June 10, 2025

Honorable Dr. Mehmet Oz
Administrator
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, Maryland 21244-1850

Via electronic submission

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

Administrator Oz:

The Arkansas Hospital Association (AHA) represents more than 100 health care facilities and over 45,000 employees across the state, all dedicated to providing essential medical care and community services to the people of Arkansas. On behalf of our member hospitals, we appreciate the opportunity to comment on the proposed Fiscal Year 2026 updates to the Hospital Inpatient Prospective Payment System (IPPS) for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System (LTCH PPS).

We commend CMS for its continued efforts to reduce administrative burdens on health care providers and support further initiatives to eliminate unnecessary reporting requirements that divert critical staff resources from direct patient care. However, we are deeply concerned about several aspects of the proposed rule. Specifically, the market basket update is undermined by an excessive productivity adjustment, and the proposed removal of the low wage index policy threatens to destabilize rural and underserved hospitals. In addition, the lack of progress on extending the low-volume hospital adjustment, and the continued push to mandate participation in the TEAM model for currently enrolled hospitals, raise significant operational concerns. Finally, the proposed changes to LTCH payment rates may impose severe financial strain on facilities that care for some of the nation’s most complex and vulnerable patients, potentially reducing access to these vital services.

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Market Basket Update and Productivity Reduction

For FY 2026, CMS has proposed a national market basket update of 3.2%. While preliminary analysis suggests Arkansas hospitals could see an average increase of 4.3%, we remain concerned about historical patterns in which the Final Rule reflects significantly lower payment increases due to post-proposal adjustments. Moreover, payment updates vary widely at the individual hospital level. Among our 43 member hospitals participating in the program, 13 (30%) are projected to face a net reduction in total payments under the proposed rule. All of these hospitals are located in rural areas and will need to identify between $81,000 and $575,000 in additional revenue during FY 2026 just to offset policy-driven shortfalls.

Statewide, the proposed $45.8 million increase in operating and capital payments barely keeps pace with inflationary pressures between the FY 2025 and FY 2026 IPPS rules. We have previously stressed to CMS the precarious financial position of Arkansas hospitals and the insufficient rate adjustments made through CMS reimbursement programs. Without a more meaningful increase in the final payment update, many hospitals will face significant financial strain, jeopardizing their ability to maintain essential health care services.

We strongly urge CMS to seek opportunities to lessen the blow of the large productivity adjustment and evaluate the cumulative burden of payment policy changes. Without such reconsideration, the positive impact of the proposed market basket update will be effectively neutralized, further undermining the financial viability of hospitals serving rural and underserved communities.

Financial Impacts of Rescinding the Low Wage Index

The financial impact of rescinding the low wage index policy is particularly alarming in Arkansas, where 43 hospitals participate in the IPPS program and will be impacted by the recension of the rule. Among these facilities, 18 are the sole hospital in their county, serving as critical access points for health care in rural communities. These hospitals often operate on narrow margins, and the removal of the low wage index policy will create significant financial strain that jeopardizes care delivery for countless Arkansans.

Third-party estimates based on the FY2026 IPPS Proposed Rule project Arkansas hospitals will experience a negative financial impact of approximately $8.6 million with the discontinuation of the Low Wage Index Hospital Policy. This is compounded by the negative impact of the area wage index that continually reduces our ability to account for inflationary effects. As we have described in previous letters, the AHA believes that the area wage index system is inherently flawed and calls for the policy to be applied in a non-budget-neutral manner, citing chronic underfunding of hospitals by Medicare. The loss of the low wage index policy means that most participating hospitals in the state are faced with significant financial losses, severely affecting their ability to serve some of the nation's most medically underserved populations**. We urge CMS to work with Congress to seek policy reform that would effectively extend and support the low wage index policy to support rural hospitals and their patients.**

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Low Volume Adjustment

The AHA continues to support the permanent extension of the Low Volume Adjustment (LVA) program to ensure hospitals continue to qualify for enhanced Medicare payments. The LVA is a critical policy that recognizes the higher fixed costs associated with operating low-volume hospitals that are often the sole providers of acute care in remote regions — particularly those serving our most rural and medically underserved areas. These hospitals face unique challenges due to their geographic isolation, limited economies of scale, and workforce constraints. Removing the LVA would create a sudden and significant financial cliff for eligible hospitals, disrupting operational stability and threatening access to essential health care services in rural communities. Based on current estimates, the LVA program provides approximately $6.8 million in additional Medicare funding to Arkansas hospitals each year — funding that is crucial to their continued viability. The abrupt elimination of this adjustment could force hospitals to reduce services, delay infrastructure upgrades, or in some cases, face the risk of closure. **Continued support for the LVA is not just a fiscal issue — it is a matter of preserving health care access for Arkansans.**

Disproportionate Share Hospital Payment and Uncompensated Care (UCC) Payments

The AHA applauds CMS's decision to increase the Disproportionate Share Hospital (DSH) payment in the FY 2026 proposed rule, resulting in an additional $11.7 million to Arkansas hospitals, but is concerned with the continued lack of transparency associated with how the Office of the Actuary (OACT) calculates DSH payments.

The current DSH payment methodology was designed to phase down over time in response to the anticipated expansion of coverage under the Affordable Care Act (ACA), which was expected to significantly reduce uncompensated care. However, that optimism was never fully realized following the 2012 Supreme Court decision in *National Federation of Independent Business et al. v. Sebelius*, which made Medicaid expansion optional for states. While Arkansas did expand Medicaid, the problem has persisted and worsened in recent years. Uninsured rates have risen dramatically since the COVID-19 public health emergency was rescinded by the federal government, and proposed federal regulatory changes — including executive actions aimed at cutting Medicaid and restricting access to marketplace insurance — threaten to further erode coverage gains.

These trends are particularly concerning for Arkansas, where many communities already face high poverty rates, health disparities, and limited access to health care providers. Any reduction in DSH funding will directly harm hospitals that serve a high proportion of low-income and uninsured patients — many of which are safety-net providers in rural and underserved areas. Without adequate DSH support, hospitals may be forced to cut services, reduce staff, or even shut down, leaving thousands of Arkansans with fewer or no local options for care. **Given the Congressional Budget Office's projection that the number of uninsured Americans will increase by 3.8 million annually from 2026 to 2034, we urge CMS to reexamine the current DSH methodology. Adjustments should reflect today's health care landscape, not outdated assumptions, to protect vulnerable populations and ensure continued access to care for all Arkansans.**

Quality Reporting Measures

The AHA supports the proposed removal of the following quality reporting measures from the Inpatient Quality Reporting (IQR) Program: Hospital Commitment to Health Equity, COVID-19 Vaccination Coverage Among Healthcare Personnel (HCP), Screening for Social Drivers of Health, and Screen Positive Rate for Social Drivers of Health. We believe the removal of these measures aligns with the current administration's broader deregulatory approach to reducing administrative burden on hospitals and providers. These measures, while well-intentioned, are often duplicative of other efforts or lack clear guidance on how data is used to inform policy or improve patient outcomes. **Removing them allows hospitals to redirect limited resources toward delivering care rather than navigating burdensome and often underutilized reporting requirements.**

At the same time, the AHA supports CMS's efforts to modernize data collection processes through the adoption of emerging technologies such as Fast Healthcare Interoperability Resources (FHIR). FHIR-based reporting offers the potential to streamline data submission and enhance the quality and timeliness of reporting. However, we stress the need for CMS to ensure its systems are prepared to receive and process data seamlessly and provide clear, accessible technical documentation and support for onboarding. Importantly, rural hospitals, which often operate with limited IT capacity and staffing, continue to lag behind in the adoption of new technologies. These facilities stand to benefit the most from streamlined reporting and interoperability, and they should not be left behind as the agency moves toward more efficient, digital-first reporting systems. **We urge CMS to establish targeted incentive programs or grant opportunities to help rural and critical access hospitals adopt these tools.**

Long-Term Care Hospital High-Cost Outlier Threshold

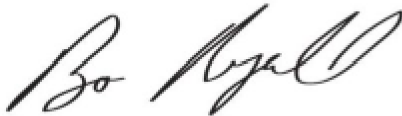
For FY 2026, CMS proposes a high-cost outlier threshold of $91,247. This marks the second consecutive year of a substantial increase in the threshold, placing added financial pressure on long-term care hospitals (LTCHs). Arkansas LTCHs already operate with tight margins while caring for some of the most medically complex patients in the state. Requiring these facilities to absorb even greater unreimbursed costs undermines the original intent of the LTCH PPS, which was designed to recognize the high severity of illness among LTCH patients and ensure appropriate payment for the efficient delivery of specialized care. Without adjustments that reflect the realities faced by Arkansas LTCHs, these hospitals may face increasing difficulty maintaining access to care for the state's most vulnerable Medicare beneficiaries.

The AHA appreciates Secretary Kennedy's willingness to consider alternatives to minimize the impact of the proposed high-cost outlier threshold increase, and we urge the Secretary to use the discretionary power granted to his office by Congress under the special adjustment authority to eliminate the proposed increase in the high-cost outlier threshold amount. Since the end of the public health emergency, LTCHs have faced persistent clinical and financial challenges, including longer patient stays, rising base operating costs, and increasing patient complexity, as reflected by higher case mix index levels. The proposed high-cost outlier threshold for FY 2026 would only compound these pressures by creating additional financial disincentives for LTCHs to admit long-

stay, high-acuity patients. This could ultimately reduce access to care for individuals who require the most intensive and specialized treatment.

The AHA appreciates the opportunity to provide feedback on the FY 2026 IPPS and LTCH PPS Proposed Rule. Our state's hospitals are deeply committed to delivering high-quality, accessible care in every corner of Arkansas; however, as outlined in this letter, several components of the proposed rule could create severe financial challenges for our hospitals, particularly those serving vulnerable populations. The combination of an aggressive productivity adjustment, the elimination of key payment protections such as the Low Wage Index and Low Volume Adjustment, and growing pressure on LTCHs threatens to erode the financial stability of hospitals already operating on thin margins. We urge CMS to adopt a more balanced approach that protects rural health care access and recognizes the real-world financial pressures facing hospitals today. **Arkansas hospitals stand ready to collaborate with CMS to strengthen the Medicare program and improve patient outcomes, but we need fair, transparent, and sustainable policies that reflect the operational realities of our health care system.**

Sincerely,



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