June 9, 2023

Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
Hubert H. Humphrey Building
200 Independence Ave., SW
Washington, D.C. 20201

SUBJECT: CMS-1785-P Medicare Program; Proposed Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Policy Changes and Fiscal Year 2024 Rates; Quality Programs and Medicare Promoting Interoperability Program Requirements for Eligible Hospitals and Critical Access Hospitals; Rural Emergency Hospital and Physician-Owned Hospital Requirements; and Provider and Supplier Disclosure of Ownership, Federal Register (Vol. 88, No. 83), May 1, 2023

Dear Administrator Brooks-LaSure:

On behalf of our more than 400 member hospitals and health systems, the California Hospital Association (CHA) is pleased to submit comments on the Centers for Medicare & Medicaid Services (CMS) inpatient prospective payment system (IPPS) proposed rule for federal fiscal year (FFY) 2024.

California's hospitals continue to face unprecedented financial pressure resulting from the COVID-19 pandemic's impact on the labor market and the health care supply chain. From 2019 to 2022, costs per adjusted discharge rose 25%[1] (driven by increases in salary costs +22%, supply expenses +18%, and pharmaceuticals +19%). However, base payment rates for Medicare have failed to keep pace with input price inflation. Chronic underfunding by Medicare contributed to the recent closure of one hospital in California (Madera Community Hospital[2,3]), drove another into bankruptcy (Beverly Hospital[4]), and has forced others to eliminate financially unsustainable services to ensure the facilities can remain open. And, unfortunately, more hospital closures are anticipated. Kaufman Hall, a nationally renowned consulting firm, estimates 20% of California's hospitals are currently on the financial brink.

The financial challenges facing hospitals — which were recognized in the Medicare Payment Advisory Commission's (MedPAC) recent hospital payment update recommendations to Congress[5] — threaten access to care for not just Medicare beneficiaries, but all members of the affected community. Following

[1] https://www.kaufmanhall.com/insights/research-report/california-hospital-financial-impact-report-april-2023-update
[2] https://calmatters.org/health/2023/01/hospital-closure/
[3] https://abc30.com/madera-commuity-hospital-remains-closed-emergency-services-residents/12922392/#:~:text=Ashraf.-,Madera%20Community%20Hospital%20closed%20its%20doors%20in%20December%20of%20last,Madera%20for%20over%20forty%20years.
[4] https://www.latimes.com/california/story/2023-04-20/beverly-hospital-in-montebello-files-for-bankruptcy-in-effort-to-avoid-closure
[5] https://www.medpac.gov/wp-content/uploads/2023/03/Mar23_MedPAC_Report_To_Congress_SEC.pdf

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hospital or service line closures, patients are forced to travel farther distances for care in already overcrowded hospitals, resulting in negative outcomes. Research shows that rural hospital closures increase inpatient mortality by 8.7%, with Medicaid patients (including those who are dually eligible) and racial minorities bearing the brunt of negative outcomes — 11.3% and 12.6% increases in mortality, respectively. These are not abstract data points. Sadly, two individuals' deaths have already been attributed[6] to Madera Community Hospital's closing.

CHA is deeply concerned that the 2024 IPPS proposed rule will only exacerbate these already dire circumstances for hospitals and the Medicare beneficiaries they serve. The proposed net market basket update of +2.8% is inadequate relative to the input price inflation faced by hospitals and continues CMS' historic trend of proposing woefully inadequate payment updates. For example, from 2019 through 2021, the average net market basket update finalized by CMS was 2.4%. However, hospitals' risk-adjusted cost per discharge increased by 4.39%[7] during that same period, further exacerbating existing Medicare payment shortfalls. To ensure broad access to inpatient care for Medicare patients, CHA offers the following comments on the 2024 IPPS proposed rule:

- *Provide an Adequate Market Basket Update*: CHA respectfully asks that CMS use data that better reflect the input price inflation that hospitals have experienced and are projected to experience in 2024. Further, CHA asks that CMS make a one-time "forecast error adjustment" to account for the prior year underestimation of the hospital market basket update. Finally, as in prior years, CHA respectfully asks CMS to use its exceptions and adjustments authority to eliminate the unjustified reduction to the market basket update as a result of the Affordable Care Act (ACA)-mandated productivity adjustment for any year covered under the COVID-19 public health emergency (PHE).

- *End the Bottom Quartile Policy*: CHA strongly opposes CMS' proposal to continue its low-wage index policy that increases the wage index for hospitals with wage index values in the bottom quartile of the national distribution at the expense of all IPPS hospitals. CHA continues to believe — as multiple U.S. District Courts have ruled — this policy is impermissible under statute and inappropriately redistributive. It penalizes all IPPS hospitals in an effort that is mistargeted and ineffective in helping the agency achieve its stated goal.

- *Revise Uncompensated Care (UCC) Disproportionate Share Hospital (DSH) Factors*: CHA Encourages CMS to recalculate Factors 1 and 2 of UCC DSH calculation. CHA is concerned that CMS has significantly underestimated the growth in utilization in the Medicare fee for service (FFS) population. And, as in prior years, there is insufficient detail in the proposed rule to understand why the "other" factor decreases in prior years. Both components negatively impacted Factor 1. Further, CHA is concerned that the uninsured rate used to calculate Factor 2 does not account for the loss of Medicaid coverage of up to 18 million individuals that will occur as states reinstitute the Medicaid redetermination process.

- *Protect Safety-Net Hospitals*: CHA appreciates the request for information (RFI) related to safety-net hospitals. We encourage CMS to ensure access to care for individuals at risk for inequitable outcomes by increasing the UCC DSH pool, refraining from further expansion of site-

[6] https://www.fresnobee.com/news/local/article272712840.html
[7] CHA analysis of Medicare cost report data.

neutral payment policies, and repaying hospitals for inappropriately withheld 340B payments in a non-budget neutral manner. CHA notes that many types of hospitals provide care to individuals and communities at greater risk of inequitable outcomes. This, coupled with the relative lack of context for how CMS plans to use the information gathered by the RFI, makes it challenging for stakeholders to address many of the specific questions raised by CMS in the proposed rule.

- *Revise Long-Term Care Hospital (LTCH) Fixed-Loss Outlier Threshold*: Given the significant increase in the LTCH fixed-loss outlier threshold, CHA is concerned that CMS may have overestimated it. We respectfully ask CMS to re-evaluate the calculation to ensure that it accurately reflects the anticipated caseloads hospitals will experience in FFY 2024.

- *Limit COVID-19 Vaccination Reporting Requirements:* CHA strongly supports ongoing efforts to maintain high levels of up-to-date vaccination for COVID-19 among both health care providers and the communities they serve. However, we urge CMS to consider limiting the COVID-19 health care personnel vaccination reporting requirements to at least one week for each quarter, and work with the Centers for Disease Control and Prevention (CDC) to move toward a version of the measure that could be reported annually.

- *Hospital Value-Based Purchasing (VBP) Program Health Equity Adjustment*: CHA supports the proposed health equity adjustment (HEA) as a first step in rewarding hospitals that provide excellent care to underserved populations, and we urge CMS to explore additional approaches to identify hospitals that care for high proportions of underserved patients. However, we caution the agency against using area-level indexes such as the Area Deprivation Index (ADI) or other similar indexes that rely on national benchmarks in value-based payment programs.

- *Maintain 180-Day EHR Reporting Period*: CHA supports CMS' proposal to establish a 180-day electronic health records (EHR) reporting period for 2025 and we urge CMS to maintain this reporting period in the future to account for upgrades and other changes to hospital EHR technology.

Our detailed comments on CMS' payment and quality proposals follow.

Inpatient Hospital Operating Update

CMS proposes a market basket increase for FFY 2024 of 3.0%. This is then reduced by the 0.2 percentage point "productivity adjustment" required under the ACA. The resulting proposed IPPS market basket update equals 2.8%.

CHA is deeply disappointed in the proposed 2.8% net market basket update as it is wholly inadequate relative to the input cost inflation experienced by acute care hospitals. This continues a longstanding trend of market basket updates that fail to keep pace with hospital input cost inflation that has been recognized by MedPAC in its March 2023 Report to Congress. MedPAC indicates that input prices in FY 2022 grew 5.7% (3.0 percentage points more than initially forecast) and that CMS may have underestimated 2023 input prices as well.[8] Between FFYs 2018 and 2022, the market basket update calculated with the "actual" IHS Global Inc. (IGI) data for the given FFY compared to the final rule market

[8] https://www.medpac.gov/wp-content/uploads/2023/03/Mar23_MedPAC_Report_To_Congress_SEC.pdf

basket update calculated with forecasted data suggests that the market basket has been understated by 1.9 percentage points.[9]

IPPS Forecast (Final Rule) vs. "Actual" Market Basket Updates:
FFYS 2018--2022

	FFY 18	FFY 19	FFY 20	FFY 21	FFY 22	5-Year Summary
Final Rule Market Basket Update[1]	2.70	2.90	3.00	2.40	2.70	
Actual Market Basket Update[2]	2.50	2.40	2.00	3.00	5.70	
Difference[3]	0.20	0.50	1.00	-0.60	-3.00	-1.90

Notes:
1) These figures do not reflect total factor productivity or other legislative adjustments.
2) All of the information in this row is from OACT's 4th quarter 2022 release of market basket information with historical data through the 3rd quarter of 2022.
3) Positive values indicate CMS' final market basket overstated cost growth between fiscal years, negative values indicate CMS understated cost growth between fiscal years.

Worse, as illustrated below, growth in costs per risk-adjusted Medicare beneficiary discharge from Medicare cost reports for a similar time frame suggests[10] the final rule market basket update understated Medicare payments by 2.92% per discharge relative to the growth in allowable costs experienced by hospitals when they provide inpatient care to Medicare beneficiaries.

IPPS Forecast (Final Rule) vs. Hospital Medicare Risk-Adjusted Cost Per Discharge:
FFYS 2017-2021

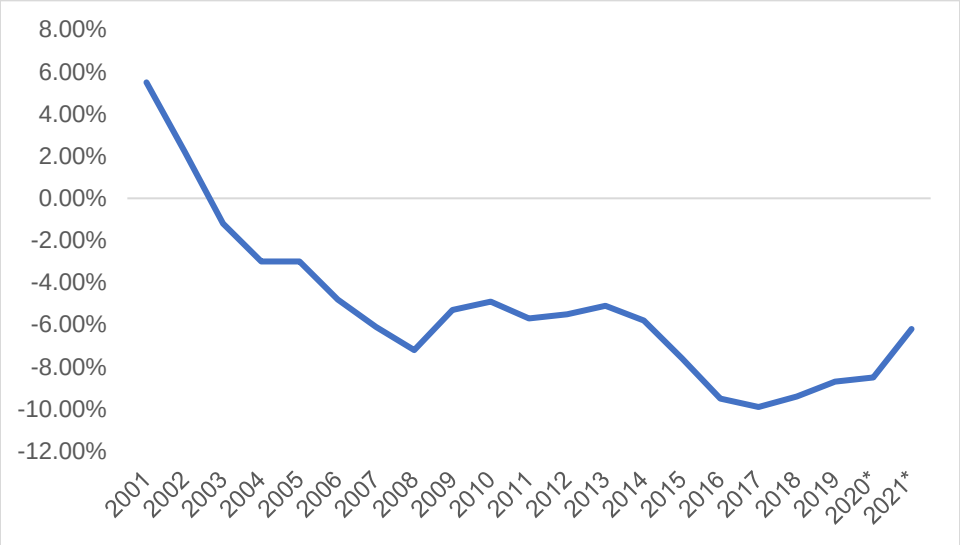
	FFY 17	FFY 18	FFY 19	FFY 20	FFY 21	5-Year Summary
Final Rule Market Basket Update[1]	2.70	2.70	2.90	3.00	2.40	
Risk Adjusted Cost Per Discharge Growth[2]	2.80	1.98	4.50	8.18	-0.84	
Difference[3]	-0.10	0.72	-1.60	-5.18	3.24	-2.92

1) These figures do not reflect total factor productivity or other legislative adjustments.
2) CHA analysis of Medicare cost report data.
3) Positive values indicate CMS' final market basket overstated cost growth between fiscal years, negative values indicate CMS understated cost growth.

Despite sustained cost reduction and efficiency efforts by hospitals, Medicare margins have declined over the last 20 years, as illustrated below. CHA believes this is due to persistently inadequate Medicare market basket updates as illustrated by the data provided above. Hospitals' financial situations are so precarious that MedPAC recommended to Congress that it increase IPPS and OPPS payments over current law to preserve access.[11] This is the first time in memory that MedPAC has made such a recommendation. Further, MedPAC recommended that Congress increase payments to hospitals that are necessary to provide access to care for individuals most at risk of inequitable outcomes by $2 billion. This additional financing is necessary given the fragile finances of these institutions.

[9] CHA analysis of CMS Office of the Actuary Data.
[10] Analysis runs through FFY 2021 as FFY 2022 cost report data for latter years are currently not available.
[11] https://www.medpac.gov/wp-content/uploads/2023/03/Ch3_Mar23_MedPAC_Report_To_Congress_SEC.pdf

IPPS Hospital Medicare Margin: 2001 to 2021[12,13,14]



This longstanding underpayment trend has been exacerbated by the labor dislocations and supply chain breakdowns directly resulting from the COVID-19 pandemic. These exacerbations are expected to persist beyond 2024, driving further inflation in input costs. Expenses per adjusted discharge have accelerated dramatically, offsetting the limited increases in revenue hospitals have experienced, which has resulted in reduced margins that threaten hospitals' financial viability. As discussed above, California hospital expenses per discharge have increased 25% since 2019 (pre-pandemic). However, during this same period, Medicare inpatient payments only increased 7.16%[15] to account for input price inflation.

While CHA appreciates that CMS will refresh the market basket update in the final rule with more recent data, we are deeply concerned that the revised update will still be insufficient relative to input cost inflation — particularly for labor. We understand that the Bureau of Labor Statistics' Employment Cost Index (ECI) only captures the salary increases associated with employed staff, and thus does not capture extraordinary labor cost growth associated with hospitals' increased reliance on clinicians contracted through staffing agencies in response to supply shortages. While the COVID-19 PHE may be over, hospitals are still experiencing profound staffing shortages as a persistent after effect. As employed nurses have left the field due to burnout and early retirement, hospitals have been forced to use increased amounts of contract labor. Not only have the hours worked by contracted staff increased, but the per unit rate for these individuals has increased with demand for agency staff. California's hospitals, for example, spent $3.8 billion more on contract labor in 2022 than they did in 2019 even though there were decreases in patient discharge (18%), ED visits (2%), and observation days (9%) comparatively.[16] Not surprisingly, during this same time frame median contract labor expense as a percentage of labor expense increased 250% for California's hospitals. Further, while contract labor expense is declining relative to the peak of the COVID-19 pandemic, we anticipate that contract labor utilization will remain

[12] https://www.medpac.gov/wp-content/uploads/2022/03/Mar22_MedPAC_ReportToCongress_Ch3_SEC.pdf
[13] https://www.medpac.gov/wp-content/uploads/import_data/scrape_files/docs/default-source/reports/mar18_medpac_ch3_sec.pdf
[14] www.medpac.gov/wp-content/uploads/2023/03/Ch3_Mar23_MedPAC_Report_To_Congress_SEC.pdf
[15] CHA analysis of Medicare market basket update data.
[16] www.kaufmanhall.com/sites/default/files/2023-04/CHA-Financial-Impact-Report.pdf

persistently elevated over 2019 levels for the foreseeable future due to a shortage of nurses and other clinicians. In a recent study, 610,388 nurses indicated their intent to leave the field by 2027.[17]

Even before the application of the productivity adjustment (discussed below), the market basket update methodology — based on IGI data —failed to keep up with cost growth year over year as illustrated above. This is a direct result of the ECI exclusion of contract labor and explains much of the difference between hospitals' reported cost growth per discharge and the market basket update. It is clear, based on rapidly rising labor costs, that CMS' current inputs for updating the IPPS market basket update are ill-suited to a highly inflationary environment. CMS itself acknowledges that setting payment updates during times of economic uncertainty can often result in large forecast errors.[18] While CMS believes forecast errors can go in either direction and will average close to zero over time, the most recent understatements of inflation have been large and to the disadvantage of hospitals at a time when many are facing insurmountable financial pressure, which is negatively impacting access to care.[19,20,21,22] **Therefore, we again ask CMS to identify more accurate data inputs and use its existing authority to calculate the final rule "base" (before additional adjustments) market basket update with data that better reflect the rapidly increasing input prices facing hospitals.**

Given the unprecedented, continuing cost growth (described earlier) triggered by a unique event — the COVID-19 pandemic — and the inadequate market basket resulting from the use of the ECI, CHA asks CMS to consider using the average growth rate in allowable Medicare costs per risk adjusted discharge[23] for IPPS hospitals between FFY 2019 and FFY 2021 to calculate the FFY 2024 final rule market basket update. We note that this growth rate will capture the increased cost of contract labor, unlike the ECI.

The data for this calculation can be obtained from Worksheets D-1, Part II, Lines 48 and 49 and S-3, Part 1, Column 13 of Medicare cost report. Based on CHA analysis, this would yield an unadjusted market basket update of 4.39%. A net market basket update of 4.19%[24] for FFY 2024 better reflects the actual input price inflation California's hospitals anticipate facing in the coming year, rather than the 2.8% net market basket update proposed by CMS.

Section 1395ww(b)(3)(B)(iii) of the Act defines the "market basket percentage increase" to mean:

> *… with respect to cost reporting periods and discharges occurring in a fiscal year, the percentage, estimated by the Secretary before the beginning of the period or fiscal year, by which the cost of the mix of goods and services (including personnel costs but excluding nonoperating costs) comprising routine, ancillary, and special care unit inpatient hospital services, based on an index of appropriately weighted indicators of changes in wages and prices which are representative of the mix of goods and services included in such inpatient hospital services, for the period or fiscal year will exceed the cost of such mix of goods and services for the preceding 12-month cost reporting period or fiscal year.*

[17] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC10074070/
[18] https://www.cms.gov/research-statistics-data-and-systems/statistics-trends-and-reports/medicareprogramratesstats/downloads/info.pdf
[19] https://www.beckershospitalreview.com/finance/10-hospitals-closing-departments-or-ending-services.html?
[20] https://www.beckershospitalreview.com/care-coordination/18-hospitals-scaling-back-care.html?
[21] https://www.beckershospitalreview.com/finance/19-hospital-closures-bankruptcies-in-2022.html?
[22] https://www.beckershospitalreview.com/finance/9-hospitals-have-closed-this-year-here-s-why.html

[24] 4.19% = (4.39% MBU - .2% ACA-mandated productivity factor)

CHA believes that the Medicare cost report data described above meets the statutory requirement. These data capture all allowable costs, including personnel costs (and excluding non-operating costs) that comprise routine, ancillary, and special care unit inpatient hospital services. Given that these data comprise all the costs — on a volume and risk-adjusted basis — necessary to deliver hospital care they represent "appropriately weighted indicators of changes in wages and prices which are representative of the mix of goods and services …" necessary to provide inpatient hospital care to Medicare beneficiaries. While these data are a measure of historical cost growth, we believe they will better reflect the inflation increases needed by hospitals to maintain services than projections of cost inflation for FFY 2024 from the IGI data used in the proposed rule.

Further, CMS typically uses proxy data wherever possible to avoid circularity issues. However, CHA does not believe this is a reasonable argument against using cost report data. In many instances, the "proxy data" used to construct the market basket update are based on BLS' surveys of hospitals.[25] Therefore, we do not believe that using cost report data in this instance introduces any additional circularity to CMS' calculation of the market basket update than already exists.

Additionally, while any hospital data obtained from the BLS are only a representative sample, using as-filed cost report data will allow CMS to base the market basket update on all IPPS hospitals. The cost reports that supply this data won't be audited and "finalized." However, the data reported on Worksheets D-1, Part II, and S-3, Part I of the Medicare cost report are likely to be highly accurate. Hospitals have decades of experience completing these worksheets (which have detailed instructions) and the data input into Worksheets A (hospital expenses) and C (hospital revenue) — from which Worksheet D-1, Part II is derived — must reconcile to the hospital's audited financial statements when the cost report is filed. BLS data are based on a survey of a limited number of hospitals reporting cost information that may not be audited or tied to financial statements. Finally, changes in volume and intensity are accounted for in the market basket update when CMS rebases or revises it. These changes to account for volume and intensity are infrequent, typically occurring once every four years. The methodology using cost report data fully accounts for changes in volume and acuity annually, resulting in a more accurate proxy.

Market Basket Update – Productivity Adjustment

The productivity adjustment required under the ACA is estimated to be -0.2 percentage points. The adjustment is based on IGI's fourth-quarter 2022 forecast.

CMS itself has acknowledged that hospitals are unable to achieve the productivity gains assumed by the general economy over the long run.[26] CHA appreciates this acknowledgment and agrees that the assumptions underpinning the productivity adjustment are fundamentally flawed. We strongly disagree with the continuation of this policy — particularly during years subject to the COVID-19 PHE. The productivity adjustment to the market basket update assumes that hospitals can increase overall productivity — producing more goods with the same or fewer units of labor — at the same rate as productivity increases in the broader economy. However, providing acute care to patients is highly labor intensive, as CMS' projection of the labor-related portion of the federal rate — 67.6% — implies in the FFY 2024 proposed rule.

[25] For example, the labor portion of the market basket update is based on the BLS' hospital Employment Cost Index.
[26] https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/ReportsTrustFunds/Downloads/ProductivityMemo2016.pdf

Inpatient hospital care must be provided on-site and has a high "hands-on" component. Therefore, hospitals — particularly in states that have nurse staffing ratios — cannot improve productivity using strategies like offshoring or automation that are commonly deployed in other sectors of the economy that produce goods (robotic automation of manufacturing plants) or services (dine-in restaurants that use automated ordering systems to reduce overall staffing count). CMS' own research, conducted prior to the COVID-19 PHE, indicates that hospitals can only achieve a productivity gain that is one-third of the gains seen in the private nonfarm business sector.[27]

CHA notes that during the COVID-19 PHE, productivity fell[28] as a result of increased staff turnover. Over 100,000 nurses are estimated to have left the field during 2021 and 2022[29] alone. During that time, as discussed above, high levels of temporary staffing were deployed to address the labor shortage. While substituting contract labor for employed staff allowed hospitals to continue delivering care to the communities they serve, it also had a negative impact on productivity. Temporary staff are not accustomed to a specific facility's workflows, which increases the number of hours required to provide patient care. This decrease in productivity can be seen in hospital discharge and labor expense data. While discharges were down in 2020, 2021, and 2022 compared to 2019, labor expenses increased significantly, implying that hospitals needed more labor to produce fewer units of care. Further, an October 2021 survey conducted by Kaufman Hall confirms this phenomenon. It found that many hospitals and health system leaders feel the COVID-19 pandemic made it significantly more difficult for them to improve their performance.[30]

Given that CMS is required by statute to implement a productivity adjustment to the market basket update, CHA asks the agency to work with Congress to permanently eliminate this unjustified reduction to hospital payments. Further, due to the extreme and uncontrollable circumstances associated with the COVID-19 PHE that reduced labor productivity, we ask CMS to use its "exceptions and adjustments" authority to remove the productivity adjustment for any fiscal year that was covered under PHE determination (e.g., 2020 -.4%, 2021 -.0%, 2022 -.7%, and 2023 -.3%) from the calculation of market basket for FFY 2024 and any year thereafter.

Market Basket Update – Forecast Error Adjustment

In prior comment letters CHA, along with other stakeholders, expressed its concern that the market basket update proposed (and subsequently finalized) in a given year was inadequate relative to input price inflation. Unfortunately, as discussed above, those concerns have been realized as a result of the impact that a unique event — the COVID-19 PHE — had on hospital labor, supply, and pharmaceutical expenses. Based on files recently released by CMS, the actual market basket update for FFY 2022 should have been 5.7%. Instead, CMS finalized an unadjusted market basket update of 2.7%, resulting in hospitals being underpaid relative to inflation by 3.0 percentage points.

In both the skilled-nursing facility (SNF) PPS and for the capital input price index (CIPI) used to update capital IPPS payments, CMS makes "forecast error adjustments" when it underestimates the market basket update. In the SNF PPS, the forecast error adjustment is made when the actual inflation rate exceeds or is less than the SNF market basket by 0.5 percentage points. In this year's SNF PPS rule, CMS

[27] ibid
[28] https://www0.gsb.columbia.edu/faculty/abartel/papers/human_capital.pdf
[29] https://www.aha.org/news/headline/2023-04-13-study-projects-nursing-shortage-crisis-will-continue-without-concerted-action
[30] https://www.kaufmanhall.com/insights/research-report/2021-state-healthcare-performance-improvement-report-covid-creates

proposes a 3.6 percentage point forecast error adjustment. In FFY 2022, the SNF market basket update was 2.7%. The actual increase for FFY 2022 was 6.3%, resulting in the actual increase being 3.6 percentage points higher than the estimated increase. Therefore, CMS proposes that the FFY 2024 market basket percentage increase of 2.7% would be adjusted upward to account for the forecast error adjustment of 3.6 percentage points, resulting in a SNF market basket percentage increase of 6.3%.

For the CIPI used to update capital IPPS payments, CMS uses a threshold of 0.25 percentage points in order to provide a forecast error correction for the capital IPPS update. For instance, in the proposed rule, CMS indicates that the FFY 2022 capital market basket used in the update was 1.1%. However, the actual increase in capital inflation was 2.0%. As the actual change to the market basket exceeded the one used in the CIPI by more than 0.25 percentage points, CMS is proposing a forecast error correction to the capital IPPS update of 0.9 percentage points for FY 2024.

Given that capital IPPS payments are part of the IPPS rule and the same payment system as operating IPPS payments, it would make logical sense for CMS to apply the same policy to operating payments as it does to capital IPPS payments. Similarly, the operating update for FFY 2022 was 2.7% while the actual rate of increase was 5.7%, a difference of 3.0% or significantly in excess of the threshold of 0.25 percentage points to make an adjustment that is used for the capital IPPS update or the 0.5 percentage point threshold used for the SNF PPS update.

CHA respectfully asks that CMS apply a *one-time* 3.0 percentage point "forecast error adjustment" to the proposed FFY 2024 market basket update. We believe this update is necessary to account for the unprecedented hospital input price inflation — particularly for labor costs — stemming from the COVID-19 pandemic. This inflation — as discussed above — was not captured in the market basket update for FFY 2022 as the input proxy used to account for labor costs does not include contract labor which saw significant growth in FFY 2022 relative to prior to the pandemic. This unique convergence of factors resulted in hospitals being significantly underpaid for services provided in FFY 2022 to Medicare beneficiaries.

While stakeholders asked CMS to provide a forecast error adjustment in response to the inadequate payment update included in the FFY 2023 proposed rule, CMS declined to do so. The agency's rationale for failing to do so in the final stated:

> *Although the statute does not include a forecast error adjustment, commenters requested that CMS use its exceptions and adjustments authority under section 1886(d)(5)(I)(i) of the Act to modify its methodology to account for the forecast error in FYs 2021 and 2022. We note that we did not propose to use our authority under section 1886(d)(5)(I)(i) of the Act to apply a forecast correction in updating the IPPS rates for FY 2023. While there is no precedent to adjust for market basket forecast error in the IPPS operating payment update, the forecast error for a market basket update is equal to the actual market basket increase for a given year less the forecasted market basket increase. Due to the uncertainty regarding future price trends, forecast errors can be both positive and negative. For example, the FY 2020 IPPS forecast error was -1.0 percentage point, and the FY 2021 IPPS forecast error was +0.7 percentage point; FY 2022 historical data are not yet available to calculate a forecast error for FY 2022. As we have discussed in past rulemaking, we believe that an important goal of a PPS is predictability. For these reasons, we do not believe it is appropriate to include adjustments to the market basket update for future years based on the difference between the actual and forecasted market basket increase in prior years.*

While CMS has not previously provided for a forecast error adjustment for the IPPS operating update, we believe it should consider such a policy for 2024 only to correct for COVID-19-related distortions in the price proxies used to calculate the FY 2022 market basket update. CMS' response in the FFY 2023 IPPS final rule suggests that it cannot adopt such a policy in the final rule because it was not proposed. However, CMS is making the operating IPPS market basket subject to public comment in the proposed rule. By foreclosing any options not explicitly proposed from being adopted in the final rule, CMS is effectively not allowing the comment process to affect its final determination of the market basket (other than more recent data) as it did not propose any methodological changes to the update.

Under section 1871(a)(4) of the Act, CMS may adopt policies in a final rule that are a "logical outgrowth of a previously published notice of proposed rulemaking." In this case, the market basket that will be used to update IPPS operating payments is being proposed and is subject to public comment. CHA's comment is that the proposed rule market basket is too low because past years' updates were lower than the actual rate of inflation and the prospective year's update should include an adjustment for that forecast error. This comment is clearly a "logical outgrowth" of an issue that CMS has made the subject of public comment in the proposed rule. CMS most certainly can adopt our suggestion in the final rule without violating section 1871 of the Act that governs the Medicare rulemaking process.

Fully Restore Documentation and Coding Adjustment

The American Taxpayer Relief Act of 2012 (ATRA) required CMS make to adjustments to inpatient PPS rates to recoup $11 billion that the agency claims is the effect of alleged documentation and coding changes from FFYs 2010–2012 that CMS says do not reflect real changes in case mix. The agency instituted these cuts in FFYs 2014 through 2017. When it completed its final ATRA recoupment in FFY 2017, CMS finalized a cut of 1.5 percentage points to inpatient PPS payments. This was almost two times what it had planned and what lawmakers had expected. Yet, the agency did not correct for this discrepancy when repaying hospitals for these cuts from 2018-2022. As a result, hospitals were left with a larger permanent cut than Congress intended when legislating the restorations. Given the financial challenges hospitals are facing as a result of persistent Medicare underpayments, CHA urges the agency to restore the 0.9412% excess cut and help ensure that hospitals have sufficient resources to care for their communities.

Hospital Area Wage Index

CHA appreciates CMS' thorough discussion of hospital area wage index policies proposed for FFY 2024. In general, we are supportive of the agency's efforts to accurately adjust Medicare payments to hospitals, based on adherence to the Medicare statute and audited wage index data, to reflect geographic variation in the cost to deliver care to Medicare beneficiaries. However, we remain concerned that CMS has arbitrarily excluded two California hospitals that have wages that are higher than the market average. Further, we do not support CMS' proposed continuation of its low-wage index hospital policy.

Area Wage Index — Low Wage Index Hospital Policy

In the FFY 2020 IPPS final rule, CMS finalized a policy that increases wage index values for certain hospitals with low-wage index values. CMS implemented this low wage index hospital policy through a budget neutrality adjustment of -.2% that reduces the standardized amount for all IPPS hospitals in FFY 2020. In finalizing the policy for FFY 2020, CMS stated that the "policy will be effective for at least 4 years."

In the FFY 2024 IPPS rule, CMS proposes to continue for a fifth year to apply the low-wage index hospital policy and concomitant budget-neutrality adjustment to the standardized amount for all IPPS hospitals. In justifying this extension — in the face of multiple court decisions that have found this policy impermissible within the Medicare statute — CMS claims that it lacks sufficient data to determine if the policy is effective. CHA opposed this policy in its comments on the FFY 2020, FFY 2021, FFY 2022, and FFY 2023 IPPS proposed rules. For FFY 2024, as in these prior years, CHA continues to strongly oppose decreasing payments to all hospitals to offset an increase in the area wage index (AWI) for the hospitals in the lowest AWI quartile. CHA has long contended that this misguided policy would not only fail to achieve CMS' stated aims of supporting rural hospitals, but the agency lacked legal authority to make the "bottom quartile" adjustment under Medicare statute.

The Low-Wage Policy Is Ineffective

CMS does not need additional time to ascertain the effectiveness of the low wage index policy. CHA again points CMS to the Office of Inspector General's (OIG) December 2020 report that calls the efficacy of the bottom-quartile policy into question.[31] The OIG found that only 53% of bottom-quartile hospitals are considered rural, and of all bottom-quartile hospitals (urban and rural), less than 39% (303) had negative profit margins. Therefore, if the agency's intent is to help rural hospitals, its current policy harms many hospitals it seeks to help. And, instead of helping unprofitable hospitals achieve sustainability, it is reducing the standardized amount for all hospitals — many of which are not profitable — to provide a payment increase to the 61% of bottom-quartile hospitals (480) that are already profitable.

The OIG report also questions the assertion that the Medicare wage index is the root cause of bottom-quartile hospitals' inability to offer higher wages. The report finds that:

> *"The average hourly wages of hospitals in the same area sometimes varied significantly. (That is, some hospitals already were paying significantly higher wages than other hospitals in the same area prior to the bottom quartile wage index adjustment.)"*

This finding suggests that Medicare's wage index policy, as it existed before the implementation of the low-wage index policy in FFY 2020, was not an insurmountable barrier in bottom-quartile core-based statistical areas preventing hospitals in those markets from paying higher wages.

The Low-Wage Policy is Impermissible Under Medicare Statute

In comment letters responding to the FFY 2020, 2021, 2022, and 2023 proposed rules, CHA provided (or referenced) a detailed legal analysis of the ways in which CMS' bottom quartile policy is impermissible under Medicare Statute. Since those letters, two separate federal district courts have found the bottom quartile policy is impermissible under Medicare statute.

On March 2, 2022, the U.S. District Court for the District of Columbia issued a decision in the case of *Bridgeport Hospital v. Becerra* in favor of hospitals challenging the Medicare program's policy of reducing hospital payments in FFY 2020 to fund increased payments to hospitals in areas with low wages.

[31] https://oig.hhs.gov/oas/reports/region1/12000502.asp

Judge Nichols' decision found that the plain language of 42 U.S.C. §1395ww(d)(3)(E)[32] undermines the validity of CMS' bottom quartile policy.[33] The statutory language clearly indicates that the U.S. Department of Health and Human Services (HHS) "is required to calculate the relative wage levels of hospitals in different geographic regions as compared to the national average hospital wage level." The low-wage index hospital policy, however, is not a calculation of "the" relative wage levels of hospitals in different geographic regions as compared to "the" national average hospital wage level, and it is not "uniformly determined and applied." Instead, the low wage index policy *inflates* the wage index values of the hospitals in the lowest quartile. As a result of this finding, the court invalidated the 0.2% reduction to IPPS rates since it paid for the invalid increase to the wage indexes of the lowest quartile hospitals for FFY 2020.

Consistent with the *Bridgeport* case, on Dec. 22, 2022, Judge Consuelo Marshall of the United States District Court for the Central District of California also found in *Kaweah Delta Health Care District, et al. v. Becerra*, the HHS Secretary committed "serious error" and exceeded his authority under the Medicare Act. In the decision,[34] Judge Marshall found that CMS' reduction to the IPPS standardized amount violates the Medicare Act and thus the federal Administrative Procedures Act. Beginning with FFY 2020, CMS increased the Medicare wage index values for hospitals in areas with wages in the lowest quartile and paid for the resulting payment increases by reducing Medicare payments for all hospitals under the IPPS by 0.2%. This payment reduction costs California hospitals over $20 million annually.

Considering the decisions in the *Bridgeport and Kaweah Delta* cases and the clear evidence in the OIG report calling into question the effectiveness of this policy to achieve CMS' goals, CHA asks the agency not to finalize the bottom-quartile adjustment in FFY 2024. Further, CHA respectfully requests the agency to eliminate the budget neutrality adjustments for FFYs 2020 (-0.2%), 2021 (-.12%), 2022 (-0.2%), and 2023 (-0.19%).

Area Wage Index – Audited Hospital Data Arbitrarily Excluded from Proposed Rule AWI File

As part of the FFY 2024 IPPS proposed rule, CMS verified the Worksheet S-3 wage data by instructing its Medicare Administrative Contractors (MACs) to revise or verify data elements that result in "specific edits failures" (88 FR 26965). CMS excluded 88 providers with "aberrant" data the agency claims should not be included in the wage index.

Several of the 88 hospitals CMS identifies as having "aberrant" data are California hospitals whose wages are higher than their core-based statistical average (CBSA) average. As in prior rules, CMS states it believes Section 1886(d)(3)(E) of the Act provides discretion to exclude aberrant data from the wage index public use files. However, CMS neither cites the specific subsection underpinning the authority it claims allows it to exclude audited, otherwise valid data from the FFY 2024 wage index public use files nor the specific regulations where the agency delineates a standard for evaluating when otherwise audited, valid data should be excluded from the calculation of the Medicare wage index. Further, in the

[32] "[T]he Secretary shall adjust the proportion, (as estimated by the Secretary from time to time) of hospitals' costs which are attributable to wages and wage-related costs, of the DRG prospective payment rates computed under subparagraph (D) for area differences in hospital wage levels by a factor (established by the Secretary) reflecting the relative hospital wage level in the geographic area of the hospital compared to the national average hospital wage level. . . . [A]t least every 12 months . . ., the Secretary shall update the factor under the preceding sentence on the basis of a survey conducted by the Secretary (and updated as appropriate) of the wages and wage-related costs of subsection (d) hospitals in the United States."

[33] Bridgeport Hospital, 1:20-cv-01574 at 14–15

[34] https://calhospital.org/wp-content/uploads/2023/01/Kaweah-Summary-Judgement-Order.pdf

FFY 2024 proposed rule, as in prior years, CMS does not cite specific reasons why the agency believes the data from these hospitals are "aberrant[35]." The proposed rule's only clue is the statement that "… we have discretion to exclude aberrant hospital data from the wage index public use files (PUFs) to help ensure that the costs attributable to wages and wage-related costs in fact reflect the relative hospital wage level in the hospitals' geographic area." Therefore, CHA, the excluded hospitals, and other stakeholders are left to infer that CMS is excluding these hospitals because their wages are higher than those of other hospitals in the CBSA.

CMS' lack of explanation for excluding certain hospitals' data is a problem in itself. In the absence of an explanation from the agency, stakeholders are left to make educated guesses as to why CMS has deemed the wage data aberrant, limiting their ability to fully comment on the exclusion of individual hospitals. It also highlights CMS' use of arbitrary and undisclosed criteria to exclude these hospitals.

Further, the FFY 2024 wage data from Worksheet S-3 of cost reports filed during FFY 2020 for the excluded hospitals with allegedly aberrant data — like all hospitals — have been reviewed by CMS and its MAC and accepted as part of the well-established Medicare wage index review process. In accordance with the wage index review process — as defined in CMS' Wage Index Development Timetable — the hospitals in question submitted corrected data in a timely manner that was reviewed and accepted by the MAC. Therefore, in accordance with Medicare's wage index review process, the excluded hospitals' FFY 2020 Worksheet S-3 wage data were determined by the MAC to be accurate.

CMS' exclusion of the foregoing California hospitals' data from the FFY 2024 Medicare wage index exceeds CMS' statutory authority for the following reasons:

- **Nothing in the applicable statute, Section 1395ww(d)(3)(E), permits CMS to exclude general acute care hospitals from the wage index data simply because those hospitals' wages are higher than the wages of other hospitals in their area. Rather, as indicated by CMS in past rulemakings, the wages of all short-term acute care hospitals must be included unless such data are incomplete or inaccurate.**

- **Even if CMS had the authority to exclude certain hospitals despite the fact that their data were accurate and verifiable (which is the case with these hospitals), the exclusion of these hospitals would be arbitrary and capricious, as CMS has promulgated no standards to govern the exercise of its discretion. CMS has established an extensive process to ensure the accuracy and reliability of hospital wage data, which the excluded hospitals have been subjected to. Yet, where the agency does not like the result, it has decided to deviate from this process by arbitrarily excluding hospitals with accurate data.**

- **CMS' exclusion of these hospitals is procedurally improper, as CMS has failed to promulgate a rule in accordance with the Administrative Procedures Act (APA) and 42 U.S.C. § 1395hh that would define what constitutes aberrant data or authorize excluding hospitals with verifiable data from the Medicare wage index.**

[35] CMS has not defined – either in regulatory or sub-regulatory guidance – the criteria it uses to determine when a hospital's audited Medicare wage index data from worksheet S-3 is aberrant.

- **CMS has failed to consider the relevant factors and has relied on factors that are not relevant under the applicable statute. As a result, its action is arbitrary and capricious.**

- **The proposed exclusions for FFY 2024 will cause significant harm to not only IPPS hospitals, but also inpatient psychiatric hospitals, SNFs, inpatient rehabilitation hospitals (IRFs), and many others. The consequence of these exclusions negatively impacting more than the IPPS hospitals appear to be unintended by CMS, as it failed to even consider them in its regulatory fiscal impact analysis in the proposed rule, which it is legally required to do. Thus, the exclusions are legally impermissible.**

- **CMS is not authorized to exclude a hospital from the determination of the wage index on the grounds that the hospital has higher than average labor costs.**

The Medicare statute requires CMS to calculate a wage index that is reflective of hospital wages in the applicable geographic area. Under Section 1395ww(d)(3)(E), "the Secretary shall adjust the proportion … of hospitals' costs which are attributable to wages and wage-related costs … for area differences in hospital wage levels by a factor (established by the Secretary) reflecting the relative hospital wage level in the geographic area of the hospital compared to the national average hospital wage level." Nothing in Section 1395ww(d)(3)(E), or any other provision of law, authorizes CMS to ignore the wages paid by hospitals that have wages that are higher than other hospitals in the same CBSA. And, CMS has pointed to no such provision in the proposed rule.

Specifically, Section 1395ww(d)(3)(E) does not exclude from the determination of wages paid by hospitals that pay higher than other hospitals in the area. Rather, Section 1395ww(d)(3)(E) requires that the Secretary adjust the labor component of payments to reflect the "relative hospital wage level in the geographic area" to the national average. The hospitals proposed for exclusion are in the geographic area of the CBSAs in which they are located. In addition — despite being correct yet allegedly "aberrant" according to CMS — the wages paid by these hospitals are the market clearing rates for those employees. If the hospitals did not pay these rates, they would be unable to staff their facilities, provide high-quality clinical care, and meet the public health needs of the communities they serve.[36] By removing hospitals with higher wages from the calculation, CMS is effectively artificially reducing the wage index for all hospitals in the same CBSA. Thus, excluding these facilities does not reflect accurately the relative wage level of hospitals in those CBSAs.

CMS does not have the discretion to ignore the wages paid by the excluded hospitals.[37] CMS' proposal to do so would violate Section 1395ww(d)(E)(3) and would be unlawful. CHA would not take issue if CMS' proposed exclusion of hospitals was for "unresponsiveness to requests for documentation or insufficiently documented data, terminated hospitals' failed edits for reasonableness, or low Medicare

[36] Notably, CMS used cost report data from FFY 2020 to calculate the FFY 2024 wage index, which included the initial months of the COVID-19 public health emergency (PHE). During that time, hospitals experienced volatile and often inconsistent labor-related costs due to variations in infection rates within a CBSA, spikes in contracted labor costs, and staff turnover and leave rates. Yet, CMS does not describe any assessment it made that the excluded hospitals' higher-than-average costs were not reflective of PHE-driven or other market factors within their service areas.

[37] CMS appears to have understood and interpreted Section 1395ww(d)(3)(E), as long ago as 1994, to require that data from all hospitals in operation are included in the wage index. *See e.g.*, 59 Fed. Reg. 45,330, 45,353 (Sept. 1, 1994) (CMS explaining why terminated hospitals should not be eliminated from the wage index computation: "[w]e have always maintained that any hospital that is in operation during the data collection period should be included in the database, since the hospital's data reflects conditions occurring in that labor market area during the period surveyed.").

utilization." 81 Fed. Reg. 56,762, 56,915 (Aug. 22, 2016). However, CMS does not dispute the accuracy of the wage data or supporting documentation provided for the California hospitals with above average hourly wages as compared to other hospitals in the CBSA that the agency proposes to exclude.

- **The exclusion of the hospitals would be arbitrary and capricious and an abuse of the agency's discretion in the absence of ascertainable standards consistently applied.**

CMS' exclusion of the hospitals from the wage index would be an abuse of discretion because it has provided no standard for when a facility's labor costs are too high to be included in the wage index determination. CMS has defined no standard and, as such, an exclusion could be applied across the board to a multitude of health care delivery systems — destabilizing the entire area wage index calculation. It is arbitrary and capricious for CMS to make unilateral *ad hoc* decisions about what constitutes excessive costs so as to exclude a hospital's data from the area wage index data without affording providers any kind of advanced notice or guidance.

Previously, CMS instituted the Wage Index Development Timetable to ensure that it receives accurate wage index data from all IPPS hospitals. Under the established process, hospital-reported data are reviewed by at least one, and maybe two, MACs to ensure that the data reported are accurate. This process is undertaken each year, and CMS invests significant resources to ensure the data reported and used in the wage index are reliable and valid. However, CMS' proposal to exclude hospitals for having accurate wage data that are too high ignores this process in an arbitrary and capricious manner.

It is imperative that CMS reject this type of unilateral agency action. To allow its implementation opens the door to a complete unraveling of the area wage index calculation and makes an already imperfect index completely and woefully inaccurate — the very opposite of the statute's intent.

- **The exclusion of the hospitals, as proposed, violates the notice and comment requirements of the APA.**

The APA and the Medicare Act itself require that CMS engage in notice-and-comment rulemaking before applying a rule of general application, whether such rule is an interpretative rule or a substantive rule. CMS must provide notice of the proposed rulemaking, afford interested parties an opportunity to comment on the proposed rulemaking, and consider the relevant matters presented in such comments. 5 U.S.C. §553; 42 U.S.C. § 1395hh. *Allina Health Services v. Price*, 863 F.3d 937, 944 (D.C. Cir. 2017) *affirmed by Azar v. Allina Health Services*, 139 S. Ct. 1804 (2019) ("[T]he Medicare Act does not incorporate the APA's interpretive-rule exception to the notice-and-comment requirement. … [o]n the contrary, the text expressly *requires* notice-and-comment rulemaking.").

In this instance, CMS is not putting forward a rule through a formal notice-and-comment process but is implying that it has the discretion to remove hospital data without any standards. If the agency wishes to exclude the data of hospitals where the hospital's labor costs appear to be unusually high or higher than average, it is incumbent on CMS to promulgate proposed rules setting forth proposed standards so that the public may review and comment. That has not occurred here. Rather, CMS is applying either no standards whatsoever or standards known only to the agency. In either case, CMS is acting improperly

and in violation of the APA and 42 U.S.C. § 1395hh.[38] (*See* 42 U.S.C. §1395hh.[39]) There has never been (and this does not so constitute) a public notice-and-comment process related to the agency's purported policy calling for the exclusion of high-cost facilities from the wage index. In the absence of a proper rulemaking process, such policy cannot be validly enforced.

Further, because CMS does not dispute the data's accuracy, its decision to exclude them is even more egregious because CMS is simply removing accurate data without any appropriate rationale and without following proper process under the APA and the Medicare Act. *Compare with Bridgeport Hospital v. Becerra*, 589 F.Supp.3d at *14, *citing Dist. Hosp. Partners, L.P. v. Burwell*, 786 F.3d 46, 56 (D.C. Cir. 2015)("[A]gencies do not have free rein to use inaccurate data.").

- **The exclusion of the hospitals would be arbitrary and capricious because CMS has failed to consider the relevant factors.**

Agency action is arbitrary and capricious and, therefore, invalid when an agency fails to consider the relevant factors or considers factors that should not be considered under the governing statute. CMS has not identified any inaccuracy in the excluded hospitals' data or any assessment suggesting that the data at issue is not reflective of those hospitals' actual labor-related costs. *See, e.g., supra* fn. 2.

Because CMS has not conducted notice-and-comment rulemaking to establish standards for excluding hospitals from the wage index, it is unknown what factors CMS considered. Further, since CMS has not proposed any ascertainable standards, the public has no meaningful opportunity to comment on the factors that should be considered. Because CMS has considered and relied on factors not authorized in or consistent with the statute, its action to exclude the hospitals is arbitrary and capricious.

- **The impact of excluding these hospitals is far greater than hospital payments; Medicare beneficiary access is threatened in the impacted CBSAs.**

CMS' actions have far-reaching consequences not contemplated in the FFY 2024 IPPS proposed rule. If implemented, this proposal will most certainly have negative financial implications not only for the excluded hospitals and the other hospitals within their CBSAs, but also for other providers whose payments are based on the "unadjusted" area wage index in the CBSA, such as SNFs, IRFs, home health agencies, LTCHs, and IPFs.

CMS proposed to utilize the FFY 2024 unadjusted hospital wage index in the FFY 2024 IRF PPS, IPF PPS, and SNF PPS rules. In these payment systems, due to the significant labor share, more than 70% of a California provider's payment is adjusted for the area wage index. The financial consequences are significant to these facilities — most notably, to hospital-based post-acute care providers who care for the most medically complex patients. As a result, by arbitrarily excluding higher-than-average hospital

[38] In both the 2016 and 2017 IPPS final rules, CMS, in relation to the determination of the area wage index, acknowledged that "it has never been CMS' policy to disclose audit protocol." 80 Fed. Reg. at 49,491 and 81 Fed. Reg. at 56,915. Moreover, in the 2017 IPPS final rule, the Secretary further stated that "the protocol is for the Secretary and MAC internal use only." 81 Fed. Reg. at 56,915. CMS cannot hide behind the talisman of "audit protocol" to avoid promulgating the standards used to exclude hospitals from the wage index calculation, if any such standards exist.

[39] The implicit criteria used by CMS to exclude the hospitals are a substantive rule, as there is nothing in the Medicare statutes directing CMS to exclude hospitals with labor costs viewed as high for the area. However, as set forth in *Allina,* the Secretary must follow notice-and-comment rulemaking in connection with Medicare payment policy regardless of whether a rule is substantive or interpretative. Thus, even if CMS were to (incorrectly) view the criteria used to exclude the hospitals (if there are any) as an interpretative rule, notice-and-comment rulemaking would be required before applying the criteria.

data from the hospital wage index, CMS is artificially suppressing payment to post-acute providers located in these CBSAs where they have to compete for healthcare labor with hospitals paying above-average wages due to market or other conditions.

Despite the foregoing, CMS has not identified the fiscal impacts on acute psychiatric hospitals and units, IRFs, and SNFs in its respective regulatory impact statements for the IPF, IRF, SNF, and IPPS proposed rules. Such failure ignores the agency's required duties under Executive Order 12866, Executive Order 13563, section 1102(b) of the Social Security Act, section 202 of the Unfunded Mandates Reform Act of 1995, Executive Order 13132, the Congressional Review Act, and Executive Order 13771. In the IPPS proposed rule — as well as the IRF, SNF, and IPF proposed rules — CMS has failed to consider the implication of these exclusions and, as such, has failed to consider the relevant factors, as required under the APA.

The exclusion of these hospitals will have significant negative consequences the agency appears not to have contemplated. The ripple effects of such an arbitrary and capricious policy will jeopardize access to care for Medicare beneficiaries in the impacted CBSAs. **We urge the agency to withdraw the exclusion of the California hospitals for having higher average hourly wages than their CBSA and reinstate their data for the purposes of the FFY 2024 area wage index. The absence of discussion of these exclusions, as well as their fiscal impacts, renders the notice of proposed rulemaking inadequate, and in itself is a reason that the proposed exclusion of the impacted hospitals may not lawfully be implemented.**

Calculation of the Rural Floor

Revisiting case law, prior public comments, and the relevant statutory language, CMS is proposing to now treat a hospital that reclassifies to a rural area under section 1886(d)(8)(E) of the Act the same as a hospital that is physically located in a rural area. Consistent with the principle of treating an urban to rural reclassified hospital like a hospital physically located in a rural area, CMS also proposes to include an urban to rural reclassified hospital in the calculation of the rural wage index of its state even when that hospital has a Medicare Geographic Classification Review Board reclassification to another area.

CHA supports the proposed policy as we believe it faithfully executes congressional intent clearly indicated by the statutory language in section 1886(d)(8)(E) of the Act. The language in that statutory provision requires the secretary to treat "for purposes of this subsection" qualifying hospitals that are reclassified from urban to rural "as being located in the rural area…of the State in which the hospital is located." The reference to "this subsection" is to all of subsection 1886(d) of the Act, which is the operating IPPS. Hospitals that reclassify under section 1886(d)(8)(E) of the Act may do so for a variety of reasons including the IPPS wage index.

CMS' proposal is reinforced by a progression of litigation on this issue. In each of the cases cited by CMS in the proposed rule, the courts have indicated that CMS' policies are impermissible because they have not treated an urban to rural reclassified hospital as rural for purposes of section 1886(d) of the Act. As a result, the courts have invalidated CMS' regulations in each case where the issue of an urban to rural reclassified hospital's status as a rural hospital was questioned by CMS.

Again, CHA supports CMS taking a proactive approach to re-evaluate its policy and to revise its policy to be consistent with the line of court cases and the statutory requirements. Understanding

CMS is bound by budget-neutrality rules, we raise concern over this policy that reduces wage index values across all hospitals and strongly support wage index policy changes that waive budget neutrality.

Disproportionate Share Hospital (DSH) and Uncompensated Care Payments

As required by the ACA — beginning with FFY 2014 — Medicare DSH payments are split into two separate payments. Hospitals receive 25% of the overall Medicare DSH funds under the traditional DSH formula, known as the "empirically justified" DSH payments. The remaining 75% (Factor 1) is reduced for decreases in the uninsured population since FFY 2013 (Factor 2) and flows into a separate uncompensated care (UCC) pool for DSH hospitals. This UCC pool is allocated based on each hospital's share of national UCC costs (Factor 3).

The DSH dollars available to hospitals under the ACA's payment formula decrease by $0.161 billion in FFY 2024 proposed IPPS rule relative to FFY 2023 final IPPS rule. This is due to a decrease in the pool from projected DSH payments largely attributable to Factor 1. Further, after reviewing Factor 2, CHA believes that CMS has significantly underestimated the increase in the uninsured that will occur due to Medicaid coverage redeterminations.

Like prior years, CHA has concerns about the FFY 2024 IPPS proposed rule's calculation of Factor 1 and Factor 2. CHA strongly supports CMS' rhetoric about efforts to address the conditions that give rise to inequitable health outcomes. However, we are deeply concerned that the agency's actions do not match its rhetoric related to improving access to care and outcomes for populations at risk of inequitable outcomes. Cutting UCC DSH payments to hospitals that serve large portions of these individuals by over $1.64 billion since 2021[40] can only hinder, not help, CMS in attaining its goal related to improving outcomes for America's most disadvantaged.

Proposed FFY 2024 Factor 1

In the proposed rule, CMS uses the CMS Office of the Actuary's (OACT) January 2023 Medicare estimate of DSH payments for FFY 2024 as the basis for Factor 1. This amount — $13.621 billion — is reduced by 25% to arrive at a proposed FFY 2024 Factor 1 of $10.216 billion. The proposed Factor 1 for 2024 is about $245 million less than the final Factor 1 for FY 2023.

The CMS OACT's estimate of Medicare DSH spending uses a baseline year updated to account for projected and actual changes in four component parts that impact DSH expenditures — the IPPS update factor, number of discharges, case mix, and a residual "other" factor to arrive at an estimated DSH amount. Below are tables from the FFY 2023 final and proposed FFY 2024 IPPS rules detailing the specific components of Factor 1 in each rule.

[40] CHA analysis of 2021 – 2023 IPPS Final Rules and 2024 IPPS proposed rule.

Factors Applied for FY 2021 through 2024 to Estimate Medicare DSH Expenditures Using 2020 Baseline

FY	Update	Discharges	Case Mix	Other	Total	Estimated DSH $, Billions
2021	1.029	0.94	1.029	0.985	0.9804	12.997
2022	1.025	0.943	0.997	1.0011	0.9647	12.539
2023	1.043	0.975	1.005	1.0484	1.0715	13.435
2024	1.028	0.976	1.005	1.0055	1.0139	13.621

Source: FFY 2024 IPPS Proposed Rule (88 FR 26991)

Factors Applied for FY 2020 through 2023 to Estimate Medicare DSH Expenditures Using FY 2019 Baseline

FY	Update	Discharges	Case Mix	Other	Total	Estimated DSH $, Billions
2020	1.031	0.862	1.038	0.9952	0.9181	12.682
2021	1.029	0.939	1.029	1.0174	1.0116	12.829
2022	1.025	0.986	0.99	1.0235	1.0241	13.138
2023	1.043	1.05	0.99	0.9793	1.0618	13.949

Source: FFY 2023 IPPS Final Rule (87 FR 49029)

UCC DSH Factor 1 Component Comparison: Proposed FFY 2024 to Final FFY 2023

FY	Update	Discharges	Case Mix	Other	Total	Est DSH Pmt $, Billions
2021	0.000	0.001	0.000	(0.032)	(0.031)	0.168
2022	0.000	(0.043)	0.007	(0.022)	(0.059)	(0.599)
2023	0.000	(0.075)	0.015	0.069	0.010	(0.515)

The proposed decrease in Factor 1 is largely driven by a decrease of .043 in FFY 2022 and .075 in FFY 2023 in the discharge component and unexplained changes in the "other" component in 2021 and 2022.

In the proposed rule, CMS notes the discharge figure for FFY 2023 is based on "preliminary data." While the rule does not specify the exact data set CMS is using, CHA assumes that discharges and case mix for FFY 2023 are based on claims data from the December update of the MedPAR file. This provides less than one-quarter of claims data given the lack of time for "claims run out." Further, CHA notes that compared to the March Medicare Trustees' Report[41] CMS has significantly underestimated the discharge factor as illustrated in the table below.

[41] www.cms.gov/oact/tr/2023

Medicare Discharge Factor Comparison
2023 Medicare Trustees' Report vs. 2024 IPPS Proposed Rule

Year	Medicare Trustees Report	2024 IPPS Proposed Rule	Diff
2022	0.976	0.943	0.033
2023	1.023	0.975	0.048
2024	0.993	0.976	0.017

Replacing the discharge factors for 2022 through 2024 in the proposed rule with those in the Medicare Trustees Report increases total DSH payments by $1.43 billion[42], as illustrated below.

Factors Applied for FY 2021 through 2024 to Estimate Medicare DSH Expenditures Using FY 2020 Baseline Using Medicare Trustees' Report Discharge Factors[43]

FY	Update	Discharges	Case Mix	Other	Total	Estimated DSH $, Billions
2021	1.029	0.940	1.029	0.985	0.9804	12.997
2022	1.025	0.976	0.997	1.0011	0.9985	12.977
2023	1.043	1.023	1.005	1.0484	1.1242	14.590
2024	1.028	0.993	1.005	1.0055	1.0316	15.050

Calculating a projected DSH pool that more accurately reflects historical and projected Medicare discharges results in a Factor 1 of $11.29 billion,[44] an increase of $1.07 billion.[45] CHA respectfully asks CMS to align the discharge factors used to calculate the overall DSH pool in the final rule with those used in the Medicare Trustees' report.

Additionally, there are significant decreases from the FFY 2023 final rule to the FFY 2024 proposed rule in the "other" category for 2021 (-.032) and 2022 (-.022). CMS does provide some data on its estimates of Medicaid enrollment that are a component of the category. However, comparing them to the data provided in the FFY 2023 IPPS final rule does not illuminate what is driving the changes in this crucial category given it's unclear how Medicaid enrollment interacts with the other components that make up the other category. **As it has in prior years, CHA respectfully asks CMS to provide more detailed information on the "other" category within Factor 1 so that stakeholders can offer substantive comments on this key component of Factor 1.**

Proposed FFY 2024 Factor 2

Factor 2 adjusts Factor 1 based on the percentage change in the uninsured since implementation of the ACA. In 2018, CMS began using uninsured estimates from the National Health Expenditure Accounts (NHEA) in place of Congressional Budget Office data as the source of change in the uninsured population.

[42] $15.050B - $13.621B = $1.43B
[43] CHA analysis of FFY 2024 IPPS proposed rule and 2023 Medicare Trustees' Report.
[44] $15.05B*.75 = $11.29B
[45] $11.29B - $10.216B = $1.07B

The NHEA estimate reflects the rate of uninsured in the U.S. across all age groups and residents (not just legal residents) who reside in the 50 states or the District of Columbia.

For FFY 2024, CMS estimates that the uninsured rate for the historical, baseline year of 2013 was 14% and for CYs 2023 and 2024 is 9.3% and 9.2%, respectively. This results in a proposed Factor 2 of 65.71%[46] yielding a total UCC pool of $6.731 billion.[47] This is approximately $161 million less than the FFY 2023 UCC payment total of about $6.713 billion, resulting in a percentage decrease of 2.3% relative to the FFY 2023.

CHA is concerned the agency has significantly underestimated the uninsured rate in 2023 and 2024 in light of the Medicaid redeterminations that are ongoing as a result of the end of the COVID-19 PHE. While CMS acknowledges it anticipates an 11% decrease in Medicaid enrollment during its limited discussion of the "other" category of Factor 1, the uninsured rate used for Factor 2 decreases from FFY 2023 to FFY 2024. For this to be true, it requires the assumption that 100% of the population that loses Medicaid coverage is able to secure another source of coverage, plus others who are currently uninsured will gain coverage. CHA questions this assumption as a recent survey of Medicaid beneficiaries revealed that many are unaware of the ongoing redetermination process, increasing the likelihood of becoming uninsured.[48] Further, the survey found that one in seven Medicaid enrollees say they will become uninsured if they are no longer eligible for Medicaid.

Modeling from NORC, at the University of Chicago, illustrates the impact of Medicaid redeterminations. It finds that approximately 18 million individuals[49] will lose Medicaid coverage. Of those 18 million, 21.1% or approximately 3.8 million individuals previously covered under Medicaid will be unable to find another source of coverage and become uninsured. For impact illustration purposes, CHA conservatively assumes that 1 million individuals will lose coverage in CY 2023 and will remain uninsured in FFY 2024. An additional 2.8 million will become uninsured during FFY 2024. Based on CHA analysis of the uninsured rate in the IPPS proposed rule and the NORC estimates, we project that the FFY 2024 uninsured rate should exceed 10%.

Projected FFY 2024 Uninsured Rate Incorporating NORC's Estimate of Coverage Losses as a Result of Medicaid Redeterminations

	2023	2024	FFY 2024 Uninsured Rate
Baseline Uninsured Uninsured	31.0	30.9	
PHE Uninsured**	1.0	3.8	
Total Uninsured	31.9	34.7	
Total Population*	333.1	335.9	
Uninsured Rate	9.59%	10.33%	
Weighting	25.00%	75.00%	
Weighted Uninsured Rate	2.40%	7.75%	10.14%

Sources:
*https://www.healthaffairs.org/doi/epdf/10.1377/hlthaff.2022.00113
**https://ahiporg-production.s3.amazonaws.com/documents/Medicaid-Redetermination-Coverage-Transitions-Methodology.pdf

[46] Proposed Factor 2 = 1-|((0.092-0.14)/0.14)| = 1 - 0.3429 = 0.6571 (65.71%)
[47] UCC Pool = (Factor 1: $10.216 billion) x (Factor 2: 0.6571) = $6.713 billion
[48] https://www.kff.org/medicaid/poll-finding/the-unwinding-of-medicaid-continuous-enrollment-knowledge-and-experiences-of-enrollees/?
[49] https://ahiporg-production.s3.amazonaws.com/documents/Medicaid-Redetermination-Coverage-Transitions-Methodology.pdf

An uninsured rate of 10.14% results in a Factor 2 value of 72.46%.[50] Using the proposed rule's Factor 1 and a Factor 2 value that accounts for coverage loss as a result of Medicaid redeterminations results in a UCC pool of $7.4 billion.[51] Using only a revised Factor 2 represents a $670 million increase over the proposed rule value. **CHA respectfully asks CMS to use an estimate of the rate of uninsured that reflects the net loss of insurance coverage that results from Medicaid redeterminations when it calculates Factor 2 in the FFY 2024 IPPS final rule.**

Based on the issues discussed above with both Factor 1 and Factor 2, CHA estimates the UCC DSH pool in the FFY 2024 final rule should be approximately $8.18 billion,[52] an increase of $1.47 billion relative to the proposed rule.

Urban to Rural Reclassifications for Capital DSH

Under capital IPPS, only urban hospitals with 100 or more beds are eligible for capital DSH payments. Section 1886(d)(8)(E)(i) of the Act indicates that when a hospital reclassifies from urban to rural, it is treated as rural for all IPPS operating payment purposes. Therefore, since Oct. 1, 2006, CMS has considered an urban to rural reclassified hospital ineligible to receive capital DSH payments.

In *Toledo Hospital v. Becerra*, the U.S. District Court for the District of Columbia ruled against CMS' policy of not providing capital DSH payments to urban hospitals that are reclassified as rural. In response to the court's ruling, CMS is proposing that effective for discharges occurring on or after Oct. 1, 2023, hospitals reclassified as rural will no longer be considered rural for purposes of determining eligibility for capital DSH and therefore eligible for the payment. **CHA appreciates CMS' thoughtful consideration of the court's decision in *Toledo Hospital v. Becerra* and supports the agency's decision to comply with the ruling.**

Medicare Severity (MS) Diagnosis-Related Groups (DRGs) – Proposed Changes to Severity Levels for SDOH

CMS, in the proposed rule, reviews data on the impact of resource use for the ICD-10-CM Z codes that describe homelessness. These codes are currently designated as NonCC, when reported as a secondary diagnosis. The data suggest that when the three codes are reported as a secondary diagnosis, the resources involved in caring for a patient experiencing homelessness support increasing the severity level from a NonCC to a CC. Therefore, for FFY 2024, CMS proposes to change the severity level designation for the three ICD-10-CM diagnosis codes describing homelessness (Z59.00, Z59.01, and Z59.02) from NonCC to CC. **CHA appreciates CMS' thoughtful analysis of increased resource use associated with caring for unhoused Medicare beneficiaries. We strongly encourage CMS to finalize its proposed policy to increase the ICD-10-CM diagnosis codes describing homelessness from NonCC to CC.**

Physician Self-Referral Law and Physician-Owned Hospitals

CMS proposes, effective Oct. 1, 2023, to reinstate the program integrity restrictions regarding the frequency of expansion exception requests, maximum aggregate expansion of a hospital, and location of expansion facility capacity as they apply to high Medicaid facilities. Thus, the same program integrity restrictions would once again apply to both applicable hospitals and high Medicaid facilities.

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[50] Revised Factor 2 = 1-|((0.1014-0.14)/0.14)| = 1 - 0.2754 = 0.7246 (72.46%)
[51] Revised UCC Pool with Factor 2 Adjusted for Increase in Uninsured= (Factor 1: $10.216 billion) x (Factor 2: 0.6571) = $6.713 billion
[52] Revised UCC pool With Updated Factors 1 and 2 = Factor 1 ($11.29b) x Factor 2 (72.46%) = $8.18 billion

Under the proposal, the reinstated program integrity restrictions would not apply to an expansion exception request submitted by a high Medicaid facility between Jan. 1, 2021, and the effective date of the revised regulations if the proposals are finalized, which CMS anticipates being Oct. 1, 2023. CMS also clarifies that no changes are proposed for program integrity restrictions for applicable hospitals. **CHA appreciates CMS' discussion of issues related to physician-owned hospitals and supports the proposal to reinstate program integrity restrictions regarding the frequency of expansion exception requests, maximum aggregate expansion of a hospital, and location of expansion facility capacity as they apply to high Medicaid facilities.**

The rule also proposes to clarify eligibility criteria or make changes to the existing regulations that implement the statutory requirement for a process by which physician-owned hospitals may apply for an exception to the expansion moratorium. The proposed rule also adds a new section, which would contain provisions relevant to the process. These changes encompass the eligibility criteria, circumstances considered when approving or denying an application, information required in an application to expand, and the requirement to obtain community input related to an expansion. **CHA appreciates the additional clarity CMS has provided related to the application process.**

Reasonable Cost Payment for Nursing and Allied Health Education Programs

Section 4143 of the Consolidated Appropriations Act (CAA) of 2023 provides relief for hospitals subjected to recoupment of overpayments for 2010 through 2019. It does this by not applying the $60 million payment limit to nursing and allied health education Medicare Advantage (MA) payments during these years. This relief only applies to hospitals that, as of the date of enactment of the CAA of 2023, were continuing to operate a school of nursing or allied health and entitled to receive reasonable cost education payments. Section 4143 also provided that CMS shall not reduce a hospital's MA direct graduate medical education payments to offset the increase in nursing and allied health MA education payments.

In the proposed rule, if the hospital were still receiving nursing and allied health MA payments on an interim basis as of Dec. 29, 2022, CMS instructs MACs to recalculate a hospital's total nursing and allied health education MA payment for 2010 through 2019 that are still within the three-year reopening window.

The MAC will then compare the hospital's share of nursing and allied health MA payments from these calculations and reconcile them with any prior amounts already paid or recouped from the hospital. Amounts previously recouped will be returned to hospitals, and recoupments that would have occurred if not for the enactment of Section 4143 of the CAA of 2023 will not occur. **CHA thanks CMS for implementing section 4143 of the CAA. However, two facets of the proposal are not aligned with the statute and therefore deeply concerning. First, the proposed rule requires MACs to "first determine whether hospitals that received revised payments under CR (Change Request) 11642 were still receiving NAH MA payments on an interim basis as of Dec. 29, 2022." Second, in the proposed rule, CMS limits the years that are subject to having recalculation to those that are still within the "3-year reopening window."**

CHA notes section 4143 of the CAA 2023 only requires the program to be in operation, not for the MAC to be making interim payments. Specifically, Section 4143(a)(2) adds the following new clause to Section 1886(l)(2)(B) of the Social Security Act:

> *(ii) Exception to annual limitation for each of 2010 through 2019.--For each of 2010 through 2019, the limitation under clause (i) on the total amount of additional payments for nursing and allied health education to be distributed to hospitals under this subsection for portions of cost reporting periods occurring in the year shall not apply to such payments made in such year to those hospitals that, as of the date of the enactment of this clause, are operating a school of nursing, a school of allied health, or a school of nursing and allied health.*[53]

In several instances, CMS and the MACs have denied pass-through reimbursement for nursing and allied health programs that were operating on Dec. 29, 2022. Many of these hospitals have challenged the denial of pass-through reimbursement and have appeals pending with the PRRB or in the courts. It can take many years to resolve cost report appeal issues, so the MAC might not have been making payments on an interim basis as of Dec. 29, 2022. Even if a hospital ultimately wins its challenge and receives pass-through reimbursement, that will not change the lack of payments on an interim basis as of Dec. 29, 2022.

There is nothing in the statute that suggests a hospital must receive payments on an interim basis, only that a nursing and allied health program was operating on Dec. 29, 2022. **Therefore, in the final rule, CHA asks CMS to clarify and correct this by eliminating the reference to payments on an interim basis and indicate that all hospitals operating a nursing and allied health program as of Dec. 29, 2022, are eligible under section 4143 to receive adjusted nursing and allied health MA payments for CYs 2010 through 2019.**

CHA also notes section 4143 of the CAA 2023 also does not limit the years that are subject to recalculation to only those from 2010 through 2019 that are still within the three-year cost report reopening window. Specifically, Section 4143(c) adds the following new clause to Section 1886(l)(2)(B) of the Social Security Act:

> *(c) Retroactive Application.--The amendments made by this section shall apply to payments made for portions of cost reporting periods occurring in 2010 through 2019.*

Nothing in either Sections 4143(a)(2) or (c) limits the recalculation of nursing and allied health payments to those cost report years that are still within the re-opening window. **Therefore, CHA respectfully asks CMS in the final rule to clarify that the MACs will reopen all cost reports from 2010-2019 to allow for recalculating nursing and allied health program payments as instructed by Congress in Section 4143 of the CAA of 2023.**

Safety-Net Hospital Request for Information (RFI)

The 2024 IPPS proposed rule contains a RFI related to safety-net hospitals. The rule notes that advancing health equity is a key pillar in CMS' strategic plan. Among the goals of CMS' health equity pillar is to evaluate policies to determine how CMS can support safety-net providers, partner with providers in underserved communities, and ensure care is accessible to those who need it. CHA notes, as CMS acknowledges in the proposed rule, that many types of hospitals provide care to individuals and communities at greater risk of inequitable outcomes. This, coupled with the relative lack of context for

[53] Emphasis added

how CMS plans to use the information gathered by the RFI, makes it challenging for stakeholders to address many of the specific questions raised by CMS in the proposed rule.

In the rule, CMS evaluates two potential alternatives to existing payment mechanisms — MedPAC's Safety-Net Index (SNI) and the ADI — that it believes may better target payments to hospitals that serve vulnerable communities than the current policies. The RFI poses a number of questions related to safety-net hospitals that include how CMS might use either the SNI or ADI to support hospitals that serve populations at risk for inequitable outcomes. CHA appreciates the RFI. We note that one of the commonalities among the approximately 100 financially distressed hospitals in California is that they serve a relatively larger percentage of Medi-Cal and Medicare beneficiaries than other hospitals in the state. **Given the financial challenges facing all hospitals, we share the agency's particular concern about the ability of certain hospitals to continue their traditional roles as the primary source of health care for populations at greater risk of inequitable outcomes.**

One of the questions posed in the RFI asks how CMS should define or identify safety-net hospitals. We do not believe that hospital type (e.g., rural, urban, teaching, non-teaching) or organization model (e.g., not-for-profit, governmental, for-profit) is appropriate to include in criteria used to identify safety-net hospitals. We note that all types of hospitals provide services to populations at risk of inequitable outcomes and this population extends well beyond just Medicare beneficiaries.

CHA asks that before CMS makes proposals related to any of the metrics or definitions collected by this RFI to identify or distribute payments to safety-net hospitals that it publishes analysis related to the identified metrics or definitions. This analysis should be incorporated into a new RFI that provides more context for how CMS is considering using the newly identified metrics or definitions. The analysis, at a minimum, must identify the national average and median for each metric (or definition as appropriate), what types of hospitals would be more likely to be eligible if said metric was used to define a safety-net provider, and how it would impact different types of hospitals financially under any new safety-net payment model (or changes to existing safety-net payment model) being contemplated.

Challenges Facing Hospitals that Serve Greater Populations of Individuals at Risk for Inequitable Outcomes

Hospitals that provide access to individuals and communities at greater risk of inequitable outcomes face significant revenue and expense challenges resulting from the populations they serve. These challenges combine to create unsustainably low margins that limit these facilities' ability to maintain existing services, much less invest in new facilities and staff.

Regardless of their location, hospitals that serve a larger portion of individuals at risk for inequitable outcomes receive a greater portion of their revenue from governmental payers (Medicare, Medi-Cal, CHIP, and State and Local Health Funds). It is well documented that payment from governmental programs does not cover the cost of providing care. On average, California's hospitals incur 25% and 26% more in cost when caring for patients covered by Medicare and Medi-Cal, respectively, than they receive in payment. Medicare and Medi-Cal combined, on average, cover approximately 73% of patients in California's hospitals. This means that California's hospitals lose approximately 25 cents for each dollar of cost to provide care to almost three-quarters of their patients. This forces the remaining commercially insured patients to cross-subsidize these losses. However, for hospitals that serve a larger portion of individuals at risk for inequitable outcomes, the commercial population isn't of sufficient size to support this level of cross-subsidy.

Additionally, it costs more to treat patients at greater risk of inequitable outcomes. Higher rates of poverty and lower levels of baseline health[54] are hallmarks of communities served by these hospitals. As a result, patients are typically sicker and their conditions more complex when they present to the hospital. Lower availability of accessible primary care in the community results in conditions that could easily be managed but often go untreated until they require emergency hospital care. When this happens, in many instances hospital stays are longer than average as a result of clinical and non-clinical factors. Difficulties discharging patients who no longer require acute care to the next appropriate setting are the result of a host of confounding factors that include homelessness, inadequate patient resources to support a safe discharge home, and/or the lack of post-acute care providers who are willing to accept more complex patients covered by governmental programs. Each of these attributes significantly increases a hospital's costs.

The negative operating margins that result from inadequately low payment rates and high costs limit hospitals' ability to invest in facilities and staff necessary to attract more commercially insured patients. As a result, many hospitals that serve large populations of individuals at risk for inequitable outcomes are forced to close service lines that, while needed by the community, are not financially sustainable[55,56] to ensure the hospital can remain in operation. In the most extreme cases of distress, these hospitals are forced to close,[57] severely limiting access to care for those in the communities served by the hospital. This is what happened to Madera Community Hospital in California.[58] A recent survey to determine the impact of Madera's closure on the Punjabi population and indigenous farm workers in the affected area found that over 60% of respondents will have to find medical centers outside of the community to receive care. Unfortunately, over half of the indigenous farm workers who responded to the survey reported they do not have a reliable mode of transportation to the nearest hospital.[59] This reduced access to care further exacerbates inequitable outcomes for patients who live in socioeconomically disadvantaged areas.[60]

Supporting Safety-Net Hospitals

In general, CHA supports the MedPAC's recommendation to increase payments to hospitals that are necessary to provide access to care for individuals at risk of inequitable outcomes by $2 billion annually. However, the concerns and open questions discussed below about the SNI must be addressed before this model can be fully evaluated by hospitals and other stakeholders. In the meantime, we encourage Congress to pass legislation that provides the recommended $2 billion in additional funding to these hospitals through the existing Medicare DSH and UCC DSH programs. If Congress does adopt a new safety-net payment model, we believe it should not replace DSH and UCC DSH, it must be supported with new funding, and must not redistribute existing DSH and UCC DSH dollars. We are concerned that any model that redistributes existing funds would irreparably harm access at hospitals that serve individuals and communities at risk for inequitable outcomes and rely on DSH and UCC DSH payments to remain financially solvent.

[54] www.irp.wisc.edu/publications/factsheets/pdfs/PoorInPoorHealth.pdf
[55] https://www.beckershospitalreview.com/care-coordination/18-hospitals-scaling-back-care.html?
[56] https://www.beckershospitalreview.com/finance/10-hospitals-closing-departments-or-ending-services.html
[57] https://www.beckershospitalreview.com/finance/19-hospital-closures-bankruptcies-in-2022.html?
[58] https://www.beckershospitalreview.com/care-coordination/in-a-matter-of-days-healthcare-access-deteriorates-in-central-california.html?
[59] https://a27.asmdc.org/press-releases/20230511-community-organizations-release-survey-effects-madera-hospital-closure
[60] https://www.fresnobee.com/news/local/article272712840.html

Further, given the precarious finances of hospitals that are necessary to provide care to individuals at risk for inequitable outcomes, CHA respectfully asks CMS not to wait for congressional action before it takes steps to improve Medicare payments for these hospitals. Taking action now will begin to stabilize hospital finances and shore up access to care in communities at risk of inequitable outcomes. CHA believes there are four steps, that do not require congressional approval, that CMS can take immediately to support hospitals that are necessary to provide care to individuals at greater risk of inequitable outcomes.

- *Stop Unjustified Medicare UCC DSH Cuts*: **As discussed above, the agency can stop unnecessarily reducing Medicare UCC DSH payments to hospitals that provide care to larger populations of individuals at risk of inequitable outcomes.** If the proposed rule is finalized without changes, over the last four years, CMS will have inappropriately reduced UCC DSH payments to these hospitals by $1.64 billion as a result of changes to Factors 1 and 2. CMS has considerable discretion in selecting the data (e.g., Factor 1: anticipated Medicare utilization, Factor 2: uninsured rate) it uses to calculate these factors. **We again encourage the agency to update Factors 1 and 2 with data that more accurately reflect anticipated Medicare utilization and the projected increase in the uninsured rate. As discussed above, CHA estimates doing so will increase payments to struggling hospitals significantly in FFY 2024 compared to the proposed rule.**

- *Reverse the Unjustified Site-Neutral Clinic Visit Policy*: **We encourage the agency to reverse its site-neutral clinic visit policy and refrain from further expanding site-neutral payment policies.** As shown below, the population receiving care in hospital-based outpatient departments is sicker and poorer — and therefore more at risk of inequitable outcomes — than the average Medicare beneficiary. Further, hospital outpatient department site-neutral payment policies are grounded in the false assumption that the physician fee schedule provides an appropriate payment level for services delivered in freestanding settings.

  Hospital outpatient department (HOPD) ambulatory payment classification (APC) weights are set annually based on Medicare claims and audited cost report data. And while the hospital market basket update is badly flawed, as discussed above, the outpatient prospective payment system conversion factor is updated annually to reflect input price inflation. By contrast, the process for updating the relative value units used to calculate physician fee schedule payments is based on an opaque process (compared to APC weight setting) that relies on physician survey[61] data which has led to questions about its reliability.[62] Further, as a result of the Sustainable Growth Rate and subsequent adjustments provided by the Medicare Access and CHIP Reauthorization Act (MACRA), the physician fee schedule conversion factor has failed to keep pace with the physician practice expense growth.

  As an example, the 2023 Medicare physician fee schedule conversion factor is $33.8872. If the current conversion factor were to have been adjusted solely for inflation as measured by the Medicare Economic Index (MEI), less an adjustment for multifactor productivity, it would be

[61] www.ama-assn.org/system/files/ruc-update-booklet.pdf
[62] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4872854/

approximately $41.81 or nearly $8 higher per relative value unit.[63] To further illustrate the example, the national average non-facility Medicare physician fee schedule payment for a moderate complexity physician office visit[64] in CY 2023 is $128.43.[65] Had the physician fee schedule conversion factor been updated by the productivity adjusted MEI since its 1992 implementation, that payment would be approximately $158.47.[66] CHA notes that the national average total Medicare payment – inclusive of the professional fee – for a HOPD clinic visit of similar complexity is $218.46.[67] While there is a difference of just under $60 between the total amount paid by Medicare for a level 4 office visit between the physician office and the outpatient department, CHA notes that approximately $7 of the difference is associated with drugs and devices that are packaged into the APC payment for a clinic visit in an HOPD, which are billed separately when they are provided in a freestanding setting.[68] The remaining higher payment in the outpatient department is necessary to account for the increased regulatory cost associated with hospital-based clinics, caring for a sicker patient population, providing the full range of medical services, and some departments being open 24/7 to be able to accommodate emergencies. These are costs that freestanding physician practices do not have.

A recent analysis of Medicare claims[69] indicates that beneficiaries receiving care in HOPDs are more likely to be non-white (1.5 and 1.4 times more likely to be Black and Hispanic), respectively, and enrolled in Medicaid (1.9 times more likely to be dually eligible) than in independent physician offices (IPO). They are also clinically more complex. Among other measures of complexity, HOPD beneficiaries were more likely to enter the Medicare program due to disability or end-stage renal disease (ESRD). Additionally, 31% of HOPD beneficiaries were originally enrolled in Medicare due to disability and/or ESRD as compared to 19% for IPO patients (1.6 times more likely for HOPD than IPO). As a result of these complicating factors, HOPD patients were 2.8 times more likely to have visited an emergency department in the past 90 days than ambulatory surgery center patients.

- *Immediately Repay 340B Hospitals in a Non-Budget-Neutral Manner*: **As requested by CHA and others,[70] CMS should immediately repay amounts illegally withheld from 340B hospitals for the years 2018–2022 in a non-budget-neutral manner.** Every day that CMS delays in taking this court-mandated action exacerbates the risk that the agency's inaction contributes to the closure of a California hospital that provides access to care for individuals at risk of inequitable outcomes. As discussed in detail in our comment letter in response to the 2023 outpatient prospective payment system proposed rule, the statute does not require CMS to make these retroactive payments in a budget-neutral manner.

[63] This figure was determined by controlling for the effect of budget neutrality adjustments on the conversion factor. The 2023 conversion factor of $33.8872 was deflated by the actual updates applied between 1992 and 2023 and then inflated for the same time period by the MEI.
[64] CPT code 99214
[65] https://www.cms.gov/medicare/physician-fee-schedule/search?Y=0&T=4&HT=0&CT=0&H1=99213&M=1
[66] CHA analysis.
[67] This equals the sum of the OPPS payment for APC 5012 ($120.86) and the amount paid to the physician under the physician fee schedule for 99214 at the "facility price" ($97.60) or $218.46
[68] https://www.cms.gov/medicaremedicare-fee-service-paymenthospitaloutpatientppshospital-outpatient-regulations-and-notices/cms-1772-fc
[69] https://www.aha.org/system/files/media/file/2023/03/Comparison-of-Medicare-Beneficiary-Characteristics-Between-Hospital-Outpatient-Departments-and-Other-Ambulatory-Care-Settings.pdf
[70] www.aha.org/lettercomment/2023-02-01-aha-requests-meeting-hhs-discuss-340b-remedial-payment-outlines-principles-accelerate-process

- *Allow Exempted Provider-Based Partial Hospitalization Program (PHPs) to Expand Access in Response to the Ongoing Opioid PHE:* Given the ongoing opioid PHE, the need for increased access to mental health services and substance use disorder treatment programs has never been greater. CHA members that have considered starting new, off-campus PHPs to meet the growing need for intensive outpatient mental health services report that doing so under the community mental health center (CMHC) rate is not financially viable. However, if these off-campus, PHPs were paid as what they are — an off-campus, HOPD — they would be financially viable. This financial viability would allow hospitals to expand access to desperately needed outpatient intensive mental health services — including substance use disorder treatment — for Medicare beneficiaries. Further expanding outpatient capacity would allow for some individuals who are currently receiving inpatient treatment to receive care in a more appropriate setting. This would also improve access to inpatient psychiatric services, which — as CMS is aware — are also in short supply.

  CHA notes that CMS has already used its Section 1135 authority to waive certain provider-based requirements in response to the COVID-19 PHE to allow for temporary expansions of provider-based locations.[71] Further, we note that CMS has also used its 1135 waiver authority to allow a hospital-based PHP to relocate part of its exempted provider-based department to a new off-campus location while maintaining the original provider-based location.[72] CMS took these steps to improve access to care during the COVID-19 PHE.

  CHA respectfully asks CMS to use its Section 1135 waiver authority to provide similar flexibilities to off-campus hospital-based PHP programs during the ongoing opioid PHE. Specifically, we ask that CMS continue waiving certain requirements under the Medicare conditions of participation at 42 CFR §482.41 and §485.623 and the provider-based department requirements at 42 CFR §413.65 to allow provider-based PHP programs to establish and operate, as part of the hospital, any location meeting the conditions of participation that apply. Further, we ask that CMS continue to allow exempted, provider-based PHPs to relocate part of their exempted provider-based PHP to a new off-campus location while maintaining the original location. We believe providing this flexibility under the opioid PHE is necessary to ensure there is sufficient access to provide outpatient substance use disorder treatment and intensive mental health care services to all Medicare beneficiaries who need them. As an example of the impact that a Section 1135 waiver of the site-neutral requirements would have, it would allow a CHA member to expand its outpatient behavioral health capacity by 30%. This health system anticipates that half of the new patients served through this PHP would be Medicare beneficiaries.

CMS Lacks the Congressional Authority to Implement a New Approach for Distributing Medicare Safety-Net Funds

Part of Congress's intent in creating the Medicare DSH program was to reimburse hospitals for the higher costs they incurred when caring for large portions of low-income patients – regardless of whether those patients are Medicare enrollees. These increased Medicare payments are intended to compensate hospitals for the higher costs associated with additional staffing, facilities, and services required to care for low-income individuals. Congress specifically intended for this portion of Medicare payments to not

[71] https://www.cms.gov/files/document/covid-19-emergency-declaration-waivers.pdf
[72] 85 FR 27561 (https://www.govinfo.gov/content/pkg/FR-2020-05-08/pdf/2020-09608.pdf

necessarily be linked to the costs of treating Medicare patients as defined under cost-based reimbursement principles[73] due to concerns that without additional financial support from Medicare, hospitals treating high volumes of low-income patients would reduce services or close outright, which would create access problems for Medicare beneficiaries. Similar to direct medical education costs, in the DSH payment, Medicare bears the cost associated with other payers to ensure that a tragedy of the commons does not occur and ensure the less fortunate among us have access to health care. In keeping with the congressional intent embodied in the Medicare DSH program, we believe that the Medicaid and SSI ratios are appropriate to identify safety-net hospitals.

CHA notes section 1886(d)(5)(F) of the Act precisely spells out which hospitals are eligible for DSH payments under certain circumstances (for both empirically justified and UCC DSH). Therefore, we currently do not believe that CMS has the statutory authority to implement a new approach for distributing existing Medicare safety-net payments.

Further, section 1886(r)(2)(C) of the Act defines the percent of the total Medicare UCC DSH pool each DSH eligible hospital is to receive as the quotient of:

> *(i) the amount of uncompensated care for such hospital for a period selected by the Secretary (as estimated by the Secretary, based on appropriate data (including, in the case where the Secretary determines that alternative data is available which is a better proxy for the costs of subsection (d) hospitals for treating the uninsured, the use of such alternative data)); and*
> *(ii) the aggregate amount of uncompensated care for all subsection (d) hospitals that receive a payment under this subsection for such period (as so estimated, based on such data).*

We note the statute instructs CMS to base the percentage of the total Medicare UCC DSH pool each hospital receives based on the amount of UCC each hospital provides. While the statute affords the secretary some flexibility to use proxy data in determining the amount of UCC, we note that that flexibility is predicated on the proxy being a better source of UCC costs for the uninsured. Given that CMS is currently using UCC costs as reported by hospitals on their annual cost report, and these costs are subject to a rigorous audit process by the MACs, we do not believe that the MedPAC SNI or other metrics would provide the agency with a better proxy for hospitals' costs of UCC.

MedPAC SNI Proposal

MedPAC has developed the SNI which is calculated as the sum of:

1. The share of the hospital's Medicare volume associated with low-income beneficiaries
2. The share of its revenue spent on UCC
3. An indicator of how dependent the hospital is on Medicare

In the RFI, CMS asks if the SNI is "an appropriate basis for identifying safety-net hospitals for Medicare purposes?"

As discussed below, CHA has multiple questions and concerns with the model. These must be addressed so stakeholders can fully understand the impact of the SNI. Further, these questions and concerns must be resolved before Congress or the agency gives further consideration to the SNI.

[73] https://www.cbo.gov/sites/default/files/101st-congress-1989-1990/reports/1990-05_disproportionatesharehospitals.pdf

- *Impact on Government Hospitals*: CHA notes that in MedPAC's analysis of the SNI, Medicare and all-payer revenue for governmental hospitals decreased by 1.5% and .6% respectively.[74] The modeling that we reviewed related to the SNI exhibited a similar trend. Given that public hospitals with more governmental payers tend to care for larger populations of patients at risk for inequitable outcomes, we are concerned about any model that shifts dollars away from these types of facilities. In California, this would have translated into $180 million in reduced Medicare revenue for these hospitals in 2021, stressing already fragile providers.

- *Include MA Patients in the Definition of Low-Income Subsidy-Eligible Patients (LIS)*: CHA believes that the definition of low-income subsidy-eligible patients should include both Medicare FFS and MA patients in the numerator and the denominator. Currently, MedPAC's definition of the LIS only includes Medicare FFS patients. We note that MedPAC's definition of "Medicare Share of Inpatient Days" includes both MA and FFS patients.

- *Determining the Amount of the DSH Pool to Distribute Via the SNI*: MedPAC recommends Congress appropriate an additional $2 billion. As part of this recommendation, the amount should be increased annually by the market basket update. However, there is no discussion in the 2024 IPPS proposed rule or the MedPAC SNI proposal about how the existing Medicare DSH pool would be adjusted for inflation in future years should the Medicare SNI be implemented. If the SNI were adopted by Congress, it is assumed that the CMS Office of the Actuary would project the amount of DSH payments that would have been made in a manner similar to the current process for determining Factor 1 of the UCC DSH formula. However, this is not clearly stated.

  As noted in CHA's discussion of the Factor 1 DSH calculation, the process used for inflating DSH dollars forward is fraught with challenges, which will only increase if the SNI is adopted. Another alternative is to calculate the SNI as add-on percentage for each hospital — untethered from a fixed pool of funds and uncapped — and apply it to Medicare inpatient and outpatient payments similar to the method currently used to calculate payments for "empirically justified" DSH payments. If the SNI were adopted, we believe this approach could resolve some of the redistributional issues inherent with the model. Regardless of which approach is selected, before hospitals can appropriately comment on the SNI, they must understand if the pool of funds will be increased annually and how that increase will occur.

- *Increase Transparency of the SNI Calculation*: CHA thanks CMS for providing data on LIS patients necessary to model the SNI. The MedPAC report to Congress contemplates including payments for MA patients in the SNI model. However, it is unclear how much additional funding should be added to the Medicare DSH pool for MA patients to fully model the impact of the SNI on Medicare safety-net payments or how those dollars would be allocated based on MA utilization. We ask CMS to provide this information.

Using Area-Level Indexes to Identify Safety-Net Hospitals Is Problematic

In the proposed rule, CMS asks if using area-level indexes such as the ADI are an appropriate basis for identifying safety-net hospitals. The ADI contains a number of variables that are based on the national

[74] www.medpac.gov/wp-content/uploads/2023/03/Ch2_Mar23_MedPAC_Report_To_Congress_SEC.pdf

average. These include median family income, percentage of families below the federal poverty level, median home value, median monthly mortgage payment, and median gross rent.

CHA has significant concerns with using the ADI or other similar indexes that rely on national benchmarks. CHA is deeply concerned that given California's higher cost of living, safety-net hospitals in California will be disadvantaged by any index that does not take into account the significant regional variation in wages and the cost of living. The table below illustrates the substantial difference in wages, rents, and home values (and, therefore, monthly mortgage payments) between the medians for each of these measures in the United States and California. Recent analysis of the relationship between ADI score and median home value has only exacerbated this concern.[75]

Median Household Income,[76,77] Home Value,[78,79] and Monthly Rent[80]
California Compared to the United States

	California	United States	Diff	% Diff
Median Household Income (2020)	$ 78,672	$ 67,521	$ 11,151	17%
Median Home Value (2022)	$ 788,679	$ 440,300	$ 348,379	79%
Median Monthly Rent (2020)	$ 747	$ 602	$ 145	24%

Further, research has shown that national and regional approaches to understanding area deprivation do not properly model the impact on health outcomes.[81] A study of over 61,000 Medicare beneficiaries found the ADI was weakly correlated with self-reported social needs (r = 0.16%) and only explained .02% of the observed variation in spending.[82] Given these considerable flaws, using a model[83] like the ADI to identify safety-net hospitals could paradoxically worsen[84] payment disparities among safety-net providers. Further, CHA notes that CMS staff have expressed similar concerns with the ADI in both the SNF PPS proposed rule[85] and the value-based purchasing section of the IPPS proposed rule.[86]

Before CMS can contemplate using any measure such as the ADI to identify safety-net hospitals, the agency must identify a model that accurately accounts for the impact of social variables on health outcomes and spending found in different communities. If CMS fails to do so and moves forward with a measure such as the ADI, it will deprive safety-net hospitals in high cost-of-living areas that care for at-risk populations of the necessary resources to address social determinants of health.

[75] https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2022.01406?
[76] https://www.census.gov/library/publications/2021/demo/p60-273.html#:~:text=Median%20household%20income%20was%20%2467%2C521,median%20household%20income%20since%202011.
[77] https://www.census.gov/quickfacts/fact/table/CA/BZA210220
[78] https://fred.stlouisfed.org/series/MSPUS
[79] https://fred.stlouisfed.org/series/MSPUS
[80] https://www2.census.gov/programs-surveys/decennial/tables/time-series/coh-grossrents/grossrents-unadj.txt
[81] https://www.cdc.gov/pcd/issues/2016/16_0221.htm#:~:text=An%20area%20deprivation%20index%20(ADI)%20is%20a%20multidimensional%20evaluation%20of,outcomes%20at%20various%20geographic%20levels.
[82] https://jamanetwork.com/journals/jama-health-forum/fullarticle/2803073?
[83] https://www.healthaffairs.org/content/forefront/aco-benchmarks-based-area-deprivation-index-mask-inequities?
[84] https://jamanetwork.com/journals/jama-health-forum/fullarticle/2803073?source=email
[85] 88 FR 21384-21385
[86] 88 FR 27049

LTCH Fixed Loss Outlier Threshold

CMS establishes a fixed-loss threshold amount so that total estimated outlier payments under the LTCH PPS for federal standard payments are projected to equal 8% of total estimated payments under the LTCH PPS. Using LTCH claims data from the December 2022 update of the FFY 2022 MedPAR file adjusted for charge inflation and adjusted CCRs from the December 2022 update of the PSF, CMS calculated a proposed fixed-loss amount for standard federal rate cases of $94,378 for FFY 2024. This is approximately a 150% increase from the FFY 2023 final rule fixed loss outlier threshold of $38,518. This increase in the outlier threshold will harm LTCHs – and access to care in this setting as most LTCHs cannot afford to incur this amount of financial loss per case. Further, CHA notes if this is finalized, it represents the second significant increase in the LTCH outlier threshold in consecutive years as it increased from $33,014 in FFY 2022 to $38,518 (16%) in FFY 2023.

CHA does not believe that trends from the FY 2022 claims data (which were used to calculate the proposed threshold) will continue. Therefore, CMS can reasonably make more conservative assumptions about growth that result in lower fixed-loss amounts. Specifically, for reasons discussed below, the challenging circumstances that LTCHs and other providers faced skewed the FY 2022 data for LTCH charges and claims, but CMS can expect LTCH claims and charge data to stabilize in 2023 due to the end of the PHE. **CHA strongly encourages CMS to review the data and process its uses to calculate the LTCH outlier threshold to ensure it accurately captures LTCH's projected caseload for FFY 2024.** Below are possible alternatives that CMS should consider when calculating a more accurate fixed loss outlier threshold for FFY 2024.

Alternative #1 – Use More Recent Data to Calculate Charge Inflation Factor and Account for Dialysis Patients: CMS determined the charge inflation factor (CIF) that it used in calculating the proposed outlier threshold by dividing the average covered charge per case from FY 2022 claims by the average covered charge per case from FY 2021 claims. This is done to give CMS an estimate of the rate by which charges might increase in FY 2023 and FY 2024. CMS used the December 2022 update of the FY 2022 MedPAR file and the December 2021 update of the FY 2021 MedPAR data as the basis for this calculation, which resulted in a one-year CIF of 13.56%. However, we believe that analysis of more recent claims data from the first six months of FFY 2023 will result in a lower CIF.

We urge CMS to explore using more recent data to calculate the CIF for multiple reasons.
First, using these data are consistent with CMS's commitment to using the most recently available data. Second, using these data would be consistent with CMS' previous finding that the PHE time-period data are aberrant and should not always be relied upon. For example, for FY 2023, CMS used a blended approach by averaging the fixed-loss amounts both with and without COVID-19 cases. And more germane, CMS used the CIF from the pre-PHE time period by comparing 2018 and 2019 data for setting the FY 2023 fixed-loss threshold.

Additionally, dialysis providers – like LTCHs and other providers – have faced unprecedented cost increases and labor shortages. For LTCHs, this made it increasingly difficult to safely discharge dialysis patients into outpatient dialysis care. In FY 2022, dialysis treatment facilities and home care providers were unable to meet demand due to staff shortages and the additional time and resources needed for COVID-19 safety precautions. This is especially true for LTCH patients, who typically have multiple co-morbidities and are more complex and resource-intensive than other types of dialysis patients.

As a result, LTCHs kept dialysis patients in their hospitals for much longer time periods than usual, driving up lengths of stay and resulting in charges. To address this challenge, LTCHs have been working with community partners and believe that the solutions implemented are creating the necessary access to dialysis and other post-acute services for complex patients. However, this is something that must be accounted for when using FY 2022 data. **More specifically, we urge CMS to exclude these dialysis claims when calculating the fixed-loss threshold.** Again, this would be consistent with CMS' past practice of excluding certain claims due to the effects of the pandemic.

Alternative #2 – Use a Market Basket-Based CIF and Account for Dialysis Patients: Prior to FY 2022, CMS calculated the CIF by inflating charges by a growth factor calculated from quarterly market basket values. When the agency proposed to change its current claims-based CIF methodology, the LTCH's warned that making such significant changes during the public health emergency was ill-advised. Unfortunately, we now see the anticipated impact of this change with a CIF that is leading to the proposed 150% increase in the outlier threshold. **Therefore, if CMS does not wish to adopt the FY 2023-based CIF calculation described above, we urge the agency to revert to its prior market basket-based CIF methodology.** This methodology produces a two-year CIF of 7.8%, a more reasonable and stable figure. It also relies on data that CMS already relies upon for the annual payment update to the LTCH PPS (and its other payment systems).

Alternative #3: Use pre-pandemic data as the health care system transitions out of the PHE: As previously mentioned, CMS deviated from its typical methodology for both HCOs and other LTCH PPS payment dynamics during the COVID-19 PHE. For FY 2023, CMS explored calculating the CIF by using pre-pandemic data. More specifically, it stated in the FFY 2023 final rule that "[w]e also believe there will be fewer COVID-19 cases in FY 2023 than in FY 2021 and therefore do not believe it is reasonable to assume charges will continue to increase at this abnormally high rate." We believe this rationale is even more applicable to setting outlier thresholds for FY 2024.

As stated earlier, the country's health care system is transitioning out of the PHE. While many challenges remain, FY 2024 in many ways will mark the transition back to as close to pre-pandemic care patterns as possible. Among other examples, LTCHs are transitioning back to their prior admissions practices due to the expiration of the site-neutral payment and 50-percent rule waivers. In addition, strain on other settings such as acute-care hospitals and outpatient care (including dialysis centers) will begin to abate. As such, it would be reasonable to assume that patient care will more closely resemble the pre-PHE time period. Therefore, if CMS does not wish to adopt alternatives #1 or #2 above, we recommend that it utilize FY 2019 data in calculating the outlier threshold, keeping all other portions of the methodology as proposed.

Inpatient Quality Reporting (IQR) Program

CMS proposes several changes to the IQR program, including the addition of three new electronic clinical quality measures (eCQMs), the removal of three measures, and refinements to existing measures.

Proposed Adoption of Patient Safety-Focused eCQMs

CHA generally supports CMS proposed adoption of three new patient safety eCQMs beginning with the FFY 2027 IQR program: Hospital Harm – Pressure Injury eCQM; Hospital Harm – Acute Kidney Injury eCQM; and Excessive Radiation Dose or Inadequate Image Quality for Diagnostic Computed Tomography in Adults eCQM. We appreciate that CMS has proposed these measures as options

available for hospital self-selection — rather than as mandatory measures — enabling hospitals to choose the measures that are most relevant to their specific quality improvement goals. As CMS continues to develop new eCQMs to support the advancement of digital quality measurement, we urge the agency to maintain reporting requirements of six eCQMs and encourage the agency to allow for additional flexibility in the selection of eCQMs for individual hospitals.

Proposed Modification to the COVID-19 Vaccination Coverage among HCP Measure

CMS proposes to modify the current HCP COVID-19 vaccination measure beginning with the FFY 2025 IQR program, consistent with proposals across all Medicare QRPs. Specifically, CMS would replace the definition of "complete vaccination course" with a definition of "up to date" for Centers for Disease Control and Prevention (CDC) recommended COVID-19 vaccines. The agency proposes this modification to incorporate evolving CDC guidance related to booster doses and their associated timeframes.

While the denominator of the current measure would not change — and is reflective of all HCP eligible to work in the hospital for at least one day during the reporting period — the numerator of the measure would be changed to be the cumulative number of HCP in the denominator population who are considered up to date with the recommended COVID-19 vaccines as defined by the CDC[87] on the first day of the quarter. Compliance with the FFY 2025 IQR program requirements would be based on reporting of eligible HCP who are up to date beginning with quarter four of calendar year 2023. Beginning with the FFY 2026 IQR program, hospitals would be required to submit data for the entire calendar year.

CMS does not propose any changes to the data submission or reporting processes for the measure, and hospitals would continue to be required to collect data for at least one self-selected week during each month of the reporting quarter and submit that data to the CDC National Healthcare Safety Network (NHSN) prior to the quarterly deadline.

CHA strongly supports ongoing efforts to maintain high levels of up-to-date vaccination for COVID-19 among both HCPs and the communities they serve. However, now that the PHE has ended and we are in an endemic phase of the disease, we are concerned that the data reporting requirements associated with the measure will divert already stretched resources from patient care to administrative processes. The CDC's definition of "up to date," can change every quarter, and it is challenging for hospitals to collect and continuously assess the vaccination status of every single employee who works in the facility for a given reporting period. Further, the requirement that hospitals collect and report on this data for at least one week each month has strained the already stressed workforce.

In developing the measure, CMS relied heavily on the specifications and experience with the Influenza Vaccination among HCP measure. The flu vaccine measure assesses vaccinations during "flu season" — defined as October through March — and is reported annually. While there are still questions about the seasonality of COVID-19, future vaccination schedules, and how often new versions of a COVID-19 vaccine will be available, an annual data collection and reporting process is significantly less burdensome than reporting data for one week out of each month of the year. **We urge CMS to consider limiting the reporting requirements to at least one week for each quarter, and work with the CDC to develop a version of the measure that could be reported annually.**

[87] https://www.cdc.gov/nhsn/pdfs/hps/covidvax/uptodateguidance-508.pdf

In addition, we continue to have concerns that the lag in timeline between reporting the data to NHSN and public reporting of the measure results in publicly reported data that are outdated and inconsistent with the public's understanding of vaccination rates in a given facility. As proposed, data for quarter four of 2023 would not be publicly reported until October 2024, at which point it is likely that the definition of "up to date" could be significantly different than when the data were collected, due to changes in recommended vaccination schedules or updated boosters. Finally, we remain concerned that the measure has not gone through rigorous testing for reliability and validity and has not been endorsed by the consensus-based entity (CBE).

Proposed Updates to the HCAHPS Survey Measure

The HCAHPS Survey was adopted into the hospital IQR program beginning with the FFY 2008 payment determination. In 2021, CMS conducted a large-scale mode experiment to test improvements to the survey, including the addition of web-based survey modes, and as a result, proposes several changes to HCAHPS Survey administration.

CHA strongly supports CMS' proposal to add three new modes of survey administration (web-mail mode, web-phone mode, and web-mail-phone mode) in addition to the current mail only, phone only, and mail-phone modes, beginning with January 2025 discharges. CHA has long called for the addition of web-based survey modes and we agree the proposal will result in increased response rates. We also welcome additional proposals intended to increase response rates, including allowing proxy responses on behalf of a patient, extending the data collection period, and providing a Spanish translation of the survey to patients for whom Spanish is their preferred language.

Hospital Value-Based Purchasing (VBP) Program

CMS proposes several changes to the hospital VBP program, including modified versions of two existing measures, one new measure under the safety domain, technical changes to the administration of the HCAHPS survey in alignment with the IQR program, as well as changes to the scoring to include a health equity adjustment (HEA).

Proposed New Measure: Severe Sepsis and Septic Shock: Management Bundle (SEP-1)

CMS proposes to add a new measure under the Safety Domain — Severe Sepsis and Septic Shock: Management Bundle (#0500) — beginning with the FFY 2026 program year. The measure, which has been reported in the hospital IQR program since October 2015, assesses hospitals' adherence to a sepsis care bundle, including measurement of lactate, obtaining blood cultures, administering broad-spectrum antibiotics, fluid resuscitation, vasopressor administration, reassessment of volume status and tissue perfusion, and repeat lactate measurement.

CHA agrees that accelerating hospital progress in providing better care to patients with sepsis is a key priority for improving patient safety and reducing health care disparities. We support the concept of including a measure that addresses sepsis within the safety domain of the hospital VBP program, however, we do not agree that the SEP-1 bundle is the appropriate measure. CHA shares stakeholder concerns that the measure contributes to the overuse of antibiotics because the bundle requires administering antibiotic therapy to all patients with *possible* sepsis, regardless of severity of illness. We also have concerns with the complexity of staying up to date with guidelines for reporting this all-or-nothing chart-abstracted measure, and note that variability in abstraction could result in skewed results inappropriate for comparison under a performance-based program such as VBP.

CMS notes in the proposed rule that it is in the process of developing a sepsis outcome eCQM that would be less burdensome for hospitals to report. In general, CHA strongly supports outcome measures over process-based and chart-abstracted measures and we urge CMS to focus its resources on engaging stakeholders in the development of a sepsis outcome measure that would be more appropriate for use in the VBP program. **We urge CMS not to finalize its proposal to include SEP-1 in the VBP program.**

Proposed Health Equity Adjustment (HEA)

CMS proposes to revise the hospital VBP program scoring methodology to reward hospitals for providing excellent care to underserved populations. Specifically, beginning with the FFY 2026 program year, CMS proposes to add HEA bonus points to a hospital's total performance score (TPS), calculated using a methodology that incorporates a hospital's performance across all four domains and the hospital's proportion of dually eligible patients. CMS also proposes to increase the potential maximum TPS value to 110 points to account for the inclusion of the HEA.

CHA supports the proposed HEA as a first step toward incentivizing improved care for patient populations that experience health disparities. CHA appreciates that CMS has proposed a policy that would reward hospitals that achieve high levels of performance while overcoming challenges associated with caring for higher proportions of underserved residents. We agree that dually eligible status can be a proxy for identifying underserved patients. However, we urge the agency to examine other factors that indicate a hospital provides care to underserved patients, such as caring for a high proportion of Medicaid patients or utilizing ICD-10 Z-codes to identify the percentage of patient populations with significant social risk factors, such as those experiencing homelessness.

As CMS considers these additional factors, we caution the agency against using area-level indexes such as the ADI as part of the HEA methodology in the VBP program. As noted in our response to the safety-net RFI included in the proposed rule, CHA has significant concerns with using the ADI or other similar indexes that rely on national benchmarks in performance-based programs. The ADI contains a number of variables that are based on the national average, including median family income, percentage of families below the federal poverty level, median home value, median monthly mortgage payment, and median gross rent. CHA is deeply concerned that given California's higher cost of living, hospitals in California would be disadvantaged by any index that does not take into account the significant regional variation in wages and the cost of living for the purposes of a VBP payment adjustment.

Medicare Promoting Interoperability Program

CMS makes several proposals related to the Medicare Promoting Interoperability Program, including the establishment of an electronic health record (EHR) reporting period for CY 2025, a modification to the reporting requirements for the Safety Assurance Factors for EHR Resilience Guides measure, and new patient safety-focused eCQMs in alignment with the proposals for the hospital IQR program.

Proposed Reporting Period for 2025

CMS previously adopted a continuous 90-day reporting period for the Medicare Promoting Interoperability Program through CY 2023, and an increase to a minimum of any continuous 180-day period beginning with CY 2024. CMS proposes to maintain a reporting period of any continuous 180 days for CY 2025. **CHA supports this proposal.**

However, CHA would be strongly opposed to increasing the EHR reporting period in 2026. An EHR reporting period that is less than a full year is essential to account for common events such as EHR system upgrades, changes in EHR vendors, and other technical updates that could impact a hospital's ability to report on a full year of activity. Hospital experience has demonstrated that vendors lack the capacity to implement upgrades across their customer base in a timely manner. As such, hospitals must often begin their reporting period later in the year to allow for testing of new upgrades, as well as education and training for staff as changes are made to EHR systems. Notably, the Office of the National Coordinator for Health Information Technology has issued a proposed rule updating EHR certification requirements. Once finalized, vendors will need to provide upgrades to hospitals across the nation to meet the new certification requirements. We urge CMS to maintain a 180-day reporting period indefinitely.

CHA appreciates the opportunity to comment on the FFY 2024 IPPS proposed rule. If you have any questions, please contact me at cmulvany@calhospital.org or (202) 270-2143, or Megan Howard, vice president of federal policy, at mhoward@calhospital.org or (202) 488-3742.

Sincerely,

/s/
Chad Mulvany
Vice President, Federal Policy