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The Honorable Mehmet Oz, MD
Administrator
Centers for Medicare and 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 (IPPS) 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 Suburban Hospital Alliance of New York State, which represents hospitals and health systems on Long Island and in the Hudson Valley, we appreciate the opportunity to comment on the Centers for Medicare and Medicaid Services' (CMS) hospital inpatient prospective payment system (IPPS) proposed rule for fiscal year (FY) 2026.

We have significant concerns about the proposed payment update, which fails to account for the extraordinary and ongoing increases in costs faced by hospitals. In addition, we offer comment on Medicare wage index policy, the Transforming Episode Accountability Model (TEAM), nursing and allied health education, and changes to quality reporting data that impacts payment.

Payment Update

Marketbasket Update

CMS proposes a market basket update of 3.2 percent for FY2026. This update, compounded by years of inadequate updates that have created a significant gap between the cost of providing care and reimbursement, will exacerbate the poor financial condition of America's hospitals.

Hospital and health system finances continue to be stressed by inflationary pressures that sharply exceed those in the economy generally. This is most evident in the healthcare labor market, which continues to face acute shortages that are expected to

persist for the next decade or longer. In a statewide survey conducted last fall, New York hospitals reported that between 2019 and 2024, contract labor expenses doubled and total labor expenses grew 36.4 percent. This exceeds general inflation by more than 13 points.

The increases in other goods and services are disproportionately impacting hospitals as well. In that same survey, hospitals across the state reported that pharmaceutical prices had increased 83 percent, supplies 36 percent and energy costs by 25 percent. The general rate of inflation for this period was only 23 percent. In addition, hospitals and health systems face the operational and financial burdens of managed care denials and the unrelenting challenges of cyberattacks, such as the Change Healthcare incident that shut down revenue cycle operations for some institutions for months last year. Proposed tariffs on medical devices and pharmaceuticals or active pharmaceutical ingredients will worsen these stresses. Hospitals will only fall farther behind relative to inflation in 2026 with a market basket update of 3.2 percent.

The shortcomings of CMS's marketbasket forecasts have been evident in recent years. In FYs 2022, 2023 and 2024, the marketbasket rates were 2.7 percent, 4.1 percent and 3.3 percent, respectively. More recent data show that the actual updates should have been 5.7, 4.8 and 3.6 percent, respectively. Because the annual updates are based on understated past increases, the gap between reimbursement and real costs gets wider.

While we appreciate the agency's stated commitment to utilizing updated information should it become available prior to the issuance of the final IPPS rule, such data has not been available in time to adequately reflect inflationary pressures on hospitals. However, under the Skilled Nursing Facility Prospective Payment System, it is the policy of CMS to make a forecast error adjustment when the marketbasket update has been underestimated. This policy should be extended across all payment rules, including the acute care hospital IPPS.

Therefore, the Suburban Hospital Alliance urges CMS to use its special exceptions and adjustments authority to implement a one-time, retrospective adjustment of 4.0 percentage points to account for the underpayments that occurred between FY2022 and FY2024, in addition to the proposed FY2026 marketbasket update.

Productivity Adjustment

Compounding the inadequate proposed marketbasket increase for FY2026 is an unusually large productivity adjustment.

Under the Affordable Care Act (ACA), the IPPS payment update is reduced annually by a productivity factor that is equal to the 10-year rolling average of changes in the annual economy-wide, private nonfarm business total factor productivity (TFP).

For FY 2026, CMS proposes a productivity cut of 0.8 percentage points. We continue to dispute the appropriateness of applying non-healthcare data to this sector, particularly given that the healthcare labor shortage – requiring the abundant use of contract labor and significant increase in employment of new clinicians – has made hospitals' workforce less productive. Although the productivity adjustment was intended by Congress to ensure that Medicare reimbursement more accurately reflects the true cost of providing patient care, that is clearly not the case for FY2026.

Here again, we urge CMS to use its "special exceptions and adjustments" authority to eliminate the productivity cut for FY 2026.

Area Wage Index

CMS in FY 2020 implemented a policy to increase wage index values for low-wage hospitals with the intent of sunsetting that policy after the 2023 fiscal year. Specifically, for hospitals with a wage index value below the 25th percentile, the agency increased the hospital's wage index by half the difference between the otherwise applicable wage index value for that hospital and the 25th percentile wage index value for all hospitals. The stated intent was to determine whether low-wage hospitals used the increased wage index to raise their wages and therefore earn a higher wage index naturally. For FY2025, CMS indicated that was unable to disentangle the effects of the COVID-19 pandemic and the low-wage index policy to determine whether the policy had successfully resulted in hospitals raising wages. Therefore, it extended the low wage index policy and the related budget-neutrality adjustment for an additional three years at minimum. The agency later retreated after an adverse court ruling at the U.S. Court of Appeals level.

As we have commented consistently since the low-wage adjustment was first proposed for FY 2020, this policy attempted to address a perceived injustice by creating a new one. The area wage index (AWI) adjustment was established in statute to compensate hospitals for the wide variations in labor costs in different parts of the country. It was designed to reflect the true range of these costs. The low-wage index policy fundamentally de-linked the Medicare AWI adjustment from the actual range of average hourly wages and other labor-related costs that exist. Its stated purpose was to artificially raise reimbursements in low-cost areas by penalizing hospitals in regions where the costs of labor and other costs of doing business are significantly higher, so long as CMS chose to implement the policy in a budget-neutral manner.

This policy penalized hospitals in high-cost parts of the country, like those represented by the Suburban Hospital Alliance. Reducing the AWI adjustment to those hospitals did not lower the cost of labor for those institutions –– they continued to meet their commitments to their employees and had to remain competitive in a tight labor market. So, while high-wage hospitals were essentially paying for the artificial increase in reimbursements to low-wage hospitals, they simultaneously bore the burden of their regions' high costs. That was neither fair nor reasonable.

We support CMS's proposal to discontinue this policy and support the implementation of a transitional period for those hospitals disadvantaged by the policy change. However, we urge reconsideration of the proposal to make the cost of these transitional adjustments budget neutral. The D.C. Circuit Court of Appeals was clear in its ruling that CMS lacked the authority to implement this policy in the first place; the burden should be on CMS to identify new funds to pay for a soft landing for those hospitals that were benefiting from it – not all other hospitals.

Labor-related Share
CMS proposes a reduction in the labor-related share from 67.6 percent for fiscal years 2022 – 25 to 66.0 percent beginning in FY2026, as a component of rebasing to a 2023 base year. The FY2026 update incorporates 2023 Medicare cost report data for wages and salaries, employee benefits and contract labor costs.

It is counterintuitive that the cost of labor as an overall cost of hospital operating expenses would decline when all evidence indicates that labor expenses continue to soar. Rather, this downward trend in the data may only reflect the level of disruption in the marketplace coming out of the COVID pandemic and the inconsistent allowance of professional fees by Medicare Administrative Contractor (MAC) auditors in some regions.

For these reasons, the Suburban Hospital Alliance urges CMS to revisit the calculation of the labor-related share for the FY2027 IPPS, rather than continuing to use this data for four years, as has been the norm. The reduction in reimbursement resulting from a low labor-related share of the Medicare base payment for hospitals with a wage index above 1.0 is yet another cut in a proposed rule that repeatedly underestimates the inflationary pressures on hospitals.

<u>Nursing and allied health education</u>

Determining indirect cost allocation
A hospital's reasonable costs for nursing allied health education are net of revenues received from tuition and student fees. Current CMS cost reporting instructions require that revenues from tuition and student fees be subtracted from the costs of nursing and allied health education *prior to allocating indirect costs*. Several hospitals filed a suit against CMS disputing the order of operations for determining net costs for pass-through payments. As a result, the U.S. District Court of Columbia ruled in favor of the plaintiffs, finding that revenue from tuition and student fees should be subtracted from the cost of educational activities *after allocating indirect costs*.

In this rule, CMS is proposing to modify the regulations to indicate that revenues received from tuition, student fees, textbooks purchased for resale and other revenue from or on behalf of students is subtracted *before completing the indirect cost allocation,* effective Oct. 1, 2025. In a circumstance where revenue from or on behalf of

students reduces direct nursing and allied health education costs to zero, there would be no indirect costs to allocate to the nursing and allied health education cost center. However, CMS will allow a hospital to seek permission from its Medicare Administrative Contractor to employ a different allocation method to mitigate the reduction in reasonable cost payment for nursing and allied health education.

This alternative allocation of indirect costs would focus on only those costs directly related to the operation of approved educational activities. Such costs would not include nursing supervisors who oversee floor nurses and student nurses. This would also exclude costs that benefit the hospital as a whole and the costs of a related organization (such as a home office).

CMS' proposal seems counter to the court's decision, which for the purpose of the indirect cost allocation is to allocate administrative and general costs that support the entire institution to each direct cost center on the Medicare cost report.

Direct costs are those expenses that can be directly related to the production of specific services within the hospital. Unlike direct costs, indirect costs cannot be easily traced to a specific product or service. These expenses are necessary for the overall operation of the hospital but are not directly tied to any services the hospital provides.

By using direct expenses in the step-down method, the nursing and allied health education cost center draws only its share of indirect expenses to the extent that those indirect cost centers support the hospital's nursing and allied health education activities.

By subtracting revenues received from tuition and books before the step-down, CMS' policy will distort this relationship and the nursing and allied health education cost center will receive less than its share of the allocation of indirect costs that are being used to support the department.

We oppose CMS's proposed changes that 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.

The Suburban Hospital Alliance 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.

Provider-operated
In 2024, CMS began disallowing all costs associated with several pharmacy residency programs on the basis that these programs were not provider-operated as required by

42 CFR §413.85(f). Specifically, those hospitals operating pharmacy programs would no longer qualify for reasonable cost payment if the program director for the pharmacy program is furnishing services to several hospitals within a multi-hospital system and a very small amount of administrative costs from a home office are being allocated to each hospital within the system through the step-down.

CMS's policy appears to be a change from its historical application of 42 CFR §413.85(f). The new policy appears to originate from Change Request 10552.[1] While CMS indicates that *"policies contained in this notice are clarifications; no changes in policy are being made,"* **the Suburban Hospital Alliance disagrees. CMS applies policy changes through sub-regulatory guidance that may only be adopted through notice and comment rulemaking.**

Rather than using the awarding of the degree, diploma or certificate as a proxy for the program being provider-operated (absent evidence to the contrary) as stated in the Jan. 12, 2001, final rule and 42 CFR §413.85(f)(2), CMS states: "*MACs shall not rely on a degree/diploma/certificate issued by the hospital as evidence that a program is provider-operated."*

This directive constitutes a sub-regulatory reversal of 42 CFR §413.85(f)(2) that instructs using the awarding of the degree, diploma or certificate as evidence of the program being provider-operated (absent evidence to the contrary). The transmittal also states that "*the hospital must first demonstrate that there is no evidence showing that the program is not provider-operated."* That is, the hospital must first prove a negative — that it is not *not* provider-operated — before CMS will accept that the hospital is provider-operated, making the awarding of the degree, diploma or certificate superfluous as a proxy.

It is impossible to view the language in Change Request 10552 as clarification. It is clearly a change in policy as it completely reverses the standard to be used for determining provider-operated status when the hospital issues the award, degree, diploma or certificate.

With respect to 42 CFR §413.85(f)(1), the providers meet all the requirements of clauses (i) through (v). A provider or providers in a multi-hospital system incur all the costs of the program. The fact that a small amount of indirect costs are incurred by a home office does not make the pharmacy residency programs non-provider-operated. Similarly, a provider's home office in a multi-hospital system issuing a W-2 to a pharmacy residency director who works across multiple hospital locations does not make the program non-provider-operated. In any other context except nursing and allied health education, these costs would be allowable provider costs and should not implicate the provider-operated status of the pharmacy residency program.

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[1] CMS Manual System Pub 100-20 One-Time Notification, Transmittal, 2133 Change Request 10552, August 17, 2018, Business Requirement 10552.1

We believe these disallowances are an incorrect application of CMS's provider-operated criteria and requests the agency instruct its MACs to reverse the disallowances for several hospitals in New York state and other similar situation hospitals in other states.

Quality program changes

Removal of HCHE and SDOH measures
CMS proposes to eliminate the Social Drivers of Health (SDOH) assessment measures to reduce administrative burden. We generally support the intent of streamlining reporting and reducing administrative burden. However, we are concerned that eliminating SDOH assessment measures will reduce providers' access to actionable information needed to improve health status and lower medical expenditures.

The collection of this data is critical to achieving HHS's Make America Health Again (MAHA) goals. There is a wide body of evidence demonstrating the impact that non-healthcare factors such as nutrition, primary and preventive care access or safe housing have on health status. Mandatory reporting contributes to this evidence and will, over time, allow hospitals to meet the needs of their communities through improved discharge planning, better integration of services across care settings, and development of referral relationships with community-based organizations that can provide wraparound services.

For these reasons, we urge CMS to reconsider its retreat from the collection of this critical data.

Removal of COVID-19 exclusions from IPPS measures
CMS proposes to eliminate COVID-19 exclusions from all applicable measures under the IPPS, including removing the exclusion of patients with a secondary diagnosis code of COVID-19 present on admission. We understand the intent to incorporate more comprehensive data into quality measurement, with public reporting scheduled to begin July 1, 2026. However, we have significant concerns regarding the immediate public reporting of these measures.

Suburban Hospital Alliance believes that hospitals should have adequate time to review and analyze their facility-specific reports to fully understand how including COVID-19 as a secondary diagnosis may affect their performance metrics. Without this opportunity, public reporting and payment determinations based on incomplete or misunderstood data could lead to inaccurate conclusions and unintended consequences.

We strongly recommend a phased implementation approach to ensure data integrity and support hospitals in adapting to this change. Specifically, we urge CMS to:

- Provide hospitals with one to two reporting cycles of data for internal review and quality improvement purposes only.

- Delay public reporting of measures that include COVID-19 as a secondary diagnosis until hospitals have had sufficient time to assess the data and address any discrepancies or concerns.
- Exclude these measures from value-based purchasing programs during the initial reporting periods to prevent premature financial implications based on untested data.

This measured approach will allow hospitals to ensure the accuracy and reliability of the data before these measures are used for public accountability or payment adjustments.

The Suburban Hospital Alliance urges CMS to adopt a gradual implementation strategy prioritizing data integrity, transparency and fairness. Providing hospitals with the necessary time and tools to adapt will support better patient outcomes and more reliable performance measurements across the healthcare system.

Value-based purchasing (VBP) program health equity adjustment
In the proposed rule, CMS would eliminate the Health Equity Adjustment to the VBP program, asserting that its costs outweigh the benefits of its continued use. We disagree. Medicare payment programs should fairly reflect the cost of caring for high-need, vulnerable patients. The Health Equity Adjustment is one mechanism for rewarding high-performing hospitals that serve a disproportionate population of dually eligible Medicare and Medicaid beneficiaries. The adjustment was scheduled to be implemented for FY2026.

We support moving forward as planned with the Health Equity Adjustment, which increases the fairness of the VBP program to safety net hospitals serving high numbers of vulnerable patients. The HEA also aligns with a similar adjustment in the Medicare Hospital Readmissions Reduction Program (HRRP). Removing it would break that alignment and unfairly disadvantage certain hospitals.

Integration of Medicare Advantage data in HRRP, Hospital VBP and IQR
The Suburban Hospital Alliance has concerns about the immediate incorporation of Medicare Advantage patient data into the HRRP, VBP and Hospital Inpatient Quality Reporting (IQR) programs. While we support efforts to improve the comprehensiveness of quality measurement, we believe this proposal could significantly affect hospital performance assessments and payments and introduces several key challenges:

- **Increased reporting complexity:** MA plans operate under unique reporting requirements and systems. Integrating their data into existing hospital quality programs could increase the administrative burden and require hospitals to invest in new infrastructure, training and workflows.
- **Impact on performance ratings and reimbursement:** Including MA data in performance calculations could unfairly influence hospital performance ratings, which affect reimbursement, public perception and patient choice. As CMS has

acknowledged, this change could potentially result in more hospitals being penalized due to factors outside their control, such as the MA patient population's demographics or health status.

We request that CMS postpone implementation until a more comprehensive evaluation can be conducted. Specifically, CMS must provide a clearer understanding of data collection methods, assess the associated burden, determine whether the benefits outweigh the new reporting challenges, and analyze potential shifts in HRRP and VBP performance resulting from the inclusion of these data. Without detailed information and a thorough impact analysis, the risk of skewed results, data inconsistencies, increased reporting burdens and unfair penalties outweigh potential advantages**.**

Should CMS choose to move forward, the Suburban Hospital Alliance recommends a phased implementation approach to ensure fairness and minimize disruption:

- **Prioritize integration into IQR first**: Focus on incorporating MA patient data into the IQR program before considering its impact on HRRP and VBP performance adjustments.
- **Conduct a multi-cycle impact analysis**: Evaluate the effects of MA data incorporation over at least two reporting cycles. This analysis should examine data validity, assess changes in HRRP and VBP performance scores, identify unintended consequences, and establish appropriate methodologies for risk adjustment and data standardization.
- **Postpone public reporting and payment adjustments**: Ensure MA data are not used in public performance reports or value-based payment determinations until the previous steps have been thoroughly completed, reviewed and refined based on stakeholder feedback. This will give hospitals adequate time to adapt to new requirements, safeguard data accuracy and reduce the risk of unjust penalties.

Taking a measured and deliberate approach will help maintain the integrity of hospital performance assessments while ensuring a fair transition to the use of MA patient data.

<u>Transforming Episode Accountability Model (TEAM)</u>

Low-volume hospital policy
For the FY2025 IPPS, CMS proposed but chose not to finalize a low-volume hospital policy; for FY2026, the agency again does not propose a low-volume policy for the first performance year but seeks comment on how to address hospitals with low volumes of covered procedures for latter performance years when providers face downside risk.

We urge CMS to implement a low-volume threshold across all performance years. Hospitals with low volume will experience unpredictable financial results during reconciliation due to random variation in Medicare episode spend, masking any actual clinical changes that may occur. To adequately protect these hospitals as TEAM

participants, there must be a minimum threshold, preferably at least 31 episodes per episode category across the three-year baseline period. This would align TEAM with prior models, such as the Comprehensive Care for Joint Replacement model or Bundled Payments for Care Improvement-Advanced model.

In addition, we recommend that when a hospital has fewer than 31 episodes in a particular episode category, it should remain a TEAM participant for the performance year but have no downside risk.

Thank you again for the opportunity to comment. If you have any questions, please do not hesitate to contact me.

Sincerely,

/s/*Wendy D. Darwell*

Wendy D. Darwell
President and CEO