial amounts of time and resources navigating the prior authorization process. A 2021 study by McKinsey estimated that hospitals spent $10 billion annually dealing with insurer prior authorizations.[9] Additionally, a 2023 study by Premier found that hospitals are spending just under $20 billion annually appealing denials — more than half of which was wasted on claims that should have been paid out at the time of submission.[10] Notably, many of these denials were ultimately overturned as noted above. In fact, a study by the HHS Office of Inspector General (OIG) found that 75% of care denials were subsequently overturned.[11] Making matters worse, MA plans paid hospitals less than 90% of Medicare rates despite costing taxpayers substantially more than traditional Medicare in 2023.[12,13] MA plans do not reimburse these costs, which instead must be absorbed by hospitals and health systems as they continue to care for a rising proportion of MA patients.

In addition, other economic headwinds are creating uncertainty. Despite ongoing efforts to build the domestic supply chain, the U.S. health care system relies significantly on international sources for many drugs, devices, and other supplies needed to both care for patients and protect our health care workers. Tariffs, as well as any reaction of the countries on whom such tariffs are imposed, could reduce the availability of these lifesaving items in the U.S. Indeed, a recent survey showed 82% of health care experts expect tariff-related expenses to raise hospital costs by at least 15%.[14]

These escalating costs for clinicians, personnel, drugs, and other essentials have put a strain on the entire health care continuum. It has also forced hospitals and health systems to divert funds that could have been invested in patient care, new technologies and other potential efficiencies, making the inadequate market basket updates provided by CMS more concerning.

Market Basket Forecasts Continue to Underestimate Actual Market Basket Growth

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

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

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

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

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

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

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

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

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

These missed forecasts have a significant and permanent impact on hospitals and health systems and the patients they care for. Further, as CMS knows, future updates are based on current payment levels; therefore, absent action from CMS, these missed forecasts are permanently established in the standard payment rate for inpatient PPS and will continue to compound.

Indeed, these trends have continued and exacerbated Medicare's underpayments to the hospital field. The Medicare Payment Advisory Commission (MedPAC) projects that 2025 Medicare margins *will be less than negative 13%*, resulting in more than *20 straight years* of Medicare paying below costs.[15] Even among relatively efficient hospitals, the median Medicare margin will remain about *negative* 2%. An AHA's analysis showed that Medicare underpayments reached $100 billion in 2023.[16] **This cannot be sustained. Therefore, we urge CMS to focus on appropriately accounting for recent and future trends in inflationary pressures and cost increases in the hospital payment update, which is essential to ensure that Medicare payments for acute care services more accurately reflect the cost of providing hospital care.**

Productivity

Under the Affordable Care Act, the inpatient PPS payment update is reduced annually by a productivity factor, which is equal to the 10-year moving average of changes in the annual economy-wide, private nonfarm business total factor productivity (TFP).[17] For FY 2026, CMS proposes a productivity cut of 0.8 percentage points.

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[15] MedPAC. (2025). MedPAC March 2025 report to the Congress--Chapter 3: Hospital inpatient and outpatient services

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

[17] CMS. (February 2016). Hospital Multifactor Productivity: An Updated Presentation of Two Methodologies. Hospital Multifactor Productivity: An Updated Presentation of Two Methodologies

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

First, measures of productivity contained in the private nonfarm business TFP are not appropriate measures of productivity for the hospital field. Outputs in the TFP are measured as a function of the total quantity and prices of the goods and services produced in private nonfarm businesses. For sectors that sell tangible, physical products, measuring these outputs is relatively straightforward and often standardized. However, hospital quantity and prices do not operate in this way. For example, hospital quantity, such as volume of visits or procedures, is not necessarily an appropriate output measure; it may actually be more reflective of the disease burden of a community. More hospital volume — thus more quantity — does not equate to more productivity in the same manner as it does for private nonfarm businesses.

In addition, hospital prices per unit of service often cannot be adjusted in response to changes in demand or quality; unlike those of private nonfarm businesses. This is because much of hospitals and health systems' reimbursement is through fixed payments, such as through the inpatient PPS. Moreover, for commercially-insured patients, hospital rates are determined through negotiations, which often lock in the payment rate for several years. Thus, it makes relatively little sense to apply a TFP output function of quantity and prices that is experienced in the private sector to the hospital sector when the same output function does not apply.

Second, the TFP does not reflect specific challenges that prevent hospitals from achieving productivity improvements consistent with those in the broader economy. Specifically, the private nonfarm business sector encompasses a broad range of industries with stable and predictable production processes. In contrast, hospitals operate in a complex environment characterized by unpredictable patient volumes, rising input costs, and varying acuity levels, not to mention natural disasters and pandemics. Hospitals also face heavy regulatory burdens beyond those of other industries. For example, hospitals face unique fixed costs such as requirements to keep emergency departments open 24/7 so that patients can seek care at all times. Private nonfarm businesses rarely have such onerous challenges and requirements.

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

assistance, compared to 1.9 to 4.9 for mining, oil and gas, information, and professional services, according to the Bureau of Labor Statistics.

In fact, CMS itself has acknowledged that hospitals are unable to achieve the same productivity gains as the general economy over the long run. Specifically, it found that hospitals can only achieve a productivity gain that is one-third of the gains seen in the private nonfarm business sector.[18] Thus, using the private nonfarm business sector TFP to adjust the market basket inappropriately exacerbates Medicare's chronic underpayments to hospitals.

Additionally, it is puzzling to see how an indicator based on a 10-year moving average could yield a near doubling of the productivity cut in a single year. Specifically, the FY 2025 cut was 0.5%, but this year CMS proposes a cut of 0.8%. Moving from one year to the next, when 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.[19] Simply put, the agency applies the productivity factor only when it cuts Medicare spending. However, the cumulative, compounding effect of these reductions year over year and the asymmetric treatment of declines in economy-wide productivity led to an increasing gap between payments and the cost of providing services, leaving hospitals increasingly underfunded, as discussed above.

Given all of the above, AzHHA continues to have deep concerns about the proposed productivity cut, particularly given the extreme pressures in which hospitals and health systems 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 demand and supply shocks, it generates significant departures from economic reality.

MEDICARE DISPROPORTIONATE SHARE HOSPITAL PAYMENT

Under the DSH program, hospitals receive 25% of the Medicare DSH funds they would have received under the former statutory formula (described as "empirically justified" DSH payments). The remaining 75% flows into a separate funding pool for DSH hospitals. This pool

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

[19] 85 Fed. Reg. 58797 (Sep 18, 2020).

is reduced as the percentage of uninsured declines and is distributed based on the proportion of total uncompensated care each Medicare DSH hospital provides.

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

AREA WAGE INDEX

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

PROMOTING INTEROPERABILITY PROGRAM FOR HOSPITALS

The Promoting Interoperability program is CMS' statutorily required program intended to encourage adoption and use of certified electronic health record (EHR) technology. Hospitals must meet the Promoting Interoperability requirements to avoid a reduction of three-quarters of their annual market basket update.

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

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

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

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

Sincerely,

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