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June 9, 2026

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-1849-P, Medicare Program; Hospital Inpatient Prospective Payment System for Federal Fiscal Year 2027, (Vol. 91, No. 71), April 14, 2026

Dear Administrator Oz:

Thank you for the opportunity to comment on the Centers for Medicare and Medicaid Services' (CMS) proposed hospital inpatient prospective payment system (IPPS) rule for fiscal year (FY) 2027.

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, I write to express our concerns about the proposed payment update in the face of significant inflationary pressures on hospitals' labor, pharmaceutical, energy and supply costs. In addition, we offer comments on the proposed decrease in Medicare Disproportionate Share Hospital funding and update to the high-cost outlier payment threshold.

Payment Update

CMS proposes an inadequate market basket update of 3.2 percent for FY 2027 as inpatient hospitals continue to be stressed by inflationary increases that sharply exceed the general rate of inflation in the economy. In our most recent statewide survey New York hospitals reported that, for the period of 2022 through 2025, their total labor expenses increased 23 percent, pharmaceuticals by 71 percent, supplies 25 percent and energy 15 percent. Yet IPPS payments have increased by only 10.7 percent over the same period. Hospitals also must prepare for significant funding reductions and increases in uncompensated care as last year's budget reconciliation legislation (H.R. 1) is fully implemented. The proposed FY2027 update, compounded by years of inadequate rate adjustments, will further widen the gap between the cost of providing care and reimbursement.

We appreciate that CMS in recent years has used its discretion to implement marginally higher marketbasket updates than were initially proposed, using data made available after the release of the proposed rules. With the exception of the 2025 fiscal year, however, these modest upward adjustments still left significant gaps between projected and actual data for which no reparation has been made. In FYs 2022, 2023 and 2024, the marketbasket rates were 2.6 percent, 4.2 percent and 3.6 percent, respectively. CMS's own data show that the actual updates should have been 5.3, 4.8

and 3.8 percent. Because the annual adjustments build on understated market basket increases from prior years, this too contributes to the widening gap between reimbursement and real costs.

While we appreciate the agency's stated commitment to again utilize updated information should it become available prior to the issuance of the final IPPS 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 IPPS, for FY 2027.

Therefore, the Suburban Hospital Alliance urges CMS to use its special exceptions and adjustments authority to implement a one-time, retrospective adjustment of 3.8 percentage points to account for the underpayments that occurred between FY 2022 and FY 2024, in addition to the proposed FY 2027 marketbasket update.

Productivity Adjustment

Compounding the impact of the inadequate marketbasket increase for FY 2027 is another substantial 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 2027, 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 continued reliance on 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 FY 2027.

Here again, we urge CMS to use its "special exceptions and adjustments" authority to eliminate the productivity cut for FY 2027.

Medicare Disproportionate Share Hospital Adjustment

The proposed rule would decrease the uncompensated care pool by $253 million. Medicare Disproportionate Share Hospital (DSH) payments are a critical means of support for those institutions that incur exceptional costs for the care of uninsured and low-income beneficiaries. These costs most certainly will rise in FY 2027 and beyond as provisions of H.R. 1 are implement that restrict access to Medicaid and Qualified Health Plans.

CMS failed to account for these impacts when proposing DSH funding for FY 2027. **We urge the use of more recent data – already reflecting increases in uninsured Americans resulting from the expiration of Enhanced Premium Tax Credits last year – to account for those who will disproportionately rely on nonprofit hospitals to provide their care in the absence of insurance coverage.**

Adjustment to High-Cost Outlier Threshold

In an effort to maintain outlier payments at 5.1 percent of total IPPS expenditures, the proposed rule would adjust the fixed-loss threshold from $40,367 in FY 2026 to $51,704 in FY 2027. Hospitals will be denied reasonable compensation for the care of a significant number of highly complex patients if this increase is finalized.

Furthermore, the need for a 28 percent increase in the outlier threshold from year to year indicates a fundamental flaw – either in CMS's assumption that 5.1 percent is an appropriate target in this inflationary environment, in the adequacy of the underlying rates relative to inflation, or a combination thereof.

The rule acknowledges anomalies in the most recent reconciliation data, from FY 2021, that it would typically use. However, rather than improve its methodology, CMS proposes instead to rely upon data from FY 2019, which precedes recent inflationary trends. **We support the recommendation of our state hospital association, the Healthcare Association of New York State (HANYS), that CMS consider using a multi-year rolling average for charge inflation calculations rather than utilizing a single year of data. This will smooth out any significant short-term increases or decreases or anomalous data. Alternatively, CMS could link the charge inflation factor to the market basket or other reasonable measures of year-to-year price trends.**

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