June 10, 2024

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

SUBJECT: CMS-1808-P, Medicare and Medicaid Programs and the Children's Health Insurance Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Policy Changes and Fiscal Year 2025 Rates; Quality Programs Requirements; and Other Policy Changes; Proposed Rule, Federal Register (Vol. 89, No. 86), May 2, 2024

Dear Administrator Brooks-LaSure:

On behalf of our than 400 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) and long-term care hospital (LTCH) PPS proposed rule for federal fiscal year (FFY) 2025.

California's hospitals continue to face unprecedented financial pressure resulting from uncontrollable input price inflation. From 2019 to 2023, 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 closure of one hospital in California (Madera Community Hospital[2,3]), drove another into bankruptcy (Beverly Hospital[4]), and has forced others to eliminate necessary but financially unsustainable services (like labor and delivery)[5] to ensure facilities can remain open. Unfortunately, more hospital closures are anticipated. Kaufman Hall, a nationally renowned consulting firm, estimates 60% of California's hospitals have unsustainable operating margins.

The Medicare Payment Advisory Commission's (MedPAC) recognizes the precarious nature of IPPS hospitals' financial situation and the deleterious impact it is having on access — not just for Medicare

[1] Current State of California Hospital Finances, Kaufman Hall, May 2024
[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://calmatters.org/health/2023/11/california-hospitals-close-maternity-wards/

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beneficiaries. Following 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[6]. These are not abstract data points. Sadly, two individuals' deaths have already been attributed[7] to Madera Community Hospital's closure.

To prevent further loss of access to care in California and other states, the Commission took the unprecedented step of recommending Congress increase the market basket update (MBU) above current law. In its FY 2024 recommendation, MedPAC recommended an increase of one percentage point over market basket plus providing an additional $2 billion to hospitals[8]. Recognizing hospitals' rapidly deteriorating financial situation, the Commission recommended Congress increase the acute hospital market basket by 1.5 percentage points over current law and increased the additional funding for hospitals to $4 billion[9] for FY 2025. Regrettably, CMS in the proposed FY 2025 IPPS rule chose to ignore the concerns expressed by MedPAC about hospital closure, service line termination, and Medicare beneficiary access to care.

CHA is concerned that the FY 2025 IPPS proposed rule will only exacerbate these already dire circumstances for hospitals and the Medicare beneficiaries they serve. The proposed net MBU of +2.6% is insufficient relative to the input price inflation faced by hospitals and continues CMS' historic trend of proposing inadequate payment updates. For example, from 2020 through 2022, the average net MBU finalized by CMS was 2.3%. However, hospitals' risk-adjusted cost per discharge increased by a volume weighted average of 4.91%[10] during that same period, deepening Medicare payment shortfalls. To ensure broad access to inpatient care for Medicare patients, the following feedback on the 2025 IPPS proposed rule is offered:

- *Provide an Adequate Market Basket Update*: CMS must use data that better reflect the input price inflation that hospitals have experienced and are projected to experience in FY 2025. Further, the agency must make a one-time "forecast error adjustment" to account for the gross underestimation of the hospital MBU that occurred from 2021 to 2023.

- *End the Bottom Quartile Policy*: CMS' proposal to continue its illegal 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, is opposed. Multiple U.S. District Courts have ruled this policy is impermissible under statute and inappropriately redistributive. It has proven ineffective and penalizes all IPPS hospitals in an effort that is ineffective in helping the agency achieve its stated goal.

- *Revise Uncompensated Care (UCC) Disproportionate Share Hospital (DSH) Factors*: CMS is encouraged to recalculate Factors 1 and 2 of UCC DSH calculation. CMS should increase projections of Medicare FFS utilization in FY 2025 given concerns about the adequacy of the CY

[6] www.nber.org/system/files/working_papers/w26182/w26182.pdf
[7] https://www.fresnobee.com/news/local/article272712840.html
[8] https://www.medpac.gov/wp-content/uploads/2023/03/Mar23_MedPAC_Report_To_Congress_SEC.pdf
[9] https://www.medpac.gov/recommendation/hospital-inpatient-and-outpatient-services-3/
[10] CHA analysis of Medicare cost report data.

2025 Medicare Advantage (MA) rate update and the recent trend of providers terminating contracts with MA plans. Additionally, the uninsured rate used to calculate Factor 2 does not fully account for the loss of insurance coverage for up to 4 million individuals because of the ongoing Medicaid redetermination process.

- *Revise Acute Care Hospital and Long-Term Care Fixed-Loss Outlier Thresholds*: Given the significant increases in the fixed-loss outlier thresholds, CMS likely overestimated them. CMS should re-evaluate the calculations to ensure they accurately reflect the anticipated caseloads and expenses that acute and LTCH PPS hospitals will experience in FY 2025.

- *Risk-Bearing Payment Models Must be Voluntary*: CMS must make the Transforming Episode Accountability Model (TEAM) voluntary. TEAM will — by design — oversample hospitals that can least afford to bear downside risk. Further, ongoing challenges discharging Medicare patients who require home health or skilled nursing facility care[11] will hamper many hospitals' ability to succeed in this model. There are concerns about the appropriateness of the episodes selected by the Center for Medicare and Medicaid Innovation (CMMI) for a mandatory bundled payment model. Finally, the aggregate costs associated with hospital participation in the model are likely greater than CMS' projected savings. If CMS finalizes TEAM as a mandatory model, it will exacerbate access issues for safety net populations. This outcome is predictable but preventable.

- *Protect Access to Labor and Delivery Services*: The request for information (RFI) related to Medicare's role in the maternal care crisis is appreciated. CMS can support access to labor and delivery services by providing adequate hospital payment updates through the IPPS and OPPS. While Medicare does not directly pay for a high volume of L&D services, Medicare payment shortfalls — like Medicaid's — must be subsidized by other payers. Increasingly, commercial payment rates are insufficient to cross-subsidize losses on Medicare and Medicaid patients cared for by hospitals that have large populations of individuals at risk of inequitable outcomes. Medicare can support access to maternal health services by paying its fair share for care provided to the elderly and disabled.

- *Revise Methodology Used to Calculate the Labor-Related Share for LTCH*: There is concern the methodology CMS uses to rebase and revise the labor-related share of Medicare payments for LTCH with a wage index of 1 or greater is premised on the flawed assumption that some categories of labor costs are not subject to geographic variation. CMS should revise its methodology for rebasing the labor-related share, to account for the geography wage variation inherent in all non-clinical professional services costs.

- *Reconsider the use of attestation-based structural quality measures:* CMS is urged not to finalize the addition of these attestation-based measures and instead focus resources on developing outcomes-based measures where there are gaps in patient safety and geriatric care.

- *Do not finalize significant increase to electronic clinical quality measure (eCQM) reporting requirements:* The proposal that would nearly double eCQM reporting requirements by 2027 for the hospital inpatient quality reporting (IQR) and Promoting Interoperability programs could jeopardize hospitals' financial stability and divert limited resources from direct patient care.

[11] Challenges with SNF access will be further exacerbated by the recently finalized long-term care nursing staffing ratio requirements.

Detailed comments on CMS' payment and quality proposals follow.

Inpatient Hospital Operating Update

CMS proposes a market basket increase for FFY 2025 of 3.0%. This is then reduced by the 0.4 percentage point "productivity adjustment" required under the Affordable Care Act (ACA). The resulting proposed IPPS MBU equals 2.6%.

CMS' proposed 2.6% net MBU is inadequate relative to the input cost inflation experienced by acute care hospitals. This continues a longstanding trend of MBUs that fail to keep pace with hospital input cost inflation that has been recognized by MedPAC in its March 2024 Report to Congress. MedPAC indicates that input prices in FY 2023 grew 4.8% (0.7 percentage points more than initially forecast).[12] It's worth noting that this is the third consecutive year — after hospitals have warned CMS its MBU was insufficient relatively to input price growth — the agency's projection of the MBU has been lower than actual inflation by more than 0.5 percentage points. As illustrated below, between FFYs 2021 and 2023, the MBU calculated with the "actual" IHS Global Inc. (IGI) data for the given FFY compared to the final rule MBU calculated with forecasted data suggests that the market basket has been understated by 4.3 percentage points.[13]

IPPS Forecast (Final Rule) vs. "Actual" Market Basket Updates:
FFYS 2021 to 2023

	FFY 21	FFY 22	FFY 23	3-Year Summary
Final Rule Market Basket Update[1]	2.40	2.70	4.10	
Actual Market Basket Update[2]	3.00	5.70	4.80	
Difference[3]	-0.60	-3.00	-0.70	-4.3

Notes:
1) These figures do not reflect total factor productivity or other legislative adjustments.
2) All information in this row is from OACT's 4th quarter 2023 release of market basket information with historical data through the 3rd quarter of 2023.
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 cost per risk-adjusted beneficiary discharge from Medicare cost reports for a similar time frame suggests[14] the final rule MBUs from 2018 to 2022 understated Medicare payments by 7.29% 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 2018-2022

	FFY 18	FFY 19	FFY 20	FFY 21	FFY 22	5-Year Summary
Final Rule Market Basket Update[1]	2.7	2.9	3.0	2.4	2.7	
Risk Adjusted Cost Per Discharge Growth[2]	1.91	4.54	8.31	0.48	5.75	
Difference[3]	0.79	-1.64	-5.31	1.92	-3.05	-7.29

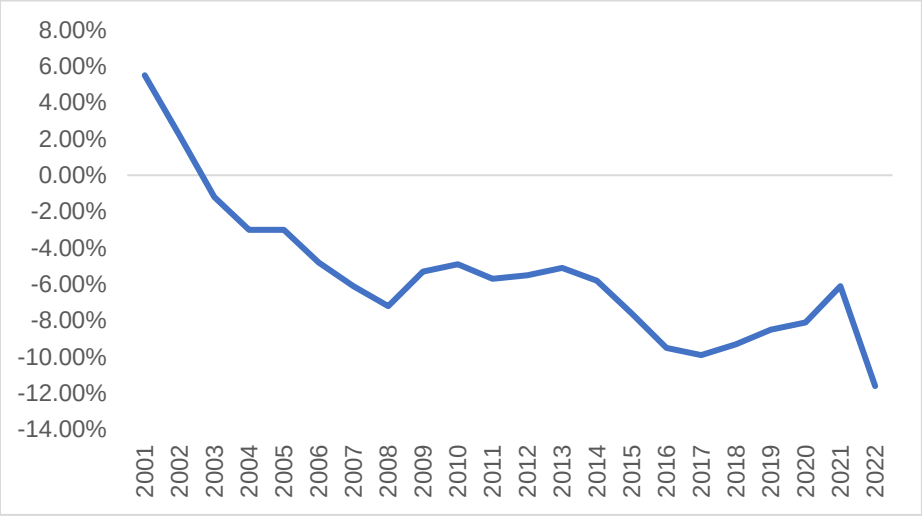
[12] www.medpac.gov/wp-content/uploads/2024/03/Mar24_Ch3_MedPAC_Report_To_Congress_SEC.pdf
[13] CHA analysis of CMS Office of the Actuary Data.
[14] Analysis runs through FFY 2021 as FFY 2022 cost report data for latter years are currently not available.

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. This is due to persistently inadequate Medicare MBUs. **Hospitals' financial situations are so precarious that MedPAC recommended to Congress that it increase IPPS and OPPS payments over current law to preserve access for the second year in a row (2024: MBU+1%; 2025: MBU+1.5%).**[15,16]

These are the only times in its history that MedPAC has made such a recommendation for hospitals. Further, recognizing the particularly precarious nature of safety net hospital finances, MedPAC again recommended that Congress increase payments to these anchor institutions (2024: $2b; 2025: $4b) to ensure access to care for Medicare beneficiaries who are most at risk for inequitable outcomes. It is not just Medicare beneficiaries' access to care and outcomes are harmed when a hospital closes or is forced to cut unsustainable service lines. It is the entire community — particularly those at risk of inequitable outcomes — who suffer as a result of inadequate Medicare payment.

IPPS Hospital Medicare Margin: 2001 to 2022[17,18,19,20]



This longstanding underpayment trend has been exacerbated by the labor dislocations and supply chain breakdowns that have continued since the COVID-19 pandemic. These challenges have increased baseline costs and are not offset by the limited increases in revenue hospitals have experienced. This 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 14.7%[21] to account for input price inflation.

[15] https://www.medpac.gov/wp-content/uploads/2023/03/Ch3_Mar23_MedPAC_Report_To_Congress_SEC.pdf
[16] https://www.medpac.gov/wp-content/uploads/2023/03/Mar23_MedPAC_Report_To_Congress_SEC.pdf
[17] https://www.medpac.gov/wp-content/uploads/2022/03/Mar22_MedPAC_ReportToCongress_Ch3_SEC.pdf
[18] https://www.medpac.gov/wp-content/uploads/import_data/scrape_files/docs/default-source/reports/mar18_medpac_ch3_sec.pdf
[19] www.medpac.gov/wp-content/uploads/2023/03/Ch3_Mar23_MedPAC_Report_To_Congress_SEC.pdf
[20] https://www.medpac.gov/wp-content/uploads/2023/10/MedPAC-Hospital-payment-adequacy-Jan-2024.pdf
[21] CHA analysis of Medicare market basket update data.

While CMS will refresh the MBU in the final rule with more recent data, the revised update will still be insufficient relative to input cost inflation — particularly for labor. The Bureau of Labor Statistics' Employment Cost Index (ECI) only captures the salary increases associated with employed staff and does not capture extraordinary labor cost growth associated with hospitals' increased reliance on clinicians contracted through staffing agencies in response to supply shortages triggered by the COVID-19 pandemic. While the COVID-19 PHE may be over, hospitals are still experiencing staffing issues as a persistent after effect.

As employed nurses 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, the per unit rate for these individuals has increased with demand for agency staff. California's hospitals, for example, spent more than double ($1.6 billion) on contract labor in 2023 than they did in 2019 even though patient days were only up 3%, ED visits were up 1%, and observation days were down 8% comparatively.[22] Additionally, the average length of stay is up 7% which begins to explain the increased demand for clinical labor in light of flat utilization[23]. Further, while contract labor expense is declining relative to the peak of the COVID-19 pandemic, contract labor utilization will likely remain 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.[24]

Even before the application of the productivity adjustment, the MBU 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 MBU. It is clear, based on rapidly rising labor costs, that CMS' current inputs for updating the IPPS MBU are ill-suited to the current environment. CMS itself acknowledges that setting payment updates during times of economic uncertainty can often result in large forecast errors.[25] 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.[26,27,28,29] **Therefore, CMS is again asked to identify more accurate data inputs and use its existing authority to calculate the final rule "base" (before additional adjustments) MBU with data that better reflect the rapidly increasing input prices facing hospitals.**

While CMS acknowledged the considerable flaw in the ECI in its response to comments in the 2024 IPPS final rule, the agency attempted to downplay concerns. In the 2024 IPPS final rule the agency states:

> *We note that the Medicare cost report data shows contract labor hours account for about 4% of total compensation hours (reflecting employed and contract labor staff) for IPPS hospitals in 2021. Therefore, while we acknowledge that the ECI measures only reflect price changes for employed*

[22] Current State of California Hospital Finances, Kaufman Hall, May 2024
[23] As CMS is aware, Medicare and most other payers do not pay for inpatient services using per diems or percent of charge payment models. Therefore, increased lengths of stay do not result in increased payments to compensate hospitals for the additional expense necessary to care for patients.
[24] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC10074070/
[25] https://www.cms.gov/research-statistics-data-and-systems/statistics-trends-and-reports/medicareprogramratesstats/downloads/info.pdf
[26] https://www.beckershospitalreview.com/finance/10-hospitals-closing-departments-or-ending-services.html?
[27] https://www.beckershospitalreview.com/care-coordination/18-hospitals-scaling-back-care.html?
[28] https://www.beckershospitalreview.com/finance/19-hospital-closures-bankruptcies-in-2022.html?
[29] https://www.beckershospitalreview.com/finance/9-hospitals-have-closed-this-year-here-s-why.html

staff, we believe that the ECI for hospital workers is accurately reflecting the price change associated with the labor used to provide hospital care (as employed workers' hours account for 96% of hospital compensation hours).

Analysis of this issue using only hours worked and only focusing on the most recent data is inadequate. In 2019 — prior to the pandemic — clinical contract labor was 2.39% of total allowable hours worked[30]. Based on analysis of the 2022 data from the FFY 2026 preliminary wage index public use file, contract labor hours were 4.55% of total allowable hours worked. This implies that clinical contract labor as a percentage of total hours doubled during the pandemic. Further, CMS does not analyze the dollars associated with these hours. Analysis shows the average hourly wage for clinical contract labor in 2019 was $61.96 and was $109.97 in 2022, up 76%. In contrast, the fully loaded average hourly wage for employed staff in 2019 was $38.92 and is $46.07 in 2022, increasing just 18%. The spread between the average hourly rate for contract staff vs. employed staff in 2022 is $63. This is 2.74 times higher than it was pre-pandemic in 2019.

Nursing and other clinical staffing shortages have caused hospitals' reliance on contract labor to double, driving rates for clinical contract labor to increase by 76% prior to the pandemic. This has significantly increased expenditures on clinical contract labor when comparing 2019 (pre-pandemic) to 2022 (during the pandemic). In 2019 hospitals spent $12 billion on clinical contract labor, while in 2022 that amount grew to almost $42 billion. **As a percentage of total allowable salaries, contract labor increased from less than 4% in 2019 to over 11% in 2022. While contract labor only reflects 4% of allowable hours worked, it represents more than 11% of allowable salaries which is material to the calculation of the market basket update. Therefore, CMS is again asked to identify more accurate data inputs and use its existing authority to calculate the final rule "base" (before additional adjustments) MBU with data that better reflect the rapidly increasing input prices facing hospitals.**

A similar analysis was provided in comments to the CY 2024 OPPS proposed rule. The agency did not address these data in its response to comments and has asserted that the alleged immateriality of contract labor hours absolves it of any need to make changes to the calculation of the MBU. This analysis shows that *contract labor is not an immaterial component of hospitals' cost structures* and must be accurately incorporated into any MBU.

Given the unprecedented, continuing cost growth and the inadequate MBUs resulting from the use of the ECI, CMS is asked to use the weighted average growth rate in allowable Medicare costs per *risk adjusted discharge* for IPPS hospitals between FFY 2020 and FFY 2022 to calculate the FFY 2025 final rule MBU. 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 analysis, this would yield an unadjusted MBU of 4.91%[31]. A net MBU of 4.51%[32] for FFY 2025 better reflects the actual input price inflation California's hospitals anticipate facing in the coming year, rather than the 2.6% net MBU proposed by CMS.

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

[30] CHA analysis of Medicare cost report data submitted in 2019 and 2021.
[31] CHA analysis of Medicare cost report data.
[32] 4.51% = (4.91% MBU - 0.4% ACA-mandated productivity factor)

> *… 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.*

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, they will more accurately reflect the inflation increases needed by hospitals to maintain services than projections of cost inflation for FFY 2025 from the IGI data used in the proposed rule.

Further, CMS typically uses proxy data wherever possible to avoid circularity issues. However, this is not a reasonable argument against using cost report data. In many instances, the "proxy data" used to construct the MBU are based on BLS' surveys of hospitals.[33] Therefore, using cost report data in this instance does not introduce any additional circularity to CMS' calculation of the MBU than already exists.

Additionally, while any hospital data obtained from the BLS are only a representative sample, using as-filed cost report data allows CMS to base the MBU 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 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 MBU 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 — Forecast Error Adjustment

In comment letters in response to the FFYs 2022, 2023, and 2024 IPPS proposed rules, many stakeholders expressed concern that the MBU 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 — continues to have on hospital labor, supply, and pharmaceutical expenses. For the last three years for which data are available, CMS' finalized market basket was lower than what it should have been by 0.6% (FFY 2021), 3.0% (FFY2022), and 0.7% (FFY 2023).

[33] For example, the labor portion of the market basket update is based on the BLS' hospital Employment Cost Index.

Medicare IPPS Market Basket Update Forecast Error
2021 - 2023

FFY	Final Rule Projected MBU	MBU Based on Actual Data	IPPS Under Reimbursement
2021	2.4	3.0	-0.6
2022	2.7	5.7	-3.0
2023	4.1	4.8	-0.7
Total	N/A	N/A	-4.3

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 MBU. 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. As an example, the table below illustrates the forecast error adjustments finalized in the 2023 (2021 MBU) and 2024 (2022 MBU) and proposed for 2025 (2023 MBU).

Skilled-Nursing Facility Forecast Error Adjustments Finalized/Proposed
Related to FFYs 2021 - 2023

FFY	Final Rule Projected MBU	MBU Based on Actual Data	SNF Forecast Error Adjustment
2021	2.2	3.7	-1.5
2022	2.7	6.3	-3.6
2023	3.9	5.6	-1.7
Total	N/A	N/A	-6.8

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. In the 2024 final rule, CMS indicated 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 finalized a forecast error correction to the capital IPPS update of 0.9 percentage points for FY 2024. Similarly, in the 2025 proposed rule, CMS proposes a CIPI forecast error adjustment of 0.5% as the actual increase was greater (3.0%) than what CMS projected in the FFY 2023 final rule (2.5%).

Given that capital IPPS payments are part of the IPPS rule and the same payment system as operating IPPS payments, it would make sense for CMS to apply the same policy to operating payments as it does to capital IPPS payments. Similarly, the operating updates finalized by CMS from FFY 2021 through 2023 were cumulatively 4.3% lower than they should have been based on the actual data. The underestimates from 2021 to 2023 significantly exceed 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.

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. The agency's rationale:

> *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 CMS has not previously provided for a forecast error adjustment for the IPPS operating MBU, it should implement such a policy for 2025 only to correct for COVID-19-related distortions in the price proxies used to calculate the FY 2021, 2022, and 2023 MBUs.

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. Commenters have observed 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 this suggestion in the final rule without violating section 1871 of the Act that governs the Medicare rulemaking process.

Further, in both the FFY 2023 and 2024 IPPS final rules, CMS responded to requests for a forecast error adjustment in part by asserting there is no need for any such adjustment as over-projections and under-projections cancel each other out over time. Specifically, in the FFY 2024 IPPS final rule, CMS states:

> *While the projected IPPS hospital market basket updates for FY 2021 and FY 2022 were under forecast (actual increases less forecasted increases were positive), this was largely due to unanticipated inflationary and labor market pressures as the economy emerged from the COVID-19 PHE. However, an analysis of the forecast error of the IPPS market basket over a longer period of time shows the forecast error has been both positive and negative. For example, the 10-year cumulative forecast error showed a negative forecast error (that is, forecasted increases were greater than actual increases) of 1.1 percentage points (2013 through 2022). In addition, for each year from 2012 through 2020, the forecasted FY hospital market basket update implemented in the final rule was higher than the actual hospital market basket update once historical data were available, with 7 out of the 9* ***years having a negative forecast error greater than 0.5 percentage point (in absolute terms)***[34]*. Only considering the forecast error for years when the final hospital market basket update was lower than the actual market basket update does not consider the numerous years that providers benefited from the forecast error.*

[34] Emphasis added.

First, CMS' response in the 2024 IPPS final rule suggests that the MBU that was used during the prior 10 years was accurately calculated. As discussed above, this is a point hospitals continue to contest given the exclusion of a labor price proxy that accurately captures changes in contract labor utilization.

Second, in looking over the 10-year window, only seven (three underestimated, four overestimated) years exceed the 0.5 percentage point threshold (in absolute terms). While there are more years where an overestimation occurs, the cumulative impact for these seven years is a -0.8% underestimation.

CMS is again asked to apply a *one-time* 4.3 percentage point "forecast error adjustment" to the final FFY 2025 MBU. This update is necessary to account for the unprecedented hospital input price inflation — particularly for labor costs — stemming from the COVID-19 pandemic in the years 2021-2023. This inflation — as discussed above — was not captured in the MBUs from 2021 through 2023 as the input proxy used to account for labor costs does not include contract labor, which saw significant growth during these years. For these years, a unique convergence of factors resulted in hospitals being significantly underpaid for services provided to Medicare beneficiaries. If this underpayment is allowed to persist, it will harm access for Medicare beneficiaries and contribute to the further loss of labor and delivery of services in communities most at risk for inequitable maternal outcomes.

In summary, CMS is requested to provide a net MBU of 8.81%. This is based on an update of 4.91% that appropriately reflects hospital input price growth — including contract labor and a forecast error adjustment of 4.3% to correct for prior years' gross underpayment, less the proposed 0.4% productivity reduction.

Hospital Area Wage Index

CMS' thorough discussion of hospital area wage index policies proposed for FFY 2025 is appreciated. In general, hospitals 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, California's hospitals 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 -0.2% 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 final rule, CMS continued its statutorily impermissible policy of applying the low-wage index hospital policy and concomitant budget-neutrality adjustment to the standardized amount for all IPPS hospitals for a fifth year. And now, in the FFY 2025 IPPS rule, CMS proposes extending it for three more years (FFY 2025-2027), with a budget neutrality adjustment of -0.28% for FFY 2025. In justifying this extension — in the face of multiple court decisions that have found this policy impermissible within the Medicare statute — CMS again claims it lacks sufficient data to determine if the policy is effective. However, as discussed below, CMS isn't seeing the result it seeks, not because it lacks "clean" data, but because the policy is flawed.

This policy was opposed in comments in response to the FFY 2020, FFY 2021, FFY 2022, FFY 2023, and FFY 2024 IPPS proposed rules. For FFY 2025 and subsequent years, as in these prior years, California's hospitals continue to oppose decreasing payments to all hospitals to offset an increase in the area wage index (AWI) for the hospitals in the lowest AWI quartile. This policy not only fails to achieve CMS' stated aims, as underscored by the lack of demonstrable increases in bottom quartile wages relative to those in the other CBSAs, but the agency lacks legal authority to make the "bottom quartile" adjustment under Medicare statute.

The Low-Wage Policy is Impermissible Under the Medicare Statute

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

The judge's decision found that the plain language of 42 U.S.C. §1395ww(d)(3)(E)[35] undermines the validity of CMS' bottom quartile policy.[36] 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*, that the HHS secretary committed "serious error" and exceeded his authority under the Medicare Act. In the decision,[37] 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.

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[35] "[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."

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

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

The Low-Wage Policy Is Ineffective

First, CMS is pointed to the Office of Inspector General's (OIG) December 2020 report that calls the efficacy of the bottom-quartile policy into question.[38] 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.)"*

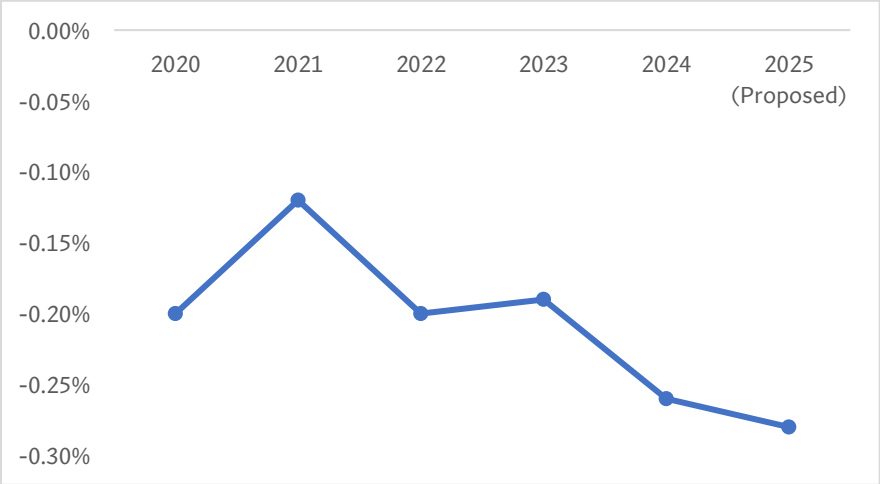
This finding suggests that Medicare's wage index policy, as it existed before the implementation of the low-wage index policy in FFY 2020, was not an insurmountable barrier in bottom-quartile core-based statistical areas preventing hospitals in those markets from paying higher wages.

CMS is encouraged to replicate the OIG's analysis using the most recently available audited data (FFY 2020 and 2021) and share the results in the IPPS final rule. If the findings are the same as in the OIG's analysis, it will further demonstrate that the bottom-quartile policy has not had the intended effect and should not be continued.

Second, the ineffectiveness of CMS' bottom quartile policy is highlighted by the budget neutrality adjustments shown in the chart below.

Final/Proposed Bottom Quartile Budget Neutrality Adjustment

FFYs 2020 – 2025



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

If bottom quartile hospitals were using the increased payments associated with the policy to raise wages at a rate faster than the national average (thereby closing the wage gap the policy targets), the budget neutrality adjustment associated with the policy should decrease, as it would cost less for CMS to maintain the policy over time as wages in bottom quartile markets converged with other CBSAs, compressing the wage index. However, the opposite is true. As illustrated by the chart, there has been a significant increase in the budget neutrality adjustment required to implement this policy in 2024[39] and 2025[40] (these use the first FFYs of wage index data impacted by the low wage index policy) suggesting that the bottom quartile policy has been ineffective.

There Are No COVID Effects Obscuring the Results

CMS attempts to justify continuing this policy until it has sufficient data to understand the impact of the bottom quartile policy in two ways. However, the agency does not need additional time for average hourly wage data from a timeframe that does not include the COVID-19 PHE to ascertain the effectiveness of the low wage index policy. First, the proposed rule discusses the various programs that provided financial support to hospitals during the COVID-19 pandemic. These include the Provider Relief Fund, state emergency relief funds and Small Business Loan Forgiveness program among others. CMS concludes the $3.6 billion received by bottom quartile hospitals "had a much greater impact on hospital operations than the approximately $230 million" impermissible redistribution of Medicare payments resulting from this policy that occurred in 2020.

The agency cites this analysis to support its argument that the COVID-19 PHE via the various provider relief programs so muddied the data that it could not possibly tease out what effect (if any) this policy had. However, CMS misunderstands the various programs that provided financial support to hospitals during the COVID-19 PHE. All of these programs were intended in some fashion to[41]:

1) Replace some or all revenue hospitals lost due to decreases in demand associated with the COVID-19 PHE
2) Cover the extraordinary costs hospitals incurred responding to the PHE that are not reimbursed through payments from Medicare, Medicaid, and commercial payers

The funds from these programs were distributed using consistent criteria that applied to all eligible hospitals. Therefore, they were not intended to advantage certain hospitals over others by increasing some hospitals' revenue (like the bottom quartile policy for some hospitals) and not others in a given category. The COVID-19 relief programs were intended to replace revenue that hospitals lost as a result of circumstances beyond their control and cover the extraordinary costs of saving patients' lives, mitigating the spread of a deadly pathogen, and protecting communities during a global pandemic.

Second, if CMS was concerned data from the COVID period were so flawed it could not determine the impact of the bottom quartile policy on impacted hospitals, it might stand to reason that the data would also be so flawed that they could not be used for payment updates. However, CMS had enough confidence in the "normalcy" of data from years (federal and calendar) impacted by COVID-19 to use it to set MS-DRG weights, fixed-loss outlier thresholds, wage index values, and other key components of

[39] 2020 data used for the 2024 wage index

[40] 2021 data used for the 2025 wage index

[41] www.hrsa.gov/sites/default/files/hrsa/provider-relief/prf-arp-rural-post-payment-notice-reporting-requirements.pdf

the inpatient prospective payment system in FFY 2024. Further, it proposes to use data from COVID impacted years for the same functions in FFY 2025.

CMS even acknowledges this in the proposed rule by stating, "While there are some differences, it is not readily apparent how any changes due to the COVID-19 PHE differentially impacted the wages paid by individual hospitals." The proposed rule attempts to justify this continuation by discussing the challenges of normalizing hospital wage data to understand the impact of this policy *"if changes due to COVID-19 did differentially impact wages paid by hospitals over time."* If CMS is confident enough in the data to use them for rate setting, then it should be confident enough to assume there was no differential impact that would spoil an impact analysis of the bottom quartile policy.

Considering the decisions in the *Bridgeport and Kaweah Delta* cases, clear evidence in the OIG report, CMS' proposed/finalized bottom quartile budget neutrality adjustments calling into question the effectiveness of this policy to achieve CMS' goals, and the lack of justification for a delay based on insufficient data to judge the impact of this policy, CMS is again asked not to finalize the bottom-quartile adjustment for FFYs 2025 through 2027. Further, CMS is respectfully asked to eliminate the budget neutrality adjustments for FFYs 2020 (-0.2%), 2021 (-0.2%), 2022 (-0.2%), 2023 (-0.19%) and 2024 (-0.26).

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 increase by $560 million in FFY 2025 proposed IPPS rule relative to FFY 2024 final IPPS rule. This is due to an increase 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.

As in prior years, there are serious concerns about the FFY 2025 IPPS proposed rule's calculation of Factor 1 and Factor 2. Hospitals support CMS' focus on addressing the conditions that give rise to inequitable health outcomes — particularly maternal outcomes. However, the agency's actions do not match its rhetoric related to populations served by DSH hospitals. While the increase in UCC DSH payments to eligible hospitals is most appreciated, it only begins to offset the reduction of $1.9 billion that occurred between 2021 and 2024.[42] As discussed below, there are statutorily authorized policy levers CMS can pull to increase funding to safety net hospitals as recommended by MedPAC. Increasing funding for these hospitals will help further CMS' goals of improving outcomes for America's most disadvantaged and improving maternal outcomes.

[42] CHA analysis of 2021 – 2024 IPPS Final Rules.

Proposed FFY 2025 Factor 1

In the proposed rule, CMS uses the CMS Office of the Actuary's (OACT) January 2024 Medicare estimate of DSH payments for FFY 2025 as the basis for Factor 1. This amount — $13.943 billion — is reduced by 25% to arrive at a proposed FFY 2025 Factor 1 of $10.457 billion. The proposed Factor 1 for 2025 is about $442 million more than the final Factor 1 for FFY 2024.

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 2024 final and proposed FFY 2025 IPPS rules detailing the specific components of Factor 1 in each rule.

Factors Applied for FY 2022 through FY 2025 to Estimate Medicare DSH Expenditures Using FY 2021 Baseline

FY	Update	Discharges	Case Mix	Other	Total	Estimated DSH $, Billions
2022	1.025	0.946	0.997	0.9937	0.9607	12.873
2023	1.043	0.945	0.99	1.0503	1.025	13.195
2024	1.031	0.977	1.005	1.0228	1.0349	13.655
2025	1.026	0.986	1.005	1.0046	1.021	13.942

Source: FFY 2025 IPPS Proposed Rule (89 FR 36192)

Factors Applied for FY 2021 through FY 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	0.9963	0.9919	13.15
2022	1.025	0.941	0.997	0.9939	0.9558	12.569
2023	1.043	0.959	1.005	1.0347	1.0398	13.069
2024	1.031	0.982	1.005	1.0043	1.0219	13.355

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

UCC DSH Factor 1 Component Comparison: Proposed FFY 2025 to Final FFY 2024

FY	Update	Discharges	Case Mix	Other	Total	Est DSH Pmt $, Billions
2022	0.000	0.005	0.000	(0.000)	0.005	0.304
2023	0.000	(0.014)	(0.015)	0.016	(0.015)	0.126
2024	0.000	(0.005)	0.000	0.019	0.013	0.300

The proposed increase in Factor 1 is largely driven by an increase of 0.005 in FFY 2022 "Discharge" component and unexplained changes of 0.016 and 0.019 in FFYs 2023 and 2024 in the "Other" component and unexplained changes in the "other" component.

While FFY 2022 discharges increased, it's worth noting the discharge component for FFY 2023 and FFY 2024 decreased from the 2024 IPPS final rule and the 2025 IPPS proposed rule. However, the proposed

rule provides no commentary on why CMS reduced its estimate from just nine months prior. This is particularly concerning for 2023 given there should have been sufficient time for claims run out in the 2024 final rule for CMS to accurately project this factor. CMS is respectfully asked to provide additional commentary in the final rule on why these factors decreased.

For FFY 2025, the discharge factor is the highest it's been in several years. However, the proposed rule went to OMB for review before CMS issued its Medicare Advantage (MA) Contract Year 2025 and Part D Final Rule. While CMS estimates MA payments will increase by 3.7%, many plans view the final rule as a -0.16% payment cut[43]. In response, some publicly traded MA plans have pulled their Wall Street earnings guidance and signaled they will "focus on profits over growth in light of the challenges, whether that entail cutting benefits, raising premiums, or even exiting markets"[44,45,46,47,48,49,50].

Additionally, there is a recent trend of physicians and hospitals terminating contracts due to excessive prior authorization denial rates and slow payments from some MA plans that place profits over patients[51,52,53,54]. This is trend that is expected to continue for the foreseeable future as almost half of hospitals recently surveyed are considering terminating a contract with one or more MA plans that place profits over patients[55]. In general MA plans' anticipated narrowing of benefits and exiting some markets in response to the 2025 MA final rule will act as a drag on MA enrollment. It is likely these actions, coupled with providers terminating contracts with plans that place profits over patients, will steer beneficiaries who are more likely to need hospital services — due to greater health needs — into Medicare FFS. **Therefore, CMS is respectfully asked to ensure the "Discharge" component of Factor 1 fully reflects these trends and is increased appropriately.**

Finally, CMS is asked to provide more detailed information on the "other" category within Factor 1 so that stakeholders can offer meaningful comments on this key component of Factor 1.

Proposed FFY 2025 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. 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 2025, CMS estimates that the uninsured rate for the historical, baseline year of 2013 was 14% and for CYs 2024 and 2025 is 8.5% and 8.8%, respectively. This results in a proposed Factor 2 of 62.14%[56]

[43] https://www.healthcaredive.com/news/medicare-advantage-final-rates-2025-modest-cut/711927/#
[44] https://www.fiercehealthcare.com/ai-and-machine-learning/bofa-cvs-warns-it-could-lose-10-its-members-next-year
[45] https://www.healthcaredive.com/news/humana-withdraws-2025-earnings-outlook-q1-2024/714105/
[46] https://www.healthcaredive.com/news/health-insurer-medicare-advantage-utilization-2024/707360/
[47] https://www.wsj.com/health/healthcare/medicare-keeps-getting-tougher-for-health-insurers-52f6ad26
[48] https://www.beckerspayer.com/payer/will-insurers-cut-back-on-medicare-advantage-extras.html
[49] https://finance.yahoo.com/news/cvs-stock-plunges-after-earnings-numbers-one-analyst-did-not-even-believe-174627586.html
[50] https://www.beckerspayer.com/payer/medicare-advantage-extras-on-the-chopping-block-in-2025.html
[51] https://www.beckershospitalreview.com/finance/hospitals-are-dropping-medicare-advantage-left-and-right.html
[52] https://www.usatoday.com/story/news/health/2023/10/27/hospitals-terminate-medicare-advantage-contracts-over-payments/71301991007/
[53] https://healthpayerintelligence.com/features/what-is-behind-rampant-medicare-advantage-contract-terminations
[54] https://finance.yahoo.com/news/medicare-advantage-chaos-is-making-life-more-difficult-for-hospitals-insurers--and-seniors-152214464.html
[55] https://www.beckershospitalreview.com/finance/nearly-half-of-health-systems-are-considering-dropping-ma-plans.html
[56] Proposed Factor 2 = 1-|((0.087-0.14)/0.14)| = 1 - 0.3786 = 0.6214 (62.14%)

yielding a total UCC pool of $6.498 billion.[57] This is approximately $560 million more than the FFY 2024 final rule UCC payment total of about $5.938 billion, resulting in a percentage increase of 9.4% relative to the FFY 2024.

There is concern the agency has, as in prior years, significantly underestimated the uninsured rate in 2024 and 2025 considering the Medicaid redeterminations that are ongoing as a result of the end of the COVID-19 PHE. CMS bases its projections of the uninsured rate used in the proposed rule on Table 17 from the most recent National Health Expenditure (NHE) data[58]. The NHE data project showed 25.7 million uninsured individuals in 2023 (7.7% uninsured rate), 28.6 million individuals uninsured in 2024 (8.5% uninsured rate), and 29.8 million individuals uninsured in 2025 (8.8% uninsured rate). Based on CMS NHE data, the projected uninsured rate increased by 2.9 million individuals from 2023 to 2024 and 4.1 million individuals from 2023 to 2025.

Research by the Kaiser Family Foundation (KFF) finds 23% of individuals who lose coverage as a result of Medicaid redeterminations ultimately become uninsured[59]. As of May, states have reviewed enrollment for 70 million individuals[60]. Of those, 22 million (31%) became disenrolled. Given these facts the number of uninsured in 2024 should have increased by at least 5.04 million[61] for those redeterminations that have already been processed. Further, KFF reports there are an additional 24 million individuals whose eligibility for Medicaid needs to be redetermined[62,63]. Assuming approximately 31% of those individuals are ineligible for Medicaid, it further increases the number of uninsured by an additional 1.73 million[64]. Analysis of the KFF Medicaid redetermination data suggest there could be as many as 6.76[65] million additional uninsured. Given Table 17 of the NHE data projects increases of 2.9 million in 2024 and 4.1 million in 2025 compared to 2023, CMS is likely under-projecting the number of uninsured by as many as 3.9 million individuals for 2024 and 2.7 million individuals for 2025. As illustrated in the table below, this would increase the uninsured rate to 9.6%.

[57] UCC Pool = (Factor 1: $10.457 billion) x (Factor 2: 0.6214) = $6.498 billion
[58] https://www.cms.gov/data-research/statistics-trends-and-reports/national-health-expenditure-data/projected
[59] https://www.kff.org/medicaid/poll-finding/kff-survey-of-medicaid-unwinding/
[60] https://www.kff.org/report-section/medicaid-enrollment-and-unwinding-tracker-overview/. As of 5/20/24
[61] 21.9 million disenrolled to date from Medicaid * 0.23 of ineligible Medicaid beneficiaries becoming uninsured = 5.04 million.
[62] www.medicaid.gov/federal-policy-guidance/downloads/cib050924-e14.pdf
[63] On May 9, 2024, CMS extended state flexibilities in processing redeterminations until June 2025. Therefore, it is likely more individuals will become uninsured during FFY 2025.
[64] ((21.9 million disenrolled to date /70 million redeterminations processed)* 24 million redeterminations remaining to be processed)* 0.23 disenrolled Medicaid beneficiaries who become uninsured = 1.74 million additional uninsured.
[65] 5.04 million estimated increase in the uninsured resulting from processed redeterminations + 1.74 million estimated increase from redeterminations that have yet to be processed.

Projected FFY 2025 Uninsured Rate Incorporating Estimates of Coverage Losses as a Result of Medicaid Redeterminations Using KFF Projections

	2024	2025	FFY 2025 Uninsured Rate
Baseline Uninsured (millions)	28.6	29.8	
~~PHE Uninsured** (millions)~~	~~3.86~~	~~2.66~~	
Total Uninsured (millions)	32.5	32.5	
~~Total Population* (millions)~~	~~336.47~~	~~338.64~~	
Uninsured Rate	9.65%	9.59%	
~~Weighting~~	~~25.00%~~	~~75.00%~~	
Weighted Uninsured Rate	2.41%	7.19%	9.60%

Sources:
**CHA Analysis - Coverage Loss Due to Redetermination
*Table 17 - Health Insurance Enrollment and Enrollment Growth Rates, Calendar Years, 2013-2031

An uninsured rate of 9.6% results in a Factor 2 value of 68.59%.[66] 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 $7.17 billion.[67] Using only a revised Factor 2 represents a $660 million increase over the proposed rule value. **CMS is asked to use an estimate of the rate of uninsured that fully reflects the net loss of insurance coverage that results from Medicaid redeterminations when it calculates Factor 2 in the FFY 2025 IPPS final rule.**

Outlier Payments and Threshold

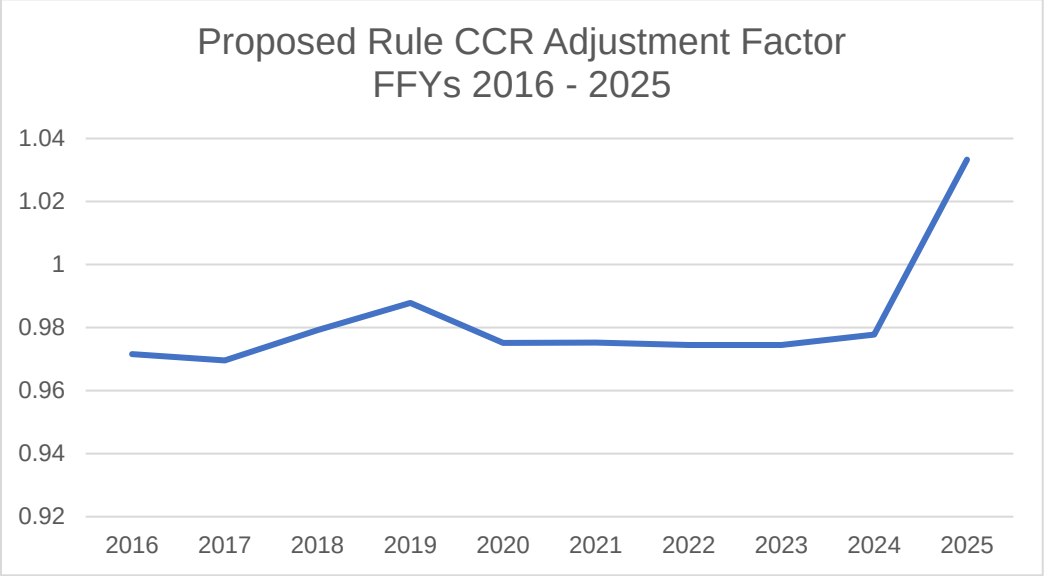
CMS proposes an outlier threshold for FY 2025 of $49,237, an increase of 15.2 percent and $6,487 from the FY 2024 amount. CMS projects that the proposed outlier threshold for FY 2025 will result in outlier payments equal to 5.1 percent of operating DRG payments and 4.23 percent of capital payments. Accordingly, CMS is applying adjustments of 0.949 to the operating standardized amounts and 0.957708 to the capital federal rate to fund operating and capital outlier payments respectively.

The increase in the fixed-loss outlier threshold is significant and unlikely reflective of the conditions that will prevail in FFY 2025. In the IPPS proposed rule, CMS notes the December 2022 operating cost to charge ratio (CCR) was 0.246416 and the December 2023 CCR was 0.254624 resulting in a CCR adjustment factor of 1.03331. As illustrated in the table chart below, it is anomalous to see a year-to-year increase in the CCR and as a result the proposed CCR adjustment factor.

[66] Revised Factor 2 = 1-|((0.0960-0.14)/0.14)| = 1 - 0.3143 = 0.6859 (68.59%)
[67] Revised UCC Pool with Factor 2 Adjusted for Increase in Uninsured= (Factor 1: $10.457 billion) x (Factor 2: 0.6859) = $7.17 billion

IPPS Proposed Rule CCR Adjustment Factor, "Prior Year" CCR and "Current Year" CCR
FY 2016 - 2025

FY Proposed Rule	CCR Adjustment Factor	Prior Year CCR	Current Year CCR
2016	0.971568	0.288792	0.280581
2017	0.969585	0.280907	0.272363
2018	0.979187	0.274139	0.26579
2019	0.987842	0.266065	0.26283
2020	0.975167	0.263267	0.25673
2021	0.975271	0.255979	0.249649
2022	0.974495	0.254027	0.247548
2023	0.974495	0.254027	0.247548
2024	0.977799	0.253006	0.247389
2025	1.03331	0.246416	0.254624



This increase in the CCR for 2022 and 2023 is a direct result of input cost inflation — particularly related to labor — resulting from the COVID-19 public health emergency. In these years, the exigencies for the pandemic resulted in anomalous cost and charge data. As a result, the increase in CCRs — which is unlikely to persist in FFY 2025 — has artificially inflated the fixed loss threshold. CMS is asked to use the FFY 2024 final rule CCR adjustment factor in the calculation of the FFY 2025 final rule fixed loss outlier threshold. This will better reflect the charge and expense environment facing hospitals in 2025. The agency took similar steps in the FFY 2021–2023 IPPS final rules to address similar issues resulting from anomalous data created by the COVID-19 PHE. If the agency does not take this step, it risks reducing payments to hospitals by setting the outlier threshold too high.

Indirect and Direct Graduate Medical Education

This year's proposed IPPS rule contains a large discussion about graduate medical education (GME) and makes several proposals related to residency programs. Many of California's hospitals support access to

services now and in the future by training the next generation of physicians. As such, the feedback below is provided in response to select proposals.

Clarification for New Residency Programs

Clarification on what CMS considers a "new" residency program for purposes of developing a residency cap is appreciated. The 90% threshold allows programs flexibility to train residents in their second or third year to improve learning and integration of experience and specialties. Adding program year (PGY) 2 or PGY 3 residents enriches the learning experience and often assists those residents with extenuating circumstances who need a new place to train.

Newness of Residents

CMS proposes a policy that would require 90% of residents who train in a program over the five-year cap-building period to not have previous experience in the same specialty as the new program. The determination of newness would be made at the end of the cap-building process, and a program that does not meet the 90% threshold would not qualify as new.

If CMS adopts a new policy based on the review of new residents, the agency should give programs the presumption of newness if they can demonstrate that at least 90% of trainees do not have previous experience in the new program specialty. In the case of a program that falls below the 90% threshold, hospitals should be allowed to demonstrate through other factors (program letter of accreditation, no overlap between program director, staff, residents in a prior program, etc.) that the program is not transferred from an established teaching hospital. Any policy should be uniform and applied to all programs regardless of size.

The proposed rule describes a resident as being "accepted, enrolled, and participated in" the residency training program (P. 36222). Residents are generally placed into residency programs through the match process, and those brought in later in their training generally fill vacancies from residents who have left a program. CMS should also accept certain mitigating factors when a hospital does not meet the 90% threshold, such as limitations due to program size, or matched residents who did not disclose prior training experiences. For example, if a three-year residency or fellowship program with only three residents per year hires just one individual at the PGY 2 level, that program would automatically fail the proposed 90% threshold requirement. For smaller programs, it is likely that residents brought in after PGY 1 are meant to maintain program stability, and CMS' policy should allow for latitude while still ensuring that programs are not transferred from established teaching hospitals.

As a point of clarification, CMS does not explicitly state in the proposed rule how individuals in fellowship programs would be treated under this policy. Fellows often have prior experience in the specialty with which they receive subspecialty training. CMS should clarify that subspecialty training would be analogous to a "different specialty program" for fellows and they will be considered "new residents" in a new fellowship program. Additionally, if residents have only participated in a transitional year program, they should meet the definition of "new resident."

Newness of Program Director

CMS proposes that new programs' directors should be out of GME for approximately 10 years to meet the "newness" criteria to serve with a new residency program in its initial cap-building phase. This prolonged hiatus for directors is problematic because it does not provide the best learning experience for residents and would likely cause the quality of new programs to be diminished. New program directors

are often chosen from among current core faculty, not practitioners that have been out of the GME arena for a decade or more. Time away from the teaching environment is not a relevant issue for hospitals establishing a new program when the recruited program director is from a different city, CBSA, or state. The Accreditation Council for Graduate Medical Education (ACGME) program director requirements expect these staff members to have at least three years of administrative or academic experience and current clinical work. CMS must eliminate any time requirement outside of the specialty as a condition for considering the program director to be new.

Newness of Faculty

The proposed criterion that at least half of a program's faculty must be new for the program to be new does not lay the best foundation for residents' learning experience. Even more concerning, it does not align with the ACGME's rules on faculty experience. The ACGME for some specialties requires faculty to demonstrate prior research and scholarly activity such as research grants and peer-reviewed publications, which normally only occurs in an academic setting. If 50% of the faculty is required to be new with no previous teaching experience, the ACGME would need to review its policies that require prior teaching and/or scholarly activity for programs to receive initial accreditation. Therefore, CMS should eliminate this requirement.

Medicare Severity (MS) Diagnosis-Related Groups (DRGs)

CMS proposes multiple changes to the MS-DRG groupings. Below please find comments on several of these changes.

Proposed Change to the Calculation of the New Technology Add-On Payment (NTAP) for Gene Therapies Indicated for Sickle Cell Disease (SCD)

Subject to the new technology add-on payment eligibility criteria, CMS proposes that certain gene therapies approved for NTAP in the FFY 2025 final rule for the treatment of SCD, effective with discharges on or after Oct. 1, 2024, and concluding at the end of the two- to three-year newness period, to increase the payment percentage from 65% to 75%. CMS notes that if finalized, this policy would be temporary; these payment amounts would only apply to any gene therapy indicated and used specifically for the treatment of SCD that CMS approves for FFY 2025 new technology add-on payments.

Hospitals support this policy. It is an important step the administration can take to expand access to an effective treatment that disproportionately affects a population that has historically suffered inequitable outcomes. Given that hospitals already incur losses on treatments that trigger an NTAP and the therapies in question are extremely expensive, CMS is asked to increase the percentage to 100% and to make this change permanent.

Proposed Changes to Severity Levels for SDOH

In this proposed rule, CMS reviewed the data on the impact on resource use for the seven ICD-10-CM SDOH Z codes that describe inadequate housing/housing instability, currently designated as non-complicating (NonCC), when reported as a secondary diagnosis. These codes include:

- Z59.10 - Inadequate housing, unspecified
- Z59.11 - Inadequate housing environmental temperature
- Z59.12 - Inadequate housing utilities
- Z59.19 - Other inadequate housing

- Z59.811 - Housing instability, housed, with risk of homelessness
- Z59.812 - Housing instability, housed, homelessness in past 12 months
- Z59.819 - Housing instability, housed unspecified

CMS discusses its analysis that shows inconsistencies in the resources used. When Z59.10 and Z59.811 are reported as a secondary diagnosis, the resources involved in caring for a patient support increasing the severity level from a NonCC to CC. In contrast the analysis shows that for diagnosis codes Z59.11, Z59.12, Z59.812 and Z59.819 shows the resources involved are more aligned with a NonCC severity level. CMS notes that these diagnosis codes have recently become effective and believes the difference in resource use may be attributed to lack of use or knowledge about the newly expanded codes and the data may not yet reflect the full impact on resource use for these patients.

In light of the impact modeling and CMS' nine guiding principles related to determining NonCC, CC, and major complication/comorbidity (MCC), CMS proposes to change the severity level designation for the seven inadequate housing/housing instability from NonCC to CC beginning in FFY 2025. **CMS' thoughtful analysis of increased resource use associated with caring for Medicare beneficiaries experiencing housing instability is appreciated. CMS is encouraged to finalize its proposed policy to increase the ICD-10-CM diagnosis codes describing housing instability from NonCC to CC.**

IPPS Add-on for End-Stage Renal Disease (ESRD) Discharges

Medicare includes an add-on payment to hospitals that provides kidney dialysis to more than 10% of their patients where the patient is not receiving a kidney transplant or has a principal diagnosis of renal failure. The add-on equals the product of the average length of stay of ESRD beneficiaries in the hospital, expressed as a ratio to one week, the estimated per treatment cost of dialysis times three (as maintenance dialysis is typically furnished three times per week) and the number of patients where the add-on is applicable. The add-on payment is intended to reflect the additional costs hospitals have of providing kidney dialysis to these patients and is based on the payment rate made to ESRD facilities for maintenance kidney dialysis.

The average direct cost of dialysis was determined from data used to establish the ESRD dialysis composite rate paid to ESRD facilities that provide outpatient maintenance dialysis. This rate has not been updated since 2013 when payment to dialysis facilities reflected a blend of the ESRD PPS payment system and the composite rate. CMS proposes changing the methodology used to calculate the ESRD add-on payment under current regulations to the ESRD PPS base rate used under the ESRD PPS beginning Oct. 1, 2024, for FFY 2025. For subsequent years, CMS will use the updated ESRD PPS base rate for the ESRD add-on payment.

The proposal to change the methodology so that it better reflects the costs incurred to provide dialysis to ESRD patients who are hospitalized for other reasons is supported. Further, CMS is requested to calculate the 10% threshold based on only Medicare FFS beneficiaries. Currently, the threshold is calculated using both MA and FFS beneficiaries in the numerator and denominator. However, the add-on payment made under FFS is not made for MA beneficiaries. Because MA plans that care more about profits than patients engage in favorable member selection strategies to increase margins[68], including MA beneficiaries — who are typically healthier — in the calculation of the ESRD add-

[68] www.medpac.gov/wp-content/uploads/2024/03/Mar24_Ch12_MedPAC_Report_To_Congress_SEC.pdf

on results in fewer hospitals qualifying. This results in further underpayment of hospitals that care for greater populations of Medicare FFS beneficiaries who are at-risk of adverse outcomes.

Maintaining Access to Essential Medicines

CMS proposes to only establish a separate payment under the IPPS to small (100 beds or fewer), independent hospitals for the estimated additional resource costs of voluntarily establishing and maintaining access to six-month buffer stocks of essential medicines. CMS is focusing this proposal on small, independent hospitals, many of which are rural, because these hospitals may lack the resources available to larger hospitals and hospital chains to establish and maintain buffer stocks of essential medicines for use in the event of drug shortages.

CMS' assessment that drug shortages are a persistent problem that, unfortunately, occurs with greater frequency. These shortages place patients at risk and unnecessarily increase health care spending as CMS has detailed. The cost necessary to establish and maintain a buffer stock of essential medicines is greater than the cost associated with more efficient pharmaceutical supply chain models that require hospitals to hold minimal reserve stock and depend on frequent resupply from wholesalers to meet patient demand.

Hospitals have been pushed to rely on these more efficient supply chain models as the gap between the cost to provide care and payment for that care from Medicare and Medicaid has grown larger. This is an unintended byproduct of chronic underpayment from governmental payers. It has compressed hospital operating margins (as described in detail in the opening paragraphs of these comments) forcing hospitals to be extremely price-sensitive, even for essential generic medicines that on average may cost only a few dollars per vial and that are at high risk of drug shortage. The cost of carrying a buffer inventory adds to expenses and threatens access to care for underserved populations by undermining a hospital's financial sustainability. CMS is applauded for recognizing that a reserve inventory model will, on average, cost more than a cost-efficient model that uses a just-in-time approach.

The availability of supplemental payments could encourage small, independent hospitals to maintain buffer stocks. However, it is worth noting that as a result of over 20 years of inadequate payment updates in the IPPS and OPPS, the agency is now slowly unbundling the MS-DRG by providing supplemental payments to cover basic hospital operating costs (e.g., add-on payment for domestically produced N-95s, this proposal). **A better approach is to provide adequate MBUs that address the inflationary pressures hospitals continue to face.**

CMS proposes to use a list of 86 essential medicines included on the Advanced Regenerative Manufacturing Institute's (ARMI) Next Foundry for American Biotechnology as those that would be eligible for the additional payment. CMS proposes that if the ARMI List is updated to add or remove any essential medicines, all medicines on the updated list would be eligible for separate payment as of the update date. The agency proposes that eligible hospitals maintain a six-month buffer stock of essential medicines in shortage although it requests comment on whether to transition to this policy over two years.

Even with this incremental payment, it may not be practical or feasible for small, independent hospitals to purchase a six-month inventory. This is especially true if their patient volume doesn't justify it, if the essential drugs have short expiration dates, or if the upfront cost of purchasing a six-month supply is out of their reach. **Therefore, if CMS finalizes its policy, it may be of benefit for the agency to allow for a**

range of buffer supply of essential drugs, perhaps between two months to six months, and to permit individual hospitals to decide the amount they can reasonably purchase and manage as a buffer supply.

CMS is proposing to base payment on the IPPS share of the additional reasonable costs of a hospital to establish and maintain access to its buffer stock. The hospital would report these costs to CMS on the forthcoming supplemental cost reporting worksheet. These costs would not include the costs of the essential medicine itself, which would continue to be paid in the current manner. Payment could be provided as a lump sum at cost report settlement or biweekly as interim lump sum payments to the hospital which would be reconciled at cost report settlement.

Given the payment is limited to the Medicare IPPS share of these costs, there are concerns that the targeted smaller, independent hospitals will not be able to meet the requirements to qualify for the payments. **CMS is asked to clarify that it will also include the costs associated with maintaining a buffer supply of essential medicines for Medicare Advantage patients in a lump sum payment if it is finalized**. If CMS finalizes this policy, it would be appropriate to make separate payment for this, similar to how CMS pays hospitals for the Medicare Advantage patients' share of indirect costs of graduate medical education for teaching hospitals.

Further, CMS is asked to expand the expenses it will cover to include the cost of the medication that is being stockpiled. And the agency must expand the expenses it will reimburse beyond just the Medicare fee-for-service and Medicare Advantage populations. Medicare FFS only accounts for 16.6%[69] of California hospitals' total patient net revenue. If CMS limits this payment to only the "Medicare share" of a buffer stock of essential medicines, the additional payment will not be sufficient to support an adequate buffer stock for all patients as no other payer provides a specific payment related to maintaining a supply of essential medicines. Therefore, hospitals will not be able to afford to maintain a buffer stock for all patients if the payment only covers the cost of maintaining a supply of essential medicines for only Medicare patients.

Therefore, CMS is encouraged to expand the proposed essential medicines payment to cover the cost of stockpiled drugs (not just the incremental expense of maintaining the stockpile) for all patients — not just Medicare FFS and Medicare Advantage patients — over the course of a hospital's fiscal year. If CMS does not have the statutory authority to do this, the agency should work with Congress to embed this flexibility into the Medicare statute.

There is concern with CMS' proposal that small, independent hospitals be required to separately complete a new supplemental cost report form detailing the additional cost of holding and maintaining their buffer stock. For hospitals that have the capacity and capability to store a buffer stock, they would need to devote critical staff to track, report, and maintain these requirements and cost report records for this separate supply. Specifically, they would need to maintain separate records for buffer stock and non-buffer stock. Moreover, since this proposal would initially only apply under the IPPS, hospitals also would need to track and segregate the recordkeeping for these buffer supply drugs to ensure that they are not allocated to nor used for the care of patients covered under other payment systems or cared for in other non-inpatient locations.

[69] CHA analysis of 2021 California Department of Health Care Access and Information data

Moreover, it is anticipated that most qualifying hospitals simply do not have the space and operational capacity to store buffer stock and would contract with upstream distributors or wholesalers. For these hospitals, they would need to obtain separate records from the distributor or wholesaler to distinguish the storage and maintenance of buffer stock from their regular contract. It remains unclear whether distributors or wholesalers would be willing to provide such separate recordkeeping for hospitals to accurately report the additional costs of maintaining its buffer stock. **Therefore, CMS is urged to work with manufacturer, distributor, and wholesaler stakeholders to determine a less burdensome method of attestation and reporting for these IPPS separate payments.**

If CMS ultimately opts to develop a specific cost report worksheet, **the agency is urged to convene a technical workgroup of hospital and health system pharmacists, supply chain, and finance professionals to provide subject matter expertise on this highly complex area as the agency develops this additional payment form.**

Finally, CMS solicited comments on separate payment for the incremental costs incurred by hospitals of maintaining a buffer stock of "essential medicines" in the 2024 Outpatient Prospective Payment System (OPPS) Proposed Rule. CMS in the final rule, in response to those comments, stated it intended to propose new Conditions of Participation (CoPs) in forthcoming notice and comment rulemaking addressing hospital processes for pharmaceutical supply. **Hospitals would oppose such a proposal.**

The CoPs set forth broad requirements that hospitals must meet to participate in and receive reimbursement from the Medicare and Medicaid programs. Failure to comply with the CoPs could result in potential termination from the programs and would jeopardize the financial and operational viability of most hospitals. Even if CMS were to finalize payment for small, independent hospitals to support the cost of maintaining a stock of essential medicines, it would be inappropriate for the agency to make maintaining an adequate supply of essential medicines a CoP for all hospitals. The agency would in essence be penalizing hospitals for CMS' continued underpayment and long-standing supply chain issues that hospitals cannot solve on their own.

Transforming Episode Accountability Model (TEAM)

CMS proposes a five-year mandatory episode-based payment model to evaluate participating hospitals' performance on cost and quality metrics for five surgical episode categories:

- Coronary artery bypass graft (CABG)
- Lower extremity joint replacement (LEJR)
- Major bowel procedure
- Surgical hip/femur fracture treatment (SHFFT)
- Spinal fusion

The episodes will span 30 days from the date of discharge or triggering procedure (if outpatient). Hospitals in selected CBSAs will be required to participate. CMS will oversample CBSAs with high concentrations of "safety net" hospitals as these facilities have not participated in large numbers in prior episodic payment models. Claims for services provided during the 30-day period will continue to be paid on a fee-for-service basis and be reconciled at the end of the performance year to a target price based on three prior years of regional data, trended forward, and adjusted to reflect hospital and patient specific factors. If spending for episodes occurring during a performance year is below the target price plus a 3%

CMS "discount factor" the hospital will receive a positive "net reconciliation payment amount" (NPRA) from CMS up to the stop gain cap, which will be reduced by a composite quality score (CQS) associated with the "risk-track" the hospital was assigned (or selected in certain circumstances). If spending exceeds the target price for a given performance year, the hospital must repay CMS for the excess spending (negative NPRA). Any amounts received from/due to CMS will be adjusted based on a limited set of quality measures.

California's hospitals support an orderly transition to value-based payment models. Episodic payment models, if properly constructed and participated in on a voluntary basis, are part of an orderly transition. Such models have the potential to improve patient outcomes while appropriately reimbursing hospitals and other participants for the costs associated with improving care processes and patient outcomes.

Ill-designed mandatory models — such as TEAM[70] — harm patient access and outcomes. The proposed rule states that mandatory participation is necessary to offset the effects of selective participation in prior CMMI models. However, evidence from many different sources shows adverse selection has not heretofore been an issue and is not a cause of the failures of past CMMI demonstrations in generating savings and improving outcomes. Other factors in the operation of the demonstrations are much more likely to explain the results[71].

Given longstanding inadequate Medicare hospital payment rates and hospitals' resulting financial fragility, it is inappropriate to press hospitals to participate in a test of concepts CMMI has already evaluated through BPCI, BPCI-A, and CJR. Additionally, as CMS notes in both the proposed rule and evaluation reports for these models, the savings generated result from participants ensuring patients are discharged to the most appropriate site of post-care. The ability to do this is predicated on the participant developing a high-value network[72,73,74,75,76.77,78,79,80] post-acute care (PAC) network. Given the current financial and staffing challenges facing home health agencies and skilled nursing facilities, this will not be possible in many markets. Additionally, the episodes selected are inappropriate for inclusion in a mandatory model. Finally, hospitals' cost to participate in the model will largely offset any savings generated by CMS. These costs will be cross-subsidized by the commercial market, crowd out other, better targeted outcome improvement efforts, and/or result in loss of services in select communities. **Therefore, California's hospitals are opposed to requiring participation in TEAM.**

Patient Access at Risk Due to Fragile Finances

California hospitals' fragile finances put patient access at risk. As discussed above, 60% of California's hospitals have unsustainable operating margins. This is a direct result of inadequate payments — particularly from governmental payers like Medicare — that do not cover the cost of providing care.

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[70] Many of the detailed concerns with the TEAM model were addressed in responses to CMMI's request for information on episode-based payment models. CHA's detailed comments are available here: https://calhospital.org/wp-content/uploads/2023/08/CHA-Episodic-Payment-Comment-Letter_Final_081723.pdf
[71] https://www.healthaffairs.org/content/forefront/mandatory-participation-medicare-demonstrations-necessary
[72] www.cms.gov/priorities/innovation/data-and-reports/2023/bpci-adv-ar4
[73] www.cms.gov/priorities/innovation/data-and-reports/2023/cjr-py5-ar-exec-sum
[74] www.cms.gov/priorities/innovation/data-and-reports/2021/cjr-py4-annual-report
[75] www.cms.gov/priorities/innovation/data-and-reports/2020/cjr-thirdannrpt
[76] www.cms.gov/files/document/cjr-secondannrptpdf.pdf
[77] www.cms.gov/files/document/cjr-firstannrptpdf.pdf
[78] www.cms.gov/priorities/innovation/data-and-reports/2022/bpci-adv-ar3
[79] www.cms.gov/priorities/innovation/data-and-reports/2021/bpci-yr2-annual-report
[80] www.cms.gov/priorities/innovation/data-and-reports/2020/bpciadvanced-firstannevalrpt

While this issue has been recognized by MedPAC, CMS has not corrected its methodology for setting the MBU, provided a forecast error correction, or taken other steps to ensure Medicare inpatient and outpatient payments are sustainable. Now the agency wants to implement a model that will further reduce payments to some hospitals for issues beyond their control.

Following 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[81] to Madera Community Hospital's closing[82]. The loss of access to care in this community has fallen disproportionately hard on those who have historically suffered from inequitable health outcomes. A recent survey[83] 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 would have to find medical centers outside of the community to receive care. Over half of the farm workers who responded to the survey reported they do not have a reliable mode of transportation to the nearest hospital.

California is not unique as hospitals across the country are closing[84,85,86,87] or shuttering service lines[88,89,90,91] that are financially unstainable yet needed by the community (like labor and delivery services). It's worth noting that one of the commonalities of hospitals closing or reducing services lines is that individuals covered by governmental payers (that pay less than the cost to provide care) like Medicare and Medicaid are a larger percentage of the patient population.

Despite this, CMS proposes to oversample "safety net" hospitals in the TEAM. This oversampling potentially includes 14 of the 17 California hospitals that received funds from the state's "Distressed Hospital Loan Program." These loans were provided by the state because the recipient hospitals were deemed at risk of imminent bankruptcy and closure[92]. CMS' rationale for oversampling is that these hospitals were underrepresented in the mandatory CJR model and voluntary models such as BPCI-A. There are many reasons why hospitals that serve higher volumes of Medicare, Medicaid, and uninsured patients have not participated in CMMI models. However, the two common ones — lack of resources and a more complex population with greater health related social needs (HRSN) whose costs are not fully factored into the risk adjustment model — are not resolved in the proposed TEAM.

As illustrated in the table below, the average "safety net" (based on CMMI's definition) and distressed hospital margins are even more negative than the average California hospital. The primary reason for

[81] https://www.fresnobee.com/news/local/article272712840.html
[82] https://www.beckershospitalreview.com/care-coordination/in-a-matter-of-days-healthcare-access-deteriorates-in-central-california.html
[83] https://a27.asmdc.org/press-releases/20230511-community-organizations-release-survey-effects-madera-hospital-closure
[84] https://www.beckershospitalreview.com/finance/9-hospitals-have-closed-this-year-here-s-why.html
[85] https://www.beckershospitalreview.com/finance/5-hospital-closures-in-2024.html
[86] https://www.beckershospitalreview.com/finance/9-hospital-bankruptcies-in-2023.html
[87] https://www.beckershospitalreview.com/finance/19-hospital-closures-bankruptcies-in-2022.html
[88] https://www.beckershospitalreview.com/finance/10-hospitals-closing-departments-or-ending-services-3.html
[89] https://www.beckershospitalreview.com/finance/8-hospitals-closing-departments-or-ending-services.html
[90] https://www.beckershospitalreview.com/finance/10-hospitals-closing-departments-or-ending-services.html
[91] https://www.beckershospitalreview.com/care-coordination/18-hospitals-scaling-back-care.html
[92] https://hcai.ca.gov/california-announces-300-million-in-financial-support-for-community-hospitals-across-the-state/

these depressed margins is a higher mix of patients covered by Medicare and Medicaid. Both of which pay rates that generally do not cover the cost of providing care.

2022 California Hospital Operating Margin and Payer Mix by Cohort

Hospital	% Governmental Payers	Operating Margin
California Average	58%	-1.6%
"Safety Net" Based on TEAM Definition	77.2%	-3.7%
"Distressed" As Determined by California Office of Healthcare Information and Access[93]	78.7%	-15.7%

These negative margins leave "safety net" hospitals with insufficient resources to participate in a model like TEAM and create an even greater risk to access to care for populations that have historically suffered inequitable outcomes if the model reduces payment. This concern is similar to that cited by CMS in the proposed rule for excluding physician group practices from participating in the model. In the rule CMS states:

> *Further, we have concerns about requiring PGPs to be financially accountable given practices can vary by size and resources. As previously noted, the BPCI Advanced model includes PGPs, and the physician groups electing to participate in BPCI Advanced have done so because their practice structure supports care redesign and other infrastructure necessary to bear financial accountability for episodes. However, these physician groups are not necessarily representative of the typical group practice. The infrastructure necessary to accept financial accountability for episodes is not present across all PGPs, and thus we do not believe it would be appropriate to designate PGPs to bear a portion of the financial accountability for episodes under the proposed TEAM.*

"Safety-net" hospitals, like group practices that have elected not to participate in BPCI-A, lack the resources to succeed in episode-based payment models. Participating in CMMI models is resource intensive. It requires considerable time from internal staff[94], retaining external consultants/analytics vendors, and engaging external stakeholders[95] to review data, re-engineer care pathways, and monitor results to make ongoing improvements to the redesigned care workflows. Additional time is required from these individuals in response to requests from CMMI's evaluation contractors. These requests — which are frequently duplicative — add no value to patient care and require effort for hospitals to respond to. And many hospitals report needing to hire additional staff such as care coordinators to successfully participate[96].

In voluntary models, hospitals — which know their patient populations and communities best — can make an informed decision as to whether there is a sufficient volume of patients and an opportunity to improve outcomes to merit the allocation of scarce resources to participate in a specific model. In mandatory models like TEAM, CMS — without knowledge of the needs of a specific hospital's patient

[93] Includes only "distressed" hospitals eligible for selection into TEAM model.
[94] Including but not limited to finance, clinical, patient registration, case management, discharge planning, social workers, and information technology.
[95] Including but not limited to community physicians, post-acute care staff, and staff from social services providers/agencies.
[96] www.cms.gov/priorities/innovation/data-and-reports/2023/cjr-py5-ar-exec-sum

population or community— foists additional, considerable costs upon hospitals (discussed below). These additional costs bring with them the potential for revenue reductions that hospitals may not have the ability to control if the bundle is ill-designed. Further, there is an opportunity cost to participating. If there are other conditions — like addressing maternal mortality — that present a better opportunity for patient outcome improvement, the hospital is forced to deploy limited resources instead toward the CMMI-mandated episodes (or risk payment reductions).

The external analytic support to participate in these models costs between $85k and $144k per hospital annually[97]. Internal staffing costs are estimated to be $100 for each individual episode. CMS may argue that these costs can be covered by the earned positive NPRA if the participant is successful. However, for many successful participants this is simply not the case. Many hospitals will need to share a significant portion of their savings with participating physicians to secure their participation in care redesign efforts.

Physician engagement is essential to success in these models. In instances where the hospital does not employ the physicians involved in the episode, engagement and alignment are achieved most frequently through net positive NPRA sharing arrangements. These arrangements can leave little earned savings to cover the other costs of participating in the model. Given that California's hospitals cannot employ physicians due to the state's corporate practice of medicine laws[98], NPRA sharing is an important strategy to secure physician engagement for the state's hospitals. And CMS knows generating savings is not guaranteed. It is even more difficult for "safety net" providers as discussed below.

Second, higher rates of poverty and lower levels of baseline health[99] are hallmarks of communities served by "safety net" hospitals. As a result, patients are typically sicker and their conditions more complex when they present to the hospital. Lower availability of primary care in the community results in conditions that could be managed but often go untreated until they require emergency hospital care. When this happens, in many instances hospital stays are longer than average because of non-clinical factors and HRSNs. Difficulties discharging patients who no longer require acute care to the next appropriate setting are the result of a host of 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 complex patients covered by governmental programs. Each of these increases hospitals' costs.

The same factors that increase the cost to deliver care to safety net populations also reduce the likelihood of success in episodic payment models. From both a financial and patient outcomes perspective, success is predicated on reducing unnecessary readmissions and, when clinically appropriate, discharging patients to lower cost post-acute care settings. However, non-clinical HRSNs pose challenges to achieving these goals within safety net populations and reduces the likelihood of success in risk-based models.

- *Reducing Readmissions*: Lower levels of baseline health, coupled with inadequate social supports and unmet HRSNs, increases readmissions risk for safety net populations. This is why CMS since FFY 2019 has compared hospitals for purposes of calculating the Medicare Hospital Readmissions

[97] Cost estimates based on discussions with hospitals that have participated in CJR and BPCI-A.
[98] California State Business and Professions Code, section 2400
[99] www.irp.wisc.edu/publications/factsheets/pdfs/PoorInPoorHealth.pdf

Reduction Program (HRRP) penalty using the hospital's decile of dually eligible Medicare beneficiaries.

- *Safety Discharging Patients to Home with Home Health*: A common strategy used by hospitals in BPCI-A and CJR to improve outcomes and reduce unnecessary spending is to discharge Medicare beneficiaries, who historically would have been discharged to a skilled nursing facility, to home with therapy and support provided by a home health agency. In the most recent BPCI-A evaluation report, reductions in SNF spending accounted for $533 of the per episode savings[100]. However, this strategy is much harder to execute for safety net populations as, all clinical conditions being equal, it may not be safe to discharge these patients to home. They may not have adequate housing. Or, if they do, they may not have the social supports[101] required to successfully recover at home and achieve optimal outcomes.

From a financial perspective, CMS is attempting to address these important issues using risk-adjustment at the patient level. The model incorporates an expanded social risk adjustment variable and relies on existing methodologies to account for beneficiary health status. However, the model does not provide differential pricing for episodes initiated on an emergent basis.

This pricing model is inadequate, and therefore inappropriate to use in a mandatory model. First, it largely relies on risk adjustment mechanisms in prior episodic payment models that did not fully adjust for the additional costs of caring for safety net populations. Second, the model does not account for the higher costs, which CMS acknowledges in the proposed rule, associated with episodes initiated on an emergent basis.

Beyond accurate target prices, addressing these challenges requires more investment to address HRSNs that are currently not reimbursed by Medicare. Hospitals typically fund these programs using positive operating margin and/or grants from governments[102] or private institutions. However, when these grants are obtained, they are time limited. As discussed above, the very hospitals that most need positive margin to fund these services don't have it. If "safety net"/distressed hospitals were to increase spending on non-medical activities that address HRSNs, it would require the reallocation of resources from other quality improvement efforts and/or reduce spending (and therefore access) to medical services needed by the community. Otherwise, these hospitals would become financially insolvent and could close.

Nothing in the TEAM model, or this proposed rule adequately addresses this lack of hospital funding for HRSN. Therefore, oversampling "safety net" hospitals, sets them up for failure and jeopardizes access to care in communities where they are forced to participate.

Further, given inadequate target prices and financial support for items and services to address HRSN, there is concern that mandatory participation has the potential to harm outcomes for populations at greater risk of adverse outcomes. Findings in a recent BPCI-A evaluation report[103] support these concerns.

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[100] www.cms.gov/priorities/innovation/data-and-reports/2023/bpci-adv-ar4
[101] These activities could include but are not limited to help with meal preparation, errands (including medication pick-up, assistance taking medications as prescribed, ability to afford medications, and transportation to and from follow-up physician appointments, including primary care which is key to avoiding readmissions
[102] Local, state, and/or federal governments.
[103] www.cms.gov/priorities/innovation/data-and-reports/2023/bpci-adv-ar4

> *We also analyzed responses to the Model Year 4 beneficiary survey for historically underserved populations.* ***We found evidence of unfavorable impacts on functional status for dual-eligible BPCI Advanced respondents relative to their comparison group and no pattern for nondual-eligible BPCI Advanced respondents, resulting in unfavorable impacts on dual-eligible respondents compared to nondual-eligible respondents****.*

It is likely[104] dually-eligible BPCI-A beneficiaries who experienced an unfavorable impact on functional status — in the absence of the model — would have received their PAC in a skilled nursing facility. In these instances, it was most likely clinically appropriate that they be discharged to home with post-acute care provided by home health. However, due to one or more HRSNs, the home setting wasn't conducive to achieving optimal functional status and therefore their recovery was harmed.

Further, the same evaluation report finds that populations that have historically experienced greater adverse health outcomes are more likely to have unfavorable experiences of care.

> *BPCI Advanced respondents with hospital-initiated episodes in some historically underserved populations were more likely to report unfavorable care experiences relative to their counterparts in the comparison group in Model Year 4 (Hispanic beneficiaries, those who lived in rural ZIP codes, and those who lived in high-ADI ZIP codes), and BPCI Advanced had unfavorable differential impacts for these respondents compared to their reference groups.* ***Black or African American BPCI Advanced respondents and Hispanic BPCI Advanced respondents with hospital-initiated episodes were 7 to 8 pp[105] less likely than comparison respondents to agree that medical staff took their preferences into account in deciding what services they should receive after leaving the hospital****.*

Given the potential harm to beneficiaries, experience of care, and access to hospital care as a result of payment cuts to hospitals that already have negative margins, it is inappropriate for CMS to mandate participation in the TEAM model.

Destabilized Post-Acute Care Market

Hospitals can ill afford to experience further reductions in payment on top of already inadequate Medicare reimbursement. Despite this, the TEAM model sets many facilities up for failure. CMS specifically selected episodes for TEAM with a greater proportion of spending in the post-acute period relative to the anchor hospitalization or procedure. CMS believes these episodes reflect a greater opportunity to improve care transitions for beneficiaries and reduce unnecessary hospitalizations and emergency care.

Creating a high-value PAC network is common strategy pursued by hospitals to improve care transitions and reduce unnecessary hospitalizations and emergency care[106,107]. This strategy includes developing a narrow list of preferred home health agency (HHA) and skilled nursing facility (SNF) providers that

[104] Unfortunately, the evaluation report does not address the root causes of the discrepancy in reported functional status between dually eligible and non-dually eligible beneficiaries. This shortcoming forces readers to make informed guesses as to the drivers of this decline in beneficiary outcomes.
[105] Percentage points
[106] https://www.healthaffairs.org/doi/epdf/10.1377/hlthaff.2018.0257
[107] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6345271/

Medicare beneficiaries are encouraged to use when they require PAC. The hospital then works with participating HHAs and SNFs to improve care.

Developing a high-value PAC network was challenging prior to the pandemic. Rarely does a hospital own sufficient PAC assets in its market to meet demand for HHA and SNF care. And in many markets, non-health system affiliated HHAs and SNFs did not find the potential financial incentives associated with increased referrals sufficient to offset the cost of partnering with the hospital in quality improvement activities. Therefore, these HHAs and SNFs did not participate in the high-value network. The more SNF and HHA capacity there is in a market, the easier it is to build a high-value PAC network. Post-pandemic, it will be even more difficult to engage PAC providers in high-value networks due to ongoing capacity and financial constraints.

Skilled nursing facilities were already struggling financially, creating delays in transitioning patients to the appropriate site for post-acute care[108,109]. Chronic underpayment by governmental payers — which comprise the majority of SNFs' payer mix[110] — creates barriers to SNF care for Medicare beneficiaries in some communities. Since 2020, an estimated 579 facilities have closed (approximately 162 per year, over the 43-month period), and 38% of these closures were 4- or 5-star rated facilities[111]. Further, analysis by nationally renowned accounting firm Clifton Allen Larsen finds that in 2023, 28% of SNF residents were in facilities considered financially challenged.[112]

The financial fragility experienced by SNFs will only be exacerbated by CMS' recently finalized Minimum Staffing Standards for Long-Term Care Facilities and Medicaid Institutional Payment Transparency (hereafter "Staffing Standards Rule") Reporting final rule[113]. The rule takes effect in 2026 for urban long-term care (LTC) facilities and 2027 for rural facilities, coinciding with the proposed start of the TEAM for urban hospitals.

It is estimated that fewer than one in five nursing facilities[114] currently meet the staffing requirements. These requirements were strongly opposed[115] by the sector due to their potential to further limit access to SNF care. These concerns are supported by the impact analysis included in the Staffing Standards final rule. CMS estimates that 12,639 additional registered nurses (RNs) and 76,376 additional nursing aides (NAs) are needed to satisfy the requirements. Facilities that are for-profit, larger, rural, or have a higher share of Medicaid residents[116] will be particularly affected. CMS projects this will cost approximately $43 billion over 10 years.

However, it is likely the cost is much higher. A recent analysis estimates that an additional 102,000 RNs and NAs — at a cost of $65 billion over 10 years[117] — are required. To meet these requirements, LTC

[108] www.aha.org/system/files/media/file/2022/12/Issue-Brief-Patients-and-Providers-Faced-with-Increasing-Delays-in-Timely-Discharges.pdf
[109] https://www.modernhealthcare.com/providers/nursing-home-closures-new-england-discharge-delays
[110] https://www.medpac.gov/wp-content/uploads/2023/03/Ch7_Mar23_MedPAC_Report_To_Congress_SEC.pdf
[111] https://vmghealth.com/thought-leadership/blog/supply-side-constraints-and-operational-headwinds-in-skilled-nursing-valuation/
[112] Economic State of Skilled Nursing Facility (SNF) Industry, Clifton, Allen, Larsen, February 2023
[113] https://public-inspection.federalregister.gov/2024-08273.pdf
[114] https://www.kff.org/policy-watch/nursing-facilities-staffing-levels-standards-final-rule/?source=email
[115] https://calhospital.org/wp-content/uploads/2023/11/CHA-Comments-LTC-Staffing-Requirements-FINAL.pdf
[116] Note these long-term care facilities are more likely to be in markets that are oversampled for TEAM based on the proposed methodology.
[117] https://www.ahcancal.org/Data-and-Research/Pages/Staffing-Mandate-Analysis.aspx?

facilities will need to decrease average daily census by 290,624 nationally (including a census reduction of 26,152 in California alone).

This final rule will lead nursing homes to reduce capacity or close outright, including those that are otherwise high performers on quality and safety metrics (and would be necessary participants of a high-value PAC network in TEAM). This makes it more challenging for hospitals forced to participate in TEAM to develop the high-value post-acute care networks that are necessary to succeed under episode-based payment models. Prior analysis of CMMI episodic payment models found the most powerful incentive to achieve alignment with high quality post-acute care providers was the ability to increase referral volumes[118]. However, capacity constraints have long limited the effectiveness of this strategy in many markets. Prior to the pandemic, 25% of freestanding SNFs had capacity rates exceeding 92%[119]. The SNFs with the highest capacity rates tended to be those with the highest quality ratings[120].

Given the IPPS proposed rule was released at the same time as the Staffing Standards Rule, CMS did not have the opportunity to consider the potential additional disruption and loss of access to SNF care that will occur as a result of these new requirements**. Establishing a PAC network that includes high quality SNFs is necessary to succeed in hospital based bundled payment models. This was difficult even before the pandemic and the finalization of the Staffing Standards Rule in many markets. Now, it will be impossible for many hospitals to do this given the loss of SNF capacity likely to occur as a result of the Staffing Standards Rule. Therefore, CMS must not make participation in TEAM mandatory.**

Episodes Selected Are Not Appropriate for a Mandatory Model

CMS proposes limiting the episode categories under TEAM to surgical procedures included in BPCI-A. CMS is not proposing to include medical episodes in TEAM as analysis of prior models shows medical episodes reflect a higher proportion of dually eligible[121] beneficiaries than surgical episodes. CMS notes that if it mandated all of the episodes in BPCI-A it "could overwhelm participants." While CMS' acknowledgement is appreciated, given the limited resources available, there is real concern that even five episodes will overwhelm many hospitals.

The episodes selected were also chosen because they represented high volume, high-cost episodes of care. However, CMS does not present any data in the proposed rule that indicates significant, unwarranted variation in utilization within each of these episodes. Based on these criteria, CMS selected the episodes shown in the table below.

Proposed Episode Categories and Billing Codes

Episode	MS-DRG	HCPCS
LEJR	469, 470, 521, 522	27447, 27130, 27702
SHFFT	480, 481, 482	N/A
CABG	231, 232, 233, 234, 235, 236	N/A
Spinal fusion	453, 454, 455, 459, 460, 471, 472, 473	22551, 22554, 22612, 22630, 22633
Major bowel procedure	329, 330, 331	N/A

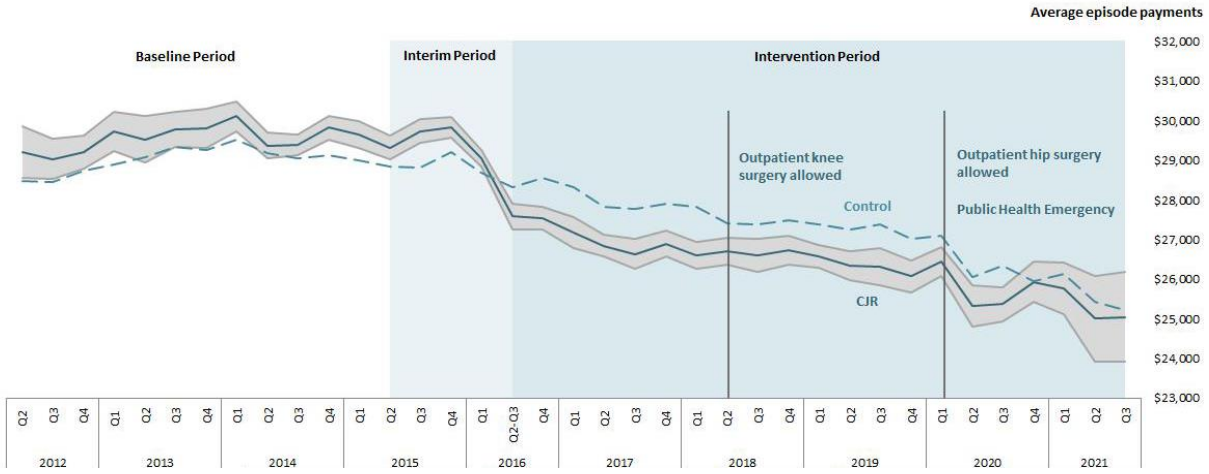
[118] https://downloads.cms.gov/files/cmmi/bpci-models2-4-yr5evalrpt.pdf
[119] https://agsjournals.onlinelibrary.wiley.com/doi/epdf/10.1111/jgs.15806
[120] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6345271/
[121] CMS' hesitation to include medical episodes due to the increased inclusion of dually eligible beneficiaries supports the argument that CMS should not mandate participation as the current proposal oversamples "safety net" hospitals.

There are significant concerns about the inclusion of each of these episode categories in a mandatory model.

LEJR: In the rule, CMS acknowledges concerns about the ratchet effect and attempts to mitigate it by proposing to calculate target prices using a weighted three-year baseline period that is inflated forward to the current year and updated annually. Further, CMS proposes to calculate target prices at the regional level and apply a 3% discount factor.

Between CJR[122] and BPCI-A[123], almost 1,000 hospitals have been accountable for LEJR episodes at some point. Not only has there been significant reduction in the average episode payment for those participating in LEJR episodes, but payments have also declined precipitously for episodes provided by non-participants (control group) over the past decade as illustrated in the chart below.

Average episode payments for CJR and Control Hospitals[124]
Q1 2012 – Q3 2021



The graph shows that episode payments for both CJR participants and non-participants have converged at approximately $25,000. As illustrated in the table below, this represents a decline of approximately 14.7% ($4,300, estimated reduction) for CJR participants and 11.6% ($3,300, estimated reduction), for non-participants[125].

Reduction in LEJR Spending
CJR Participants Vs. Non-Participants
Q1 2012 – Q3 2021

	Q1 2012	Q3 2021	Change	% Change
Control Group	$28,500	$25,200	$(3,300)	-11.6%
CJR Participants	$29,300	$25,000	$(4,300)	-14.7%

This substantial reduction in payment over the last decade will place downward pressure on the regional target price and disadvantage all hospitals that are chosen to participate. While CMS asserts variation in

[122] www.cms.gov/priorities/innovation/data-and-reports/2023/cjr-py5-annual-report
[123] www.cms.gov/priorities/innovation/data-and-reports/2020/bpciadvanced-firstannevalrpt
[124] www.cms.gov/priorities/innovation/data-and-reports/2023/cjr-py5-ar-exec-sum
[125] CHA analysis of CMMI data

care remains in these episodes, it does not provide any data at the episode level to illustrate the potential opportunity for savings. Further, the agency contradicts itself in the rule by stating that "…post-acute care spending has been declining in recent years for the episodes we are proposing to include in TEAM which could limit the potential for TEAM participants to achieve significant improvements in efficiency."

LEJR episodes have had much of the variation removed from it due to broad participation by hospitals in this bundled payment models for this procedure. **Therefore, CMS should not include LEJR episodes in a mandatory model as hospitals will struggle to generate sufficient savings to meet the target price — which has likely converged to the cost to provide an efficient LEJR episode — less the 3% discount.** If CMS forces hospitals to assume risk for LEJR episodes, the agency is setting them up for failure.

SHFFT and CABG: CMS first proposed a mandatory episodic payment model — the Advancing Care for Episodic Payment Model (EPM) — in 2015 that included SHFFT and CABG episodes. In 2017, CMS rescinded the final rule[126], canceling the model due to concerns about the increased regulatory cost (see discussion below) on providers and negative impact on patients due to the model's flawed design. In the *Federal Register* notice rescinding the rule, CMS states, "…we agree with commenters that the design of the specific EPMs we are cancelling in this final rule and interim final rule with comment period should be further studied and refined, and we also agree with commenters that seeking additional stakeholder input in future model design is important." Later in the final rule, CMS acknowledges there were "concerns with multiple aspects of the models," which resulted in their cancellation.

Additionally, SHFFT and CABG procedures are frequently performed on an emergent basis. As CMS notes in the proposed rule, procedures performed on an emergent basis have higher episode expenditures. Currently, the TEAM model does not have separate target prices for SHFFT and CABG episodes performed on an emergent basis.

The proposed target pricing model in TEAM and structure of the episodes is not materially different from the design finalized in EPM and subsequently canceled due to concerns about negatively impacting beneficiary outcomes. Additionally, the model's current target pricing structure inappropriately exposes hospitals to actuarial risk instead of performance risk given the lack of a separate target price for SHFFT and CABG procedures performed on an emergent basis.

Until CMS can design an episodic payment model that clearly addresses the concerns about negative beneficiary outcomes and includes a target pricing model that eliminates hospitals' exposure to actuarial risk, CMS should not include SHFFT and CABG episodes in a mandatory model.

Spinal Fusion and Major Bowel: CMS' BPCI-A evaluation reports have analyzed the payment impact of the model on hospital episode spending and quality through Model Year 3. However, none of the reports provides detail on the spending, quality, or patient outcomes impact of spinal fusion or major bowel episodes. Despite having relatively strong hospital participation, CMS did not have enough episodes in any of the first three years to report results with confidence for either episode. **Until CMS can provide publicly available data ensuring that spinal fusion and major bowel[127] episodes do not have a negative**

[126] https://www.federalregister.gov/documents/2017/12/01/2017-25979/medicare-program-cancellation-of-advancing-care-coordination-through-episode-payment-and-cardiac

[127] The lack of outcome data for major bowel is particularly concerning given the procedure is most frequently performed on patients with intestinal cancer.

impact on patient quality, outcomes, and experience of care, these episodes should not be included in a mandatory model.

CMS Does Not Take into Account Hospital Participation Costs

The impact analysis included in the proposed rule estimates that over the five-year duration of TEAM it will generate $705 million in net savings for the Medicare program. $403 million of the net savings is projected to result from hospitals paying CMS because actual episode costs exceeded the target price (negative NPRA). In the proposed rule, CMS does not estimate how much it will pay hospitals that generated positive NPRA.

The proposed rule's impact analysis does not consider what it will cost hospitals to participate in TEAM. Based on the volume projections for each episode and assuming 25% of the targeted CBSAs are required to participate, it is estimated that hospital costs[128] to participate will range between $530 million[129] and $744 million[130]. These costs are between 75% to 106% of CMS' net projected savings and represent an unfunded mandate by the agency. The expenses associated with participation are not conceptual. They will either be cross-subsidized by the private sector, require hospitals to redeploy funding and resources from other outcome improvement efforts that are targeted to communities' needs, and/or result in further loss of access to services for Medicare beneficiaries and the broader community.

It is most likely hospitals that care for patients from groups that have historically experienced adverse outcomes at a greater rate than the general population as a larger percentage of their patient populations will be unable to cross-subsidize these costs. They will most likely be forced to redeploy funds and resources from more targeted outcome improvement efforts and/or reduce access to services needed by the community. Either outcome only further exacerbates the inequitable outcomes that CMS seeks to reduce in service of testing concepts already evaluated through prior models such as BPCI-A and CJR. **Therefore, the agency should not finalize the TEAM as a mandatory model. It's worth reiterating that the agency canceled the EPM final rule due to similar concerns about the unnecessary "administrative burden" imposed on hospitals by that model.**

Changes Necessary to Ensure Participation in a Voluntary Model

The following recommended changes are offered to help CMS secure broad participation in a *voluntary TEAM*. These recommendations are also applicable if the agency ignores stakeholders' concerns and elects to finalize TEAM as a mandatory model. These recommendations come from hospitals that have participated in CMMI's episodic payment models and were shared with CMS in response to last summer's request for information[131].

Episode Selection

CMS current is requiring hospitals to participate in all five TEAM episodes. **To secure broader participation, the agency is encouraged to allow hospitals to select the episode(s) that it identifies as having the great opportunities to improve patient outcomes for the specific populations served by the hospital.** This will allow hospitals with limited resources to participate without over-extending staff or expending resources on episodes for which it has marginal volume.

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[128] Estimates include both the cost of consulting/analytic support and incremental staffing costs per episode. Examples of these activities are provided earlier in the letter.

[129] $530m = ($85k*5 years *724 hospitals) + (445k episodes annually * $100 per episode * 5 years)

[130] $744m = ($144k*5 years *724 hospitals) + (445k episodes annually * $100 per episode * 5 years)

[131] https://calhospital.org/wp-content/uploads/2023/08/CHA-Episodic-Payment-Comment-Letter_Final_081723.pdf

Setting Target Prices

Separate Target Prices for I/P and O/P: CMS proposes site-neutral target prices for certain HCPCS and MS-DRG combinations as illustrated in the table below. This has been long-standing practice in the CJR model.

Episode	MS-DRG	HCPCS
LEJR	470	27130 and 27447
	469	27702
Spinal Fusion	455	22633
	460	22612 and 22630
	473	22551 and 22554

It continues to be concerning that CMS proposes a blended pricing structure for these episodes. This structure does not recognize the resources required to care for sicker patients who, due to their clinical condition, must receive care in the hospital, or patients — who due to HRSNs — will have better outcomes if their procedure occurs on an inpatient basis. **Therefore, CMS is asked to recognize these costs and create separate pricing for inpatient and outpatient episodes of care in TEAM.** Failing to do this will further disadvantage "safety-net" hospitals that participate in their model as the populations they serve are more likely — due to adverse clinical factors or HRSNs — to have a procedure performed on an inpatient basis.

Separate Pricing for Emergent and Non-Emergent Procedures: The proposed target pricing methodology does not include a risk adjuster for episodes initiated on an emergent basis. The proposed rule notes 47% of CABG procedures are performed on an emergent basis. It also acknowledges these episodes are more expensive. The rule states, "…episodes following an emergency room visit on the same day or the day before tend to involve sicker patients, leading to greater clinical variability and less predictable episode spending."

Similar to BPCI-A, CMMI should include a risk adjuster or create a separate target price for episodes initiated on an emergent basis. Otherwise, the agency is inappropriately transferring actuarial risk, not performance risk, to the participating hospitals. While this will adversely impact all hospitals, it will likely have a greater negative impact on hospitals that care for patients who are at greater risk for inequitable outcomes as they are more likely to present with exacerbations of conditions due to a lack of access to primary care and/or specialists.

Further, CMS states it is using the CJR pricing model methodology. In CJR, CMS includes a separate target price for LEJR episodes that are initiated as a hip fracture treatment. **The agency is encouraged to clarify the TEAM model provides separate target prices for LEJR episodes that are initiated to repair a hip fracture.**

Regional Target Pricing: CMS proposes that TEAM participants' target prices would be based on aggregated regional data, rather than hospital-specific or a blend of regional/hospital-specific prices. The proposed rule notes research shows safety-net hospitals are disproportionately disadvantaged by the 100 percent regional price targets under CJR.

CMS proposes to risk adjust episode-level target prices at reconciliation by beneficiary age, the beneficiary's Hierarchical Condition Count (HCC), and social risk. CMS proposes to calculate risk adjustment multipliers prospectively at the MS-DRG/HCPCS episode type level based on baseline data, and hold those multipliers fixed for the performance year.

The use of regional target prices as proposed will disadvantage "safety net" hospitals as shown by the literature, hospitals that care for more complex/costly patients, and those that have not participated in episodic payment models before. **CMS should mitigate this issue by calculating regional target prices based only on episodes that have not been included in either BPCI-A or CJR. Further the agency should calculate a separate regional target price for "safety net" hospitals.** Not only will this prevent penalizing "safety net" hospitals for caring for more complex populations but will also reduce the ratchet effect by removing claims associated with prior episodic payment models.

Weigh Years Equally: CMS proposes to use three prior years of baseline data to calculate the target prices. The agency believes baseline episode spending from more recent years are likely to be a better predictor of performance year spending. Therefore, CMS proposes to weight recent baseline episode spending more heavily than episode spending from earlier baseline years (BY) (BY 1 at 17%, BY 2 at 33%, and BY 3 at 50%). **To minimize the ratchet effect, CMS should weigh all three years equally, especially if it rebases the benchmark annually (see below). Overweighing the most recent year penalizes hospitals for the cost savings they achieved in prior performance years.**

Eliminate Discount Factor: CMS proposes applying a 3% discount factor to the benchmark price to serve as Medicare's portion of reduced expenditures from the episode. This discount is similar to the 3% discount factor applied to target prices in the CJR model and to surgical episode target prices in BPCI-A. It's worth noting that both CJR and BPCI-A models were based on 90 episodes of care.

CMS also proposes to rebase the target price annually. While the proposed rule states that basing the target price on the weighted average of a three-year period will reduce the ratchet effect, it will not. Instead, perpetually rebasing will only exacerbate the problem. Even if the agency uses weighted average of the prior three years, hospitals will be forced to compete against not only their performance but of other hospitals in the region. Applying any discount factor to a model where the agency rebases the target price is "double-dipping."

This double-dipping on CMS' part makes it harder for hospitals to generate sufficient savings to support care redesign efforts. Hospitals will make substantial upfront investments and incur significant ongoing costs to coordinate care across the continuum to participate. Further, in the current environment, most, if not all, of the revenue generated through the delivery of inefficient care is not realized by the hospital responsible for the anchor admission/outpatient procedure that bears risk. Hospitals must receive a reasonable return on their investments in care coordination and process re-engineering if they successfully improve outcomes and reduce spending. Therefore, it is inappropriate for CMMI to both apply a discount factor and continually rebase the benchmark based on more recent data periods that eventually will include performance periods covered under the model. **CMMI is urged to either take an appropriate discount factor or rebase the benchmark, but not both.**

In a 90-day episode, less of the episode cost is associated with the anchor admission expense (both Part A for acute care and Part B for physician services). This means that in both BPCI-A and CJR there was greater opportunity for savings in these longer bundles. CMS proposes to reduce the length of the

episode to 30 days. In the TEAM model the spending associated with the anchor admission will be a considerably larger portion of the episode cost. As an example, analysis shows that the cost of a 30-day episode based on the BPCI-A definition is between approximately 9.4% (CABG) and 30% (SHFFT) lower than a 90-day episode[132]. However, CMS does not reduce the discount factor to reflect the decreased opportunity for cost savings. This is a significant flaw in the model that will disadvantage all participants. **Therefore, the discount factor — if CMS retains one — should be reduced to 1%.**

Patient Level Risk Adjustment: CMS proposes to use an HCC count variable (TEAM HCC count), collecting HCCs from the FFS claims for each beneficiary starting 90 days before the anchor hospitalization/procedure. **Patient level clinical risk adjustment for pre-existing conditions is strongly supported. However, the agency is asked to use the annual HCC file like what is used in CJR. This will ensure that the patient level risk adjustment accurately reflects patient complexity.**

Risk-Tracks and Low Volume Thresholds
CMS proposes the risk tracks presented in the table below for TEAM.

Summary of Proposed TEAM Participation Tracks by Performance Year (PY)

Track	PY	Participant Eligibility	Financial Risk
Track 1	PY 1	All participants	- Upside risk only (10% stop-gain limit)
Track 2	PYs 2-5	Participants that meet one of following criteria: - Safety net hospital - Rural hospital - Medicare Dependent Hospital - Sole Community Hospital - Essential Access Community Hospital	- Upside and downside risk (10% stop-gain/stop-loss limits) - CQS adjustment percentage of up to 10% for positive reconciliation amounts and CQS adjustment percentage of up to 15% for negative reconciliation amounts
Track 3	PYs 1-5	All TEAM participants	- Upside and downside risk (20% stop-gain/stop-loss limits) - CQS adjustment percentage of up to 10% for positive and negative reconciliation amounts

CMS proposes allowing all hospitals to participate in an upside only track (Track 1) in year 1 is supported. In subsequent years, any "safety net" or rural hospital should be allowed to elect to remain in Track 1 if it has 100 or fewer discharges[133] per year at the individual episode level in either the baseline or performance year.

Not only does a threshold of at least 100 episodes provide financial stability in target prices, but also supports care process re-engineering in several ways. First, there needs to be a sufficient volume of

[132] Institute for Accountable Care; personal email; May 23, 2024
[133] For example, if a safety net hospital elects to participate in LEJR and CABG. For PY3 it has 111 LEJR episodes 60 CABG episodes. Based on these volumes, it could elect to participate in Track 2 or 3 for LEJR and Tracks 1 – 3 for CABG.

claims to identify systematic unwarranted variance. Feedback from participants in prior episodic payment models indicates minimum scale is necessary to successfully re-engineer care to both identify opportunities for improvement and implement redesigned care pathways. Second, the opportunity to improve patient outcomes needs to be significant enough to engage physicians — both those managing the acute phase of the admission, primary care physicians managing the ongoing chronic condition(s), and post-acute partners.

Due to state law, California's hospitals are not allowed to employ physicians. While engaging community physicians is critical in any care redesign effort, the success or failure of a California hospital in an episodic payment model is largely dependent on community physicians given hospitals cannot directly employ providers. There is a significant opportunity cost for physicians when they participate in care redesign efforts, as the time they spend reviewing data and attending meetings is currently not billable to the Medicare program. Therefore, for any hospital to engage physicians, there must be a sufficient volume of cases such that the potential NPRA available covers the opportunity cost of community physicians' time.

Episode Definitions

Exclusions: CMS proposes using the BPCI Advanced exclusions list in TEAM. This excludes from episodes all Part A and B items and services, for both the baseline period and performance years, for hospital admissions and readmissions for specific categories of diagnoses, such as oncology, trauma medical admissions, organ transplant, and ventricular shunts determined by MS–DRGs, as well as all of the following excluded Major Diagnostic Categories (MDC):

- MDC 02 (Diseases and Disorders of the Eye)
- MDC 14 (Pregnancy, Childbirth, and Puerperium)
- MDC 15 (Newborns)
- MDC 25 (Human Immunodeficiency Virus)

CMS also proposes excluding from episodes IPPS new technology add-on payments for drugs, technologies, and services identified by value code 77 on IPPS hospital claims for episodes in the baseline period and performance, items covered by OPPS transitional pass-through devices, items and services paid for outside of the MS-DRG, and Part B payments for certain drugs.

These exclusions are supported but are insufficient. To date, CMMI's models have included narrow carve-outs for unrelated clinical conditions that have transferred insurance risk to hospitals and other participants. **CMS is encouraged to expand the clinical conditions that are excluded from the calculation of an episode's target and actual price. These exclusions should include, but are not limited to, categories such as treatment for substance use disorder, unrelated chronic conditions, patients under hospice care, and planned inpatient or outpatient services.**

Excluding previously planned services is consistent with existing CMS policy (e.g., CMS currently excludes planned readmissions from the Hospital Readmissions Reduction Program). Additionally, CMS must ensure that for any excluded readmission from an episode definition and calculation of target price and actual price, it also excludes post-acute care following an excluded readmission. Holding a participant accountable for all patient pathways is unreasonable given how little is known about the causal relationship between the hospital readmission and subsequent post-acute care services.

Quality Measures

CMS proposes that for a participating hospital to be eligible for a reconciliation payment, it must meet or exceed performance thresholds on certain quality measures. Two measures would apply to all TEAM episodes: Hybrid Hospital-Wide All-Cause Readmission Measure and CMS Patient Safety and Adverse Events Composite (CMS PSI 90). One measure — Hospital-Level Total Hip and/or Total Knee Arthroplasty (THA/TKA) Patient Reported Outcome-Based Performance Measure (PRO-PM) — would apply to LEJR episodes. However, all three measures would be combined into an aggregate CQS that would be used to adjust payments as part of the annual reconciliation process.

It is appreciated that CMS proposes to use measures that would be reported following existing hospital inpatient quality reporting (IQR) program processes to reduce reporting burdens. However, hospitals are concerned that CMS has proposed measures that are used in other pay-for-performance programs, which could result in duplicative penalties for TEAM participants.

For example, the Hybrid Hospital-Wide All-Cause Readmission measure could capture readmissions that hospitals are already held accountable for under the Hospital Readmissions Reduction Program, which reduces payments to Medicare PPS hospitals if their readmissions exceed an expected level. Similarly, PSI-90 is included in the measure set for the Hospital Acquired Condition (HAC) Reduction Program, which adjusts payments to hospitals that rank in the worst-performing quartile by 1% of overall Medicare fee-for-service payments. **Under a voluntary TEAM model, CMS should consider measures that hospitals are not already held financially accountable for under other CMS quality programs.**

Further, hospitals have long expressed concerns with the inclusion of PSI-90 in pay-for-performance programs. PSIs use hospital claims data to identify patients that may have experienced a safety event. However, claims data alone do not fully reflect the details of a patient's history, clinical risk factors, and care delivered in the hospital. Differences in coding and documentation practices could introduce variability into scores that are not reflective of a hospital's quality of care. While PSI data may assist hospitals in identifying specific cases to investigate for quality improvement purposes, it is not well suited to meaningfully assessing hospital performance on safety issues in comparison to other hospitals.

One significant issue with PSI-90 is its disproportionate impact on "safety net" hospitals, which see a larger volume of vulnerable populations who often have complex medical needs with unmet HRSNs not addressed by the measure's risk adjustment model. The inclusion of this measure could disadvantage these hospitals, further exacerbating the challenging financial situation of these vital facilities.

In the proposed rule, CMS acknowledges longstanding stakeholder concerns with PSI-90, and suggests that it may be replaced with newly proposed hospital harm and patient safety measures as early the TEAM second performance year. **CMS should not finalize the inclusion of PSI-90 for the TEAM model and should only propose new measures through notice and comment rulemaking after hospitals have had sufficient experience reporting the measures under the IQR program.**

There are also concerns about the use of patient-reported outcomes performance measures — including the proposed THA/TKA PRO-PM — in alternative payment models like the TEAM. While these newly developed measures are promising in concept, hospitals that participated in the CJR model report the data collection burden for the voluntary measure was significant, and that measure results were not useful for evaluation data due to high levels of missing PRO data. In particular, hospitals report that it is incredibly challenging to get completed post-operative survey data from patients, as many patients travel

to a specific hospital for their elective surgeries — often from significant distances — and complete follow-up care back in their home communities under the care of other providers. **If finalized, the THA/TKA PRO-PM should be a voluntary measure and should not impact the CQS applied to all episodes.**

NPRA Reconciliation

Ensure Fair NPRA Reconciliation Process: **Reconciliation must occur separately for each episode, not at the enterprise level.** It is unfair to base NPRA sharing for one set of physicians on the results of another, unrelated group of physicians. If CMMI nets the results of gainsharing across multiple episodes for participants, CMMI is violating one of the basic tenets of incentive design by inappropriately holding providers at risk for performance results they cannot influence. In any episodic payment model, CMMI must allow participants to develop and execute separate gainsharing arrangements with physicians (or physician practices) that are tied to the individual episodes for which the hospital is assuming performance-based risk. The ability to share gains with physicians and other participants should be predicated only on the episode-specific outcomes (both financial and quality), not the results of all of the episodes aggregated across the enterprise. Moving to episode-specific gainsharing will hold the physician group(s) that are directly involved with re-engineering and managing beneficiary care for an episode responsible only for outcomes that they can control.

If CMS fails to do this, there will be instances where enterprise reconciliation disincentivizes physician participation. In BPCI and BPCI-A it was not uncommon to hear of instances where a hospital was successful in one bundle (e.g., LEJR) but not another (e.g., CABG) and therefore the NPRA sharing available to the orthopedic surgeons was less than anticipated due to results of an episode the orthopedic surgeons had no control over. CMS' policy had the opposite effect of the intent of episodic payments. It created misalignment and mistrust between the hospital and its physicians when the orthopedic surgeons opted not to continue participating in the model.

Composite Quality Score (CQS) – Reconciliation: CMS proposes, as part of the annual reconciliation process, to adjust the difference between the TEAM participant's performance year spending and the reconciliation price (the reconciliation amount) by its CQS, an approach like that used in CJR and BPCI Advanced. CMS proposes that prior to calculating the CQS, the quality measures would be weighted based on the volume of episodes for a TEAM participant. A normalized weight would be calculated by dividing the TEAM participant's volume of episodes for a given quality measure by the total volume of all the TEAM participant's episodes. This calculation would be applied to all quality measures for the TEAM participant.

Beyond the general concerns about the quality measures described above, there is concern that CMS is holding groups of physicians accountable for a measure they have do not control over. Specifically, CMS proposes calculating NPRA based on a composite quality score that includes a measure that is applicable only to orthopedic procedures — the THA/TKA PRO-PM. **Similar to the comments above, it is inappropriate to hold the participating cardiac surgeons, gastrointestinal surgeons, and orthopedic surgeons who do not perform LEJR procedures responsible for the quality outcomes of the participating orthopedic surgeons who perform hip and knee replacements. Should CMS not consider recommendations to make the THA/TKA PRO-PM a voluntary measure, it should only include the measure in the reconciliation calculation for applicable episodes.**

Minimize Cost and Support Broad Participation
Streamline Evaluation Process: TEAM participants and their downstream participants must comply with the requirements and otherwise cooperate with CMS' model evaluation and monitoring activities as may be necessary to enable CMS to evaluate TEAM. This participation in the evaluation may include, but is not limited to, responding to surveys and participating in focus groups.

Hospitals that have participated in prior models report CMMI evaluation activities — data requests, reporting requirements, and site visits — have been time-consuming. Many of these requirements and requests are duplicative and take valuable resources away from improving direct patient care. Examples cited include:

- Overlapping reporting requirements related to updating program implementation plans and data requested by Medicare's contractor in an attempt to identify best practices/shareable care protocols
- Meeting monthly with program monitors

As discussed above, there is concern about the costs associated with duplicative and overlapping evaluation efforts. CMMI must make a concerted effort to limit site visits, data requests, and other reporting requirements to the minimum necessary to understand the impact of the program. Further, CMMI must compensate hospitals on an hourly basis for the time their staff spends on administrative activities resulting from CMS evaluation efforts. It is highly inappropriate for CMMI to mandate participating physician practices permit site visits. With the considerable time required of physicians to participate in an episodic payment model as partner, there is concern the additional burden will limit the pool of physician practices willing to partner with California's hospitals.

Reduce Costs Associated with Beneficiary Notification: CMS' proposal puts the onus and costs of educating beneficiaries about episodic payment models on the model participants. However, this education should be a collaborative partnership between CMMI, CMS, and participants. **Therefore, CMS must include education about this bundled payment initiative (and other value-based programs) as part of the Welcome to Medicare packet, Medicare beneficiary manual, and specific letters sent to beneficiaries who live in any area where hospitals are participating.**

Further, the mandatory beneficiary engagement letter is cumbersome and labor-intensive to administer as required. It is also challenging for hospitals to administer in many circumstances. The letter is typically provided to beneficiaries based on the "working" Medicare severity diagnosis-related group (MS-DRG) given the mandated time frame in which participants must provide the letter to a beneficiary. As a result, hospitals end up missing some patients (typically patients admitted due to the emergent nature of stays, their short duration, and/or a change in the final discharge MS-DRG). Hospitals note that while they try to provide the letter to all episode-eligible beneficiaries, some inevitably slip through the cracks despite their best efforts. When these instances are flagged on audit reports it is demotivating for the care teams involved.

CMS is strongly encouraged to work with providers and beneficiaries to design a notification process that is more useful for beneficiaries and less challenging for providers to administer.

Infrastructure Funding: CMS must **offer infrastructure funding to smaller hospitals and distressed hospitals, similar to the accountable care organization (ACO) advanced incentive payment available**

to smaller ACOs. These funds could be used — among other things — to make investments in analytical infrastructure, support staff, payment for physicians participating in care redesign efforts, or to create linkages with community support organizations that can address social issues that negatively impact outcomes for the targeted population and foster better transitions of care. These funds will not only support participation, but prevent spending required to participate in TEAM from crowding out investments in other activities that are targeted to specific outcome improvement opportunities based on these hospitals' knowledge of their communities.

Exclude Distressed Hospitals If Participation Is Mandatory

If CMS finalizes TEAM as mandatory, it must protect distressed hospitals. **Hospitals that can demonstrate they are experiencing financial distress should not be required to participate in a mandatory episodic payment model.** CMS should explore using metrics such as the presence of a negative operating margin and days cash on hand below the average ratings agency median for below investment grade debt.

The determination of distress is specific to an individual hospital. Therefore, the determination of whether a hospital is distressed for purposes of excluding it from a mandatory episodic payment model must be made at the individual hospital level. Many hospitals experiencing financial distress are affiliated with larger health care systems that may not be financially distressed overall. Historically, these systems have acquired distressed or safety-net facilities to further their missions of ensuring access to health care for all — especially for individuals who are at greater risk of inequitable health care outcomes. However, if legislators and regulators evaluate financial distress at the corporate level for hospitals that are affiliated with health systems, it will have a chilling effect on these systems' continued willingness to acquire distressed facilities to preserve access in underserved communities.

The determination of whether a hospital meets the criteria for financial distress should be based on hospital-submitted data, not publicly available data. First, this will allow for more current data to be used in the determination, which avoids the time lag between most recently available financial results and publicly available data. Second, the days cash on hand and current ratio metrics cannot be accurately calculated for individual hospitals within a health system using publicly available data. To accurately calculate facility-level days cash on hand and current ratios for individual system hospitals, these facilities will need to submit additional documentation that documents the intercompany transfers of funds, allowing for the accurate calculation of both measures.

Despite the concerns discussed above, if CMMI elects to move forward with a mandatory model with limited exclusions for low-volume hospitals and no exclusion for financially distressed hospitals, TEAM must make the model upside only for these facilities. This will protect financially fragile hospitals from risk and related payment reductions that could negatively impact access for historically underserved populations.

Maternity Care – Request for Information

The proposed rule seeks information on differences between hospital resources required to provide inpatient pregnancy and childbirth services to Medicare patients relative to non-Medicare patients. Medicare's rates for childbirth services are based on the 13% of beneficiaries who are under 65 and eligible for Medicare based on disability, having ESRD or amyotrophic lateral sclerosis. This population is likely to be very different than non-Medicare patients in need of childbirth and maternity services.

Further, the proposed rule seeks feedback on actions Medicare can take to support access to labor and delivery services and improve maternal outcomes.

Hospitals agree that relative to deliveries covered by payers other than Medicare, births covered by the program tend to be more complex and resource intensive. However, all DRG payment models are based on a relative weighting system. While labor and delivery services covered by Medicare are more complex it is unclear if that complexity is translated into the MS-DRG relative weights. Therefore, it is recommended CMS crosswalk the weights from the most commonly used DRG payment systems to understand whether the additional complexity of Medicare covered labor and delivery services is reflected in the weights or does that complexity get canceled out by the overall increased complexity of services provided to the Medicare population (relative to the populations used to determine AP-DRG and APR-DRG weights).

While it is likely that some commercial health plans in California contract for inpatient services using MS-DRGs as the payment system, it is not widespread. Further, Medi-Cal FFS does not use MS-DRGs to pay for inpatient services. It currently uses APR-DRG (3M Grouper Software version 40) for 2023-24. This will be updated to version 41 in 2024-25. The state does other policy adjustments/multipliers based on categories of service (such as pediatrics), but the backbone of it all is APR-DRG.

It's worth noting that only 5,739 claims were paid by Medicare for labor and delivery services in 2023. This is just 0.08%[134] of all Medicare covered inpatient services and 0.16%[135] of all births in the United States in the same year. Given the relatively low volume of labor and delivery services provided to Medicare beneficiaries, the agency should not attempt to support access to labor and delivery services by manipulating the MS-DRG weights. Or, if it does manipulate the MS-DRG weights, it should do so in a non-budget neutral manner.

CMS is encouraged to take steps to improve maternal outcomes and ensure access to labor and delivery services. Since 2016, approximately 45 labor and delivery units have been closed in California. In the year before closure, these hospitals delivered 19,975 children (an average of 485 per hospital). The list of hospitals is diverse. It is composed of rural and urban facilities, large and small facilities. However, the one thing all have in common is a higher-than-average governmental payer mix. In 2022, 78%[136] of patients receiving care at these facilities were covered by Medicare and Medi-Cal and as a result had an average operating margin of -6.3%. By contrast, the average California hospital's governmental payer mix is 58%[137] with a margin of -1.6%[138].

Given that hospitals that have recently closed labor and delivery services have a higher governmental payer, they provide care to a larger percentage of patients from groups that have historically experienced inequitable health outcomes. These hospitals also have a smaller base of commercial insurance to cross subsidize losses on governmental payers. This significantly reduces these hospitals' ability to support programs that are necessary for the community but unsustainable based on their costs and the fact that they are used by individuals covered by payers that pay less than the cost to deliver care.

[134] CHA analysis of IPPS proposed rule.
[135] CHA analysis of IPPS proposed rule, https://apnews.com/article/how-many-babies-are-born-us-25d99f438645908e5ed6ae29d3914b89
[136] CHA analysis of 2022 HCAI data. Numbers do not sum due to rounding issues.
[137] CHA analysis of HCAI data.
[138] https://www.kaufmanhall.com/sites/default/files/2023-04/CHA-Financial-Impact-Report.pdf

Therefore, the single most important action CMS can take to support access to maternal health services and access to labor and delivery services is to provide an adequate market basket update that fully reflects the growth in input costs to provide care for Medicare beneficiaries. As noted above, Medicare pays for a de minimis share of births annually. However, if Medicare reimbursement covered the cost (or more of the cost) to provide care for Medicare beneficiaries, it would reduce the need for cross-subsidy from commercial health plans and free up financial resources to support necessary community services that are disproportionately used by and funded by individuals enrolled in state Medicaid programs.

CoP Requirements for Hospitals and CAHs to Report Respiratory Illness

In 2020, CMS adopted a Condition of Participation (CoP) requiring hospitals and CAHs to submit certain data related to COVID-19 and other acute respiratory illnesses to HHS for the duration of the COVID-19 public health emergency (PHE). CMS then updated the CoP to extend modified reporting requirement beyond the PHE through April 30, 2024. In this proposed rule, CMS proposes to revise the hospital and CAH infection prevention and control program and antibiotic stewardship program CoPs to extend a modified form of the COVID-19 and influenza reporting requirements to include data for respiratory syncytial virus (RSV) and other data elements effective Oct. 1, 2024. However, CMS encourages hospitals to voluntarily report this data in the five-month gap between the expiration of PHE requirements and the newly proposed requirement.

CMS proposes that hospitals and CAHs would have to report this data on a weekly basis through a Centers for Disease Control and Prevention (CDC)-owned or supported system. Under the COVID-19 PHE requirements, hospitals reported data through the CDC's National Healthcare Safety Network (NHSN) system. In the final rule, CMS should confirm the specific system that hospitals will use to report the proposed data elements. Should hospitals continue to report via NHSN, the CDC should improve the enrollment processes and procedures so that hospitals experience less challenges with reporting. Specifically, California hospitals report that the process to enroll a new employee/reporter with the NHSN module is lengthy and overly cumbersome, jeopardizing the ability of the hospital to meet reporting requirements if the designated reporter is out sick, on vacation, or otherwise unavailable.

CMS proposes the following data elements will be required for weekly reporting: confirmed infections of respiratory illnesses, including COVID-19, influenza, and RSV, among hospitalized patients; hospital bed census and capacity (both overall and by hospital setting and population group [adult or pediatric]); and limited patient demographic information, including age.

CMS is urged to not finalize required reporting of patient-level demographic information. Reporting of patient-level data is significantly more onerous than data reported in aggregate. For small hospitals and CAHs, shifting resources to this level of data collection could come at the expense of clinical care and access to care in the community. Further, the current data reporting already requires hospitals to report on COVID patients by age band and reporting information on bed type — adult or pediatric — should provide the agency with an indication of patients' ages, in line with CMS' desire to continue the collection of minimal necessary data in order to maintain a level of situational awareness.

Similarly, CMS seeks comments on whether it should also require patient-level reporting on information including race, ethnicity, socioeconomic, and disability status information. The concerns shared above regarding the reporting of patient-level age data would also apply to this policy, with additional

complicating factors. As CMS notes in the proposed rule, standards for the collection of race and ethnicity data are evolving, and while some hospitals collect this data at intake, it would be a challenging undertaking to review each record to report this data. Other elements that CMS is considering — such as socioeconomic status — are not typically collected. Implementation of such a policy would require intake procedures to be altered to capture this data, inappropriately increasing the burden associated with data collection and reporting required to meet the CoPs.

CMS also proposes that during a declared PHE for infectious disease, the Health Secretary may require reporting of additional or modified data elements at up to a daily frequency. **Hospitals do not support the proposed ability of the secretary to add and modify data reporting requirement during a PHE absent additional notice and comment rulemaking, and sufficient lead time to alter data reporting procedures.**

Adding reporting requirements during a PHE could have detrimental effects on hospital staff's ability to treat patients. During a PHE, hospitals have the least flexibility in altering their reporting procedures. One of the most common complaints about the COVID data reporting came during surges when hospitals reported that their staff did not have the time to report an excessive amount of data elements when they needed to dedicate those resources to treat patients. Adding or modifying data requirements could negatively affect data quality and may negatively affect patient treatment.

Finally, hospitals urge CMS to consider alternative approaches to incentivizing hospital reporting of respiratory illness data — such as through the hospital IQR or Promoting Interoperability programs — rather than relying on the CoPs. Failure to comply with the CoPs could result in extreme consequences, including termination from the Medicare program, threatening patient access to care provided by the hospital. CMS is encouraged to engage with its partners across federal, state, and local governments to improve the infrastructure of public health reporting systems to enable automated, real-time sharing of symptom and confirmed case data that could be used to proactively prevent outbreaks of infectious illnesses.

Hospital Inpatient Quality Reporting Program

CMS proposes significant changes to the hospital inpatient quality reporting (IQR) program including the addition of seven new measures, modifications to two existing measures, the removal of five measures, and increased reporting requirements for electronic clinical quality measures (eCQMs).

Proposed Structural Measures

CMS proposes to add two new structural, attestation-based measures — the Patient Safety Structural measure and Age Friendly Hospital measure — beginning with the CY 2025 reporting year/FFY 2027 payment determination. While the proposed measures address different topics, both are structured similarly with five attestation domains, each of which includes several attestation statements. To receive a point for a domain, a hospital would need to attest affirmatively to each of the statements that correspond to that domain. A hospital would not be able to receive partial points for a domain, and therefore would receive zero points for any domain for which it cannot attest affirmatively to each of the corresponding statements. If a hospital includes more than one acute care hospital facility reporting under the same CCN, all the facilities would need to satisfy these criteria for the hospital to affirmatively attest and receive points. For each measure, the hospital's overall performance score (0-5 points) would be publicly reported on *Care Compare* beginning in 2026.

While hospitals share CMS' commitment to ensuring patient safety and providing high-quality care to the aging population, there are concerns that that structural measures do not meaningfully distinguish performance among hospitals or measurably assess quality improvement efforts. There are also concerns that the proposed scoring methodology and public reporting proposals may result in misleading public views of hospitals' performance, particularly due to the all-or-nothing nature of how points are awarded in each domain. For example, the Patient Safety Structural Measure has 25 separate, detailed attestation statements across its 5 domains. Because a hospital must attest affirmatively to each statement to receive credit, a hospital could conceivably attest "yes" to 20 out of 25 attestation statements, while still receiving an overall score of 0 out of 5, leading the public to incorrectly believe that the hospital does not value patient safety.

Further, attestation-based measures lack validation, capturing a "yes/no" answer based on the hospital's internal judgement that it meets the requirements as laid out in the measure, without providing any substantive information on what the hospital is doing that constitutes that answer. Absent detailed guidance and more burdensome documentation requirements, hospitals could reasonably attest "yes" to the same domain while making very different assessments about how their organization approaches the activities described by the attestation statements. This does not provide CMS or patients with actionable information about how the hospital prioritizes patient safety or the care it provides to geriatric populations. **CMS is urged not to finalize the addition of these attestation-based measures and instead focus its resources on developing outcomes-based measures where there are gaps in patient safety and geriatric care measurement.**

Should CMS move forward in finalizing these measures, additional concerns specific to the Patient Safety Structural measure should be addressed. As previously noted, the measure includes 25 separate attestation statements — two of which also have several detailed sub-bullets — and is more appropriately described as a survey than a quality measure. Many of the practices described by these statements have merit and are already widely adopted across hospitals and health systems, but they are also redundant with other regulatory or accreditation requirements for hospitals.

For example, many of the practices listed in Domains 1 and 2 reflect whether hospitals have patient safety included in their strategic plans and have mechanisms for sharing both the goals and progress with senior organizational leaders and their Boards. Most of the practices listed overlap with the Quality Assessment and Performance Improvement (QAPI) requirements that hospitals must meet under the Medicare Conditions of Participation (CoPs), and thus, additional reporting of them should be of little value. Similarly, providing access to patient information (Domain 5, attestation C) is already a requirement of the Promoting Interoperability Program and further duplicated by information blocking regulations.

Hospitals also have concerns with the attestation statement under Domain 4 that reads "(B) Our hospital reports serious safety events, near misses and precursor events to a Patient Safety Organization (PSO) listed by the Agency for Healthcare Research and Quality (AHRQ) that participates in voluntary reporting to AHRQ's Network of Patient Safety Databases." PSOs are private, market-based programs that were created to assist health care providers of all types create innovative learning systems to solve their own quality issues concerning patient care delivery under a "culture of safety" in which health providers are confident that the patient safety events that they report will be used for learning and improvement, not oversight, penalties, or punishment.

Under the Patient Safety Act, the health care and PSO community have developed innovative programs to connect the health care continuum to revolutionize patient safety practice and to allow health care providers to talk to each other to improve the quality of patient care, while ensuring privilege and confidentiality protections for quality information, analysis collected and developed within the structure provided by the statute. The Patient Safety Act prohibits a federal oversight agency, including CMS, from controlling — directly or indirectly — what information a PSO collects or compelling the PSO to report patient safety work product (PSWP) to the government[139]. Though the proposed attestation statement includes language describing this reporting as voluntary, the measure's all-or-nothing scoring methodology would make it seem that CMS is indirectly requiring hospitals to report PSWP to a federal agency, in violation of the Patient Safety Act.

CMS is again urged not to finalize the Patient Safety Structural measure as proposed. However, if the agency finalizes a version of the measure, it should revise and simplify the attestation statements to ensure the practices included are those that have demonstrated clinical evidence for improving patient safety, are not duplicative of other regulatory or accreditation requirements, and are not inconsistent with the Patient Safety Act.

Proposed Hospital Harm eCQMs

CMS proposes to add two Hospital Harm eCQMs — Falls with Injury and Postoperative Respiratory Failure — beginning with the CY 2026 reporting period/FFY 2028 payment determination. Both measures would be added to the list of eCQMs for which a hospital could self-select to meet reporting requirements. Both measures are risk-adjusted outcome eCQMs. The Falls with Injury measure assesses the number of inpatient hospitalizations with at least one fall with moderate or major injury, and the Postoperative Respiratory Failure measure assesses elective inpatient hospitalizations for patients aged 18 years and older without an obstetrical condition who have a procedure resulting in postoperative respiratory failure, defined as unplanned intubation or prolonged mechanical ventilation after an operation.

Hospitals appreciate that CMS has focused on developing outcome measures with more sophisticated approaches that utilize clinical and EHR-based data in addition to administrative data. However, it is noted that during the pre-rulemaking measure review (PRMR) processes, concerns were raised with unintended consequences. For example, the use of the falls measure may result in reduced patient mobilization, which can be crucial for recovery. The use of the post-operative respiratory failure measure may result in inappropriate use of noninvasive positive-pressure ventilation in lieu of mechanical respiration, excessive use of preventive tracheostomy, or avoidance of offering necessary procedures for high-risk patients.

While CHA does not oppose the addition of these measures as eCQMs on the measure set available for self-selection, CMS is urged to continuously monitor patient outcomes for unintended consequences and to achieve endorsement from the consensus-based entity (CBE) prior to mandatory reporting of the measures in the IQR program or any performance-based programs.

Proposed Failure-to-Rescue Measure

CMS proposes to adopt the 30-Day Risk-Standardized Death Rate Among Surgical Inpatients with

[139] (42 C.F.R. 3.102(a)(2)(ii)(B))

Complications (Failure-to-Rescue) measure, which is a risk-standardized measure of death after hospital-acquired complication, beginning with the July 1, 2023, through June 30, 2025, performance period affecting the FY 2027 payment determination. The Failure-to-Rescue measure is designed to improve upon the Death Rate Among Surgical Inpatients with Serious Treatable Complications (PSI-04) measure in the Hospital IQR Program and would replace that measure contingent on adoption of this Failure-to-Rescue measure.

Hospitals appreciate that CMS has addressed long-standing stakeholder concerns with PSI-04 in developing the Failure-to-Rescue measure. The new measure was expanded to include Medicare Advantage populations, and CMS is encouraged to continue to expand quality measurement for these patients. The new measure also limits the denominator to patients in general surgical, vascular, and orthopedic MS-DRGs, and excluding patients whose relevant complications preceded their first inpatient operating room procedure while broadening the definition of denominator-triggering complications to include other complications that may predispose to death.

However, hospitals remain concerned that the new measure could potentially hold hospitals accountable for factors outside their control by including deaths regardless of site. A person may die within 30 days of a hospital procedure for any number of reasons unrelated to the hospital's quality of care, including trauma or self-harm. **CMS should consider additional exclusions to ensure the measure is reflective of the hospital's performance.**

In addition, while the measure is claim-based and does not require additional data submission, it is noted that the proposed measurement period would begin July 1, 2023, more than a year prior to finalization for inclusion in the Hospital IQR Program. **CMS should delay adoption of the measure for at least one year to allow hospitals time to familiarize and educate staff around the measure requirements and changes compared to PSI-04.**

Proposed Measure Removals

In conjunction with its proposal to adopt the new Failure-to-Rescue measure, CMS proposes to remove PSI-04 from the IQR program beginning with the FFY 2027 payment determination. **This proposal is strongly supported.**

Hospitals also support CMS' proposal to remove four clinical episode-based payment measures (Hospital-level, Risk-Standardized Payment Associated with a 30-Day Episode-of-Care for Acute Myocardial Infarction; Hospital-level, Risk-Standardized Payment Associated with a 30-Day Episode-of-Care for Heart Failure; Hospital-level, Risk-Standardized Payment Associated with a 30-Day Episode-of-Care for Pneumonia; and Hospital-level, Risk-Standardized Payment Associated with a 30-Day Episode-of-Care for Elective Primary Total Hip Arthroplasty). Hospitals agree that the Medicare spending per beneficiary measure is more broadly applicable and justifies the removal of the episode-based payment measures under measure removal factor 3.

eCQM Reporting Requirements

Currently, hospitals must report four quarters of data for six eCQMs, three of which are mandatory (Safe Use of Opioids, Cesarean Birth, and Severe Obstetric Complications) and three that are self-selected from the available measure set. CMS proposes to progressively increase the number of eCQMs that a

hospital must report so that by the 2027 reporting period reporting requirements would nearly double from the current policy.

Specifically, CMS proposes that beginning with the CY 2026 reporting period/FFY 2028 payment determination, hospitals would need to report on nine total eCQMs: six mandatory and three self-selected eCQMs. In addition to the current three mandatory eCQMs, CMS proposes to require reporting on the following eCQMs: Hospital Harm - Severe Hypoglycemia eCQM; Hospital Harm - Severe Hyperglycemia eCQM; and Hospital Harm - Opioid-Related Adverse Events eCQM. Beginning with the CY 2027 reporting period/FFY 2029 payment determination, hospitals would need to report on 11 total eCQMs: eight mandatory eCQMs and three self-selected. In addition to the current three mandatory eCQMs and the three eCQMs proposed to be mandatory beginning with the 2028 payment determination, the following would be included as mandatory eCQMs: Hospital Harm – Pressure Injury eCQM; and Hospital Harm – Acute Kidney Injury eCQM. These proposals would apply both to the hospital IQR program and the Promoting Interoperability Program.

Hospitals oppose the proposed increase to the number of eCQMs that must be reported. While the field continues to gain valuable experience with eCQMs, numerous questions remain about their accuracy and feasibility, and many hospitals report that they largely do not rely on eCQMs to track their quality improvement efforts. Notably, feedback to hospitals about their performances on eCQMs is infrequent and seldom provides information that can inform performance improvement. CMS should refocus its resources on ensuring that the feedback reports hospitals receive under existing reporting requirements are useful to improving the quality of care.

Hospitals also continue to report significant challenges with reporting eCQMs under the current requirements. Challenges include difficulties extracting data from "production-ready" eCQM products delivered by developers and insufficient time to complete testing, validation, staff education and rollout of eCQMs before their reporting is required. Further, the deployment of new eCQMs requires that hospitals draw upon finite staff time and budgets of many hospital departments, including quality, health IT, pharmacy, medical records, and finance, diverting limited resources from direct patient care. There is also a heavy reliance on a hospital's EHR vendor's capability in supporting additional eCQMs.

In California, hospitals have had to dedicate significant IT resources to complying with state requirements on information sharing. This includes compliance with Assembly Bill 352[140] (AB 352), which made significant changes to California's privacy and health information interoperability laws that impact hospitals, EHR developers, and other stakeholders that handle medical information related to gender affirming care, abortion, abortion-related services, sexual health, fertility, or contraception. The work necessary to meet the law's data segmentation requirements has been intensive and draws from the same resources that would be required to nearly double the number of eCQMs a hospital must report.

CHA is concerned that due to competing priorities and limited resources, California hospitals may not be able to achieve these significantly increased eCQM reporting requirements, putting them at great financial risk by jeopardizing their full Medicare annual payment update – one quarter for the IQR, and three-quarters for the Promoting Interoperability Program.

[140] https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=202320240AB352

Should CMS finalize a more gradual increase in eCQM reporting requirements, hospitals continue to advocate for flexibility in selecting the eCQMs that are most appropriate to that facility's specific quality improvement goals. As such, CMS should not be overly prescriptive in mandating which eCQMs a hospital must report, and rather, maintain a menu of measures available for hospital self-selection that reflect the quality measurement priorities of the agency.

Medicare Promoting Interoperability Program

Under the Medicare and Medicaid Promoting Interoperability Program — previously the EHR incentive program — hospitals that are not identified as meaningful EHR users are subject to a reduction equal to three quarters of the market basket. CMS proposes several changes to the program, including changes to one of its public health reporting measures, increasing the program's minimum scoring threshold, and increasing eCQM reporting in alignment with the proposed IQR requirements.

As noted in comments on the IQR program, hospitals strongly oppose the significant increase in eCQM reporting requirements and refer readers to those comments above, which are also applicable to the Promoting Interoperability Program.

Proposed Increase to Minimum Scoring Threshold

For the CY 2025 reporting period, CMS proposes to increase the minimum scoring threshold that a hospital must achieve under the Promoting Interoperability Program to be considered a meaningful user of EHR technology from 60 to 80 points. In the proposed rule CMS notes that based on 2022 performance results, 98.5% of hospitals (97% of CAHs and 99% of eligible hospitals) that reported to the program successfully met the current minimum threshold of 60 points, and 81.5% of hospitals (78% of CAHs and 83% of eligible hospitals) would have exceeded the proposed threshold of 80 points.

Taken alone, an increase to the scoring threshold may be appropriate given that 98.5% of hospitals currently achieve the minimum threshold of 60 points. However, as described above, CMS proposes a significant increase to eCQM reporting requirements, which must also be met to achieve meaningful use. Should hospitals be required to direct limited resources to the implementation of new eCQM requirements, CMS is urged to maintain the existing scoring methodology, including the minimum scoring threshold of 60 points.

Proposed Change to Antimicrobial Use and Resistance (AUR) Surveillance Measure Beginning with EHR Reporting Period in 2025

CMS previously adopted a measure under the Public Health and Clinical Data Exchange objective that requires hospitals to report antimicrobial use (AU) data and antimicrobial resistance (AR) data to the CDC NHSN as one measure, AUR Surveillance. Beginning with the CY 2025 EHR reporting period, CMS proposes to separate the AUR Surveillance measure into two measures: (1) AU surveillance measure; and (2) AR surveillance measure. Under the proposal, hospitals would need to report a "yes" response or claim an exclusion separately for each measure to receive credit. **This proposal is supported.**

Hospitals agree that this change will better clarify reporting requirements, incentivize data reporting, and more appropriately target exclusions because the AU and AR data rely on different data sources. This will also ensure that CAHs and smaller hospitals that lack the infrastructure to report on this level of data are not excessively penalized. CMS and its partners should continue to provide technical assistance to ensure

that small and rural facilities have the resources and ability to improve public health data reporting and achieve interoperability.

LTCH PPS

LTCH – Labor Related Share Rebasing

CMS' proposed total labor-related share of 72.8% for FFY 2025 is 4.3 percentage points higher than the FFY 2023 labor share of 68.5%. The higher labor-related share is due to the incorporation of the 2022 Medicare cost report data, which increased the compensation cost weight significantly compared to the 2017-based LTCH market basket. **CMS' proposal to increase the labor-related share based on data that better reflect increased labor costs as a percentage of LTCH's overall cost structure is appreciated.**

CMS proposes to continue to classify a cost category as labor-related if the costs are labor intensive and vary with the local labor market. Similar to the 2017-based LTCH market basket (and in other PPS payment systems that incorporate a labor-related share), the proposed 2022-based LTCH market basket includes two cost categories for nonmedical Professional Fees (including, but not limited to, expenses for legal, accounting, and engineering services). These are Professional Fees: Labor-Related and Professional Fees: Nonlabor-Related. **California's LTCHs disagree with CMS' assertion that some portion of professional contract labor costs is not subject to geographic variation in labor costs. In the final rule, CMS is asked to allocate all 3.6 percentage points for professional services costs to the Professional Services: Labor-Related Category.**

For the proposed 2022-based LTCH market basket, CMS proposes to estimate the labor-related percentage of non-medical professional fees (and assign these expenses to the Professional Fees: Labor-Related services cost category) based on the same method used to determine the labor-related percentage of professional fees in the 2017-based LTCH market basket.

As it has during prior rebasing of the labor-related share, CMS proposes to determine the proportion of legal, accounting and auditing, engineering, and management consulting services that meet its definition of labor-related services based on a survey of hospitals conducted in 2008. Based on these results, CMS proposes to apportion approximately 2.3 percentage points of the 3.6 percentage point figure into the Professional Fees: Labor-Related share cost category and designate *the remaining 1.3 percentage points into the Professional Fees: Nonlabor-Related cost category*[141].

CMS' assumption that fees for services provided by firms located outside of a hospital's core-based statistical area (CBSA) do not vary based on geography is invalid. The implied underpinning of this assumption is that national and regional professional services firms do not compete with local professional services firms based in a hospital's CBSA. However, this is an erroneous assumption. When hospitals seek professional services, the services they are seeking are not so unique (e.g., accounting, engineering, management consulting) that they could only be provided by regional or national firms. CMS' own survey data support this conclusion, as approximately 64% of these services are sourced from firms in the local market. Therefore, hospitals solicit proposals for "professional services" from local, regional, and national firms.

[141] Emphasis added.

When competing with local firms for a given contract or project, regional and national firms have every incentive to adjust their pricing in response to local labor market conditions. If the local labor market has lower wages than the national average — which will influence the pricing of a local firm's response to a request for proposal from a hospital — regional and national firms must reduce the offered price of their services to be competitive with local firms that offer the same services. Conversely, if the local labor market has higher wages than the national average, regional and national firms have every incentive to price accordingly to increase their profit margins on a given contract. Therefore, pricing for services offered by regional and national firms to hospitals in differing CBSAs will vary significantly based on local rates due to these firms competing with local firms that provide the same service.

CMS is asked to provide evidence that pricing for professional services delivered by regional and national firms to hospitals is offered in a market that is not subject to geographic cost variation. Unless the agency can produce strong evidence that prices for professional services provided by firms outside of a hospital's local labor market are homogenous — that an LTCH in San Antonio, Texas, is charged the same hourly rates for audit services by the same national accounting firm as a hospital in Sacramento, Calif. — CMS is asked to restore the 1.3 percentage points it proposes to inappropriately reclassify to Professional Services: Nonlabor-Related to the Professional Services: Labor-Related category. In the absence of data that show standardized pricing by regional and national professional services firms, the Professional Services: Labor-Related category cost weight should be 3.6 percentage points.

LTCH – Fixed Loss Outlier Threshold

CMS establishes a fixed-loss amount so that total estimated outlier payments under the LTCH PPS for federal standard payments are projected to equal 7.975 percent of total estimated payments under the LTCH PPS for federal standard payment cases. Using LTCH claims data from the December 2023 update of the FY 2022 MedPAR file adjusted for charge inflation and adjusted CCRs from the December 2023 update of the PSF, CMS calculated a proposed fixed-loss amount for standard federal rate cases of $90,921 for FY 2025. This amount is significantly higher than the fixed-loss amount finalized for FY 2024 ($59,873), which in turn was significantly higher than the fixed-loss amount finalized for FY 2023 ($38,518).

Given the significant increases (52% increased proposed 2025 compared to finalized 2024 and 136% increased proposed 2025 compared to 2023 finalized) in the fixed loss outlier threshold LTCHs are concerned CMS has overestimated the outlier threshold. This in turn will negatively impact access to LTCH services for Medicare beneficiaries who require this intense level of care after an acute hospitalization by inappropriately reducing payments. To mitigate this risk and preserve access to this important site of care, CMS should take the following steps in the proposed rule.

Revert to a Market Basket-based Methodology for Calculating the Fixed-loss Amount

Until FY 2022, CMS forecasted growth in charges using the market basket for LTCHs. It did this because indexing charge growth to market basket growth helped ensure the fixed-loss amount grew consistent with payment. However, in FY 2022, the agency began utilizing a methodology that examines recent claims data to forecast growth in charges for the coming FY. When CMS made the change, the field warned it would lead to volatility, and these concerns have borne out and there have since been sharp

increases in the fixed-loss amount. **Therefore, CMS is asked to revert to its pre-FY 2022 methodology for updating its fixed-loss amount.** That methodology has proven to provide more stability for both beneficiaries and providers alike.

Phase in the New Methodology Over Longer Period

If CMS does not revert back to the prior methodology, the agency is asked to phase it in over a longer period of time. This would reduce the volatility currently experienced by providers and beneficiaries alike. It would also allow providers greater time to adjust to the new methodology.

Implement a Hold Harmless Cap

In several other areas within the IPPS rule, CMS applies a hold harmless cap to protect providers from volatility in key inputs to the payment formula. Specifically, CMS limits the decrease in any one MS-DRG's weight to 10% and a CBSA's area wage index value to a 5% decrease. **Given the significant volatility created by CMS' methodology for calculating the LTCH standard federal fixed loss outlier threshold, it would be appropriate to apply a similar policy. Therefore, CMS is asked to do so.**

Analyze LTCH DRG Cost Variation

The decreasing number of LTCH cases is consolidating payment calculation into a group of 10 DRGs. This consolidation lessens the accuracy of the payment system. **CMS is asked to analyze these variations.** The analysis should include variation driven by differences in beneficiaries' complications and comorbidities, and consider how the payment accuracy of DRGs can be improved to mitigate the negative effects to the LTCH payment system.

The opportunity to comment on the FFY 2025 IPPS proposed rule is appreciated. 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