Suburban Hospital Alliance of New York State, LLC

Phone: 631-435-3000
suburbanhospitalalliance.org
800 Veterans Memorial Hwy, Suite 150, Hauppauge, NY 11788

June 10, 2025

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-1829-P, Medicare Program; Inpatient Rehabilitation Facility Prospective Payment System for Federal Fiscal Year 2026, (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) proposed inpatient rehabilitation facility (IRF) prospective payment system (PPS) 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 inpatient rehabilitation facilities.

Marketbasket Update
CMS proposes a market basket update of 3.4 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 challenging financial condition of IRFs.

IRF finances, like acute hospitals and other providers, 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, which included IRFs, 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 increased prices of 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.

IRFs will only fall farther behind relative to inflation in 2026 with a market basket update of 3.4 percent.

The shortcomings of CMS's marketbasket forecasts have been evident in recent years. In FYs 2022, 2023 and 2024, the marketbasket rates were 2.6 percent, 4.2 percent and 3.6 percent, respectively. More recent data show that the actual updates should have been 5.3, 4.8 and 3.8 percent. 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 IRF rule, such data typically 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 IRF PPS rule, for FY2026.

Therefore, the Suburban Hospital Alliance urges CMS to use its special exceptions and adjustments authority to implement a one-time, retrospective adjustment of 3.5 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 IRF 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 a significant increase in employment of new clinicians – has made healthcare facilities' 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
We disagree with the continuance of CMS's policy of utilizing pre-rural floor data from an IRF facility's Core-Based Statistical Area (CBSA) to determine a facility's area wage index, in light of other significant changes to wage index calculations.

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. Providers within a CBSA can

request a change in their assigned geographic area for the purpose of calculating their Medicare payments, if they meet certain criteria that reflect the rate of their wages relative to the market in which they are naturally located. Urban providers also have the ability to reclassify to rural areas.

Changes in CMS policy over the past two years as the result of litigation have changed the calculation of the rural floor to reflect the reclassification urban providers. As CMS predicted, this policy change is increasingly resulting in statewide rural floors that have higher wage indexes than those of any individual CBSA in a state. CMS policy is that no acute care hospital can have a wage index lower than the rural floor so, in such cases, all acute care hospitals in the state receive the rural floor rate by default.

However, inpatient rehabilitation facilities do not benefit from this policy shift due to CMS's decision to continue reimbursing IRFs at the pre-rural floor calculation of their home CBSA's wage index. IRFs are subject to the same inflationary pressures and compete for the same workforce as neighboring acute care facilities but in some regions will be reimbursed at a much lower rate than their competitors. CMS policy is explicitly disadvantaging IRFs in such cases.

When a provider is eligible for more than one wage index – i.e. natural CBSA or the state's rural floor – CMS has typically reimbursed providers at whichever rate is higher. The same default should be applied to inpatient rehabilitation facilities.

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