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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-1845-P, Medicare Program; Inpatient Rehabilitation Facility Prospective Payment System for Federal Fiscal Year 2027, (Vol. 91, No. 65), April 6, 2026

Dear Administrator Oz:

Thank you for 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) 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 market basket update and application of the productivity adjustment in the face of significant inflationary pressures on IRFs' labor, pharmaceutical, energy and supply costs. Inpatient rehabilitation facilities are already financially challenged; if payment rates are finalized as proposed, their financial condition will worsen.

We also respond to the request for feedback on the use of alternative data sources for the wage index adjustment.

Market Basket Update
CMS proposes an inadequate market basket update of 3.2 percent for FY2027 as inpatient rehabilitation facilities, like all 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 IRF PPS payments have increased by only 10.7 percent over the same period. 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 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 FY2027.

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 FY2022 and FY2024, in addition to the proposed FY2027 marketbasket update.

Productivity Adjustment
Compounding the impact of the inadequate marketbasket increase for FY2027 is another substantial 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 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 FY2027.

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

Area Wage Index
We disagree with the continuance of CMS's policy of utilizing pre-rural floor, pre-reclassified acute care hospital 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. Unlike IRFs, acute care hospitals paid under the Inpatient Prospective Payment System (IPPS) can apply for 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 can reclassify to rural areas.

Changes in CMS policy over the past three years in response to successful litigation have changed the calculation of the rural floor to reflect the reclassification of 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 the agency's policy of 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 institutions. Nevertheless, in some states and regions, this policy results in significantly lower reimbursement rates for IRFs than for their acute care competitors. CMS policy is explicitly disadvantaging IRFs in such cases.

We also oppose the use of proxy data, such as county-level Bureau of Labor Statistics (BLS) data, as an alternative source for calculating a Medicare wage index for rehabilitation facilities. BLS data that is collected semi-annually from a sampling of employers and then extrapolated cannot achieve the level of granularity necessary to fairly distribute billions of Medicare dollars.

For example, there are many job titles in hospital employment that also exist in other settings, but these roles are not necessarily comparable. The Bureau of Labor Statistics' Occupational Employment and Wage Statistics data does not distinguish between registered nurses practicing in hospitals – with higher levels of credentials and training and therefore higher wages, treating more complex patients -- and nurses practicing in doctor's offices, clinics or schools. It is likely that there also are significant differentials in typical working hours, availability of overtime, and fringe benefits between work settings.

The use of BLS data has been considered and wisely rejected in the past. The Medicare wage index must remain linked to actual hospital wage and benefit data, for which the Medicare Cost Report is the only standardized, nationwide source.

We urge a far simpler reform that utilizes actual hospital wage data and would provide parity for IRFs within their home markets. When a hospital 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