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President and CEO

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**Via electronic submission at *<http://www.regulations.gov>***

The Honorable Chiquita Brooks-LaSure  
Administrator  
Centers for Medicare & Medicaid Services  
U.S. Department of Health and Human Services  
Hubert H. Humphrey Building, Room 445-G  
200 Independence Avenue, S.W.  
Washington, DC 20201

**RE: CMS-1785-P, Proposed Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Policy Changes and Fiscal Year 2024 Rates; Safety Net Hospitals—Request for Information: Proposed Rule (Vol. 88, No. 83), May 1, 2023.**

Dear Administrator Brooks-LaSure,

The Federation of American Hospitals (FAH) is the national representative of more than 1,000 leading tax-paying hospitals and health systems throughout the United States. FAH members provide patients and communities with access to high-quality, affordable care in both urban and rural areas across 46 states, plus Washington, D.C. and Puerto Rico. Our members include teaching, acute, inpatient rehabilitation, behavioral health, and long-term care hospitals and provide a wide range of inpatient, ambulatory, post-acute, emergency, children's, and cancer services.

The FAH appreciates the opportunity to submit comments to Centers for Medicare & Medicaid Services (CMS) about the above-referenced Proposed Rule, published in the Federal Register (88 Fed. Reg. 26,658) on May 1, 2023.

## **EXECUTIVE SUMMARY**

### **Market Basket Update**

The FAH requests CMS adopt a one-time forecast error adjustment to the FY 2024 IPPS operating update based on the 3.0 percentage point difference in the hospital market basket in FY 2022. In addition to the large understatement of the FY 2022 market basket, CMS should consider our joint analysis with AHA of the shortcomings of the Bureau of Labor Statistics' Employment Cost Index, which has not adequately captured the shift from salaried employees to the extraordinary growth in labor costs associated with hospitals' increasing reliance on nursing personnel that are contracted through staffing agencies during a time of labor supply shortage. A closely related measure, the Employer Costs for Employee Compensation is more dynamic and may better account for growth in hospital compensation costs and changes in the mix of labor inputs. We also note that CMS itself acknowledges that the total factor productivity adjustment applied to the update is more than hospitals can realize. Adopting our suggestion would make the market basket equal to 3.0 percent plus 3.0 percentage points for forecast error less 0.2 percentage points for total factor productivity or 5.8 percent.

The FAH further notes that adopting our suggestion would have the benefit of lowering the outlier fixed loss threshold. CMS proposed an FY 2024 outlier threshold of \$40,732 or an increase of \$1,944 and 5 percent from FY 2023 outlier threshold of \$38,788. With an update of 5.8 percent, modeling by Watson Policy Analysis indicates that the FY 2023 outlier threshold would instead decline to \$38,689, highlighting that the inadequate market basket update is not only dampening base payment rates, but distorting the calculation of the outlier threshold and inappropriately driving up outlier utilization and hospital losses.

### **Disproportionate Share Hospital Payments**

The FAH is concerned with the continued contraction of the Uncompensated Care DSH Pool, which, as proposed, would mark the smallest pool over the past seven years. With the end of the COVID PHE on May 11, 2023, the FAH is particularly concerned that the proposed calculation of Factor 2, which turns exclusively on the uninsured rate, significantly underestimates expected contractions in Medicaid enrollment that will precipitate a growing uninsured rate over FY 2024 and urges CMS to adjust estimates by broadening its data sources to more fully capture the impact of the conclusion of the PHE on the uninsured rate. For example, even acknowledging an additional 0.7 percentage point of growth in the uninsured rate in FY 2024 (9.9 percent uninsured, reflecting a projection of approximately 2.4 million additional uninsured individuals), would increase the proposed UC DSH pool by approximately \$511 million above CMS' proposal.

The FAH is also concerned that CMS' proposal to use discharge data from FY 2019, FY 2021, and FY 2022 for purposes of determining hospitals' FY 2024 per-discharge amounts will likewise significantly overstate expected discharges and depress interim UC-DSH payments in FY 2024. Rather, the FAH urges CMS to consider using the average of the two most recent years of data (FY 2021 and FY 2022), but to apply a national adjustment factor to normalize the data based on projected discharge trends. It is inconsistent for CMS to project falling discharges for purposes of the Factor 1 calculation (thereby reducing the UC-DSH pool) but not similarly

assume falling discharges for purposes of projecting the discharges used to calculate the per-discharge amount (thereby reducing interim UC-DSH payments).

### **Safety Net Hospitals RFI**

The FAH and its member hospitals strongly support CMS' efforts to make "advancing health equity the first pillar in its Strategic Plan" by enhancing the much-needed support for safety-net providers. In furthering these goals, however, the FAH urges CMS to ensure that any action for safety-net hospitals maintains stability in rather than destabilizing existing programs for safety-net hospitals by enhancing rather than replacing those programs, and using additional funds (e.g., the \$2 billion in additional funding recommended by MedPAC) to achieve these goals. In addition, the FAH notes that addressing the significant erosion in Medicare payments that result from recent forecast errors due to once-in-a-lifetime events and from CMS' failure to fully reverse the payment adjustments under section 7(b)(1)(B) of the TMA both contribute to Medicare rates that are insufficient to pay the typical costs of providing care – 10 percent below care costs according to MedPAC. To better address the particular challenges faced by rural safety-net hospitals the FAH strongly supports, among other policies, rural DSH equity—eliminating the inequitable treatment of rural hospitals within the DSH program and under the IPPS capital payment program.

### **Physician-Owned Hospitals**

The FAH commends CMS for its careful evaluation of its statutory authority with respect to requests for exceptions from the prohibition on expansion of facility capacity for physician-owned hospitals (POH) and revisiting comments previously submitted in connection with previous rulemaking and POH expansion requests. The FAH has been deeply concerned that the CY OPPS 2021 changes that eliminated key program integrity restrictions for high Medicaid facilities opens the door to expansion exception requests that violate the spirit of the general statutory band on POH expansions and fails to adequately protect the Medicare program, beneficiaries, and others from harms such as overutilization, patient steering, cherry-picking, and lemon-dropping. Therefore, the FAH strongly supports and urges CMS to finalize its proposals (1) clarifying CMS' discretion to deny expansion requests, (2) adjusting the process for obtaining community input on and approving or denying expansion exception requests, and (3) reinstating key program integrity restrictions with respect to high Medicaid facilities.

### **Long-Term Care Hospitals**

Similar to the IPPS market basket, data for LTCHs show that CMS has understated the LTCH market basket by a combined 4.1 percentage points for the past three years (FY 2023 actual remains an estimate). FAH therefore recommends that for FY 2024 CMS provide for LTCHs the same 3.0 percentage point forecast error adjustment to the FY 2022 LTCH market basket that FAH is recommending for IPPS hospitals. Adopting our suggestion would make the market basket equal to 3.1 percent plus 3.0 percentage points for forecast error less 0.2 percentage points for total factor productivity or 5.9 percent.

For FY 2024, CMS is proposing to increase the HCO fixed-loss amount from \$38,518 to \$94,378, a staggering, untenable 150% increase. The FAH is concerned that the data used to project the fixed-loss threshold is not representative of what LTCHs will experience in FY 2024 because of the unique circumstances LTCHs and their short-term, acute-care partners faced throughout the pandemic. FAH describes three alternative proposals for calculating the outlier threshold, each of which would produce more appropriate outlier projections for FY 2024.

## **Quality Reporting**

The FAH believes that it is too soon to include a measure on COVID-19 vaccinations for healthcare personnel since the underlying evidence for this measure is still emerging and the current specifications are flawed given the lack of a stable definition of “up to date.” The lack of a stable definition of “up to date” could negatively impact the reliability and validity of the measure and a standardized way to collect this information must be made available before required reporting of the measure.

Should CMS choose to move forward with this measure, we recommend that it be aligned with the requirements of the Hospital Conditions of Participation (COPs) and allow not only medical contraindications but also capture when individuals decline vaccination. We also recommend CMS revise the measure specifications to require data to be submitted in monthly or quarterly periods instead of one week a month for each quarter, in line with other Quality Reporting Program measures.

## **MS-DRG CLASSIFICATIONS AND RELATIVE WEIGHTS**

### **II.C Proposed Changes to Specific MS-DRG Classifications**

The FAH generally supports the proposed changes recommended for MS-DRG and/or ICD-10 code classification changes for FY 2024 except for the items to follow.

#### ***1. II.C.1.b Basis for Proposed FY 2024 MS-DRG Updates***

In the FY 2021 IPPS/LTCH PPS final rule (85 FR 58448), CMS finalized a proposal to expand the existing criteria to create a new complication or comorbidity (CC) or major complication or comorbidity (MCC) subgroup within a base MS-DRG. Specifically, this rule finalized the expansion of the criteria to include the NonCC subgroup for a three-way severity level split. In the FY 2022 IPPS/LTCH PPS final rule and FY 2023 final rule, CMS delayed applying this technical criterion to existing MS-DRGs and acknowledged the impact of PHE on the data.

The finalized criteria included NonCC Subgroup includes parameters for three way for MCC, CC and NonCC, two way split for MCC vs CC/NonCC as well as a two way split for MCC/CC vs NonCC. Criteria include five items relating to the number of cases in each group, the percentage of patients in the group, the difference in average costs (percentage and dollars) between subgroups, and the R2 value. The application of the NonCC Subgroup criteria that requires 500 cases in each subgroup is the most common parameter when applied to existing

MS-DRGs that impacts the severity levels created with the base MS-DRG. The volume of cases impacted by the application of the criteria has been as follows:

- In FY 2022 final rule, 32 MS-DRGs would be subject to change based on the three-way severity level split criterion finalized in FY 2021 which would result in the deletion of 96 MS-DRGs and creation of 58 new MS-DRGs.
- For FY 2023 final rule, were revised to 41 MS-DRGs would be subject to change based on the three-way severity level split criteria finalized FY 2021 which would result in deletion of 123 MS-DRGs and creation of 75 new MS-DRGs.
- For FY 2024 proposed rule, CMS is utilizing claims data from September 2022 and December FY 2022 MedPAR file and proposes 45 base MS-DRGs would be subject to change which would result in deletion of 135 MS-DRGs and 86 new MS-DRGs.

Additionally, for FY 2024, CMS proposed the exclusion of 12 Obstetric MS-DRGs. This would include MS-DRGs 783, 784, 785 (Cesarean Section with Sterilization with MCC, CC, without MCC/CC), 796, 797, 798 (Vaginal Delivery with Sterilization with MCC, CC, without MCC/CC), 817, 818, 819 (Other Antepartum Diagnosis with O.R. Procedure with MCC, CC, without MCC/CC), 831, 832, 833 (Other Antepartum Diagnosis without O.R. Procedure with MCC, CC, without MCC/CC).

With the Proposed Rule, CMS made available several files reflecting application of the NonCC subgroup criteria. These files included, for the first time, weights and an alternate grouper for data analysis. CMS noted they were available to aid the public with additional analysis for review and comment on the application of the NonCC subgroup for future rulemaking. For example, CMS referenced table 6p.10f, which provides alternative cost weights analysis with the Non-CC Subgroup and calculated weights with application of the NonCC subgroup criteria using an alternative GROUPER software version 41.A that included MS-DRG numbers, narratives, weights, as well as the percent of change with relative weights when compared with the proposed GROUPER software version 41. The FAH appreciates the additional data that CMS made available because it facilitates stronger stakeholder engagement and more meaningful comments, and we encourage CMS to continue to provide this data in future IPPS rulemaking.

CMS proposes to continue to delay application of the NonCC subgroup criteria to existing MS-DRGs with a three-way severity split for FY 2024. CMS indicated that “we are interested in hearing feedback regarding the experience of large urban hospitals, rural hospitals and other hospital types . . . for consideration for our development of the FY 2025 proposed rule.” 88 Fed. Reg. at 26,676.

The FAH appreciates and strongly agrees with CMS’ proposal to delay the application of the NonCC subgroup criteria to existing 45 MS-DRGs with a three-way level split and to maintain that current structure of these 135 MS-DRGs. The FAH also supports the exclusion of the 12 obstetric MS-DRGs from the NonCC subgroup criteria.

The FAH also appreciates the availability of V41A grouper as well as the proposed new MS-DRGs with the weights and volume shifts included within the tables. **After reviewing this information, the FAH respectfully requests that the NonCC subgroup criteria be reassessed and not applied to the existing MS-DRGs.** The FAH supports this conclusion for the reasons outlined below.

The FAH believes that the dynamic nature of the MS-DRGs that are impacted for the last three fiscal years demonstrates a need to reassess the structure of the criteria. Since the initial proposal in FY 2021, the MS-DRGs impacted have changed annually. This change has not been a simple addition of new MS-DRGs each year. MS-DRGs have been demonstrated to revolve year to year with MS-DRGs being appropriate for a three-way split one year and reduced to fewer tiers in subsequent years and vice versa. As mentioned, the deletions and additions of MS-DRGs have increased annually (*e.g.*, MS-DRG deletions from 96 to 123 to 135 and MS-DRG additions from 58 to 75 to 86). Examples of the dynamic nature for consideration of additional explanation or revisions to the methodology as well as transparency on the frequency to review the criteria include:

- MS-DRGs that were proposed in FY 2022 to be removed, changed in FY 2023 to not impacted, and now again proposed to be removed for FY 2024 (*e.g.*, MS-DRGs 283-5 Acute MI Expired and MS-DRGs 722-4 Malignancy Male Reproductive).
- MS-DRGs that have never been proposed to the removal list and are new for FY 2024 (*e.g.*, MS-DRGs 11-3 Tracheostomy and MS-DRGs 539-41).
- MS-DRGs that were proposed in FY 2023 for removal, but have dropped off in the FY 2024 Proposed Rule (*e.g.*, MS-DRGs 597-9 Malignant Breast Disease and 802-4 Other OR Blood and Blood Forming Organs).
- It appears this methodology could result in reporting challenges when the same narratives are used with new MS-DRGs assigned. The tables this year included actual MS-DRG numbers proposed to be assigned instead of “XX” placeholders as in prior years. All of these numbers are new numbers for the three tier MS-DRGs that would become double or single tier MS-DRGs if implemented. The first tier of every one of the 45 base pairs has the same narrative. For example, MS-DRG 180 is Respiratory Neoplasms with MCC in V41 and would become MS-DRG 209 still titled Respiratory Neoplasms with MCC in V41a. From a reporting standpoint, should MS-DRGs with the same narrative have new MS-DRG numbers assigned? How would this be impacted with updates especially when a three tier MS-DRG goes to a two tier MS-DRG one year and returns to a three tier MS-DRG another year? What is the frequency for which the cases will be reviewed with the NonCC Subgroup Criteria?
- The importance of good data has been supported by CMS and typically, CMS has required two years of good data to reassign MS-DRG classifications. In the FY 2023 final rule CMS stated “we believe that reliability and stability of the data is an important consideration with respect to the NonCC subgroup criteria and will give careful consideration to the number of years of data to analyze in connection with any proposed policy changes as well as the impacts on the relative weights, as we continue to assess all the comments received, particularly in light of the ongoing public health emergency.” 87 Fed. Reg. at 48,803-04. The FAH agrees with the importance of considering the reliability and stability of the data, particularly in light of the May 11, 2023 end to the

COVID-19 public health emergency (PHE), and the FAH recommends that CMS ensure the data does not include pandemic data and provide transparency around data considerations on the number of years if more than two have been considered. For example, CMS might consider a run out period through the end of FY 2025 for the FY 2026 MedPAR file to use for a FY 2027 rule.

The FAH believes that the application of the Non-CC subcriteria for the new and existing MS-DRGs further demonstrates that the methodology needs to be reassessed as this resulted in the elimination of two way splits for with and without MCC/CC. Not a single existing or new MS-DRG resulted in the two way split of with and without MCC/CC over the three fiscal years of proposals. Since the application of the NonCC subgroup would clearly result in fewer MS-DRGs split by the presence of a CC, the impact of the presence of a CC on MS-DRG assignment is diminishing. Additionally, there are MS-DRGs that clearly demonstrate all of the cost criteria considerations but are excluded simply because of low volume. The FAH provides the following for consideration and examples of the need to reassess the methodology.

- The data with table 6p.10f included volumes and weights as well as the percentage of change in the weights. The multiplication of the volumes by the case weights in just these MS-DRGs nets a negative case weight number of -5718.571008.
- The weight differences are calculated with percentages between V41 and V41A and appear to have a wide range with increases that range from 0.01% to 278.36% and declines ranging from -0.13% to -5.47%.
- With the significant impact, CMS should consider whether there are considerations that should be evaluated with the NonCC Subgroup for revisions. Examples include but are not limited to:
  - Should there be considerations that two tier MS-DRGs be impacted by MCC or CC? Currently there are 36 pairs that are impacted by presence of MCC or CC (*e.g.*, MS-DRG 16 and 17 Autologous Bone Marrow Transplant with CC/MCC and Autologous Bone Marrow Transplant without CC/MCC, respectively). As previously noted, not a single existing or new MS-DRG resulted in a two way split of with and without MCC/CC which is concerning. The only two-tier that was met by any of the proposals was that of with and without MCC. The FAH would like CMS to address if there is an error in that NonCC Subgroup Criteria in that tier that makes it impossible for any MS-DRG to ever meet these criteria.
  - What consideration is given with a triplet with weighting when a higher percentage of cases falls in the higher tier of the MS-DRG?
  - Should any additional MS-DRGs be excluded with low volume in Medicare population like the obstetrical MS-DRG proposal such as those that are for small volume diagnoses or associated with only a section of population (*e.g.*, only males or females, newborns, pediatrics, etc.)?
  - Should low volume of total cases within the MS-DRG be considered differently when the thresholds for meeting cost have been met. For example, New MS-DRG 173 only had 1,573 cases for consideration across the three tiers for the Accelerated Thrombolysis of the Pulmonary Embolism. The requirement of 500 cases with MCC, with CC and without MCC/CC is almost mathematically impossible to achieve with a margin of only 73 cases over the 1500 that would be

- necessary for 500 in each tier. The costs for this MS-DRG were met for a MCC and without MCC split but was not put in place simply because of low volume.
  - Would guiding principles similar to those created for MCC/CC be helpful in determining weight impact to minimize the higher negative impact especially with surgical MS-DRGs?
  - Should patients that expire, especially in single tier MS-DRGs have special consideration with weight determination?
- CMS should provide clarity as to why MCC tiers increased or decreased between V41 and V41A as these MS-DRGs are identical in description; however, the weights are not the same. The FAH would like CMS to provide a clear explanation as to why the MCC tier increased between V41 and V41a since they both are still impacted by the presence of the MCC. Many of the MCC tiers increased by 0.01%; however, there were increases that ranged 5.31% to 10.17% increase. There are also MCC tiers that decreased -3.13% to -13.11%.
  - For example, the tracheostomy MS-DRG with MCC (MS-DRG 11 or MS-DRG 43) increased 10.17% from 5.1611 to 5.6862 and respiratory neoplasm MS-DRGs with MCC (MS-DRG 20 or MS-DRG 104) increased 6.24% from 8.4673 to 8.9958.
  - For example, Skin Graft with Skin Ulcer or Cellulitis with MCC MS-DRGs (MS-DRG 573 or 529) decreased -13.11% from 6.2307 to 5.4138 and Infectious Dx with OR with MCC decreased -3.13% declining from 4.9905 to 4.8341.
- CMS should re-consider the single tier weighting of those cases that are adjusting from a triple to single tier MS-DRG. It seems illogical for the highest volume of cases to be in MCC tier and the new weight will be less than that level.
  - For example, Acute MI, expired is proposed to go to a single tier MS-DRG. The existing triple tier MS-DRG has MCC weight of 1.9646 with 9,418 cases, CC weight of 0.7375 with 724 cases and no MCC/CC weight of 0.4894. The majority of cases are in the higher tier and this tier is going to have a -5.75% decrease of the weight. The new weight is 1.8517. The weights applied to the volumes net a weight loss of -1063.2922.

The FAH acknowledges the NonCC Supgroup criteria was finalized in FY 2021; however, requests better insight into CMS' rationale as to why the NonCC subgroup criteria has been applied to the new proposed MS-DRGs for FY 2024 since the criteria has been delayed for FY 2024. Since CMS has comments for the development of future rule making with the NonCC Subgroup Criteria and the intent is to delay application to obtain these comments, the FAH requests transparency for why the NonCC subgroup was applied to the current MS-DRG proposals when it is acknowledged with the delay that that more analysis is needed with the methodology. The methodology has been used with the new MS-DRGs which include MS-DRGs 173, 212, 275, 276, 277, 278, 279, 321, 322, 323, 324, 325, 397, 398, 399 for FY 2024.

## 2. *II.C.4.a MDC 04 (Diseases and Disorders of the Respiratory System) – Ultrasound Accelerated Thrombolysis (USAT) for Pulmonary Embolism (PE)*

CMS proposes to create a new base MS-DRG 173 (Ultrasound Accelerated and Other Thrombolysis for Pulmonary Embolism. This new MS-DRG would shift cases from MS-DRGs



166, 167 and 168 that have the principal diagnosis of pulmonary embolism with ultrasound accelerated and other thrombolysis.

The original request from the manufacturer of EKOS was to reassign cases reporting USAT with administration of thrombolytic(s) from treatment of pulmonary embolism from MS-DRGs 166, 167, 168 (Other Respiratory System OR Procedures with MCC, CC, and without MCC/CC respectively). The requestor, the manufacturer of EKOS device, suggested they shift to MS-DRGs 163, 164, 165 (Major Chest Procedures with MCC, with CC, and without CC/MCC, respectively). CMS created new codes for various anatomic sites for the USAT procedure in FY 2021.

CMS noted that the data demonstrates cases with PE and USAT have shorter LOS and cost than those included within the higher severity MS-DRGs but the costs were more on the lower MS-DRGs tiers. CMS noted it is unclear if this is direct result of the EKOS device or the reporting of one or more secondary CC diagnoses or a combination of both factors. After analysis, CMS did not agree with reassigning cases reporting USAT procedure with administration of thrombolytic and pdx of PE from MS-DRGs 166, 167, 168 to MS-DRGs 163, 164, 165. The FAH agrees with CMS that the procedures do not meet the criteria to shift to MS-DRGs 163, 164, 165 from MS-DRGs 166, 167, 168.

CMS stated the initial analysis suggest administration of the thrombolytic is not a significant factor in the consumption of resources for cases in MS-DRGs 166, 167, 168 reporting an USAT procedure for treatment of PE or that a code describing the administration of the thrombolytic may not have been consistently reported on a subset of claims. Based on these findings, CMS examined the standard CDT procedures with or without thrombolytic for treatment of PE in MS-DRGs 166, 167, and 168 to compare with the cases reporting USAT.

CMS stated that based on this review, they believe while a subset of cases of patient undergoing a thrombolysis (CDT or USAT) procedure for PE does not clinically align with patients undergoing surgery for malignancy or treatment of infection, the difference in resource consumption warrant proposed reassignment of cases. Specifically, they believe a new base MS-DRG is warranted to reflect more appropriate payment for USAT and standard CDT procedures in the treatment of PE.

CMS provided volumes, LOS, and average costs to consider for the creation of the new MS-DRG, indicating that with the NonCC Subgroup Criteria, the base MS-DRG fails to meet criterion of 500 cases in both CC and NonCC as well as the 20% difference in average cost range with the two. There are a total of 1058 with MCC, 3939 with CC and 83 without MCC/CC with average costs ranging \$20,886 - \$28,618 but it fails to meet three tier criteria.

CMS also provided information for with and without MCC which showed 1058 cases with MCC and 476 cases without. The average costs were \$22,676 to \$28,618. The two tier MS-DRG failed the two way split criterion for not having 500 cases in each tier. This was only short by 24 accounts in the without MCC tier. The cost criteria was met. Low volume since the total of cases is 1534.

As a result CMS is proposing a new base MS-DRG 173 (Ultrasound Accelerated and Other Thrombolysis with Principal Diagnosis Pulmonary Embolism) stating that the resulting proposed MS-DRG better recognizes the consumption of resources. This single MS-DRG has average LOS of 4.8 and average costs of \$26,802 for the 1,534 cases.

The FAH supports shifting cases from MS-DRGs 166, 167 and 168 that have the principal diagnosis of pulmonary embolism with ultrasound accelerated and other thrombolysis; however, the FAH does not support the creation of a single MS-DRG. CMS within their analysis outlined that it was unclear if the device or the reporting of secondary codes or the combination of both were impacting the average costs and FAH has determined that the creation of a single level MS-DRG does not acknowledge the secondary diagnosis impact.

The FAH believes that this example demonstrates that the NonCC Subgroup is not appropriate for application with some MS-DRGs. The entire patient mix has only 1,534 patients that require more complicated care with a pulmonary embolism. It is impossible to have 500 cases in each of the three tiers as the distribution is never equal in the MS-DRG tiers. The average cost has a continuous decline with a three tier and two tier with MCC the average costs are \$28,618 and this falls slightly to \$27,141 when using MCC/CC criterion and the single tier falls further to \$26,802. Unfortunately, this results in a single tier MS-DRG with a weight that has been significantly lowered from the prior multiple tiers that does not appear to recognize the consumption of resources for the diagnosis and the device.

3. *II.C.4.b MDC 04 (Diseases and Disorders of the Respiratory System) - Respiratory Infections and Inflammations Logic*

CMS is proposing to correct logic for case assignment of MS-DRG 177 (Respiratory Infections and Inflammations with MCC) excluding 16 diagnosis codes from the first logic list “Principal Diagnosis with Secondary Diagnosis” from acting as MCC when any of the listed codes is reported as a secondary diagnosis from the second logic list or Principal Diagnosis reported as a principal diagnosis.

CMS noted the first logic list is entitled Principal Diagnosis with Secondary Diagnosis which includes the following:

- List of 5 ICD-10-CM codes describing influenza due to other or unidentified influenza virus with pneumonia in combination with a separate list of 10 diagnosis codes describing specific pneumonia.
- When any of the five diagnoses is reported as principal diagnosis in combination with one of the 10 as secondary diagnosis, the case results in MS-DRG 177, 178 or 179 depending on the presence of MCC or CC as secondary diagnosis.
- All 15 diagnosis codes with this first logic are MCC.

CMS noted the second list being entitled “or Principal Diagnosis” and is defined by a list of 57 diagnosis codes describing various pulmonary infections. When any of the 57 codes are reported as principal diagnosis, the case results in assignment of MS-DRG 177, 178, 179 depending on the presence of MCC or CC as secondary diagnosis.

Currently when a diagnosis from the second list is reported as principal diagnosis and diagnosis from the first logic is reported as secondary diagnosis, the case is grouping to MS-DRG 177. CMS notes that consistent with similar logic it should require “any other diagnosis designated as an MCC and reported as a secondary diagnosis for appropriate assignment and not diagnoses currently listed in the logic for the definition of the MS-DRG.”

The FAH acknowledges CMS proposal to correct the logic for MS-DRG assignment. The FAH compared the current MS-DRG Definition Manual list of codes within the logic for the current Version 40 of the GROUPER as well as the proposed Version 41. Every single code is identical on the list with the expansion of the J15.6 codes which have been expanded for their new additional digits that go into effect 10/1/23. The FAH supports correcting any error in the grouper logic; however, this proposed grouper logic is not clearly stated and the FAH requests transparency on exactly what is changing.

The FAH notes that logic such as the first set of logic is very important to maintain in light of coding guidelines and classification system. For example, the coding guidelines require that the J codes for Influenza due to a specific type of pneumonia be sequenced before the pneumonia code designating the actual type of pneumonia. It would be important for appropriate capture of resources for the logic to continue to recognize the secondary diagnosis with the MS-DRG assignment of MS-DRG 177.

The coding structure is an important consideration as evident with a diagnosis such as COVID as principal diagnosis (pdx) with a secondary diagnosis of secondary pneumonia. COVID is going to group to the complicated pneumonia MS-DRGs 177, 178 or 179 just based on the pdx of COVID. This MS-DRG assignment to the complicated pneumonia would result regardless of any pneumonia diagnosis. The patient may not even have pneumonia documented and reported and it would still go to this MS-DRG. However, if there is a secondary diagnosis on this same patient of a bacterial pneumonia; the grouper will then recognize it and that code hasn't been used in any assignment of the MS-DRG yet nor is it inherent to the disease process as not all patients have bacterial pneumonia. It is important to note that the FAH believes it is not appropriate to exclude that specific bacterial pneumonia code from acting as a MCC on the case for the grouping into MS-DRG 177 as it will with the existing GROUPER V40 but will not with the proposed GROUPER V41 which groups to MS-DRG 179.

4. *II.C.5. MDC 05 (Diseases and Disorders of the Circulatory System*  
*II.C.5.a Surgical Ablation*

For FY 2024, CMS received a request to review cases involving open concomitant surgical ablation procedures for atrial fibrillation from MS-DRGs 219, 220, 221 (Cardiac Valve and Other Major Cardiothoracic Procedures without Cardiac Catheterization with MCC, with CC, and without CC/MCC respectively) to MS-DRGs 216, 217, 218 (Cardiac Valve and Other Major Cardiothoracic Procedures with Cardiac Catheterization with MCC, with CC, and without CC/MCC, respectively) or create new MS-DRGs for all open mitral or aortic valve repair or replacement procedures with concomitant surgical ablation for AF to improve clinical coherence when three to four open heart procedures are performed in one setting. CMS stated that the data

analysis shows that for numerous procedure combinations that would comprise an open concomitant surgical ablation procedure, the increase in average costs appears to be directly correlated with the number of procedures performed. CMS also noted that cases that describe Open MVR + Open AVR in addition to other concomitant procedures generally demonstrate higher average costs in their respective MS-DRGs.

CMS performed further analysis while applying the NonCC Subgroup criteria and indicated the data reflected that “cases that report Open MVR + Open AVR in addition to other concomitant procedures generally demonstrate higher average costs in their respective MS-DRGs, even in instances where an open surgical ablation was not reported.” CMS stated that analysis of the claims data suggested the performance of the multiple valve procedure plus another concomitant procedure was associated with hospital resource utilization not solely the performance of surgical ablation.

The analysis of the cases with the procedures would not meet the two or three tier severity based on the methodology. Only 992 total cases are impacted. It is numerically impossible to meet a three way criteria since there are only 992 cases and the criteria requires 500 in each tier. It is important to note the data showed distinct cost differences between those with MCC (\$102,194) and those with (\$67,682) and those without CC/MCC (\$39,567).

Slicing the data into two tier MS-DRGs such as with and without MCC again showed impact with cost at \$102,194 and \$66,890 but the volume is only 679 and 213 respectively. Therefore, CMS is not proposing to subdivide the proposed new MS-DRG for cases reporting procedures describing an aortic valve repair or replacement procedure, a mitral valve repair or replacement procedure, and another concomitant procedure into severity levels.

After analysis, CMS proposes to create a base MS-DRG for cases reporting an aortic and/or mitral valve repair replacement procedure and another concomitant procedure in MDC 05 including surgical ablation and CABG to MS-DRG 212 (Concomitant Aortic and Mitral Valve Procedure).

The FAH supports the additional MS-DRG; however, would suggest that CMS reconsider the potential of making this a two tier MS-DRG with and without MCC. It is mathematically impossible for these cases to ever be more than a base MS-DRG with only 992 cases which does not take into account the disparity in the average costs of \$102,194 with MCC vs \$66,890 of those without CC. The FAH suggests that CMS re-consider the title of this single MS-DRG as it is not intuitive that CABG and Surgical Ablation surgeries are included within this MS-DRGs. This is a common area of hospital reporting.

Lastly, the FAH noted the various buckets of procedures that are included within table 6p.4a and are repeated within the V41 DRG Definitions Manual. The FAH requests transparency and clarification with these categorized lists as noted below.

- CMS noted in table 6p.4a and the draft version of the MS-DRG V41.0 Definitions Manual, the procedure codes are categorized by type. There are valve procedures that are listed under the “other concomitant procedure” list. Not all valve repair procedures

would have the root operation of repair or replacement. Those procedures that are supplement for the specific aortic and mitral valve should be re-considered to be moved under their respective valve repair category. “Supplement” is the root operation utilized for valve replacements. Additionally, there could be other open valve procedures to consider that may have a root operation of restriction or release that could apply to the open valve procedures.

- The language in the V410 Definition manual logic is unclear. There are no instructional notes included in the V410 definition manual on the intent of the various categories of procedures (e.g. aortic valve, mitral valve, etc.) Please consider revision so it clearly indicates the intent to have procedure from which categories for the MS-DRG assignment (e.g. require aortic and mitral valve procedure (one from each list), in conjunction with a procedure under the concomitant procedure list). This type of instruction would be consistent with similar sections of the MS-DRG Definition manual (e.g. See MS-DRG 321 and 322).

#### 5. *II.C.5.b External Heart Assist Device*

CMS received a request to reassign cases reporting procedure codes describing the insertion of a short-term external heart assist device using an axillary artery conduit from MS-DRG 215 (Other Heart Assist System Implant) to MS-DRGs 001, 002 (Heart Transplant or Implant of Heart Assist System with and without MCC respectively), and 003 (ECMO or Tracheostomy with MV >96 hours or pdx except Face, mouth, and neck with major OR Procedures). The device involved was Impella 5.5 with SmartAssist System. A proposal to consider new codes for the condition have been discussed at the March 7-8, 2023, ICD-10 Coordination and Maintenance Committee Meeting. Public comments in response to the code proposal were due by April 7, 2023.

CMS agrees with requestor that the specific code is not separately identifiable in the claims data with current data. CMS provided three procedure codes that were utilized within their data analysis and noted excluding MS-DRG 003. After analyzing LOS and charges, CMS proposed to reassign ICD-10-PCS code 02HA0RZ (Insertion of short-term external heart assist system into heart, open approach) when reported as a stand-alone procedure from MS-DRG 215 to MS-DRG 001 and 002. CMS noted that the New Procedure Codes for FY 2024 was not finalized in time for inclusion in the FY 2024 proposed rule and that there would be a need to examine the MS-DRG assignment if new procedure codes are created and released in June.

In general, the FAH supports the revision of procedure code 02HA0RZ to assign to MS-DRG 001 or 002 instead of MS-DRG 215. The FAH is concerned that a procedure code change could result in a new MS-DRG in which no options for providing comments would be available for a year with a new procedure code that may not be available for finalizing until June after the comment period for the IPPS rule. The FAH would recommend that the new code result in the same MS-DRG as proposed with the current code assignment.

#### 6. *II.C.5.d Coronary Intravascular Lithotripsy*

CMS noted a request to review MS-DRG assignment for percutaneous coronary intravascular lithotripsy (IVL) involving insertion of coronary drug-eluting stent. The requestor provided an explanation of the procedure and indicated that percutaneous coronary interventions (PCI) are more complex because coronary IVL is a therapy deployed in severely calcified coronary lesions and request review of the MS-DRG assigned for these procedures. CMS analysis involved four procedure codes for IVL. CMS noted the Shockwave C2 Intravascular Lithotripsy System utilized on coronary arteries prior to stenting was approved for new technology add-on payments for FY 2022 and FY 2023. CMS noted the requestor was correct that these cases would group to MS-DRGs 246 (Percutaneous Cardiovascular Procedures with Drug-eluting stent with MCC or 4+arteries or stents) and 247 (Percutaneous Cardiovascular procedures with drug-eluting stent without MCC) if a drug-eluting intraluminal device was involved and MS-DRGs 248 and 249 if a non-drug eluting intraluminal device was utilized. CMS noted that the coronary IVL is a vessel preparation technique and it is possible that an intraluminal device would be unable to be inserted after the pulses and for that reason they also added MS-DRGs 250 and 251 (Percutaneous Cardiovascular Procedures without Coronary Artery Stent with and without MCC respectively) in their claims analysis. CMS provided data that included case volume, average LOS and average costs for MS-DRGs 246, 247, 248, 249, 251 for all cases vs cases reporting coronary IVL.

CMS indicated that the data analysis showed that the average costs of cases reporting percutaneous coronary IVL, with or without involving the insertion of intraluminal devices were higher for all cases in their respective MS-DRG. CMS noted that when the insertion of the intraluminal device was reported with percutaneous coronary IVL, the average costs were similar without regard to when a drug-eluting or non-drug-eluting intraluminal device was placed. CMS agreed that performance of percutaneous coronary IVL contributes to increased resource consumption for these PCI procedures. CMS also agreed that clinically the presence of severe calcification can increase the treatment difficulty and complexity of service. And this is clearly displayed with higher average costs and longer LOS.

CMS noted that “while there is not a large number of cases reporting percutaneous coronary IVL without the insertion of an intraluminal device represented in the Medicare data, and we generally prefer not to create a new MS-DRG unless it would include a substantial number of cases, we believe creating a separate MS-DRG for these cases as well would appropriately address the differential in resource consumption”. The proposal is to create new MS-DRGs for cases describing percutaneous coronary IVL without the insertion of an intraluminal device. Further data analysis by CMS found that all five criteria were met for a two-way split for with MCC and without MCC.

For FY 2024, CMS proposes to create two new MS-DRGs for cases describing coronary intravascular lithotripsy involving the insertion of intraluminal device which would be MS-DRG 323 and 324 (Coronary Intravascular Lithotripsy with Intraluminal Device with MCC and without MCC, respectively). Additionally, CMS is proposing to create new MS-DRGs for cases describing coronary intravascular lithotripsy without an intraluminal device which would be MS-DRG 325 (Coronary Intravascular Lithotripsy without Intraluminal Device). Table 6p.6a provides a list of procedures for these MS-DRGs.

CMS reviewed a separate request that was discussed in FY 2022 requesting that CMS review drug eluting and bare metal coronary stents within MS-DRG classification. In the FY 2022 final rule, CMS noted that it would be appropriate to consider the request in future rulemaking. CMS noted their data review with this current request with percutaneous coronary IVL with insertion of intraluminal device average costs are generally similar regardless of use of drug-eluting or non-drug-eluting device usage. This resulted in CMS further examining claims for MS-DRGs 246, 247, 248, 249 for all other cases within the MS-DRGs that did not report percutaneous coronary IVL. CMS believes it may no longer be necessary to sub-divide the MS-DRGs based on the type of coronary intraluminal device inserted noting the current practice defaults generally to drug-eluting for patient undergoing PCI while non-drug eluting stents can be used in PCI procedures for range of conditions such as angina, MI and multiple vessel disease. CMS felt the average LOS and charges were the same and are proposing the deletion of MS-DRGs 246, 247, 248, 249 with the creation of the new MS-DRGs.

CMS performed additional analysis of MS-DRGs 246 and 248 since the current GROUPE logic requires at least one secondary diagnosis designated as MCC or procedures involving four or more arteries or intraluminal devices with the data on the following table:

MS-DRG		Number of Cases	Average Length of Stay	Average Costs
246	All cases	40,647	5.2	\$25,630
	Cases reporting percutaneous cardiovascular procedures involving four or more arteries or intraluminal devices	3,430	3.2	\$27,397
248	All cases	555	5.9	\$25,740
	Cases reporting percutaneous cardiovascular procedures involving four or more arteries or intraluminal devices	21	3.4	\$28,251

CMS noted that currently these two MS-DRGs are defined as base MS-DRGs each of which is split by a two way severity level subgroup. CMS proposal is to create one base MS-DRG also split by two way severity.

CMS stated that when applying the NonCC Subgroup criteria, the new MS-DRG failed to meet the criterion that there is 20% difference between CC and NonCC subgroup as well as a \$2000 difference in the average costs between CC and NonCC subgroup.

MS-DRG	Number of Cases	Average Length of Stay	Average Costs
With MCC	37,604	5.3	\$24,871
With CC	33,088	2.7	\$17,407
Without CC/MCC	26,646	2	\$15,492

CMS applied the two way split for with MCC and without MCC subgroups for the proposed MS-DRGs and found all criteria to be met as noted in the table below.

<b>Proposed new MS-DRGs</b>	<b>Number of Cases</b>	<b>Average Length of Stay</b>	<b>Average Costs</b>
With MCC or 4+ Arteries/Intraluminal Devices	37,604	5.3	\$24,871
Without MCC	59,734	2.4	\$16,553

Therefore, CMS is proposing to delete MS-DRGs 246, 247, 248, and 249 and create a new base MS-DRG with two way severity level split for cases describing percutaneous cardiovascular procedures with intraluminal device. The new MS-DRGs proposed are:

- MS-DRG 321 (Percutaneous Cardiovascular Procedures with Intraluminal Device with MCC or 4+ Arteries/Intraluminal Devices.
- MS-DRG 322 (Percutaneous Cardiovascular Procedures without MCC.

CMS also proposes to revise the titles of MS-DRGs 250 and 251 from “Percutaneous Cardiovascular Procedures without Coronary Stent with MCC and without MCC respectively” to “Percutaneous Cardiovascular Procedures without Intraluminal Device with MCC and without MCC respectively” better reflect terminology of intraluminal devices vs stents.

The FAH acknowledges there are two unique MS-DRG groupings of new MS-DRGs that CMS proposes for creation that would shift from the same set of four MS-DRGs that are proposed for deletion. Specifically, CMS proposes to delete MS-DRGs 246, 247, 248, 249 and rename MS-DRGs 250, 251. The cases that the current GROUPER would assign to the four deleted MS-DRGs would shift to the new MS-DRGs as well as the renamed MS-DRG. The new MS-DRGs involve:

- MS-DRG 321 and MS-DRG 322 for cases with Percutaneous Cardiovascular procedure with device with either MCC or 4+ arteries/devices and without either MCC respectively. This is paired with the revised MS-DRG of 250 and 251 for those without the use of Intraluminal devices.
- MS-DRGs 323, 324 and 325 for cases that involve Coronary Intravascular Lithotripsy with 323 and 324 impacted by intraluminal device and MCC and the later 325 being impacted by only the absence of intraluminal device. There is no severity level for cases with coronary intravascular lithotripsy without intraluminal device with MCC.

The FAH agrees with CMS that MS-DRGs 246-251 are impacted with LOS and charges by the presence of complicated diagnoses and the use of intraluminal device and not if the device is drug-eluting or non-drug-eluting. The FAH strongly disagrees with the application of the NonCC Subgroup criteria that has been delayed to this group of MS-DRGs on this complex group of cardiac surgical patients. The FAH has performed calculations utilizing CMS’ data for this group of MS-DRGs, with the volume information included on CMS Table FY 2024 NPRM AOR-BOR V40 V41 for the case volumes and weights using MedPAR data and the current and proposed version of the GROUPER demonstrates that this group of MS-DRGs after the shifts from the old to new MS-DRGs will result in a significant negative impact that does not seem to capture the resources for this patient mix. The overall weight difference nets to a loss of - 4361.4787. It seems like the change should be more budget neutral. At a minimum, the FAH



would request that CMS provide transparency as to why they believe the weight has such a significant decline with these MS-DRGs.

The FAH agrees with CMS logic that the presence of complicating diagnosis such as MCC and the presence of the intraluminal device impact the LOS and charges for the proposed new MS-DRGs 323, 324 and 325 when reviewing the data. It is logical that there would be a tier with device impacted by MCC and one not impacted by MCC as demonstrated with MS-DRG 323 and 324. It is not logical that there is not a pair for the base MS-DRG 325 which is impacted by the fact there is no device utilized but no impact based on the presence of a complicating diagnosis such as MCC or CC. The FAH recommends creation of additional MS-DRG pair for MS-DRG 325 as we believe the MS-DRG should reflect not only the fact that no device was utilized but the impact from the diagnosis as well with and without MCC/CC options. The FAH requests that CMS re-evaluate the use of the NonCC Subgroup criteria for potential opportunity for improvement with the methodology.

In regards to the creation of new MS-DRGs 321 and 322, the FAH request review of the weights for these MS-DRGs with the weight decline to ensure it adequately captures the resources for the complex treatment of these patients. The FAH would again request that there be consideration if these MS-DRG pairs should include with MCC or CC instead of just with MCC.

#### 7. *II.C.5.e. Shock (Defibrillators)*

CMS provided data analysis and indicated “it appears to no longer be necessary to subdivide MS-DRGs for cases reporting a cardiac defibrillator implant based on the diagnosis code reported”. CMS proposes to delete:

- MS-DRGs 222 (Cardiac Defibrillator Implant with Cardiac Catheterization with AMI, HF or Shock with MCC),
- MS-DRG 223 (Cardiac Defibrillator Implant with Cardiac Catheterization with AMI, HF or Shock without MCC),
- MS-DRG 224 (Cardiac Defibrillator Implant with Cardiac Catheterization without AMI, HF or Shock with MCC),
- MS-DRG 225 (Cardiac Defibrillator Implant with Cardiac Catheterization without AMI, HF or Shock without MCC),
- MS-DRG 226 (Cardiac Defibrillator Implant without Cardiac Catheterization with MCC), and
- MS-DRG 227 (Cardiac Defibrillator Implant without Cardiac Catheterization without MCC).

CMS proposes “to create a new MS-DRG for cases reporting a cardiac defibrillator implant with cardiac catheterization and a secondary diagnosis designated as MCC in MDC 05. We are also proposing to create two new MS-DRGs with a two-way severity level split for cases reporting a cardiac defibrillator implant without additionally reporting both a cardiac

catheterization and a secondary diagnosis designated as an MCC.” These proposed new MS-DRGs are as follows:

- MS-DRG 275 (Cardiac Defibrillator Implant with Cardiac Catheterization and MCC)
- MS-DRG 276 (Cardiac Defibrillator Implant with MCC)
- MS-DRG 277 (Cardiac Defibrillator Implant without MCC)

The FAH acknowledges and agrees that it is no longer necessary to differentiate defibrillator MS-DRGs based on the diagnosis of AMI, HF or Shock. The FAH is seeking clarity and disagrees with the severity split of the MS-DRGs for the newly created MS-DRGs for Defibrillator Implants.

The FAH seeks to understand the rationale for implementation of NonCC Subgroup with the creation of the new severity level splits for these new MS-DRGs. CMS proposed to continue to delay application of the NonCC subgroup criteria to existing MS-DRGs with a three way severity level split for FY 2024; however, the methodology was applied to the new MS-DRGs. The FAH believes that the complicated nature of the patients should have made this meet two way tier of with or without MCC/CC instead of with or without MCC only. Please see the Non-CC subgroup criteria comments.

The FAH strongly believes there is a new MS-DRG tier missing and that there should be an additional new MS-DRG that captures Cardiac Defibrillator Implant with Cardiac Catheterization without MCC. This would pair with MS-DRG 275. CMS stated “...cases reporting cardiac defibrillator implant with cardiac catheterization continue to demonstrate higher average costs and lengths of stays, however, these increased costs appear to be more related to the procedures performed than the diagnoses reported on the claim, and therefore we believe it is time to restructure these MS-DRGs accordingly. It is for this reason that it appears that it is underreporting of the resources for this MS-DRG to not have a level for Cardiac Defibrillator Implant with Cardiac Catheterization without MCC. With the proposed methodology, it would fall into MS-DRG 277 – Cardiac Defibrillator Implant without MCC without any regard to the additional resources to perform the cardiac catheterization on the patients.

8. *II.C.6.a (MDC 06 Diseases and Disorders of the Digestive System): Appendicitis*

In FY 2023 Final Rule, CMS discussed a request related to the MS-DRG assignment of diagnosis codes describing acute appendicitis with generalized peritonitis, with and without perforation or abscess reported with an appendectomy code. With that discussion in the FY 2023 Final Rule, CMS stated that “any future proposed changes to the MS-DRGs for appendectomy procedures would be dependent on the diagnosis code revisions that are finalized by the CDC/National Center for Health Statistics (NCHS) since the CDC/NCHS staff presented a proposal for further revisions to the diagnosis describing appendicitis with generalized peritonitis at the March 8-9, 2022 ICD-10- Coordination and Maintenance Committee meeting.” The proposal was to expand the K35.20 (Acute appendicitis with generalized peritonitis without abscess) and K35.21 (Acute appendicitis with generalized peritonitis, with abscess) with further specificity to describe the conditions with perforation and without perforation.

The new diagnosis codes are included with the proposed rule and go into effect October 1, 2023. They are included in table 6A – New Diagnosis Codes and include K35.200, K35.201, K35.209, K35.210, K35.211, K35.219. These new codes reflect with and without perforation and abscess of the appendicitis with generalized peritonitis.

CMS provided analysis of the MS-DRGs for appendicitis to differentiate all cases compared to the diagnoses that are considered complicated to review the average LOS and cost information as noted below with MS-DRGs 338, 339, 340. CMS stated the “data shows that overall, each of the “complicated” diagnoses appear to have a comparable average length of stay and similar average cost when compared to the average length of stay and average costs of all cases. CMS also provided data for the “non-complicated” diagnoses below with MS-DRGs 341, 342, and 343. CMS noted that the findings were similar with both “complicated” and “uncomplicated” diagnoses and “we believe the findings support a prior comment...that both localized and generalized peritonitis in association with an appendectomy require the same level of care, including extensive intraoperative irrigation at the surgical site, direct inspection or imaging of the abdomen to identify possible abscess, use of intravenous antibiotics and prolonged monitoring.”

It is important to note that this demonstrated, for MS-DRGs 338, 339 and 340, that the code K35.21 did look different than the rest with higher Average LOS and charges.

CMS further analyzed the data of the 8,060 cases with 3.7 LOS and average cost of 12,838 when you combine all these MS-DRGs together and applied all five criteria to create subgroups the conditions are met to support a three tier MS-DRG.

CMS is proposing to delete the following MS-DRGs:

- 338 Appendectomy with complicated principal diagnosis with MCC
- 339 Appendectomy with complicated principal diagnosis with CC
- 340 Appendectomy with complicated principal diagnosis without CC/MCC
- 341 Appendectomy without complicated principal diagnosis with MCC
- 342 Appendectomy without complicated principal diagnosis with CC
- 343 Appendectomy without complicated principal diagnosis without CC/MCC

CMS is proposing to replace these deleted MS-DRGs with the following three MS-DRGs which would no longer require a diagnosis in the definition for the MS-DRG logic:

- 397 Appendix procedures with MCC
- 398 Appendix procedures with CC
- 399 Appendix procedures without CC/MCC

The FAH agrees with CMS that the data supports the average LOS and charges are comparable within the Appendectomy MS-DRGs with and without a “complicated” principal diagnosis. The FAH concurred last year with CMS’ decision to await the ICD-10-CM code revisions for the appendicitis codes. The FAH would like to emphasize the yellow highlighted data within CMS’ table for “complicated” diagnoses by MS-DRG associated with diagnosis code

K35.21 as within each MS-DRG this specific code stood out with higher LOS and charges. As CMS noted this same diagnosis code is being further expanded to capture perforations with October 1, 2023 discharges. The FAH requests that CMS continue to monitor this diagnosis within the MS-DRG to determine if there are additional resources associated with patients with diagnosis of acute appendicitis with generalized peritonitis with abscess with and without perforation.

9. *II.C.12.b. Proposed Changes to the MS-DRG Diagnosis codes for FY 2024 – Proposed Changes to Severity Levels*

In FY 2024, CMS noted they continue to solicit feedback regarding the guiding principles, as well as other possible ways to incorporate meaningful indicators of clinical severity. In FY 2023, public comments were solicited on SDOH Z codes likely to influence hospital resource utilization related to inpatient care. Homelessness Z59.00 (Homeless Unspecified), Z59.01 (Sheltered Homeless), Z59.02 (unsheltered homeless) were commonly suggested for consideration.

For FY 2024, CMS re-reviewed the data that included the expanded codes for homelessness and is now proposing to change the severity level designation for diagnosis codes Z59.00, Z59.01 and Z59.02 from NonCC to CC.

The FAH supports this revision to designate these homeless codes as CC. The FAH would also request that CMS consider the fate of CC with future rulemaking. The application of the NonCC Subgroup Criteria appears to frequently not recognize the need for a severity level of CC. It is possible that the creation of a CC may not be enough without addressing this methodology. If there are limited MS-DRGs impacted by presence of CC, the designation of diagnoses to CC would accomplish the documentation and reporting goals for optimal patient care. The CC designation is important when considering the resources and care of the patient as it does tend to impact the LOS and charges of the patient.

10. *II.C.15 Proposed Changes to Surgical Hierarchies*

CMS proposes multiple revisions to the surgical hierarchy table as noted in the table below within MDC 05 MS-DRGs:

<b>Proposed Surgical Hierarchy: MDC 05</b>	
MS-DRG 215	Other Heart Assist System Implant
Proposed New MS-DRG 212	Concomitant Aortic and Mitral Valve Procedures
MS-DRGs 216-221	Cardiac Valve and Other Major Cardiothoracic Procedures

MS-DRGs 231-236	Coronary Bypass
Delete MS-DRGs 222-227	Cardiac Defibrillator Implant
Proposed New MS-DRG 275	Cardiac Defibrillator Implant with Cardiac Catheterization and MCC
Proposed New MS-DRG 276	Cardiac Defibrillator Implant with MCC
Proposed New MS-DRG 277	Cardiac Defibrillator Implant without MCC
MS-DRGs 266-267	Endovascular Cardiac Valve Replacement and Supplement Procedures
MS-DRGs 268-269	Aortic and Heart Assist Procedures
MS-DRGs 228-229	Other Cardiothoracic Procedures
MS-DRGs 319-320	Other Endovascular Cardiac Valve Procedures
MS-DRGs 270-272	Other Major Cardiovascular Procedures
MS-DRGs 239-241	Amputation for Circulatory System Disorders Except Upper Limb and Toe
MS-DRGs 242-244	Permanent Cardiac Pacemaker Implant
MS-DRG 245	AICD Generator Procedures
MS-DRG 265	AICD Lead Procedures
MS-DRGs 273-274	Percutaneous and Other Intracardiac Procedures
Delete MS-DRGs 246-249	Percutaneous Cardiovascular Procedures with Coronary Artery Stent
Proposed New MS-DRGs 323-324	Coronary Intravascular Lithotripsy with Intraluminal Device
Proposed New MS-DRG 325	Coronary Intravascular Lithotripsy without Intraluminal Device
Proposed New MS-DRGs 321-322	Percutaneous Cardiovascular Procedures with Intraluminal Device
MS-DRGs 250-251	Percutaneous Cardiovascular Procedures without Intraluminal Device
Proposed New MS-DRGs 278-279	Ultrasound Accelerated and Other Thrombolysis of Peripheral Vascular Structures
MS-DRGs 252-254	Other Vascular Procedures
MS-DRGs 255-257	Upper Limb and Toe Amputation for Circulatory System Disorders
MS-DRGs 258-259	Cardiac Pacemaker Device Replacement
MS-DRGs 260-262	Cardiac Pacemaker Revision Except Device Replacement
MS-DRG 263	Vein Ligation and Stripping
MS-DRG 264	Other Circulatory O.R Procedures

After reviewing the proposed revisions to the hierarchy. The FAH recommends that CMS consider the following:

- MS-DRG 270-272 (Weight 5.0627, 3.4669, 2.4548) and MS-DRG 319-320 (Weight 4.3607, 2.2290) should switch places in hierarchy with MS-DRGs 270-2 before MS-DRGs 319-320;
- MS-DRG 245 (Weight 4.57.85) should be after MS-DRG 266-7 (Weight 6.3253, 4.9574); and
- MS-DRGs 323-5 (Weight 4.1576, 2.9848, 2.6810) should be after MS-DRGs 319-320 (Weight 4.3607, 2.2290) after it switches places with MS-DRG 270-272 (Weight 5.0627, 3.4669, 2.4548) (*i.e.*, 270-2, 319-20, 323-5).

## WAGE INDEX

### III.G.1 Proposed Application of the Rural Floor

In order to provide greater transparency and permit a more meaningful evaluation of CMS' policy with respect to implementation of the rural floor, the FAH requests that CMS provide an impact table with the FY 2024 final rule and with subsequent rulemakings showing the number of hospitals and total payments impacted by the policy, with results aggregated at the state level. In the Proposed Rule, CMS acknowledges the "significant financial consequences" that may result from the proposed policy, 88 Fed. Reg. at 26,974, and the FAH believes it is appropriate to carefully monitor these impacts, which can be done most effectively with state-level data.

### III.G.4 and Addendum II.A.4.f. Proposed Continuation of the Low Wage Index Hospital Policy and Budget Neutrality Adjustment

The FAH supports CMS' proposal to continue its low wage index hospital policy. Under this policy, which was first adopted in FY 2020, CMS has temporarily increased the hospital wage index values below the 25th percentile by half of the difference between the hospital's wage index value and the 25th percentile wage index value. CMS has indicated its intent for these policies to remain in place for four years to account for the minimum four-year lag between the hospital cost reporting year (FY 2020) where wages are paid and the federal fiscal year (FY 2024) that is used to determine the wage index and to revisit the duration of the policy as CMS gains experience under the policy.<sup>1</sup> In the Proposed Rule, CMS notes that the single year of relevant data currently available (from FY 2020) is not sufficient for a proper evaluation of the low wage index hospital policy. Therefore, CMS proposes to continue the low wage index hospital policy and associated budget neutrality adjustment for FY 2024.

***The FAH applauds CMS' continued efforts to resolve the negative feedback loop the wage index creates for low wage hospitals and strongly supports CMS addressing this critical problem that disproportionately impacts rural hospitals by continuing its policy to increase the wage index values of low wage index hospitals.***

As CMS observed when first adopting the low wage index hospital policy, the wage index has created a "downward spiral" whereby low wage index hospitals receive lower reimbursement, which decreases their ability to invest in recruiting and retaining employees, which then further depresses reimbursement. This negative feedback loop has a particularly detrimental effect on rural hospitals, and a disproportionate number of low wage index hospitals have traditionally been rural hospitals.

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<sup>1</sup> 87 Fed. Reg. at 28,369.

Rural hospitals play a critical role in ensuring access to care for the approximately 61 million Americans that live in rural areas across the United States.<sup>2</sup> Dependence on rural hospitals is particularly acute for Medicare beneficiaries—approximately one out of every four Medicare beneficiaries live in rural areas and depend on rural hospitals for care.<sup>3</sup> Because Medicare beneficiaries disproportionately rely on rural providers to access care, Medicare payments tend to have a greater influence on rural hospitals’ revenue as compared to non-rural hospitals.

The wage index, however, has only aggravated the financial problems for many rural hospitals, impeding their ability to invest in recruiting and retaining employees. As a result, Medicare beneficiaries continue to encounter in rural areas what CMS has described as “a stretched and diminishing rural workforce,”<sup>4</sup> a problem which has only been exacerbated as rural hospitals continue to face workforce shortages and facility closures due to the impact of COVID-19.<sup>5</sup>

The FAH appreciates CMS’ much needed efforts to continue addressing the acute problems that rural hospitals face. CMS policy must ultimately ensure that Medicare payment formulas do not operate to magnify the stress on the rural health delivery system and contribute to access issues for Medicare beneficiaries living in rural areas. Thus, the FAH supports CMS’ proposal to continue its policy of increasing the wage index values for hospitals with a wage index value in the lowest quartile of the wage index values across all hospitals. Continuation of this policy would help those hospitals that have been most severely impacted by the wage index’s negative feedback loop to make much needed investments in their labor forces.

***The FAH urges CMS to remove the FY 2024 Proposed Rule’s continuation of a budget neutrality adjustment to the IPPS standardized amounts, as we believe such budget neutral adjustments are neither required nor authorized by Congress.***

In the FY 2020 IPPS Final Rule, CMS invoked 42 U.S.C. § 1395ww(d)(3)(E) and its exceptions and adjustments authority under § 1395ww(d)(5)(I)(i) as the basis for raising low wage index values.<sup>6</sup> CMS made this policy budget neutral for FY 2020 through 2023 and proposes to continue budget neutral implementation in FY 2024 through a 0.2629 percent budget

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<sup>2</sup> CMS Framework for Advancing Health Care in Rural, Tribal, and Geographically Isolated Communities (Nov. 2022). <https://www.cms.gov/files/document/cms-geographic-framework.pdf>.

<sup>3</sup> CMS, Improving Health in Rural Communities: FY 2021 Year in Review, 1 (Nov. 2021).

<sup>4</sup> CMS, Rural Health Strategy, 2 (May 8, 2018); *see* CMS, Improving Health in Rural Communities: FY 2021 Year in Review, 1 (Nov. 2021).

<sup>5</sup> CMS Framework for Advancing Health Care in Rural, Tribal, and Geographically Isolated Communities (Nov. 2022). <https://www.cms.gov/files/document/cms-geographic-framework.pdf>.

<sup>6</sup> 84 Fed. Reg. 42,044, 42,329 (Aug. 16, 2019).

neutrality adjustment. The budget neutrality adjustment proposed for FY 2024 would be the largest budget neutrality adjustment related to the low wage index hospital policy to date, and the FAH continues to urge CMS to provide the much-needed rural relief under the low wage index hospital policy in a non-budget neutral manner.

If CMS could adopt this policy under 42 U.S.C. § 1395ww(d)(3)(E), budget neutrality would be required. However, subsection (d)(3)(E) requires the wage index to reflect “the relative hospital wage level in the geographic area of the hospital compared to the national average hospital wage level.”<sup>7</sup> Although CMS has and is proposing to intervene to override the result produced by 42 U.S.C. § 1395ww(d)(3)(E) for sound policy reasons, it can only do so to the extent that another provision of the Medicare Act provides the necessary statutory authority. For this reason, CMS originally cited the exceptions and adjustments authority under 42 U.S.C. § 1395ww(d)(5)(I)(i) as an alternative statutory basis for its low wage index hospital policy.<sup>8</sup>

Subsection (d)(5)(I), however, restricts the Secretary’s authority to adopt budget neutrality adjustments to only adjustments for transfer cases, and budget neutrality is neither required nor authorized in other circumstances. Clause (i) of § 1395ww(d)(5)(I) authorizes the Secretary to “provide by regulation for such other exceptions and adjustments to such payment amounts under this subsection as the Secretary deems appropriate.” No budget neutrality authority is included under this clause. Rather, Congress adopted clause (ii) at CMS’ express request in order to provide limited authority for a budget neutrality adjustment only when CMS makes an adjustment under clause (i) for transfer cases. This clause states:

In making adjustments under clause (i) for transfer cases . . . the Secretary may make adjustments...to assure that the aggregate payments made under this subsection for such fiscal year are not greater or lesser than those that would have otherwise been made in such fiscal year.

Because the statute explicitly restricts the Secretary’s authority to adopt budget neutrality adjustments in connection with adjustments for transfer cases, budget neutrality is neither required nor authorized in other circumstances. Moreover, it is also worth noting that where Congress has amended § 1395ww(d)(3)(E) to mitigate the impact of the wage index on certain low wage index hospitals (clause (ii)) and hospitals in frontier states (clause (iii)), it has expressly done so in a non-budget neutral manner, instructing CMS to disregard the impact clauses (ii) and (iii) in developing any budget neutrality adjustment under subsection (d)(3)(E)(i). This legislative history indicates that, contrary to CMS’ assertion in the FY 2020 IPPS Final Rule,<sup>9</sup> it is inappropriate to mitigate the wage index’s impact on low wage index hospitals in a budget neutral manner. For this reason, CMS’ low wage index hospital policy may properly be adopted as an adjustment under 42 U.S.C. § 1395ww(d)(5)(I)(i) but may not be implemented in a

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<sup>7</sup> See *Bridgeport Hospital, et. al. v. Becerra*, No. 1:20-cv-01574, at \*9 (D.D.C. Mar. 2, 2022).

<sup>8</sup> 84 Fed. Reg. 19,158, 19,396 (May 3, 2019).

<sup>9</sup> 84 Fed. Reg. 42,331 (Aug. 16, 2019) (“[W]e would consider it inappropriate to use the wage index to increase or decrease overall IPPS spending.”).



budget neutral manner. Accordingly, the FAH urges CMS to remove the Proposed Rule's budget neutrality adjustment to the IPPS standardized amounts for the low wage index hospital policy.

Beyond the CMS low-wage policy to assist rural hospitals, the FAH supports the Save Rural Hospitals Act of 2023, which would establish a wage index floor of 0.85 in a non-budget neutral manner, and urges CMS' support. This legislation would provide stability to low wage index hospitals, fostering long-term planning and investing in recruiting and retaining staff in low wage index markets without eroding Medicare to other hospitals.

## **DISPROPORTIONATE SHARE HOSPITAL PAYMENTS**

### **IV.E.2 Calculation of Proposed Factor 2 for FY 2024**

With the end of the COVID PHE on May 11, 2023, the FAH is concerned that the proposed calculation of Factor 2 significantly underestimates expected contractions in Medicaid enrollment that will precipitate a growing uninsured rate over FY 2024 and urges CMS to adjust estimates to fully capture the impact of the conclusion of the PHE on the uninsured rate. Factor 2 of the UC DSH calculation adjusts Factor 1 for the change in the number of uninsured individuals in the United States since 2013, the last year before the ACA's coverage expansion. The higher the uninsured rate, the larger the aggregate dollar amount of UC DSH payments that are distributed to IPPS hospitals under Factor 3. Because Factor 2 turns exclusively on the uninsured rate, it is critical that CMS' estimate accurately accounts for significant factors that are expected to fuel the uninsured rate. For FY 2024, OACT estimates the uninsured rate as 9.2 percent, which is the same uninsured rate that CMS projected for FY 2023. The 2013 uninsured rate is calculated at 14 percent. Based on this difference, OACT estimates that Factor 2 is equal to 0.6571. When multiplied by Factor 1 (\$10.216 billion), proposed Factor 2 produces a UC DSH pool of only \$6.713 billion. This amount would mark the smallest UC DSH pool over the past seven years. The proposed reduction to aggregate UC DSH payments fails to adequately account for the anticipated significant loss of coverage with the recent expiration of the PHE, producing a depressed uninsured rate that does not capture the projected outlook for FY 2024.

The National Health Expenditure Accounts (NHEA) projects that the insurance rate writ large will "peak in 2022 at 91.1%" mainly due to the growth in Medicaid enrollment before the conclusion of the PHE.<sup>10</sup> As NHEA acknowledges, the significant growth in Medicaid enrollment in recent years has been significantly fueled by the maintenance of eligibility requirements that states must satisfy through the end of the month in which the PHE ends in order to receive increased Federal medical assistance percentage (FMAP) under the Families First Coronavirus Response Act, Pub. L. 117-127. In light of this requirement, NHEA projects "rising expected growth in [Medicaid] enrollment of 8.2 percent" in 2021, followed by a 0.9

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<sup>10</sup> National Health Expenditure Projections 2021-2030: Forecast Summary, p.1, <https://www.cms.gov/files/document/nhe-projections-forecast-summary.pdf>.

percent reduction in enrollment in 2022.<sup>11</sup> “In 2023, Medicaid enrollment is projected to drop significantly (by 2.6 million, or 3.2 percent) as states are expected to continue to proactively trim their enrollments,” followed by “modest growth in enrollment (0.8 percent)” in FY 2024.<sup>12</sup> Ultimately, this projection indicates Medicaid enrollment of 79.5 million in 2024, an increase of 7.2 million compared to Medicaid enrollment prior to the PHE in 2019 (72.3 million).<sup>13</sup>

The FAH is concerned that the NHEA’s projected 2023 enrollment contraction and 2024 enrollment expansion vastly understate the impact of the maintenance of eligibility requirements on Medicaid enrollment and the expected decline in coverage in FY 2024 following the end of the PHE. The 14-month Medicaid unwinding period recently began April 1, 2023, and both pre-unwinding analyses and early data from the unwinding suggest significant coverage losses that are not reflected in NHEA’s projections. A recent analysis by Kaiser Family Foundation (KFF) of survey data from state Medicaid and CHIP program officials projects that Medicaid enrollment will decline between 7.8 million (7 percent) and 24.4 million (33 percent) by May 2024, with a median estimate of 16.6 million (18 percent) losing Medicaid coverage.<sup>14</sup> These projections reflect a more significant loss of coverage than previously estimated by estimating the difference between baseline growth and growth due to the maintenance of effort requirement. That earlier analysis projected an enrollment decline of between 5 and 13 percent in 2023 (5.3 million to 14.2 million enrollees),<sup>15</sup> and both projections significantly exceed the relatively modest 2023 contraction and 2024 growth projected by the NHEA. Similarly, the Urban Institute analyzed the anticipated impact of an April 2023 end to the PHE, concluding a

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<sup>11</sup> *Id.* at p.3; National Health Expenditure Projections 2021–30: Growth to Moderate as COVID-19 Impacts Wane, p.9 (Mar. 28, 2022), <https://www.cms.gov/files/document/national-health-expenditure-projections-2021-30-growth-moderate-covid-19-impacts-wane.pdf>.

<sup>12</sup> *Id.*

<sup>13</sup> NHE Projections, Table 17, Health Insurance Enrollment and Enrollment Growth Rates, <https://www.cms.gov/files/zip/nhe-projections-tables.zip>.

<sup>14</sup> Tricia Brooks et al., Medicaid and CHIP Eligibility, Enrollment, and Renewal Policies as States Prepare for the Unwinding of the Pandemic-Era Continuous Enrollment Provision (March 2023), at <https://files.kff.org/attachment/REPORT-Medicaid-and-CHIP-Eligibility-Enrollment-and-Renewal-Policies-as-States-Prepare-for-the-Unwinding-of-the-Pandemic-Era-Continuous-Enrollment-Provision.pdf>.

<sup>15</sup> Elizabeth Williams, Robin Rudowitz, Bradley Corallo, Fiscal and Enrollment Implications of Medicaid Continuous Coverage Requirement During and After the PHE Ends (May 10, 2022), at <https://www.kff.org/medicaid/issue-brief/fiscal-and-enrollment-implications-of-medicaid-continuouscoverage-requirement-during-and-after-the-phe-ends/>.

significant loss of Medicaid coverage (18 million) in the 14 months following the end of the PHE.<sup>16</sup> Many of those disenrolled (21 percent, 3.8 million) are expected to become uninsured.<sup>17</sup>

Early data from the unwinding has validated these projections. Available data from the 12 states that resumed Medicaid disenrollments in May 2023 show a median disenrollment rate of 34.5 percent with over 560,000 losing Medicaid coverage.<sup>18</sup> The disenrollment rates at the state level varied from between 10 percent (Virginia) to 54 percent (Florida), with the latter disenrollment percentage far exceeding the 33 percent upper bound previously estimated based on survey data. These twelve states represent approximately 20 percent of the Medicaid population, providing an initial glimpse into the likely loss in enrollment over the coming year.

Against this backdrop, significant increases in the uninsured rate well beyond OACT's estimates in the Proposed Rule look to be a certainty that must be accounted for by OACT in Factor 2 of the UC DSH determination. The FAH strongly urges OACT to broaden its data sources to more fully reflect current estimates of the uninsured rate in FY 2023 in light of the profound impact of the unwinding of the PHE. These estimates have significant impacts on the UC DSH funding available to support critical hospital services to the uninsured and underinsured. For example, even acknowledging an additional 0.7 percentage point of growth in the uninsured rate in FY 2024 (9.9 percent uninsured, reflecting a projection of approximately 2.4 million additional uninsured individuals), would increase the proposed UC DSH pool by approximately \$511 million above CMS' proposal.

#### **IV.E.3(c) Methodology for Calculating Factor 3 for FY 2024**

The FAH commends CMS for its efforts over the past several years to: (1) better define the costs of uncompensated care, in particular by including the cost of uninsured discounts into the definition of charity care for Worksheet S-10 ("WS S-10") purposes to be consistent with ACA section 3133's mandate; (2) better define the terms of its instructions to providers for the preparation of Worksheet S-10 so that costs are more accurately and consistently reported by hospitals; (3) allow providers to amend their Worksheet S-10s to comply with CMS' revised instructions; and (4) develop, engage in, and improve an audit process aimed at more accurately allocating and disbursing UC-DSH payments to providers. Given the relative weights Factor 3 assigns to hospitals, the FAH appreciates CMS' efforts over recent fiscal years to rigorously

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<sup>16</sup> Matthew Buettgens & Andrew Green, The Impact of the COVID-19 Public Health Emergency Expiration on All Types of Health Coverage (Dec. 2022), at [https://www.urban.org/sites/default/files/2022-12/The%20Impact%20of%20the%20COVID-19%20Public%20Health%20Emergency%20Expiration%20on%20All%20Types%20of%20Health%20Coverage\\_0.pdf](https://www.urban.org/sites/default/files/2022-12/The%20Impact%20of%20the%20COVID-19%20Public%20Health%20Emergency%20Expiration%20on%20All%20Types%20of%20Health%20Coverage_0.pdf)

<sup>17</sup> *Id.*; see also NORC at the University of Chicago, Medicaid Redetermination Coverage Transitions, at <https://ahiporg-production.s3.amazonaws.com/documents/Medicaid-Redetermination-Coverage-Transitions-Methodology.pdf>.

<sup>18</sup> Kaiser Family Foundation, Jennifer Tolbert et al., What do the Early Medicaid Unwinding Data Tell Us? (May 31, 2023), at <https://www.kff.org/policy-watch/what-do-the-early-medicaid-unwinding-data-tell-us/>.

audit all hospitals' reported data to ensure hospitals are reporting costs consistently and accurately so that the audited Worksheet S-10 data better captures reliable, relative differences in hospitals' uncompensated care levels, and eligible hospitals receive their fair share of the UC-DSH pool.

The FAH also supports CMS' proposal to use the average of the audited FY 2018, FY 2019, and FY 2020 (the three most recent fiscal years for which audited data are available) Worksheet S-10 data for purposes of calculating Factor 3 in FY 2024. Following the extensive FY 2018 audits, Worksheet S-10 audits are becoming more uniform, allowing CMS to again blend multiple years of data in allocating UC-DSH funds. Doing so promotes predictability and minimizes volatility in UC-DSH payments.

Finally, the FAH notes with approval that CMS appears to be using the latest available data in determining UC-DSH eligibility. The Proposed Rule uses the December 2022 HCRIS extract and indicates CMS' intent to use the March 2023 update of HCRIS to calculate Factor 3 for the final rule. The use of the latest available data is critical to the proper allocation of UC-DSH payments, and the FAH encourages CMS to use the latest available data that becomes available prior to the development of the final rule.

#### **IV.D.3(d) Per Discharge Amount of Interim Uncompensated Care Payments**

The FAH urges CMS to reconsider the data used to estimate the number of FY 2024 for purpose of calculating the per discharge amount of interim UC DSH payments in order to ensure that per discharge payments better reflect the anticipated volume of discharges in FY 2024 and to reduce reliance on the reconciliation process for UC DSH payments. Hospitals generally receive interim UC-DSH payments on a per-discharge basis, and the amount of these payments is calculated by dividing the hospital's total UC-DSH payments by the historical 3-year average of discharges.<sup>19</sup> For FY 2022, CMS modified this calculation to be based on an average of FY 2018 and FY 2019 based on the "belief that computing a 3-year average with the FY 2020 discharge would underestimate discharges, due to the decrease in discharges during the COVID-19 pandemic." 88 Fed. Reg. at 26,999. Likewise, for FY 2023, CMS calculated a 3-year average of discharges excluding data from FY 2020 (*i.e.*, the average of FY 2018, FY 2019, and FY 2021 data). *Id.* Since that time, CMS and stakeholders have had additional time to assess actual discharge trends. With more recent data and experience, it appears that the FY 2022 and FY 2023 methodologies both significantly overstated hospital discharges in each year. This can be seen by comparing the ratios in the discharges column used for Factor 1 in the Proposed Rule (0.975 for FY 2023 and 0.943 for FY 2022) against the corresponding discharge ratios set forth previously in the FY 2023 Final Rule (1.050) and the FY 2022 Final Rule (1.059)—more current data produces a lower discharge ratio for both years.<sup>20</sup> The overestimation of discharges

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<sup>19</sup> Some hospitals may receive a lower amount through a voluntary process where documentation demonstrates that there would likely be a significant recoupment at cost report settlement if the per-discharge amount is not lowered. 88 Fed. Reg. at 26,999.

<sup>20</sup> Compare 88 Fed. Reg. at 26,991 (discharge ratios of 0.975 for FY 2021 and 0.943 for FY 2022 in the Proposed Rule) with 86 Fed. Reg. at 49,029 (discharge ratio of 1.050 for FY

depresses interim UC-DSH payments, producing cash flow issues for hospitals notwithstanding the reconciliation process. Inadequate interim payments compromise the UC DSH program's effectiveness in supporting hospital care for uninsured and underinsured patients, particularly amidst record inflation, labor shortages, and supply chain shortages that have severely disrupted hospital budgeting and operations on the heels of the COVID-19 PHE.

The FAH is concerned that CMS' proposal to use discharge data from FY 2019, FY 2021, and FY 2022 for purposes of determining hospitals' FY 2024 per-discharge amounts will likewise significantly overstate expected discharges and depress interim UC-DSH payments in FY 2024. Starting with total IPPS claims for FY 2020 based on the FY 2022 Proposed Rule alternatives considered impact file data (7,680,365 cases)<sup>21</sup> and using the Factor 1 discharge ratios in the Proposed Rule for FY 2021 (0.94), FY 2022 (0.943), FY 2023 (0.975), and FY 2024 (0.976) the projected IPPS discharges in FY 2024 would be 6,478,521. Performing this calculation beginning with an FY 2021 baseline (7,221,576 cases) or an FY 2022 baseline (6,761,166 cases) and using the intervening discharge ratios from the Proposed Rule produces similar FY 2024 projections (6,480,345 and 6,433,926 cases, respectively). All of these projections are within one percentage point of each other, suggesting that it is improper to assume that the FY 2020 discharge data is aberrant and appropriately excluded.

Based on these projections, it appears that the discharge estimation methodology in the Proposed Rule (using data from FY 2019, FY 2021, and FY 2022) would likely overstate discharges by 15 to 16 percent nationally for FY 2024. Using the average of the three most recent years of data (FY 2020, FY 2021, and FY 2022) would similarly overstate discharges by 10 to 11 percent based on this methodology to approximate projected FY 2024 discharges.<sup>22</sup> Rather, the FAH urges CMS to consider using the average of the two most recent years of data (FY 2021 and FY 2022), but to apply a national adjustment factor to normalize the data based on projected discharge trends. This approach incorporates more than one year of data to appropriately temper volatility in year-to-year changes in discharges, but it excludes FY 2020 data and corrects for the overestimation of FY 2024 discharges that would generally result from using the unadjusted numbers. Alternatively, a similar methodology could be adopted using the three most recent years of data (FY 2020, FY 2021, and FY 2022) with a national adjustment factor to account for discharge trends. If a national adjustment factor based on discharge trends from the Factor 1 calculation is not adopted, then, the FAH supports using a single year of data (FY 2022 discharges). Based on our efforts to validate the reliability of different discharge data, it appears that using FY 2022 data alone produces the most plausible and verifiable projection of FY 2023 discharges without the use of an adjustment factor (only overstating discharges by

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2023 in the FY 2023 Final Rule) and 87 Fed. Reg. at 45,228 (discharge ratio of 1.059 for FY 2022 in the FY 2022 Final Rule).

<sup>21</sup> Available at <https://www.cms.gov/files/zip/fy2022-ippms-nprm-alternatives-considered-impact-file.zip>.

<sup>22</sup> We also modeled FY 2024 discharges using a two-year average of FY 2021 and FY 2022, but this overstated projected discharges by 7 to 8 percent when FY 2024 numbers were projected from FY 2020 or FY 2022 discharge using the discharge ratios from the Factor 1 calculation in the Proposed Rule.

between 4 and 5 percent).<sup>23</sup> In the end, it is inconsistent to project falling discharges for purposes of the Factor 1 calculation (thereby reducing the UC-DSH pool) but not similarly assume falling discharges for purposes of projecting the discharges used to calculate the per-discharge amount (thereby reducing interim UC-DSH payments).

## **MARKET BASKET UPDATE AND STANDARDIZED AMOUNT**

### **V.B. Proposed Changes in the Inpatient Hospital Update for FY 2024**

#### *1. The Proposed Market Basket Update Does Not Capture Real Changes in Wages and Prices for Hospitals.*

CMS proposes a market basket update of 2.8 percent for FY 2024 which will likely understate hospital inflation for the 4<sup>th</sup> consecutive year. This market basket update is a product of CMS' use of historical data to forecast FY 2024 hospital operating costs without adjustments designed to capture the profoundly aberrant and historic economic forces that are fueling rapid cost increases for goods and services. For example, the FY 2022 market basket update was a full 3.0 percentage points below the actual rate of increase while the FY 2021 market basket was 0.6 percentage points below the actual rate of increase. Recent data suggests that the market basket for FY 2023 will mark the 3<sup>rd</sup> consecutive year that the forecasted hospital market basket increase will be below the actual rate of increase. CMS data released simultaneous to the FY 2024 IPPS proposed rule indicates that the FY 2023 market basket increase will be 4.6 percent or 0.5 percentage points in excess of the 4.1 percent forecast market basket update hospitals received.

In addition, CMS proposed reducing the proposed market basket update with a 0.2 percentage point total factor productivity adjustment. This total productivity adjustment is inappropriate in that it contemplates improbable and overstated gains in productivity for the hospital sector as noted by the CMS Office of the Actuary (OACT) itself and detailed below.

**In light of the foregoing, the FAH urges CMS to do a one-time adjustment to the market basket update methodology to account for forecast error in the FY 2022 market basket when applying the FY 2024 market basket update.**

#### *Background*

Under section 1886(b)(3)(B)(iii) of the Act, CMS is required to update hospital rates based on:

the percentage, estimated by the Secretary before the beginning of the...fiscal year, by which the cost [of] ... inpatient hospital services...will exceed the cost...for the preceding 12-month cost reporting period or fiscal year.

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<sup>23</sup> We note that, to the extent that a hospital documents that the use of FY 2023 discharge data alone would understate its projected FY 2023 discharges, the hospital could make use of CMS' process to request a lower per discharge interim UC-DSH payment.

The update is subject to the productivity adjustment and further adjustments for hospitals that fail to submit quality information and/or are not meaningful EHR users.<sup>24</sup> CMS is proposing to use a hospital market basket of 3.0 percent to update inpatient hospital rates for FY 2024. This market basket is based on the forecast of CMS' contractor, IHS Global Insight, Inc. (IGI). IGI's fourth quarter 2022 forecast (with historical data through the third quarter of 2021) for the hospital market basket is 3.0 percent. IGI's fourth quarter 2022 forecast of total factor productivity is 0.2 percent.

The Proposed Rule indicates that CMS' forecast of the FY 2024 hospital market basket and the offset for productivity will be updated if more recent data become available before the final rule. If CMS follows past practice, this will mean that the FY 2024 final rule update will be based IGI's second quarter 2023 forecast of the FY 2024 hospital market basket with historical data through the first quarter of 2023. The FAH strongly urges CMS to use later data on the market basket increase for FY 2024 as it has in past years and to further adjust its estimate to account for forecast error in the FY 2022 hospital market basket update which understated the actual rate of inflation by a full 3.0 percentage points. Upward pressure on hospitals costs that has been occurring throughout the pandemic and other global economic developments is not well represented using third quarter 2022 historical data.

#### *CMS' Understatement of Prior Year Hospital Inflation*

In our public comments on the FY 2023 IPPS Proposed Rule, the FAH provided several sources of data that indicated that the historical data upon which the proposed FY 2023 forecast of the market basket was based was less than the rate of increase that hospitals were experiencing at that time.<sup>25</sup> The evidence in these data that CMS' forecasts of the market basket during a time of high inflation and economic instability understate the actual rate of increase have been borne out by CMS' own data. The below table<sup>26</sup> shows how CMS' forecast of the market basket compares to the actual market basket based on later data since FY 2020:

IPPS Market Basket	FY 2021	FY 2022	FY 2023
Forecast Used in the Update	2.4	2.7	4.1
Actual Based on Later Utilization	3.0	5.7	4.6
Difference	-0.6	-3.0	-0.5

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<sup>24</sup> Social Security Act § 1886(b)(3)(B)(i)(XX), (vii), (ix), (xi)

<sup>25</sup> These data came from the KaufmanHall, National Hospital Flash Report, p.4 (Jan. 2021) and Premier, Inc. (PINC) AI™ Data: CMS Data Underestimates Hospital Labor Spending (Apr. 12, 2022) and demonstrated that the latest data that CMS uses for the market basket in the proposed rule seriously underestimated cost increases hospitals were experiencing using other data sources.

<sup>26</sup> OACT, 4<sup>th</sup> quarter 2022 release of the market basket information with historical data through the 3<sup>rd</sup> quarter of 2022 (<https://www.cms.gov/research-statistics-data-and-systems/statistics-trends-and-reports/medicareprogramratesstats/marketbasketdata>) for the actual update based on later utilization. Data for FY 2023 remains an estimate as it only reflects data through the 3<sup>rd</sup> quarter of FY 2022.



These data show that CMS has understated the market basket by a combined 4.1 percentage points for these three years. While FY 2023 remains an estimate as the historical data is only through the 3<sup>rd</sup> quarter of 2022, CMS' own data indicates that it will likely have underestimated the hospital market basket for the 3<sup>rd</sup> consecutive year.

One reason that CMS' market basket data may be reflecting lower increases in staffing costs compared to what hospitals are experiencing relates to use of contract labor. Hospitals have confronted worrying shortages of hospital workers during the COVID-19 pandemic, necessitating an outsized reliance on contract staff – particularly travel nurses – to meet patient demand. In 2019, hospitals spent a median of 4.7 percent of their total nurse labor expenses for contract travel nurses, which skyrocketed to a median of 38.6 percent in January 2022. A quarter of hospitals – those who have had to rely disproportionately on contract travel nurses in order to serve their communities during a global pandemic – saw their costs for contract travel nurses account for over 50 percent of their total nurse labor expenses. We understand that the Bureau of Labor Statistics' (BLS) Employment Cost Index (ECI) has not incorporated several significant shifts in hospitals' labor force – particularly the greater use of contract labor – because it lacks timeliness and only periodically updates the frequency with which a particular job is expected to occur. This discrepancy may explain why the ECI data is so divergent from that being reported to Premier Inc (PINC) AITM. It is unreasonable to rely on the ECI data for labor expenses without appropriate adjustments that reflect the profound increase in hospital expenses for contract and travel nurses.

As we noted in our public comments on the FY 2023 IPPS Proposed Rule, the FAH and the American Hospital Association (AHA) provided a report from FTI Consulting that likewise recognized that hospital use of contracted staff has increased markedly since 2019. According to FTI:

[H]ospitals face more competition than ever from travel and temporary nurse staffing firms that are attracting a greater share of the workforce with higher pay and more generous benefits, a trend driving up hospital labor costs. The cost of contract labor relative to total labor expenses increased five-fold in 2022 compared to 2019, primarily due to the need to replace departing staff nurses with travel or agency nurses. Median wages for contract nurses reached triple the median wages of employed nurses in March 2022.<sup>27</sup>

In the attached analysis jointly undertaken by FAH and AHA (Attachment A), we found that the ECI is unlikely to catch up with overall level of hospital labor cost increases. Since contract labor use and general workforce composition will not likely revert to its earlier levels, growth in the ECI will continue to lag behind growth in hospital labor costs.<sup>28</sup> This report relies

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<sup>27</sup> FTI Consulting, Report: Assessing the Adequacy of Proposed Updates to the Hospital Inpatient Prospective Payment System, page 4. Included in FAH letter at: <https://www.fah.org/wp-content/uploads/2022/06/FY2023-IPPS-FAH-061722.pdf>

<sup>28</sup> American Hospital Association and Federation of American Hospitals Report: CMS Misses the Mark in Payment Updates Due to Changes in Labor Composition and Cost Growth, June 2023 in Attachment A to this letter. Page 13-15.



on many of the sources we provided in our FY 2023 IPPS Proposed Rule comments documenting that the ECI understates the growth in hospital labor costs because it does not account for contract labor being a higher proportion of total hospital costs.

This report builds on last year’s work by finding that a closely related measure—the Employer Costs for Employee Compensation (ECEC) may better and more timely account for growth in hospital compensation costs than the ECI. As explained in the attached report, the ECI is constructed through a multi-step process that is intended to smooth short-term fluctuations in the labor pool. However, when the underlying hospital employment structures are changing rapidly and permanently, the ECI will understate labor costs by relying on a job type that is only in the sample for two consecutive quarters, using a sampling weight for when a job first enters the sample and holding the mix of occupations fixed before there is a rebasing.<sup>29</sup>

The ECEC, however, is dynamic and will reflect increases in compensation and changes in the mix of labor inputs on a timelier basis. For the wages and salaries component, the ECI and the ECEC show a growth rate of 13.3 percent and 20.0 percent respectively, a 6.7 percentage point gap between the 4<sup>th</sup> quarter of 2019 and the 4<sup>th</sup> quarter of 2022. The growth in the total compensation component, which CMS uses to track benefits, is slightly lower with the ECI and the ECEC recording growth of 12.4 percent and 16.6 percent, respectively, a 4.2 percentage point gap. Combining wages and salaries and employee benefits into a single composite measure shows the ECEC was 6 percentage points higher during this period than the ECI for items that account for 52.9 percent of the total hospital market basket. All else equal, if the hospital ECI growth had matched the hospital ECEC growth, this would have meant an additional three percentage point increase in the IPPS hospital market basket over this period. Given the parallel trends to CMS’ own market basket data, these data clearly show that the ECI is too low, not that the ECEC is too high.

#### *Total Factor Productivity*

Pursuant to section 1886(b)(3)(B)(xi)(II) of the Act, the Secretary reduces the IPPS market basket increase by the “10-year moving average of changes in annual economy-wide private nonfarm business multi-factor productivity (as produced by the Secretary for the 10-year period ending with the applicable fiscal year).” The theory behind the offset for economy wide total productivity is that the hospital sector should be able to realize the same productivity gains as the general economy.

However, CMS itself takes issue with the assumption that hospitals can recognize the same kinds of productivity gains as the general economy. In a memorandum dated June 2, 2022, OACT stated: “over the period 1990-2019, the average growth rate of hospital TFP using the two methodologies ranges from 0.2 percent to 0.5 percent, compared to the average growth of private nonfarm business TFP of 0.8 percent.” The memorandum also indicates that an assumed future rate of hospital industry productivity growth of 0.4 percent per year remains reasonable

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<sup>29</sup> See pages 7-8 of the AHA and FAH Report in Appendix A for more detail.

compared to an assumed rate of productivity growth in the private nonfarm business sector of 1.0 percent.<sup>30</sup>

The FAH shares OACT's skepticism regarding the offset to the hospital market basket for the 10-year average in economy-wide nonfarm total factor productivity. One reason that hospitals may not be able to realize the same growth in general economy wide productivity is that hospital services are highly labor intensive. As labor represents nearly 70 percent of the index, hospitals have little opportunity to obtain productivity gains from non-labor inputs as may be occurring in other industries that are less labor intensive.

The FAH understands that CMS is required by law to adjust the IPPS market basket update for total factor productivity. However, the FAH asks CMS to consider that the adjustment for total factor productivity reduces the update below what even OACT says is reasonable for hospitals to achieve when deciding on our request to make an adjustment for forecast error as detailed below.

*CMS Should Do a One-time Adjustment to the FY 2024 Update for FY 2022 Forecast Error*

As indicated above, the hospital update in FY 2022 understates the actual rate of inflation as measured by the hospital market basket by 3.0 percentage points. This understatement of the market basket results in a permanent reduction to hospital rates below the rate of inflation unless adjusted for in a future rate update. In the FY 2023 IPPS final rule, CMS indicates that "an important goal of a PPS is predictability" and that "due to the uncertainty regarding future price trends, forecast errors can be both positive and negative." 87 Fed. Reg. at 49054.

The FAH agrees that predictability in the future rate updates is a worthwhile goal of a prospective payment system. However, we also believe the large understatements of past year rates must be corrected in the future to prevent what has already been chronic Medicare underpayment from becoming even worse.<sup>31</sup> In two other payment systems, CMS uses a threshold level of difference between the update based on a forecast and a later increase based on after-the-fact data to make a forecast error adjustment. For the SNF PPS, CMS makes a forecast error adjustment when the difference between the market basket used in the update and based on

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<sup>30</sup> Paul Spitalnic, Stephen Heffler, Bridget Dickensheets and Mollie Knight, "Hospital Multifactor Productivity: An Update Presentation of Two Methodologies Using Data through 2019" (June 2, 2022), at <https://www.cms.gov/files/document/productivity-memo.pdf>.

<sup>31</sup> MedPAC's March 2023 report indicates that Medicare margins in 2021 were -8.3 percent exclusive of federal relief funds provided during the pandemic and this margin was an increase from even more negative Medicare margins in prior years. Medicare Payment Advisory Commission, "Report to the Congress: Medicare Payment Policy," ch. 3, p. 4 (March 2023), available at [https://www.medpac.gov/wp-content/uploads/2023/03/Mar23\\_MedPAC\\_Report\\_To\\_Congress\\_SEC.pdf](https://www.medpac.gov/wp-content/uploads/2023/03/Mar23_MedPAC_Report_To_Congress_SEC.pdf). Further, MedPAC states, "Medicare margins in 2023 will be lower than in 2021, driven in part by growth in hospitals' input costs, which exceeded the forecasts CMS used to set Medicare payment rate updates." *Id.* p. 56.

later data exceeds a threshold of 0.5 percentage points. For the capital IPPS, the threshold is 0.25 percentage points.

For the FY 2024 SNF update, CMS is proposing to increase the market basket update of 2.7 percent by 3.6 percentage points for forecast error in application of the FY 2022 update. 88 Fed. Reg. at 21,321. For the FY 2023 capital IPPS update, CMS is proposing a forecast error adjustment of 0.9 percentage points due to an underestimate of FY 2022 capital inflation. 88 Fed. Reg. at 27,229. As the difference between the FY 2022 update and the market basket based on after-the-fact data far exceeds these thresholds for making a forecast error adjustment, the FAH requests that CMS do a one-time adjustment of +3.0 percentage points to the IPPS operating update for FY 2024.

For both the SNF PPS and the capital IPPS, CMS is making the forecast error adjustments based on a threshold level of difference between the update and the market basket that was adopted through rulemaking in prior years. In the FY 2023 IPPS final rule, CMS indicated 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.” 88 Fed. Reg. at 49,054. The implication of this statement is that CMS is not permitted by rulemaking procedures under section 1871 of the Act to adopt a forecast error adjustment for the FY 2024 IPPS operating update because such a policy was not proposed. However, the IPPS market basket update for FY 2024 has been made subject to public comment in the FY 2024 IPPS proposed rule. The FAH’s suggestion is a logical outgrowth of a policy adjustment that is subject to public comment consistent with section 1871(a)(4) of the Act.

If CMS were to reject any comment that makes a suggestion to revise a market basket policy that was not explicitly proposed, there would be no point in making a public comment as CMS could reject any suggestion as being out-of-scope of the proposed rule as CMS did not make any explicit proposals to change its methodology for determining the market basket. As the FAH’s comment is a logical outgrowth of a policy subject to public comment, CMS may certainly adopt our suggestion consistent with the rulemaking procedures in section 1871 of the Act.

**In summary, the FAH requests CMS adopt a one-time forecast error adjustment to the FY 2024 IPPS operating update based on the 3.0 percentage point difference in the hospital market basket in FY 2022. In addition to the large understatement of the FY 2022 market basket, we further ask CMS to consider the points above showing that the ECEC has been a better measurement of recent compensation growth than the ECI and that CMS itself acknowledges that the total factor productivity adjustment applied to the update is more than hospitals can realize. Adopting our suggestion would make the market basket equal to 3.0 percent plus 3.0 percentage points for forecast error less 0.2 percentage points for total factor productivity or 5.8 percent.**

The FAH further notes that adopting our suggestion would have the benefit of lowering the outlier threshold. CMS proposed an FY 2024 outlier threshold of \$40,732 or an increase of \$1,944 and 5 percent from FY 2023 outlier threshold of \$38,788. With an update of 5.8 percent, modeling by Watson Policy Analysis (WPA, included in Attachment B) indicates that the FY

2023 outlier threshold would instead decline to \$38,689 (see page 69 *infra*). The WPA analysis highlights that the inadequate market basket update is not only dampening base payment rates but distorting the calculation of the outlier threshold and inappropriately driving up outlier utilization and hospital losses.

2. *The Proposed Rule Would Unlawfully Extend the Remaining –0.9412% Adjustment Under TMA § 7(b)(1)(B) Beyond FFY 2023*

The Proposed Rule would violate the express statutory mandate that the recoupment adjustments be fully reversed and not apply to discharges after FFY 2023, and ***the FAH strongly urges CMS to instead comply with the relevant requirements by fully eliminating the remaining negative 0.9412% payment adjustment in the FFY 2024 Final Rule.*** In section 7(b)(4) of the TMA, Abstinence Education, and QI Program Extension Act of 2007, Pub. L. No. 110-90 as amended<sup>32</sup> (“TMA”), Congress expressly prohibited the “appl[ication] of the adjustment under paragraph (1)(B) other than for discharges occurring” during specified fiscal years, ending with FFY 2023. At present, the cumulative net adjustment under section 7(b)(1)(B) of the TMA effective for FFY 2023 is negative 0.9412 percent. As such, in order to comply with Congress’ mandate that the adjustment under section 7(b)(1)(B) not apply to any year after FFY 2023, CMS is required to fully eliminate this remaining section 7(b)(1)(B) adjustment with a one-time, offsetting positive adjustment of 0.9412 percent for FFY 2024. The Proposed Rule, however, does not make mention of section 7(b) of the TMA and fails to provide any rationale or legal basis for effectively making the net adjustments under section 7(b)(1)(B) permanent.

Over the years, CMS has made the following adjustments under section 7(b)(1)(B) of the TMA:

FFY	Adjustment	Cumulative Adjustment
2011	–2.9 percent	–2.9 percent
2012	0 percent <sup>33</sup>	–2.9 percent
2013	+ 2.9 percent	0 percent
2014	–0.8 percent	–0.8 percent
2015	–0.8 percent	–1.6 percent
2016	–0.8 percent	–2.4 percent
2017	–1.5 percent	–3.9 percent
2018	+0.4588 percent	–3.4412 percent
2019	+0.5 percent	–2.9412 percent

<sup>32</sup> Section 7 of the TMA was amended by the American Taxpayer Relief Act of 2012, Pub. L. No. 112-240, § 631(b) (“ATRA”) in 2013, by Medicare Access and CHIP Reauthorization Act of 2015, Pub. L. No. 114-10, § 414 (“MACRA”) in 2015, and by the 21st Century Cures Act, Pub. L. No. 114-255, § 15005 in 2016.

<sup>33</sup> The FFY 2012 adjustment included both a +2.9 percent adjustment to off-set the one-time FFY 2011 adjustment as well as a –2.9 percent adjustment such that there was no net change in the adjustment between FFY 2011 and FFY 2012. 76 Fed. Reg. 51,475, 51,497 (Aug. 18, 2011).

2020	+0.5 percent	–2.4412 percent
2021	+0.5 percent	–1.9412 percent
2022	+0.5 percent	–1.4412 percent
2023	+0.5 percent	–0.9412 percent

The FFY 2011 and FFY 2012 adjustments were authorized under section 7(b)(1)(B)(i) of the amended TMA and were fully reversed in FFY 2013.<sup>34</sup> Then the FFY 2014 through FFY 2017 adjustments were authorized under section 7(b)(1)(B)(ii) of the amended TMA,<sup>35</sup> followed by the adjustments for 2018 through 2023 under amended section 7(b)(1)(B)(iii) of the TMA.<sup>36</sup>

As illustrated in the above table, the series of negative and positive adjustments that have been made under TMA section 7(b)(1)(B) between FFYs 2011 and 2023 have produced a cumulative, net adjustment of negative 0.9412%. If this adjustment under section 7(b)(1)(B) of the TMA is not fully eliminated with a one-time offsetting positive adjustment of 0.9412 percent, then the adjustments under section 7(b)(1)(B) would apply to discharges in FFY 2024 and thereafter in violation of the express statutory mandate of section 7(b)(4). As outlined above, TMA § 7(b)(4) provides that “[n]othing in this section shall be construed as providing authority to apply the adjustment under paragraph (1)(B) other than for discharges occurring during fiscal years 2010, 2011, 2012, 2014, 2015, 2016, and 2017 and each succeeding fiscal year *through fiscal year 2023*” (emphasis added). This language makes clear that CMS must fully eliminate the payment adjustment under section 7(b)(1)(B) for any year not listed in section 7(b)(4). And, in fact, that is precisely what CMS did in the FFY 2013 Final Rule by fully eliminating the section 7(b)(1)(B) adjustment at that time with a one-time positive 2.9 percent adjustment. 77 Fed. Reg. at 53,276. The Proposed Rule provides no rationale for diverging from CMS’ established approach to eliminating section 7(b)(1)(B) adjustments to comply with section 7(b)(4) of the TMA or authority for making the section 7(b)(1)(B) adjustments permanent.

*In light of the foregoing concerns, the FAH urges CMS to fully eliminate the remaining section 7(b)(1)(B) adjustment with a one-time, offsetting positive adjustment of 0.9412 percent for FFY 2024.*

#### **VIII.C. Proposed FY 2024 LTCH PPS Standard Federal Payment Rate Annual Market Basket Update**

CMS is proposing an annual update to the LTCH PPS standard federal payment rate of 2.9 percent that is equal to the LTCH market basket of 3.1 percent less 0.2 percentage points for total factor productivity. For LTCHs failing to submit data to the LTCH Quality Reporting Program (QRP), the annual update would be further reduced by 2.0 percentage points. All of the

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<sup>34</sup> In FFY 2013, CMS finalized “a +2.9 percent adjustment, as proposed, completing the recoupment portion of section 7(b)(1)(B) of Public Law 110-90.” 77 Fed. Reg. 53,257, 53,276 (Aug. 31, 2012). With this adjustment, “the standardized amount [was] returned to the appropriate baseline.” *Id.*

<sup>35</sup> See 82 Fed. Reg. 37,990, 38,008–009 (Aug. 14, 2017).

<sup>36</sup> See 87 Fed. Reg. 48,780, 48,799–48,800 (Aug. 10, 2022).

same issues that are stated above would also apply to the LTCH market basket. Below is a table that compares the LTCH update to the LTCH market basket based on later data since FY 2021:

LTCH Market Basket	FY 2021	FY 2022	FY 2023
Forecast Used in the Update	2.3	2.6	2.6
Actual Based on Later Utilization	3.0	5.7	4.6
Difference	-0.6	-3.0	-0.5

Like the IPPS market basket, these data show that CMS has understated the LTCH market basket by a combined 4.1 percentage points for these three years (with the FY 2023 data still being an estimate). Like we requested for the FY 2024 IPPS operating update, **the FAH also requests that CMS provide for a forecast error adjustment to the FY 2022 LTCH market basket when updating the FY 2024 LTCH rates. Adopting our suggestion would make the market basket equal to 3.1 percent plus 3.0 percentage points for forecast error less 0.2 percentage points for total factor productivity or 5.9 percent.**

The FAH further notes that CMS is proposing an extraordinary increase to the LTCH outlier threshold from \$38,518 to \$94,378, an increase of more than 145 percent. In the proposed rule, CMS seeks comments:

...on all aspects of our proposed methodology...and whether there are any modifications to the methodology or the assumptions underlying it that may result in more accurate estimations of the total outlier payments and/or the total LTCH PPS payments for LTCH PPS standard Federal payment rate cases.<sup>37</sup>

Similar to the comment we made above regarding the operating IPPS update, a higher market basket update would contribute to lowering the final rule LTCH outlier threshold. Not only would an adjustment for forecast error make overall LTCH rates more accurate long-term, it would also improve the accuracy of the outlier threshold by making it lower consistent with CMS' comment solicitation.

## MEDICAL EDUCATION

### **V.G.2 Calculation of Prior Year IME Resident to Bed Ratios When there is a Medicare GME Affiliation Agreement**

The FAH opposes the proposal by CMS to revise the cost reporting instructions for calculating the indirect medical education (IME) prior-year (PY) intern and resident-to-bed ratio (IRB) when a hospital increases its cap of full-time equivalent (FTE) residents due to an affiliation agreement with another teaching hospital.<sup>38</sup> CMS' proposal would not accurately

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<sup>37</sup> 88 Fed. Reg. 27242, May 1, 2023

<sup>38</sup> Medicare Program; Proposed Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Policy

reflect the impact of an affiliation agreement on the PY IME IRB because it would compare inconsistent FTE calculations in the current and prior years, it does not account for rural track FTE affiliations, and it would improperly reduce the PY IRB in certain instances when the penultimate-year (PPY) FTEs are lower than the PY and current-year (CY) FTEs.

### *1. Background*

The Medicare statute requires CMS to calculate the IME adjustment based on the ratio of interns and residents to available beds as follows:

$c \times [(1 + r)n - 1]$  = “indirect teaching adjustment factor” where—

$c$  = a statutorily set adjustment factor;

$r$  = ratio of FTEs to hospital beds; and

$n$  = .405 (measurement factor for teaching activity).<sup>39</sup>

The resulting “indirect teaching adjustment factor” is then multiplied by the hospital’s diagnostic-related group (DRG) payments for the cost reporting year to arrive at the IME reimbursement amount.<sup>40</sup> Each hospital’s FTEs are capped at the number the hospital trained in its most recent cost reporting period ending on or before December 31, 1996.<sup>41</sup> In any given year, the number of FTEs is calculated by averaging the lower of the actual or capped FTE count in the current cost reporting period and the preceding two cost reporting periods.<sup>42</sup> This capped and averaged FTE count is divided by the number of hospital beds in that hospital to arrive at the hospital’s current-year IRB. Finally, the current-year resident-to-bed ratio is compared to the resident-to-bed ratio in the prior year, and the smaller of the two ratios is used as the variable “ $r$ ” to calculate the current-year IME payments.<sup>43</sup>

Teaching hospitals may form an “affiliated group” to aggregate and reapportion their FTE caps.<sup>44</sup> Currently, Medicare cost report instructions state that if a provider’s IME FTE cap and current-year IME FTE count increase as a result of a Medicare affiliation agreement, the prior-year IRB should be adjusted as follows: “identify the lower of: (a) the difference between the current-year numerator and the prior-year numerator, and (b) the number by which the FTE cap increased per the affiliation agreement, and add the lower of these two numbers to the prior

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Changes and Fiscal Year 2024 Rates, 88 Fed. Reg. 26,658, 27,015–18 (May 1, 2023) (FFY 2024 Proposed IPPS Rule).

<sup>39</sup> 42 U.S.C. § 1395ww(d)(5)(B)(ii).

<sup>40</sup> *Id.* § 1395ww(d)(5)(B)(i).

<sup>41</sup> *Id.* § 1395ww(d)(5)(B)(v).

<sup>42</sup> *Id.* § 1395ww(d)(5)(B)(vi)(II).

<sup>43</sup> *Id.* § 1395ww(d)(5)(B)(vi)(I).

<sup>44</sup> *Id.* §§ 1395ww(d)(5)(B)(viii), 1395ww(h)(4)(H)(ii).

year's numerator (see FR Vol. 66, No. 148 dated August 1, 2001, page 39880)."<sup>45</sup> The numerator of the IRB is the FTE count as adjusted by the cap.

## 2. *CMS' Proposal*

CMS proposes to revise the cost report instructions for calculating the PY IRB on Worksheet E, Part A, line 20 when a hospital has an increase in its current-year FTEs and FTE cap due to an affiliation agreement:

If the provider is participating in a Medicare GME affiliation agreement or rural track Medicare GME affiliation agreement under 42 CFR 413.79(f), and the provider increased its current year FTE cap (*difference of current year line 8 and prior year line 8 is positive*) and increased its current year allowable FTE count (*difference of current year line 12 (excluding current year dental and podiatry from line 11) and prior year line 12 (excluding prior year dental and podiatry from line 11) is positive*) due to this affiliation agreement, identify the lower of: (a) the difference between the current year numerator *line 15* and the prior year numerator *line 12 of the prior year cost report*, and (b) the number by which the FTE cap increased per the affiliation agreement (*difference of current year line 8 and prior year line 8*), and add the lower of these two numbers to the prior year's numerator *line 12 of the prior year cost report*.<sup>46</sup>

CMS' proposed calculation of "(a) the difference between the current year numerator, Line 15 and the prior year numerator, line 12 of the prior year cost report" would compare dissimilar FTE calculations. The current-year FTEs on Line 15 are an average of the current-year, prior-year and penultimate-year allowable FTEs, which include FTEs for dental and podiatry residents. Line 12 of the prior-year Worksheet E, Part A includes allowable FTEs including dental and podiatry residents. The difference between these two numbers does not accurately represent the impact an affiliation agreement has on the current year as compared to the prior year.

Two examples illustrate how the proposals could distort the prior year IRB.

### **Example #1: Dental Residents Decrease in Current Year**

<b>Worksheet E, Part A</b>	<b>Current Year</b>	<b>Prior Year</b>
Line 5 (1996 FTE Cap)	90	90
Line 8 (Affiliation Agreement)	10	2
Line 9 (Adjusted FTE Cap)	100	92
Line 10 (CY Allopathic and Osteopathic FTEs)	150	142

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<sup>45</sup> Provider Reimbursement Manual, Part 2, CMS Pub. No. 15-2, Ch. 36, § 3630.1.

<sup>46</sup> FFY 2024 Proposed IPPS Rule, 88 Fed. Reg. at 27,018 (emphasis in original).



Line 11 (CY Dental and Podiatric FTEs)	20	45
Line 12 (CY Allowable FTEs)	120	<b>137</b>
Line 13 (PY Allowable FTEs)	137	135
Line 14 (PPY Allowable FTEs)	135	136
Line 15 (3-year rolling average)	<b>130.67</b>	136.00

In this example, CMS' policy would impact the prior-year IRB because the hospital increased its current-year FTE cap (difference of current-year line 8 and prior-year line 8 is positive, *i.e.*, 8 FTEs), and it increased its current-year allowable FTE count (difference of current-year line 12 (excluding current-year dental and podiatry from line 11, *i.e.*, 100 FTEs) and the prior-year line 12 (excluding prior-year dental and podiatry from line 11, *i.e.*, 92 FTEs)) is positive, *i.e.*, 8 FTEs.

However, this hospital will not see an increase in its IRB due to the affiliation agreement because the hospital's dental and podiatric FTEs declined from 45 to 20. The hospital's current-year affiliation agreement increased the cap slots by 8 FTEs, and the current-year FTE count also increased by 8 FTEs, but the hospital would not receive an adjustment under CMS' proposed policy due to the drop in dental/podiatric FTEs. The proposed policy would add to the numerator of the prior-year IRB the lower of: (a) the difference between the current year-numerator line 15 (*i.e.*, 130.67) and the prior-year numerator line 12 of the prior-year cost report (*i.e.*, 137), and (b) the number by which the FTE cap increased per the affiliation agreement (difference of current-year line 8 and prior-year line 8, *i.e.* 8 FTEs). This example would actually result in a *reduction* to the prior-year IRB numerator of 6.33 FTEs because 130.67 minus 137 is -6.33, which is lower than the 8 FTEs that the FTE cap increased under the affiliation agreement.

#### Example #2: PPY FTEs Were Lower Than the PY and CY FTEs

Worksheet E, Part A	Current Year	Prior Year
Line 5 (1996 FTE Cap)	90	90
Line 8 (Affiliation Agreement)	10	2
Line 9 (Adjusted FTE Cap)	100	92
Line 10 (CY Allopathic and Osteopathic FTEs)	150	142
Line 11 (CY Dental and Podiatric FTEs)	0	0
Line 12 (CY Allowable FTEs)	100	<b>92</b>
Line 13 (PY Allowable FTEs)	92	80
Line 14 (PPY Allowable FTEs)	80	90
Line 15 (3-year rolling average)	<b>90.67</b>	87.33

In this example, CMS' policy would also impact the prior-year IRB. Even though the hospital's current-year line 8 increased by 8 FTEs due to the affiliation agreement, and the current-year FTE count increased by 8 FTEs, the hospital would not receive an adjustment to its IRB under CMS' proposal. The proposed policy would add to the numerator of the prior-year

IRB the lower of: (a) the difference between the current-year numerator line 15 (i.e., 90.67) and the prior-year numerator line 12 of the prior-year cost report (i.e., 92), and (b) the number by which the FTE cap increased per the affiliation agreement (difference of current year-line 8 and prior-year line 8, i.e. 8 FTEs).

Again, CMS' proposal would result in a *reduction* to the numerator of the prior-year IRB because 90.67 minus 92 is -1.33, which is lower than the 8 FTEs in which the FTE cap increased per the affiliation agreement. In this example, the numerator of the prior-year IRB would go down by 1.33 FTEs, even though the cap and current-year counts both increased due to the affiliation agreement.

3. *CMS Should Revise Its Policy to Include All Affiliation Agreements and to Remove Distortions in the Prior-Year IRB*

CMS should amend its proposed policy in several respects. First, the prior-year IRB should reflect the impact of all affiliation agreements. Therefore, CMS should amend its policy so that hospitals will use both line 8 and line 7.02 (rural track affiliation agreement) to compare the current and prior-year affiliation agreements and to calculate any adjustment to the numerator of the prior-year IRB. Second, CMS should compare current and prior-year allopathic and osteopathic FTEs, instead of allowable FTEs, to ensure that changes in dental or podiatric FTEs do not distort the prior-year IRB calculation. We have modified CMS' proposal to reflect the changes that we believe are necessary:

If the provider is participating in a Medicare GME affiliation agreement or rural track Medicare GME affiliation agreement under 42 CFR 413.79(f), and the provider increased its current year FTE cap (difference of the sum of current year line 7.02 and line 8 and the sum of prior year line 7.02 and line 8 is positive) and increased its current year **allowable** FTE count (difference of current year line 10 12 (excluding current year dental and podiatry from line 11) and prior year line 10 12 (excluding prior year dental and podiatry from line 11) is positive) due to this affiliation agreement, identify the lower of: a) the difference between the current year **numerator** line 10 15 and the prior year **numerator** line 10 12 of the prior year cost report, and b) the number by which the FTE cap increased per the affiliation agreement (difference of the sum of current year line 7.02 and line 8 and the sum of prior year line 7.02 and line 8), and add the lower of these two numbers to the prior year's numerator line 12 of the prior year cost report.

These proposed modifications will also prevent distortions that arise under CMS' proposal due to the inclusion of penultimate-year FTEs in line 15. By comparing the current-year FTEs on line 10 in both the current and prior year, rather than using the current-year line 15, the penultimate-year FTEs will not improperly reduce the numerator of the prior-year IRB.

### **V.G.3 Training in New Rural Emergency Hospitals (REH) Facility Type**

Section 125 of CAA, 2021 established REHs as a new Medicare provider type, effective January 1, 2023. REHs are facilities that do not provide acute care inpatient hospital services. Only critical access hospitals (CAH) or rural hospitals (or hospitals treated as rural for IPPS payment purposes) with fewer than 50 beds may convert to REH status.

Hospitals may count residents training in “non-provider” sites for DGME and IME payment as long as the resident is engaged in patient care activities and the hospital incurs the costs of the resident salaries and benefits while the resident is training in the non-provider site. For cost reporting periods beginning on or after October 1, 2019, a hospital may include FTE residents training at a CAH in its direct GME and IME FTE counts as long as the hospital meets the non-provider setting requirements. Effective for portions of cost reporting periods beginning on or after October 1, 2023, CMS is expanding this policy to REHs (e.g., a hospital may include FTE residents training at an REH in its direct GME and IME FTE counts as long as the hospital incurs the cost of the resident salaries and fringe benefits while training in the REH.

As an alternative to the hospital counting the resident for DGME and IME payment purposes, a CAH may incur the costs of the resident training at the CAH and be paid for the training at 101 percent of reasonable cost. CMS proposes an analogous policy for REHs except the REH would be paid 100 percent rather than 101 percent of reasonable cost under section 1861(v) of the Act that authorizes payment based on reasonable cost principles.

**The FAH supports CMS’ proposals.**

### **V.H. Reasonable Cost Payment for Nursing and Allied Health Education Programs**

Medicare pays for provider-operated nursing and allied health education programs on the basis of reasonable cost. Under the reasonable cost payment methodology, a hospital is paid Medicare’s share of its reasonable costs. Beginning in 1999, Medicare’s share included Medicare Advantage (MA) utilization. These additional payments for nursing and allied health education attributed to MA utilization are funded through a reduction to analogous payments made to teaching hospitals for DGME and limited to \$60 million per year.

An oversight resulted in CMS not updating the factors that determine MA nursing and allied health reasonable cost payments for more than 17 years. CMS did not apply the \$60 million limitation to nursing and allied health education MA payments. Hospital-based schools of nursing and allied health education were overpaid for their reasonable costs and CMS reduced DGME payments too much. This issue was brought to CMS’ attention several years ago. CMS rectified the issue by repaying amounts owed to teaching hospitals for DGME and recouping hundreds of millions in reasonable cost payments from hospital-based nursing and health education schools.

Section 4143 of the Consolidated Appropriation Act, 2023 provides relief for hospitals subjected to recoupment of overpayments for 2010 through 2019 without requiring these additional payments to be financed with a reduction to a hospital’s DGME MA payments. The

Proposed Rule details the process CMS is instructing the MAC to use to implement section 4143 of the CAA. CMS' process will provide hold harmless for hospitals that were overpaid for their nursing and allied health education costs without requiring any reduction to hospitals DGME payments. **The FAH supports CMS' implementation of CAA section 4143.**

## **HOSPITAL VALUE-BASED PURCHASING (VBP) PROGRAM: PROPOSED CHANGES**

### **V.K.2.C.1. Proposed Substantive Measure Updates to the Medicare Spending per Beneficiary (MSPB)—Hospital Measure**

CMS proposes to adopt substantial measure updates to the MSPB hospital measure in the Hospital VBP Program beginning with the FY 2028 program year.

The FAH continues to question the scientific acceptability of the measure as outlined in our letter on the FY 2023 proposed rule dated June 17, 2022. While we believe that CMS must address the concerns with the risk model prior to implementation of this updated measure in the Hospital VBP Program, we appreciate that the proposals to adopt these changes in this program and remove the measure from the Hospital IQR Program address our previous concerns of public reporting of duplicate but differing measure results across programs.

### **V.K.2.C.2. Proposed Substantive Measure Updates to the Hospital-Level Risk-Standardized Complication Rate (RSCR) Following Elective Primary Total Hip Arthroplasty (THA) and/or Total Knee Arthroplasty (TKA) Measure**

CMS proposes to adopt substantive measure updates to the Hospital-level Risk-Standardized Complication Rate (RSCR) Following Elective Primary Total Hip Arthroplasty (THA) and/or Total Knee Arthroplasty (TKA), beginning with the FY 2030 program year.

The FAH appreciates that the proposals to adopt these changes in this program and remove the measure from the Hospital IQR Program respond to our previous concerns of public reporting of duplicate but differing measure results across programs. However, we note that the inclusion of the additional ICD-10 codes for mechanical complications in response to feedback from subject matter experts has not yet been reviewed and endorsed by the Consensus-Based Entity (CBE). We encourage CMS to have these changes reviewed by the CBE as soon as possible.

### **V.K.3.A.2. Proposed New Measure Beginning with the FY 2026 Program Year: Severe Sepsis and Septic Shock: Management Bundle**

CMS proposes to adopt the measure, as updated, for the Hospital VBP Program, beginning with the FY 2026 program year.

The FAH continues to believe that the concerns over the evidence used to support this measure as specified, have the potential to incentivize unintended negative consequences, and its feasibility given the complexity of the specifications warrant further review and reconsideration.

As a result, the FAH does not support inclusion of this measure in the Hospital VBP Program at this time.

### **V.K.3.C. Proposed Updates to the Data Collection and Submission Requirements for the HCAHPS Survey Measure**

CMS proposes to make the same updates to the form and manner of the administration of the HCAHPS Survey measure under the Hospital VBP Program as what is proposed for the Hospital IQR Program.

The FAH appreciates CMS' commitment to alignment across quality programs and its work to update the HCAHPS Survey measure. Our detailed comments on the proposed changes to the data collection and submission requirements can be found under the Hospital IQR Program section of this letter.

### **V.K.6.B. Proposal to Revise the Hospital VBP Program Scoring Methodology**

CMS proposes to add Health Equity Adjustment bonus points to a hospital's Total Performance Score (TPS) that would be calculated using a methodology that incorporates a hospital's performance across all four domains for the program year and its proportion of patients with dual eligibility status (DES).

The FAH supports the inclusion of a health equity adjustment for hospitals and agrees with the current approach of only using DES as well as simplifying what is a complex calculation. We encourage CMS to explore methods by which bonus points could be achieved using more straightforward approaches such as the Merit-Based Incentive Payment System (MIPS) complex patient bonus.

We recognize that CMS is limited in the data currently available but are also aware of recent research<sup>47</sup> outlining concerns that the Area Deprivation Index (ADI) may be imprecise and could misrepresent a health system's population, particularly in urban areas. All of the variables such as DES and ADI are proxies, measuring different characteristics, and are imprecise and CMS must be cautious when applying any one of these factors. The FAH also agrees with the proposal to not require a minimum percent of patients with DES but rather allow any hospital regardless of the number of these patients they serve to be eligible to receive a bonus. This approach has a greater potential of avoiding misrepresentation of the characteristics of the individuals served by a hospital rather than limiting the potential number of bonus points available based on arbitrary cut points and imprecise data.

We encourage CMS to consider other variables such as the Low-Income Subsidy for potential inclusion in this calculation but with the caution that the concerns raised regarding ADI should also be examined with any potential variable considered for this adjustment. The current

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<sup>47</sup> Azar et al. (2023). ACO Benchmarks Based On Area Deprivation Index Mask Inequities. *Health Affairs*, (Project Hope), February 2023.  
<https://www.healthaffairs.org/doi/10.1377/forefront.20230215.8850>.

set of variables used to identify individuals at risk remain insufficient and we urge CMS to continue to refine and improve on the data that are used.

Regarding the proposed vs. the alternative methodology that simulates only awarding 4 measure performance scaler points to the hospitals in the top third of performance for each domain, while hospitals in the middle and bottom third of performance received 0 measure performance scaler points, the impact analysis does not make a compelling case to indicate that this alternative approach would be superior to what is proposed. The FAH believes that CMS should finalize a methodology that is not overly complex and allows hospitals to have every opportunity to receive the maximum number of points in this adjustment.

The FAH also supports the proposal to modify the total performance score maximum to accommodate the addition of the health equity adjustment.

## **HOSPITAL-ACQUIRED CONDITION (HAC) REDUCTION PROGRAM**

### **V.L.4. Advancing Patient Safety in the HAC Reduction Program – Request for Comment**

CMS invites public comment on potential future measures as well as on how the HAC Reduction Program can further promote patient safety. Specifically, CMS requests feedback on potentially adopting patient safety related eCQMs, which are currently used in the Hospital Inpatient Quality Reporting (IQR) Program, including: Hospital Harm—Opioid-Related Adverse Events eCQM, Hospital Harm-Severe Hypoglycemia eCQM, Hospital Harm-Severe Hyperglycemia eCQM, Hospital Harm-Acute Kidney Injury eCQM, Hospital Harm-Pressure Injury eCQM, and Excessive Radiation Dose or Inadequate Image Quality for Diagnostic Computer Tomography in Adults eCQM.

The FAH strongly supports efforts to ensure that patients receive the safest and highest quality care. Our members continually seek to identify the root cause of problems and focus on targeted solutions that address today's patient safety challenges, including those that were exposed during the recent public health emergency. Hospitals and health systems face many challenges in meeting their commitments to advancing patient safety and we encourage CMS to support the research that is needed to better understand the impact of the pandemic on patients and the health care system.<sup>48</sup> We believe that those learnings can be applied to forging a new era in patient safety that detects and addresses patient harm at every point in the care-giving process including:

- identifying and testing new team-based models that address longstanding workforce issues;
- optimizing the use of Patient Safety Organizations;
- distinguishing between non-preventable and preventable harms; and
- remove barriers to innovation.

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<sup>48</sup> Sands KE, Blanchard EJ, Fraker S, Korwek K, Cuffe M. Health Care–Associated Infections Among Hospitalized Patients With COVID-19, March 2020-March 2022. *JAMA Netw Open*. 2023;6(4):e238059. doi:10.1001/jamanetworkopen.2023.8059.

While many of these efforts are focused on building or reinforcing infrastructures, we believe that these actions would result in a strong foundation on which future patient safety focused measures could be implemented. No additional measures should be considered for inclusion in this program until we collectively have a better understanding on how care delivery has changed and what levers and metrics would be most effective in facilitating the safest care possible.

Specific to the HAC Reduction program, the FAH encourages CMS to use rewards instead of penalties. As it is currently designed, this program penalizes the lowest performing twenty-five percent of all subsections (d) hospitals with a one percent reduction in Medicare payments annually. Although statutorily defined, this flawed methodology results in catastrophic consequences for hospitals with low volumes, such as small and rural hospitals. CMS should explore options within its current authority to adjust for lower patient volumes wherein one event would place a hospital in the lower performance quartile.

Regarding the existing and proposed patient safety related eQMs, we caution CMS on considering inclusion of these measures in the HAC Reduction Program. We believe that any measure that is considered for this program should demonstrate sufficient variations in performance to enable hospitals to use the resulting scores to inform quality improvement efforts and for patients in their decision making. While we believe the move to eQMs is important, the data provided to support the current set of hospital harm eQMs do not meet this minimum criteria. In addition, it is essential that any eQM included in the HAC Reduction Program be sufficiently tested across a wide set of EHRs and hospitals. To date, CMS has primarily conducted testing in only two vendor systems for each measure and across no more than 20 hospitals. The FAH does not believe that this level of testing truly ensures that the required data are feasible for hospitals to collect, nor does it ensure that the measures produce reliable and valid performance scores. eQMs require significant resources and time for hospitals to implement and only those eQMs that are widely tested and with sufficient variation in performance should be included in the program. In addition, we do not believe that CMS should put forward measures that require interfaces with additional databases as proposed with the Excessive Radiation Dose or Inadequate Image Quality for Diagnostic Computer Tomography in Adults eQM.

## **CAPITAL-RELATED COSTS**

### **VI.D. Capital DSH Payments**

The FAH supports CMS' proposal to expand eligibility for capital DSH consistent with *Toledo Hospital v. Becerra*, No. 19-cv-3820 (D.D.C. 2021) by permitting geographically urban hospitals that are reclassified as rural under § 412.103 to receive capital DSH payments if they are otherwise eligible, but the FAH strongly encourages CMS to go further by expanding capital DSH eligibility to rural hospitals as well. As CMS has observed, rural communities have higher poverty and age-adjusted mortality rates, are home to a higher proportion of older residents and persons living with a disability, and experience disparities in health outcomes compared to urban

areas and national averages.<sup>49</sup> In order to better support Medicare beneficiaries living in rural communities and to improve health equity, the FAH favors systematic action to protect rural hospitals.

As the Proposed Rule acknowledges, 42 U.S.C. § 1395ww(g) affords the Secretary “broad authority in establishing and implementing the IPPS for acute care hospital inpatient capital-related costs.” 88 Fed. Reg. at 27,058. In particular, CMS has the authority to adjust capital payments to take into account variations in the relative costs of capital and construction for different types of facilities or areas, adjust capital payments to reflect hospital occupancy rates, and to make appropriate exceptions. 42 U.S.C. § 1395ww(g)(1)(B)(ii) – (iv). Using this broad grant of authority, CMS can extend capital DSH to rural hospitals that would otherwise be eligible under 42 C.F.R. § 412.320 but for their rural status, and CMS should do so as part of its concerted efforts to bolster the rural health care safety net.

The financial pressures facing rural hospitals have been well documented and extend to capital costs. Rural capital margins are deeply negative, contributing to the precarious situations of rural hospitals. Based on the latest cost report information in the March 31, 2023, HCRIS database, capital margins are deeply negative among rural hospitals (negative 33 percent), while capital margins among urban hospitals (negative 16 percent) are slightly more favorable than the national average (negative 17 percent). Moreover, occupancy rates in rural hospitals have been and continue to be lower than in urban hospitals. According to MedPAC, in 2019, “IPPS hospitals in rural non-micropolitan counties had a . . . low occupancy rate (34 percent), while those in micropolitan areas had a slightly higher occupancy rate (47 percent). In contrast, IPPS hospitals in metropolitan areas had an occupancy rate of 68 percent.”<sup>50</sup> Faced with these financial pressures, nearly 150 rural hospitals have closed since 2010, and when rural hospitals close, the median distance to the most common health care services increases by 20 miles. The FAH appreciates CMS’ much needed efforts to continue addressing the acute problems faced by Medicare’s rural hospitals through the low wage index hospital policy and otherwise, but more is needed, including action to address inadequate capital payments to rural hospitals. The FAH estimates that extending capital DSH eligibility to rural hospitals would result in only approximately \$30 million in increased capital DSH payments, and these capital DSH payments would appropriately support Medicare beneficiary access in rural communities by reducing rural hospitals’ disproportionate capital pressures and mitigating the impact of low occupancy rates on capital payments to rural hospitals.

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<sup>49</sup> CMS Framework for Advancing Health Care in Rural, Tribal, and Geographically Isolated Communities (Nov. 2022), at <https://www.cms.gov/files/document/cms-geographic-framework.pdf>.

<sup>50</sup> Medicare Payment Advisory Commission, “Hospital Inpatient and Outpatient Services”, p. 62 (March 2021), available at [https://www.medpac.gov/wp-content/uploads/2021/10/mar21\\_medpac\\_report\\_ch3\\_sec.pdf](https://www.medpac.gov/wp-content/uploads/2021/10/mar21_medpac_report_ch3_sec.pdf).



## **PROPOSED QUALITY DATA REPORTING REQUIREMENTS FOR SPECIFIC PROVIDERS**

### **IX.B.2.A. Proposed Modification of the COVID-19 Vaccination Coverage Among Healthcare Personnel Measure for the Hospital Inpatient Quality Reporting Program**

CMS proposes to modify the COVID-19 Vaccination Coverage Among HCP measure to replace the term “complete vaccination course” with the term “up-to-date” in the HCP vaccination definition and update the numerator to specify the time frames within which an HCP is considered up to date with recommended COVID–19 vaccines, including booster doses, beginning with the quarter 4 2023 reporting period/FY 2025 payment determination for the Hospital IQR Program

The FAH supports the intent of this measure, but we remain concerned that the current specifications are flawed given the lack of a stable definition of “up to date” and the numerator, which refers the end user to a document with varying definitions of “up to date,” could negatively impact the reliability and validity of the measure. A standardized way to collect this information must be made available. The FAH continues to believe that it is too soon to include a measure on COVID-19 vaccinations since the underlying evidence for this measure is still emerging and methods to address measure collection challenges related to anticipated “booster” shots will likely be required.

Should CMS choose to move forward with this measure, we recommend that it be aligned with the requirements of the Hospital Conditions of Participation (COPs) and allow not only medical contraindications but also capture when individuals decline vaccination. We also recommend CMS revise the measure specifications to require data to be submitted in monthly or quarterly periods instead of one week a month for each quarter, in line with other Quality Reporting Program measures. The updated specifications and testing results must also be endorsed by the CBE prior to implementation in the Hospital IQR Program.

## **PROPOSED CHANGES TO THE HOSPITAL IQR PROGRAM**

### **IX.C.5.A.3. Proposed Adoption of Hospital Harm – Pressure Injury eCQM**

CMS proposes to adopt the Hospital Harm – Pressure Injury eCQM, beginning with the CY 2025 reporting period/FY 2027 payment determination and for subsequent years.

The FAH supports addressing important patient safety concerns during an inpatient stay but questions whether this measure demonstrates a sufficient performance gap to support its use in the Hospital IQR Program since performance ranged from 0.00 to 2.02% across 18 hospitals.

The FAH also strongly encourages CMS to assess the feasibility of collecting the required data elements from EHRs and determine if the measure is reliable and valid across a broader set of EHRs vendors and hospitals. Assessment of how the measure performs using only two vendor systems and 18 hospitals should not be considered sufficient. eCQMs require significant resources and time for hospitals to implement and only those eCQMs with

demonstrated gaps in care should be included in the program. We recommend that CMS continue to test this measure across a broad range of hospitals and vendor systems to determine the extent to which there is sufficient variation in performance scores to warrant the measure's use in the Hospital IQR Program.

#### **IX.C.5.B.3. Proposed Adoption of Hospital Harm – Acute Kidney Injury eCQM**

CMS proposes to adopt the Hospital Harm – Acute Kidney Injury eCQM, beginning with the CY 2025 reporting period/FY 2027 payment determination and for subsequent years.

The FAH supports addressing important patient safety concerns during an inpatient stay but questions whether this measure demonstrates a sufficient performance gap to support its use in the Hospital IQR Program since performance ranged from 0.76 to 4.43% across 20 hospitals. We note that this measure is also risk adjusted, which is unlike the other hospital harm eCQMs. Additional information on how an eCQM with risk adjustment will be operationalized in this program would be helpful.

The FAH also strongly encourages CMS to assess the feasibility of collecting the required data elements from EHRs and determine if the measure is reliable and valid across a broader set of EHRs vendors and hospitals. Assessment of how the measure performs using only two vendor systems and 20 hospitals should not be considered sufficient. eCQMs require significant resources and time for hospitals to implement and only those eCQMs with demonstrated gaps in care should be included in the program. We recommend that CMS continue to test this measure across a broad range of hospitals and vendor systems to determine the extent to which there is sufficient variation in performance scores to warrant the measure's use in the Hospital IQR Program.

#### **IX.C.5.C.4. Proposed Adoption of Excessive Radiation Dose or Inadequate Image Quality for Diagnostic Computed Tomography in Adults (Hospital Level – Inpatient) eCQM**

CMS proposes to adopt the Excessive Radiation Dose or Inadequate Image Quality for Diagnostic Computed Tomography in Adults (Hospital Level – Inpatient) eCQM, beginning with the CY 2025 reporting period/FY 2027 payment determination and for subsequent years.

While the FAH appreciates that hospitals are able to self-select the eCQMs on which they will report, we believe additional time for hospitals to integrate and gain experience with the required software is needed before widespread implementation and reporting begins. We suggest that measure adoption be delayed for at least an additional year.

#### **IX.C.6.A.3. Proposed Modification of Hybrid Hospital-Wide All-Cause Risk Standardized Mortality (HWM) Measure**

CMS proposes to modify the measure to expand the cohort of the Hybrid HWM measure from only Medicare fee-for-service (FFS) patients to a cohort which includes both FFS and Medicare Advantage (MA) patients 65 to 94 years old for the FY 2027 for the FY 2027 payment determination and subsequent years.

The FAH appreciates the expansion to the MA population and supports the changes to the measure.

#### **IX.C.6.B.3. Proposed Modification of Hybrid Hospital-Wide All-Cause Readmission (HWR) Measure**

CMS proposes to expand the cohort of the Hybrid HWR measure from only Medicare FFS patients to a cohort which includes FFS and MA patients 65 years and older beginning with the FY 2027 payment determination.

The FAH appreciates the expansion to the MA population and supports the changes to the measure.

#### **IX.C.7.A. Proposed Removal of Hospital-Level Risk-Standardized Complication Rate Following Elective Primary Total Hip Arthroplasty and/or Total Knee Arthroplasty Measure**

CMS proposes to remove the measure beginning with the April 1, 2025, through March 31, 2028, reporting period associated with the FY 2030 payment determination under measure removal factor 8, the costs associated with a measure outweigh the benefit of its continued use in the program.

The FAH agrees with removing this measure since the benefits of continued use do not outweigh the costs required to collect and report the measure.

#### **IX.C.7.B. Proposed Removal of Medicare Spending Per Beneficiary (MSPB)—Hospital Measure**

CMS proposes to remove this measure beginning with the FY 2028 payment determination under measure removal factor 8, the costs associated with a measure outweigh the benefit of its continued use in the program.

The FAH agrees with removing this measure since the benefits of continued use do not outweigh the costs required to collect and report the measure.

#### **IX.C.7.C. Proposed Removal of Elective Delivery Prior to 39 Completed Weeks Gestation: Percentage of Babies Electively Delivered Prior to 39 Completed Weeks Gestation (PC-01) Measure**

CMS proposes to remove the Elective Delivery (PC-01) measure beginning with the CY 2024 reporting period/FY 2026 payment determination under measure removal factor 1: Measure performance is so high and unvarying that meaningful distinctions and improvements in performance can no longer be made (that is, “topped out”) with statistically indistinguishable performance at the 75th and 90th percentiles; and truncated coefficient of variation  $\leq 0.10$  (83 FR 41540 through 41544).

The FAH agrees with removing this measure given the lack of variation in performance scores.

#### **IX.C.9.A. Potential Future Inclusion of Two Geriatric Care Measures**

CMS identified potential future measures on geriatric care that address areas that are important to interested parties, but which are not currently included in the Hospital IQR Program's measure set. CMS seeks public feedback on these measures as they consider how best to develop the Hospital IQR Program's measure set.

The FAH does not support either of these measures since they rely on attestation of a hospital's performance against a broad set of criteria. We do not believe that either will drive improvement on meaningful patient outcomes nor does an aggregated score of many structural components inform patients in their decision-making process. The FAH believes that CMS should focus on developing and/or selecting outcome measures or process measures that are closely linked to outcomes rather than measures of attestation. Furthermore, if CMS does pursue measures on this topic, which we would support, we encourage CMS to focus on a discrete set of processes and/or outcomes rather than the lengthy and duplicative topics addressed in these two measures.

### **FORM, MANNER, AND TIMING OF QUALITY DATA SUBMISSION**

#### **IX.C.10.H.1. Proposed Updates to the HCAHPS Survey Measure**

CMS proposes to update the form and manner of the administration of the HCAHPS Survey measure for the Hospital IQR Program. Specifically these updates are to the administration and submission requirements of the HCAHPS Survey measure beginning with the FY 2027 payment determination, including: (1) adding three new modes of survey administration (Web-Mail mode, Web-Phone mode, and Web-Mail-Phone mode) in addition to the current Mail Only, Telephone Only, and Mail-Phone modes, beginning with January 2025 discharges; (2) removing the requirement that only the patient may respond to the survey to thus allow a patient's proxy to respond to the survey, beginning with January 2025 discharges; (3) extending the data collection period for the HCAHPS Survey from 42 to 49 days, beginning with January 2025 discharges; (4) limiting the number of supplemental items to 12 in order to align with other CMS CAHPS surveys; (5) requiring hospitals to collect information about the language that the patient speaks while in the hospital (whether English, Spanish, or another language) and requiring the official CMS Spanish translation of the HCAHPS Survey be administered to all patients who prefer Spanish, beginning with January 2025 discharges; and (6) removing two currently available options for administration of the HCAHPS Survey that are not used by participating hospitals, beginning in January 2025.

The FAH supports many of these proposed changes to the administration of the HCAHPS Survey measure but also calls for CMS to continue refining and improving the measure and data collection and reporting processes. Specifically, we support the proposed expansion to electronic modes of administration, which align with the "Modernizing the HCAHPS Survey" report

released in July 2019 where Patient Experience Leaders (PELs) were interviewed to provide their insights into the effectiveness of the survey to capture patient experience and the authors examined the current survey and the ways in which it should be updated.<sup>51</sup> A key recommendation in this report was that a digital mode of delivery be added and the FAH is pleased to see this expansion.

We applaud CMS in broadening the potential avenues by which patients and caregivers can provide input and appreciate the rigorous testing that demonstrated that response rates could be improved after expanding the data collection options to enable electronic surveying. The 2019 report's analysis of response rates for HCAHPS from 2008 (33%) to 2017 (26%) revealed a percentage change of -22% overall and an average 0.8 percentage point drop per year. We hope that this erosion of participation can be reduced with the inclusion of digital options and increase the validity of the survey results.

In addition, we agree with every effort made to further improve response rates and support allowing proxies designated by the patient to complete the survey. We also support the requirement to collect information about the language spoken by the patient, requiring that the Spanish translation be administered to those individuals who prefer Spanish, and removing the two administration options that are not used by participating hospitals.

While we understand the goal of extending the data collection period due to the need to allow additional time for follow-up, we are concerned that this extension could further exacerbate a patient's recall bias and lead to additional delays in public reporting of the results. The FAH urges CMS to revisit the time window during which a survey can be sent to a patient with an emphasis on allowing hospitals to administer surveys as soon as a patient is discharged. This change in timing will allow patients to better recall their experience while it is still fresh in their minds and result in data that will be more actionable by hospitals.

The FAH believes that additional work must be completed to ensure that the topics addressed in HCAHPS remain relevant and capture what matters most to patients. During the PELs interviews for the 2019 report, many identified a subset of the existing questions that continue to be important, new topics that should be considered for possible inclusion, and sections that should be reframed (i.e., care transitions, discharge planning). As a result, we question whether the proposal to limit the number of supplemental items fully achieves the goal of increasing response rates and encourage CMS to conduct a comprehensive review of the topics and associated questions covered in HCAHPS. As healthcare continues to evolve, so must the tools used to evaluate patient experiences. The FAH is encouraged to see CMS' move in this direction through these proposed changes but urges that the work continue.

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<sup>51</sup> Federation of American Hospitals. Modernizing the HCAHPS Survey. Released July 2019. Available at: [https://www.fah.org/wp-content/uploads/2021/05/Modernizing\\_HCAHPS - Recommendations from PELs.pdf](https://www.fah.org/wp-content/uploads/2021/05/Modernizing_HCAHPS_-_Recommendations_from_PELs.pdf).

## **PROPOSED CHANGES TO THE MEDICARE PROMOTING INTEROPERABILITY PROGRAM**

### **IX.F.2. Proposed EHR Reporting Changes**

For eligible hospitals and CAHs, CMS is proposing that the EHR reporting period in CY 2025 would be a minimum of any continuous 180-day period within CY 2025. A 180-day EHR reporting period would be the minimum length, and eligible hospitals and CAHs would be encouraged to use longer periods, up to and including the full CY 2025.

The FAH agrees that lengthening the EHR reporting period may yield more comprehensive and reliable data for required measures but stress the importance of flexibility prior to and during the reporting period. Extending the reporting period past 180 days may potentially create converse results. Flexible reporting periods still provide the opportunity for valid data submissions and attestations which aid hospitals in demonstrating meaningful use of health IT.

The FAH strongly urges CMS to consider an alternative approach that produces accurate and reliable data for qualified facilities without extending the reporting period past 180 days.

### **IX.F.3.B. Proposed Change to the SAFER Guides Measure**

CMS is proposing to modify the requirements for the SAFER Guides measure beginning with the EHR reporting period in CY 2024, to require eligible hospitals and CAHs to attest “yes” to having conducted an annual self-assessment using all nine SAFER Guides at any point during the calendar year in which the EHR reporting period occurs. Under this proposal, an attestation of “no” would result in the eligible hospital or CAH not meeting the measure and not satisfying the definition of a meaningful EHR user, which would subject the eligible hospital or CAH to a downward payment adjustment.

The FAH appreciates the value CMS places on developing a “culture of safety” within healthcare organizations, as well as encouraging greater IT use. However, we recommend CMS reconsider its requirement of attesting “yes” for the SAFER Guides measure starting in 2024. While we recognize that the SAFER Guides measure is intended to promote safety and effectiveness across EHR implementations, the proposed process requires extensive resources to complete. Smaller hospitals and hospital systems are at a disadvantage in gathering the required documentation from various staff, partner organizations, and other vendors.

The SAFER Guides are redundant to the required annual Security Risk Assessment (SRA) under the Promoting Interoperability Program, in addition to other policies and procedures that hospitals already enforce. Additionally, the SAFER Guides have not been updated since CY 2016. The FAH questions their place in the Promoting Interoperability Program altogether. The EHR landscape, as well as the Promoting Interoperability Program requirements, have significantly evolved since 2016. Instead, we propose that CMS reevaluate its stance on incentive payments and apply its Meaningful Measures 2.0 framework when

deciding how best to promote optimal patient safety outcomes and progress IT use. The SAFER Guides require a significant undertaking in comparison to other aspects of the Program; attributing funds to their completion would be more plausible and less burdensome than including it as another prerequisite to compliance with the Promoting Interoperability Program.

The FAH disagrees with the SAFER Guides incorporation to the program and believe this places an undue burden on eligible hospitals. Should CMS finalize this proposal to require a "yes" attestation, they would be doing so without true merit to the program.

#### **IX.F.7.A.2. Proposed eCQM Adoptions**

CMS proposes to add the following two eCQMs that address factors contributing to hospital harm to the Medicare Promoting Interoperability Program eCQM measure set on which hospitals can self-select to report, beginning with the CY 2025 reporting period: (1) the Hospital Harm – Pressure Injury eCQM (CBE #3498e); and (2) the Hospital Harm – Acute Kidney Injury eCQM (CBE #3713e). In addition, CMS proposes to add the Excessive Radiation Dose or Inadequate Image Quality for Diagnostic Computed Tomography in Adults (Hospital Level – Inpatient) – (CBE #3663e) to the Medicare Promoting Interoperability Program eCQM measure set on which hospitals can self-select to report, beginning with CY 2025 reporting period.

The FAH has concerns about these measures as already stated above with our comments on the HIQR Program. Regarding the Excessive Radiation Dose or Inadequate Image Quality for Diagnostic Computed Tomography in Adults (Hospital Level – Inpatient) we believe additional time for hospitals to integrate and gain experience with the required software is needed before widespread implementation and reporting begins. We suggest that measure adoption be delayed for at least an additional year.

### **OTHER PROVISIONS**

#### **X.B. Physician Self-Referral and Physician-Owned Hospitals (42 C.F.R. §§ 411.362 and 411.363)**

The FAH commends CMS for its careful evaluation of its statutory authority with respect to requests for exceptions from the prohibition on expansion of facility capacity for physician-owned hospitals (POH) and revisiting comments previously submitted in connection with previous rulemaking and POH expansion requests. The FAH has been deeply concerned that the 2021 changes that eliminated key program integrity restrictions for high Medicaid facilities opens the door to expansion exception requests that violate the spirit of the general statutory band on POH expansions and fails to adequately protect the Medicare program, beneficiaries, and others from harms such as overutilization, patient steering, cherry-picking, and lemon-dropping. *Therefore, the FAH strongly supports and urges CMS to finalize its proposals (1) clarifying CMS' discretion to deny expansion requests, (2) adjusting the process for obtaining community input on and approving or denying expansion exception requests, and (3) reinstating key program integrity restrictions with respect to high Medicaid facilities.*

First, the FAH endorses CMS' interpretation of the statutory language concerning POH expansions to provide CMS with "discretion to approve or deny a request for an expansion exception even if the requesting hospital meets the criteria for an applicable hospital or high Medicaid facility." 88 Fed. Reg. 27,176. The Secretary is statutorily required to deny a request that does not comply with the statutory and regulatory requirements for eligibility, but the Secretary may also deny a request based on additional, case-specific considerations, including those raised by community members. This interpretation is consistent with the statutory requirement to implement a process by which an applicable hospital or a high Medicaid facility "may apply for an exception" from the prohibition on facility expansion for POHs. 42 U.S.C. § 1395(i)(3)(A)(i); *see also* § 1395(i)(3)(C)(i) (referencing the "grant[]" of exceptions), (C)(ii) (not "permitting" certain increases), and (H) (referencing a final "decision" with respect to an expansion "application"). Certainly, CMS lacks discretion to deny an exception request from a POH that is not an applicable hospital or a high Medicaid facility. But, as acknowledged in the Proposed Rule CMS is not required to grant any particular request, and a denial of a request is not subject to administrative or judicial review under 42 U.S.C. § 1395(i)(3)(I).

The FAH generally supports CMS' proposed revisions to the expansion exception process, and particularly appreciates CMS' clarification that community input is not confined to the narrow question of whether the requesting POH satisfies the eligibility criteria as an applicable hospital or a high Medicaid facility. As the Proposed Rule accurately summarizes, "Congress intended for hospitals, patients, and others that are most likely to be affected by the expansion of the requesting hospital to have input in CMS' decision whether to approve or deny the request, as well as to provide information that may confirm or refute the requesting hospital's claim that it meets the criteria for an applicable hospital or high Medicaid facility." 88 Fed. Reg. at 27,181. In particular, the FAH notes with approval that proposed 42 C.F.R. § 411.363(f)(3)(i) explicitly provides that community input may address both eligibility for the expansion exception and the factors set forth at 42 C.F.R. § 411.363(i)(2), but is "not limited to" eligibility and the listed factors. Broad community input on exception requests will better enable CMS to provide the case-by-case evaluation of requests and ensure that requests are only granted in cases where permitted under the applicable facility or high Medicaid facility requirements and where the totality of the information supports the appropriateness of the expansion.

Finally, the FAH strongly supports reinstatement of program integrity restrictions on the maximum aggregate expansion of a hospital and location of an expansion facility. As CMS notes, "the removal of the program integrity restrictions as they apply to high Medicaid facilities [in the CY 2021 OPPS/ASC final rule] was not the result of a determination that they were unnecessary. Rather, the purpose of the regulatory change was to streamline regulations in order to eliminate burden." 88 Fed. Reg. 27,185. The FAH agrees with CMS that these program integrity restrictions are critical to protect the Medicare program, beneficiaries, and other patients from harms such as overutilization, patient steering, cherry-picking, and lemon-dropping, and these goals outweigh any perceived burden on high Medicaid facilities. In the aftermath of the CY 2021 OPPS/ASC, the FAH has been concerned to see expansion exception requests from POHs seeking to bring physician ownership to entirely new markets.

In sum, the FAH greatly appreciates CMS' close attention to this pressing issue and the resulting clarifications and changes set out in the Proposed Rule.



## **X.D. Safety Net Hospitals RFI**

The FAH appreciates the opportunity to submit comments in response to CMS’ Request for Information (“RFI”) on Safety Net Hospitals. The FAH and its member hospitals strongly support CMS’ efforts to make “advancing health equity the first pillar in its Strategic Plan,” consistent with President Biden’s Executive Order 13985 on “Advancing Racial Equity and Support for Underserved Communities Through the Federal Government” and Executive Order 14091 on “Further Advancing Racial Equity and Support for Underserved Communities Through the Federal Government,” by enhancing the much-needed support for safety-net providers. In furthering these goals, however, the FAH urges CMS to ensure that any action for safety-net hospitals maintains stability in existing programs for safety-net hospitals by enhancing rather than replacing those programs and using additional funds (*e.g.*, the \$2 billion in additional funding recommended by MedPAC) to achieve these goals. In addition, the FAH notes that addressing the significant erosion in Medicare payments that result from recent forecast errors due to once-in-a-lifetime events and from CMS’ failure to fully reverse the payment adjustments under section 7(b)(1)(B) of the TMA both contribute to Medicare rates that are insufficient to pay the typical costs of providing care – 10 percent below care costs according to MedPAC. (*See* discussion in connection with Part V.B, above.) Moreover, inadequate Medicare rates drive up the outlier fixed-loss threshold, such that safety-net hospitals are less able to access outlier payments for high-cost cases. (*See* further discussion in connection with Addendum II.A.4.i, below.)

As noted in the Proposed Rule, hospitals play a crucial role as safety-net providers by making essential services available to the uninsured, underinsured, and other populations that face barriers to accessing healthcare. Hospitals are uniquely obligated to open their doors to patients and provide emergency services regardless of income or coverage under the Emergency Medical Treatment and Active Labor Act (EMTALA), and hospitals serve their communities well beyond the scope of their legal obligations, providing services that would not otherwise be available in the community, supporting outreach and coverage expansion efforts, and supplementing safety nets with charity and uncompensated care. Particularly in rural areas, hospitals are lifelines to care, providing vital access to a broad continuum of services, and recruiting and retaining professionals in underserved communities.

These safety-net activities are undertaken by hospitals regardless of ownership type and eligibility under programs like the 340B drug discount. For example, a large study of 2018 data found that the median charity-care-to-expense ratio was highest among tax-paying hospitals (1.4 percent) as compared to tax exempt (0.9 percent) and governmental (0.86 percent) hospitals.<sup>52</sup> In fact, in “46 percent of hospital service areas, government or nonprofit hospitals had a lower aggregated charity-care-to-expense ratio than for-profit hospitals.”<sup>53</sup> Similarly, an analysis of

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<sup>52</sup> Ge Bai, Hossein Zare, Matthew D. Eisenberg, Daniel Polsky, and Gerard F. Anderson, “Analysis Suggests Government And Nonprofit Hospitals’ Charity Care Is Not Aligned With Their Favorable Tax Treatment,” *Health Affairs*, No. 40(4), pp. 629-636 (Apr. 2021), *available at* <https://doi.org/10.1377/hlthaff.2020.01627>.

<sup>53</sup> *Id.*

FY 2018 data by Avalere Health indicates that uncompensated care services account for a greater or comparable proportion of operating costs for tax paying and other non-340B acute care hospitals as compared to hospitals participating in the 340B drug discount program.<sup>54</sup>

The RFI requests comments on how CMS should define or identify safety-net hospitals. The FAH supports a broad understanding that reflects the full range of safety-net activities undertaken by hospitals, especially the provision of uncompensated care. Consistent with MedPAC’s recommendations, programs supporting safety-net hospitals should not have unreasonable “cliffs” that render a subset of hospitals providing safety-net services in their communities ineligible for safety-net support. Rather, broad eligibility should be the hallmark of safety-net programming, with the amount of funds adjusted based on appropriate measures of safety-net activities (*e.g.*, uncompensated care costs, as is currently the case with UC-DSH). Moreover, because hospitals serve as safety-net providers regardless of their ownership type or participation in the 340B drug discount program, any criteria for identifying safety-net hospitals should not include such criteria. Artificial distinctions between classes of hospitals providing safety-net services would not be well-targeted to supporting safety-net activities and would inappropriately harm these hospitals and the communities that rely on them for care.

The FAH particularly appreciates CMS’ request for information on the particular challenges facing rural safety-net hospitals and acknowledgment that safety-net providers “play a crucial role in the advancement of health equity by making essential services available to . . . rural communities” that face barriers to accessing healthcare. Among safety-net hospitals, rural hospitals not only serve critical safety-net functions, but they are also faced with unique and significant challenges. Forty-six percent of rural hospitals have a negative operating margin, and over 100 rural hospitals have closed since 2010.<sup>55</sup> When rural hospitals close, the median distance to the most common health care services increases by 20 miles, creating crises for health access and equity.<sup>56</sup> As discussed in conjunction with the low wage index hospital policy (Part III.G.4, above), approximately one out of every four Medicare beneficiaries live in rural areas and depend on rural hospitals for care,<sup>57</sup> and Medicare payments tend to have a greater influence on rural hospitals’ revenue as compared to non-rural hospitals. Because non-hospital care tends

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<sup>54</sup> See Avalere Health, OPPS Medicare Part B Payment Impact Analysis, at 11 (Mar. 2021), [https://www.fah.org/wp-content/uploads/2021/04/20210326\\_OPSPS\\_Analysis\\_for\\_FAH.pdf](https://www.fah.org/wp-content/uploads/2021/04/20210326_OPSPS_Analysis_for_FAH.pdf).

<sup>55</sup> American Hospital Association, “Rural Hospital Closures Threaten Access” (September 2022), available at <https://www.aha.org/system/files/media/file/2022/09/rural-hospital-closures-threaten-access-report.pdf>.

<sup>56</sup> United States Government Accountability Office: GAO-21-93, “Rural Hospital Closures: Affected Residents Had Reduced Access to Health Care Services” (December 2020), available at <https://www.gao.gov/assets/gao-21-93.pdf>.

<sup>57</sup> CMS, Improving Health in Rural Communities: FY 2021 Year in Review, 1 (Nov. 2021).

to be less accessible in rural communities, rural hospitals often serve patients that have deferred care, making their conditions more complicated and costly to treat.<sup>58</sup>

With respect to policy approaches to support safety-net hospitals, the FAH strongly supports retaining existing programs already in place and making necessary adjustments to ensure these programs better serve the particular needs of rural safety-net hospitals. These programs, such as the Medicare DSH adjustments and UC-DSH payments, provide critical support to many safety-net hospitals, and the FAH believes safety-net hospitals would be best supported with targeted program expansions and improvements to address particular gaps for rural hospitals while minimizing volatility. Moreover, any such expansions of or improvements to existing safety-net programs should be implemented through new funding that expands the funds available to support safety-net hospitals, consistent with MedPAC's recommendation of \$2 billion in additional funding. This enhancement-oriented approach would be consistent with MedPAC's suggestion that policymakers limit "cliffs" in targeted payment adjustment programs for safety-net hospitals, allowing most hospitals to qualify with the magnitude of payments increasing with the hospital's safety-net activities.<sup>59</sup> But, unlike MedPAC's safety-net index proposal, the enhancement of existing programs would promote continuity in payment structures, improving rather than destabilizing longstanding safety-net hospital programs.

Medicare DSH adjustments currently support safety-net hospitals by providing additional payments to hospitals that treat a significantly "disproportionate number" of low-income patients. 42 U.S.C. § 1395ww(d)(5)(F)(i)(I). Recognizing that low-income patients are typically sicker and more costly to treat in a hospital setting than other patients with similar diagnoses and that these additional costs are not captured by the IPPS' payment of fixed rates based on *average* costs, Congress requires the Secretary to make Medicare DSH payments to those hospitals that serve a disproportionate share of low-income patients. At the time Congress originally established Medicare DSH, Medicare was "a relatively profitable payer," but now hospitals' average Medicare margins are negative,<sup>60</sup> making Medicare DSH a critical lifeline for DSH

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<sup>58</sup> Although outside the scope of the IPPS, the FAH notes that CMS' site-neutral clinic visit policy compounds these issues by disincentivizing the provision of primary care services and other clinic visits in off-campus hospital outpatient departments. Particularly in rural communities, off-campus hospital outpatient departments provide a vital web of care that would not otherwise be accessible to the patients served, and rural safety-net hospitals should be encouraged rather than financially harmed for providing outpatient care across the broad geographic areas they serve.

<sup>59</sup> Medicare Payment Advisory Commission, "Report to the Congress: Medicare Payment Policy," p. 91 (March 2023), available at [https://www.medpac.gov/wp-content/uploads/2023/03/Mar23\\_MedPAC\\_Report\\_To\\_Congress\\_SEC.pdf](https://www.medpac.gov/wp-content/uploads/2023/03/Mar23_MedPAC_Report_To_Congress_SEC.pdf).

<sup>60</sup> Medicare Payment Advisory Commission, "Report to the Congress: Medicare and the Health Care Delivery System," p. 67 (June 2022), available at [https://www.medpac.gov/wp-content/uploads/2022/06/Jun22\\_MedPAC\\_Report\\_to\\_Congress\\_v2\\_SEC.pdf](https://www.medpac.gov/wp-content/uploads/2022/06/Jun22_MedPAC_Report_to_Congress_v2_SEC.pdf). Significantly, MedPAC estimates Medicare IPPS margins will further decrease in FY 2023 to negative 10 percent and suggests that "Medicare is not a profitable payer in aggregate in the hospital sector." Medicare Payment Advisory Commission, "Report to the Congress: Medicare Payment Policy,"

hospitals. Today, the Medicare DSH program remains a vitally important, long-standing payment program that supports hospitals caring for low-income patients that rely on the safety-net these hospitals provide. The fact that 80 percent of hospitals receive DSH payments proves the point. Likewise, the UC-DSH program created under the ACA provides DSH-eligible hospitals with a share of payments based on another measure of safety-net activities—the provision of uncompensated care. 42 U.S.C. § 1395ww(r).

To better address the particular challenges faced by *rural* safety-net hospitals, the FAH strongly supports rural DSH equity—eliminating the inequitable treatment of rural hospitals within the DSH program. At present, Medicare DSH provides comparatively greater financial support to larger, urban hospitals than to rural hospitals. *See* 42 C.F.R. § 412.106(d). For example, the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 imposed a 12 percent cap on the DSH payment adjustment for certain hospitals whose disproportionate patient percentage exceeds 15 percent, including for rural IPPS hospitals with fewer than 500 beds (excluding rural referral centers) and urban hospitals with fewer than 100 beds. Rural hospitals are disproportionately impacted by this cap, both in terms of the number of hospitals impacted and the scale of the financial impacts (*e.g.*, rural hospitals lost a higher average amount and lost a higher average percentage of total inpatient revenue than did urban hospitals as a result of the cap). The FAH urges CMS to support a legislative fix to address this inequitable DSH treatment for rural safety-net hospitals. In addition, as discussed in connection with capital DSH (Part VI.D, above), rural hospitals are not eligible to receive capital DSH payments despite their significant, negative capital margins and low occupancy rates. CMS has the authority to adjust capital DSH, and should act to support rural safety-net hospitals by expanding capital DSH eligibility to rural hospitals.

Refinements to the Medicare DSH program that promote rural DSH equity (*e.g.*, eliminating the 12% Medicare DSH Payment Adjustment Cap and extending eligibility for capital DSH payments for rural hospitals) would promote more equitable support for rural hospitals serving low-income Medicare beneficiaries. Critically, these enhancement-oriented strategies would promote stability and predictability by building upon longstanding programs rather than introducing the volatility of wholly new indices and measures. In contrast, the FAH strongly opposes any policy approaches that would replace operating DSH, UC DSH, or capital DSH programs, or, as MedPAC suggests, force rural hospitals to choose between the current dedicated programs such as Medicare Dependent and Sole Community and a new safety net program. The redistribution of existing funds risks irreparable harm to safety-net hospitals that rely on these programs to provide care in their communities and, at a minimum, would create destabilizing uncertainty for these hospitals.

In sum, the FAH strongly supports efforts to improve the financial security of safety-net hospitals, including those that serve our rural communities, and urges CMS to explore policies—including rural DSH equity—that retain and enhance longstanding safety-net hospital programs without introducing unnecessary uncertainty or eroding IPPS rates.

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pp. 56, 83 (March 2023), available at [https://www.medpac.gov/wp-content/uploads/2023/03/Mar23\\_MedPAC\\_Report\\_To\\_Congress\\_SEC.pdf](https://www.medpac.gov/wp-content/uploads/2023/03/Mar23_MedPAC_Report_To_Congress_SEC.pdf).

## **X.E. Disclosures of Ownership and Additional Disclosable Parties Information**

The FAH has deep concerns with CMS’ proposal to collect information on the ownership of hospitals by private equity companies (PECs) and real estate investment trusts (REITs) because such collection is unnecessary and inappropriate and the definitions proposed are ambiguous such that reporting will be inherently unreliable. First, ownership of hospitals by PECs and REITs, unlike ownership by physicians, is not inherently problematic or subject to heightened scrutiny as a matter of law. As described in Part X.B., *supra*, Congress, built off years of research regarding the risks associated with POHs when adopting section 6001 of the ACA. In contrast, PEC and REIT hospital ownership is not the object of statutory scrutiny, and the Proposed Rule does not identify any research suggesting a need to monitor PEC-owned and REIT-owned hospitals. Against this backdrop, it is unnecessary and inappropriate for providers to designate entities with reportable ownership interests as PECs or REITs on Form CMS—855A or otherwise.

Moreover, the definitions of PEC and REIT set forth in the Proposed Rule are vague such that a hospital’s designation (or non-designation) of an entity as a PEC or a REIT will not provide usable data regarding these types of entities. With respect to PECs, the proposed definition (“a publicly-traded or non-publicly traded company that collects capital investments from individuals or entities (that is, investors) and purchases an ownership share of a provider”) could be read expansively as referring to virtually any publicly traded company or privately held company with a reportable ownership interest in a hospital. Some hospitals might thus broadly designate entities as PECs, but others might designate PECs more narrowly, excluding entities that do not engage in typical private equity activities. Moreover, the proposed revisions to Form CMS—855A released on May 4, 2023 uses a different definition of PEC,<sup>61</sup> increasing the likelihood of inconsistent designations by hospitals.

It would be premature and inappropriate to gather data on hospital ownership by PECs where there is no established definition of a PEC and the proposed definition is vague with uncertain boundaries. Notably, the literature cited in the February 15, 2023 Proposed Rule titled “Disclosures of Ownership and Additional Disclosable Parties Information for Skilled Nursing Facilities and Nursing Facilities,” does not include a clear and consistent definition of PEC, often times focusing on particular private equity *activities* rather than distinctive entities that qualify as PECs. For example, MedPAC’s 2021 report on the role that private equity plays in the Medicare program “focused primarily on buyouts . . . and [used] the term *private equity* to refer to them specifically unless noted otherwise.”<sup>62</sup> Similarly, the 2021 National Bureau of Economic Research (NBER) report on private equity investment in healthcare described private equity firms as “conduct[ing] leveraged buyouts (LBOs), in which a target firm is acquired primarily with debt financing – which is placed on the target firm’s balance sheet – and a small portion of

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<sup>61</sup> 88 Fed. Reg. 28,554 (May 4, 2023); <https://www.cms.gov/regulations-and-guidance/legislation/paperworkreductionactof1995/pralisting/cms-855a>.

<sup>62</sup> Medicare Payment Advisory Commission, “Congressional Request: Private Equity and Medicare” ( June 2021), at [https://www.medpac.gov/wp-content/uploads/import\\_data/scrape\\_files/docs/default-source/default-document-library/jun21\\_ch3\\_medpac\\_report\\_to\\_congress\\_sec.pdf](https://www.medpac.gov/wp-content/uploads/import_data/scrape_files/docs/default-source/default-document-library/jun21_ch3_medpac_report_to_congress_sec.pdf).

equity.”<sup>63</sup> This focus on particular activities or business models complicates or precludes the consistent identification of PECs.

With respect to the proposed definition of REIT, the FAH is concerned that the proposed definition is overly broad and would encompass entities that are not REITs. A REIT is a defined entity under established and longstanding Treasury Regulations, 26 C.F.R. § 1.856-1, but the proposed Medicare definition would, without explanation, designate non-REITs as REITs for Medicare purposes. Under the proposed definition, the touchstone of a Medicare REIT would be partial or full ownership of a hospital’s buildings or real estate by a company with a reportable ownership interest in the hospital. This would include entities that do not meet the status conditions or gross income and asset diversification requirements for REITs. This proposed definition of a REIT is not “modestly different” from the definition of REIT in other settings—rather, it includes entities that simply are not REITs and without any supporting rationale. Finalizing this definition would work against CMS’ objectives in gathering data regarding REIT ownership of hospitals because (1) the overinclusive definition would preclude CMS from making any conclusion with respect to the actual impacts of REIT ownership of providers and (2) the non-standard definition would result in inconsistent designations by hospitals of similar entities on the Form CMS—855A enrollment application.

In light of the foregoing, at this time, the FAH urges CMS to decline to finalize the proposed definitions of PEC and REIT and to decline to finalize the addition of PEC and REIT designations to Section 5 of Form CMS—855A. At a minimum, CMS should ensure that the definition of a REIT for Medicare purposes does not include any entity that is not a REIT under Treasury Regulations and should limit reporting on PEC and REIT ownership to skilled nursing facilities. Focusing initially on skilled nursing facilities would enable CMS to develop experience with the PEC and REIT definitions and refine them to ensure reporting is meaningful and consistent before considering extending reporting of PEC and REIT ownership interests to all providers and suppliers completing the Form CMS—855A enrollment application.

## **OUTLIER PAYMENTS FY 2024**

### **Addendum II.A.4.i. Proposed Outlier Payments**

For FY 2024, CMS has proposed that a case will be eligible for a high-cost outlier payment when the cost of the case exceeds the sum of the prospective payment rate for the MS-DRG plus any IME, empirically justified Medicare DSH payments, estimated uncompensated care payment, and any add-on payments for new technology, plus the proposed fixed loss threshold of \$40,732. The current fixed loss threshold, which has been in effect since October 1, 2022, is \$38,788. The proposed fixed loss threshold remains significantly elevated over the level at which CMS set the threshold before to the COVID-19 PHE. CMS states that it has used the same basic methodology to calculate the fixed loss threshold as it has since FY 2014, with limited exceptions in prior years (including, beginning in FY 2020, modifying its methodology to account

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<sup>63</sup> Atul Gupta, Sabrina T. Howell, Constantine Yannelis, and Abhinav Gupta, *Does Private Equity Investment in Healthcare Benefit Patients? Evidence from Nursing Homes*, No. W28474, National Bureau of Economic Research, 2021, p. 8.



for the estimated impact of outlier reconciliation and using public, FY data to calculate the charge inflation factor). In contrast to FY 2023, however, for which FY CMS used a blend of data predating the period of the PHE and more recent data from during the PHE to establish the fixed-loss threshold, CMS is resuming its use of what it states is the most recent data—here, data from the PHE, including the peak of national COVID-19 hospitalizations—to calculate the fixed loss threshold.

Overall, the proposed fixed loss threshold for FY 2024 would be a roughly \$1,900 increase over the already anomalously high FY 2023 fixed loss threshold. Looking back to the period before the PHE, CMS’ proposed threshold represents a more than 55 percent increase (roughly \$14,500) over the average fixed loss threshold over the three most recent FYs (2018-2020) when the threshold was not influenced by the PHE. The dramatic increase in the proposed threshold compared to what it was before the PHE suggests that the data used to set the proposed threshold is abnormal and CMS needs to modify its process further to adjust the data so that the threshold will be set at a level that both is likely to produce total outlier payments at CMS’ 5.1 percent target and helps ensure that all hospitals, including rural and safety-net hospitals, whose DRG payments are offset 5.1 percent to fund outlier payments, can access outlier payments. As explained further below, the FAH supports methodological adjustments in the outlier calculation to address the distorting impact of the PHE on FY 2024 projections as well as necessary and (in the case of eliminating the remaining TMA section 7(b)(1)(B) adjustments) required IPPS rate updates to ensure that IPPS rates are sufficient for typical cases and relieve growing pressure on the outlier system driven by the erosion of IPPS rates.

*1. Continuation of Methodological Changes Adopted for FY 2020, With the Resumption Using the Most Recent MedPAR Data Sets*

CMS proposes to again apply key methodological refinements that were first applied in the FY 2020 IPPS rulemaking and also to resume using the most recent data sets: MedPAR files from FY 2022 for claims and from FYs 2021 and 2022 for computing charge inflation; and the December 2021 and 2022 PSF updates for computing the CCR adjustment factor. First, CMS proposes to again account for outlier reconciliation in the FY 2023 outlier threshold calculation. The FAH has repeatedly requested that CMS release information on the outlier reconciliation process and data showing the amounts recovered so that it can evaluate the impact of the reconciliation process on the outlier threshold, and we again commend CMS for proposing to continue addressing the impact of outlier reconciliation in setting the FY 2023 fixed-loss threshold. WPA matched CMS’ calculation of a -0.01 percent reconciliation factor, using the December 2022 cost report data CMS used for the Proposed Rule; however, WPA noted that the March 2023 cost report data, which CMS is expected to use for the final rule, produced a higher reconciliation factor of -0.02 percent.

Second, the Proposed Rule charge inflation factor calculation conceptually mirrors the method CMS adopted in the FY 2020 final rule, relying on charge data from the most recent publicly available MedPAR files to compute the one-year charge inflation factor. Using the FY 2021 and FY 2022 MedPAR data files, CMS has computed a one-year charge inflation factor of 5.755 percent and has converted that into a two-year charge-inflation-factor of 11.8412 percent. However, unlike with the LTCH PPS high-cost outlier threshold (LTCH threshold), CMS does not propose to apply any trims to the charge data in the FYs 2021 and 2022 MedPAR data files.

Specifically, for the LTCH threshold, CMS has appropriately proposed “to remove all claims from providers whose growth in average charges was a statistical outlier.” 88 Fed. Reg. at 27,240. CMS explained, “We remove these statistical outliers prior to calculating the charge inflation factor because we believe they may represent aberrations in the data that would distort the measure of average charge growth.” *Id.* at 27,240-41. Yet CMS has not articulated any principled basis not to apply similar trims to the charge inflation data used to set the IPPS outlier threshold. If not removed from the IPPS charge inflation data, the statistical outliers “will distort the measure of average charge growth” for IPPS hospitals. We therefore urge CMS to apply such trims when computing the final charge inflation factor. We also continue to believe that CMS should disclose all aspects of its edits to the most current data used for the Proposed Rule and commit to the same process and methods when it recalculates the threshold for purposes of the final rule. Additionally, CMS should commit to make public the data files it uses for the final rule, including all edits and calculations, when it publishes the final rule.

Third, the Proposed Rule applies the same method, first adopted in the FY 2014 IPPS Rule, to project the change in CCRs. For FY 2024, CMS proposed comparing the CCRs in the December 2021 update of the PSF to the CCRs in the December 2022 update of the PSF and computed a proposed one-year national operating CCR adjustment factor of 0.977799. We note that for the FY 2023 IPPS, CMS declined to use CCR data from the period of the PHE because the CCR data was aberrant. CMS has not explained why it is appropriate for purposes of the FY 2024 threshold to use data from the PHE to calculate the CCR adjustment factor. The FAH expects that CCRs will decrease on average even more than the adjustment factors set forth in the Proposed Rule.

2. *Excessive COVID-19 Cases in the FY 2022 MedPAR Data Set Significantly Skew the Fixed Loss Threshold and are Inconsistent with Trends and FY 2023 Projections*

The FAH also urges CMS to model a significant reduction in COVID-19 cases compared to FY 2022 numbers when calculating the FY 2024 fixed-loss threshold because recent data trends strongly suggest that the frequency of COVID-19 hospitalization will be significantly less than what the FY 2022 MedPAR data set would suggest. FY 2022 represents the period of the PHE impacted by both the Delta and Omicron variant surges, which produced significant spikes in COVID-19 hospitalizations.<sup>64</sup> In the Proposed Rule, CMS states its belief that there is not “a reasonable basis for us to assume that there will be a meaningful difference in the number of COVID-19 cases treated at IPPS hospitals and LTCHs in FY 2024 relative to FY 2022, such that modifications to our usual rate setting methodologies would be warranted.”<sup>65</sup> An update of the graphical presentation of COVID-19 hospitalizations from the Proposed Rule, however, indicates

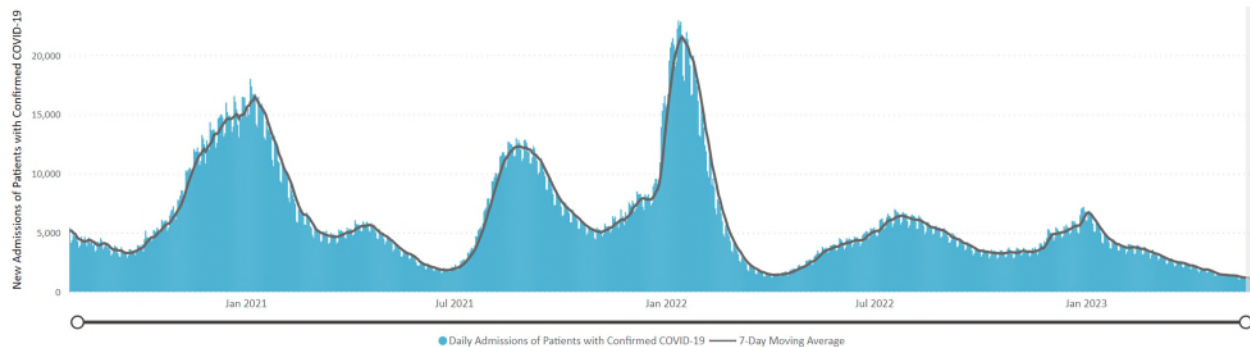
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<sup>64</sup> See, e.g., 88 Fed. Reg. at 26,671 (graphing hospital admissions through January 2023 and noting that with respect to FY 2022 “the share of admissions at IPPS hospitals and LTCHs for MS-DRGs and MS-LTC-DRGs that are associated with the treatment of COVID-19 continued to remain at levels higher than those observed in the pre-pandemic data”).

<sup>65</sup> *Id.*



that the post-Omicron reduction in COVID-19 hospitalizations has now been sustained for over a year according to CDC data.<sup>66</sup>



Based on these trends, the FAH believes that the FY 2022 MedPAR data is not informative with respect to expected FY 2024 COVID-19 hospitalizations and that it should be adjusted in a targeted manner to better reflect expectations around post-PHE COVID-19 hospitalizations. To do so, the FAH supports suppressing the COVID-19 cases from the FY 2022 MedPAR data for the first half of FY 2022 and duplicating the COVID-19 cases from the second half of the year, essentially applying an extrapolation methodology based on data from the second half of FY 2022 for COVID-19 cases. This approach is a rational and targeted strategy for adjusting the FY 2022 MedPAR data for use in estimating post-PHE outlier cases.

As the attached report of WPA shows, adjusting the COVID-19 cases in the FY 2022 MedPAR data in this manner has the effect of reducing the threshold by over \$700.<sup>67</sup> The FAH urges CMS to apply this or a similar adjustment to the FY 2022 MedPAR data set to avoid factoring in COVID-19 case volumes that are reflective of circumstances during the PHE and are unlikely to recur in FY 2024.

### 3. *CMS Should Correct for the Inadequate Market Basket Updates that Inflate the Fixed-Loss Threshold*

The FAH is deeply concerned that year-over-year significant increases in the fixed loss threshold reflect the underlying inadequacy of market basket updates such that hospitals incur costs well in excess of base IPPS payments in a growing proportion of cases. In other words, growth in the fixed loss threshold appears to be symptomatic of inadequate IPPS rates that should be critically evaluated and remedied so that outlier system can be rightsized for true outlier cases. As explained above in connection with comments on Part V.B of the Proposed Rule, the FAH believes that the calculation of the IPPS market basket significantly understates

<sup>66</sup> CDC, COVID Data Tracker, New Hospital Admissions with Confirmed Covid-19, United States (August 1, 2020 – May 27, 2023), at <https://covid.cdc.gov/covid-data-tracker/#new-hospital-admissions> (accessed June 6, 2023).

<sup>67</sup> See WPA Report at p. 8 (“Alternative 2”).

expected inflation and urges CMS to adopt a 5.8 percent update (a market basket of 3.0 percent, plus a forecast error adjustment of 3.0 percent, less 0.2 percent for total factor productivity) and also to implement the required reversal of the payment adjustments under section 7(b)(1)(B) of the TMA with a positive 0.9412 percent adjustment. If CMS adopts these recommendations, there would be an increase in IPPS payments per discharge as well as in the total IPPS payments. Addressing issues with IPPS base payments in this way would reduce the level of the fixed loss threshold, based on CMS' methodology. With an update of 5.8 percent, modeling by WPA indicates that the FY 2023 outlier threshold would instead decline to \$38,689, a number that is far more in line with pre-PHE trends.<sup>68</sup> In addition, if the fixed-loss threshold is recalculated with an adjustment for FY 2022 COVID cases, as described above, and a market basket update of 5.8 percent, the fixed-loss threshold would decline another \$800.<sup>69</sup>

Therefore, the FAH strongly urges CMS to finalize a higher market basket update that captures ongoing inflationary pressures, implements a one-time adjustment to address the untenable erosion of IPPS rates, and reverses the remaining TMA section 7(b)(1)(B) adjustments. If CMS adopts the recommendation to increase the market basket, the FAH urges CMS also to factor that change into its payment assumptions for cases in the FY 2022 MedPAR data when calculating the FY 2024 fixed loss threshold.

#### 4. *Extreme Charge Cases Significantly Skew the Fixed Loss Threshold*

As we have in past years, the FAH also asks CMS to consider whether it is appropriate to include extreme cases when calculating the fixed-loss threshold and whether recent volume increase in such cases points to a larger problem that CMS should investigate. WPA conducted various examinations and probing of data to understand the factors that drove CMS to increase the threshold over \$15,000 between FY 2017 and FY 2023, and to propose to increase the threshold almost an additional \$1,900 for FY 2024, and observed that the inclusion of extreme cases in the calculation of the threshold, the rate of which are increasing over time, significantly impacts CMS' determination of the fixed-loss threshold.<sup>70</sup>

In the IPPS rate-setting process for the MS-DRG relative weights, statistical outliers (*i.e.*, extreme cases) are generally removed from calculations on the basis that they improperly skew those calculations. In calculating the outlier threshold, however, those statistical outliers are not excluded from the calculation. To observe the impact of these statistical outliers on the calculation of the threshold, WPA calculated how the proposed FY 2024 threshold would differ after the removal of cases that had total charges above particular trim points. The results of WPA's analysis are included in the tables below:

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<sup>68</sup> See WPA Report at p. 8 ("Alternative 2").

<sup>69</sup> See WPA Report at p. 9 ("Alternative 3").

<sup>70</sup> See WPA Report at pp. 6-8. The tables from the WPA report have been reproduced here with minor editing for formatting purposes.

### FY 2024 Proposed Rule Table

<b>Trim threshold</b>	<b>Cases remaining</b>	<b>Removed cases</b>	<b>FLT</b>	<b>Percentage of cases removed</b>
None	6,801,215	-	\$40,835	0.00%
\$3,000,000	6,800,464	751	\$38,247	0.01%
\$2,750,000	6,800,207	1,008	\$37,856	0.01%
\$2,500,000	6,799,857	1,358	\$37,355	0.02%
\$2,250,000	6,799,382	1,833	\$36,777	0.03%
\$2,000,000	6,798,705	2,512	\$36,093	0.04%
\$1,750,000	6,797,569	3,646	\$35,210	0.05%
\$1,500,000	6,795,849	5,366	\$34,123	0.08%
\$1,250,000	6,792,704	8,511	\$32,640	0.13%
\$1,000,000	6,786,035	15,180	\$30,477	0.22%
\$750,000	6,770,411	30,804	\$27,335	0.45%
\$500,000	6,720,300	80,915	\$22,290	1.19%
\$250,000	6,449,456	351,759	\$13,298	5.17%

The FY 2024 table illustrates that the removal of a relatively small number of extremely high cost (using total charges as a proxy for cost) cases from the calculation significantly decreases the threshold. For example, removing all cases with total charges above \$2,000,000 (2,512 cases) lowers the threshold over \$4,500. Removing all cases at certain other thresholds, lower than \$2,000,000, but still high enough to be considered extreme high-cost cases, drives the threshold down even further. For example, removing all cases with total charges above \$1,000,000 (15,180 cases) drives the threshold down over \$10,000, and removing all cases with charges above \$500,000 (80,915 cases) drives the threshold down almost \$20,000.

Furthermore, these high charge cases are increasing quickly over time, but still represent a very small percentage of total cases. To demonstrate this trend of an increase in extremely high charge cases, WPA created the following table illustrating the number of cases with covered charges above \$1.5 million for each of the past several years:<sup>71</sup>

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<sup>71</sup> See WPA Report at p. 8.

<b>Year</b>	<b>Number of cases over \$1.5 million</b>	<b>Percentage of total cases</b>	<b>Number of unique providers</b>
2011	926	0.0088%	272
2012	994	0.0098%	272
2013	1,092	0.0111%	283
2014	1,329	0.0141%	306
2015	1,539	0.0161%	320
2016	1,733	0.0185%	334
2017	2,291	0.0250%	403
2018	2,650	0.0286%	398
2019	3,128	0.0348%	441
2020	3,666	0.0474%	474
2021	4,719	0.0650%	530
2022	5,366	0.0789%	581

If this trend continues (that is, if the number (and proportion) of extreme cases continues to increase each year), the impact of this population of cases on the threshold will likewise increase. Thus, it is imperative that CMS carefully consider what is causing this trend, whether the inclusion of these cases in the calculation of the threshold is appropriate, or whether a separate outlier mechanism should apply to these cases that more closely hews outlier payments to marginal costs.

The FAH urges CMS to carefully study this problem as it pertains to outlier payment policy. Not only is this consistent with the calculation process used for IPPS rate setting generally, but it will also produce a threshold that more accurately reflects the universe of cases.

##### *5. Using the Most Recent Data to Calculate the Threshold*

We also note that with each IPPS rulemaking for more than a decade (with the exception of FY 2022), the final fixed-loss threshold established by CMS has consistently been lower than the threshold set forth in the proposed rule, and the variance between the proposed and final thresholds has generally exceeded 4 percent. The table below derived from WPA Report at p.5 shows this trend of regular, significant variances between proposed and final fixed-loss thresholds:

<b>FY</b>	<b>Proposed</b>	<b>Final</b>	<b>Variance</b>	<b>% of Variance</b>
2009	\$ 21,025	\$ 20,045	\$ (980)	-4.66%
2010	\$ 24,240	\$ 23,140	\$ (1,100)	-4.54%
2011	\$ 24,165	\$ 23,075	\$ (1,090)	-4.51%
2012	\$ 23,375	\$ 22,385	\$ (990)	-4.24%
2013	\$ 23,630	\$ 21,821	\$ (1,809)	-7.66%
2014	\$ 24,140	\$ 21,748	\$ (2,392)	-9.90%
2015	\$ 25,799	\$ 24,626	\$ (1,173)	-4.55%
2016	\$ 24,485	\$ 22,544	\$ (1,941)	-7.93%
2017	\$ 23,681	\$ 23,573	\$ (108)	-0.46%
2018	\$ 26,713	\$ 26,537	\$ (176)	-0.66%
2019	\$ 27,545	\$ 25,769	\$ (1,776)	-6.45%
2020	\$ 26,994	\$ 26,552	\$ (442)	-1.63%
2021	\$ 30,006	\$ 29,064	\$ (942)	-3.31%
2022	\$ 30,967	\$30,988	\$ 21	0.07%
2023	\$ 43,214	\$ 38,788	\$ (4,355)	-11.21%
2024	\$40,732			

Although the FAH can only speculate as to why this drop in the threshold occurs, the FAH believes the decline is most likely due to the use of updated CCRs and/or additional/other data in calculating the final threshold. This again emphasizes that CMS must ordinarily use the most recent data to appropriately calculate the outlier threshold.

With regard to the current rule-making WPA was able to replicate the threshold within \$103. Thus, we have high confidence that WPA understands CMS' methodology and has accurately modeled that methodology.

#### 6. *FY 2024 Outlier: Conclusion*

The FAH is not proposing a threshold for FY 2024. While we have confidence in the work of WPA, its work is dependent on large number of variables in the outlier calculation. We also note that the impact of the inclusion of extreme cases in the calculation of the fixed loss threshold is significant and we urge CMS to carefully study this trend and whether outlier payment policy should be adjusted so that it is fair to all hospitals that fund outlier payments. Finally, we recognize that with the release of the MedPAR final data with additional claims, which will lead to new weights being calculated, and with updated cost to charge ratios, it is appropriate to recalculate the fixed loss threshold from the data that will be released with the final rule.

#### **Addendum V.D. Proposed Adjustments for LTCH PPS High-Cost Outlier (HCO) Cases**

As part of the standard LTCH PPS, Medicare makes additional payments for HCO cases that have high costs relative to typical discharges. CMS sets a fixed-loss amount for HCOs, which is an amount by which costs must exceed reimbursement in order for a claim to be paid an outlier adjustment. CMS sets the HCO fixed-loss amount by projecting what it would need to be for 7.975% of total LTCH PPS payments to be HCO payments. For FY 2024, CMS is proposing to increase the HCO fixed-loss amount from \$38,518 to \$94,378, a staggering 150% increase.

The FAH is concerned that the data used to project the fixed-loss threshold is not representative of what we can expect to see in FY 2024 because of the unique circumstances facing LTCHs and their short-term, acute-care partners throughout the pandemic. The resulting proposed amount of \$94,378 is simply untenable for LTCHs – most cannot afford to absorb this amount of financial loss. Such a threshold would thus jeopardize LTCHs’ ability to care for the sickest of the sick, which is a patient population LTCHs serve despite the already unfavorable payment rates, and would thus risk limiting access to care for the most critically ill Medicare beneficiaries.

Below, we provide three alternative proposals for calculating the outlier threshold, which we understand are consistent with in-depth analyses undertaken by other stakeholders, including the American Hospital Association (AHA). Each option would produce more appropriate outlier projections for FY 2024. Overall, the FAH and its members do not believe that trends from the FY 2022 claims data (which were used to calculate the proposed threshold) will continue in FY 2024; therefore, CMS can reasonably make more conservative assumptions about growth that will result in lower (and more realistic) fixed-loss amounts. Specifically, for reasons elaborated on below, the tumultuous circumstances that LTCHs and other providers have faced skewed the FY 2022 data for LTCH charges and claims, but CMS can expect several transitions in FY 2024 that will see LTCH claims and charge data stabilize.

**Alternative #1: Use more recent data to calculate charge inflation factor and account for health system capacity issues.** CMS determined the charge inflation factor (CIF) that it used in calculating the proposed outlier threshold by dividing the average covered charge per case from FY 2022 claims by the average covered charge per case from FY 2021 claims. CMS used the December 2022 update of the FY 2022 MedPAR file and the December 2021 update of the FY 2021 MedPAR data as the basis for this calculation, which resulted in an extraordinary one-year CIF of 13.56%. Because the underlying data is not representative of FY 2024 expectations, the FAH urges CMS to use data from the first six months of FY 2023 in determining the CIF. As is shown by the graph of COVID-19 hospitalization shown on page 65, above, the largest surge of COVID-19 hospitalizations occurred in FY 2022, making the FY 2022 data non-representative of FY 2024 expectations.

As part of this approach, we also urge CMS to include site neutral patients when calculating the fixed-loss threshold. This change is necessary to account for the waiver of the site neutral payment policy and significant capacity issues in acute-care hospitals during the PHE. It is our understanding that the proportion of site neutral LTCH cases rose significantly during COVID-19 surges (like those that marked FY 2022), but that in the absence of the unique circumstances in FY 2022, many of these patients would have been criteria-compliant patients.

Finally, as part of this approach, the FAH recommends that CMS exclude dialysis claims when calculating the fixed-loss threshold because LTCH dialysis cases in FY 2022 are not generally representative of FY 2024 expectations. During the PHE, LTCHs faced particular challenges with respect to safely discharging dialysis patients into outpatient dialysis care due to PHE-driven capacity issues. These circumstances increased the length of stay for LTCH dialysis patients, but industry expectations are that the unique discharge barriers for this patient

population is abating with the end of the PHE and improved coordination targeted to this patient population.

**Alternative #2: Use a market basket-based CIF and account for health system capacity issues.** Prior to FY 2022, CMS calculated the CIF by inflating charges by a growth factor calculated from quarterly market basket values. The FAH urges CMS to return to this pre-PHE methodology if CMS does not adjust its methodology to address data anomalies produced by FY 2022-specific circumstances as described in “Alternative #1,” above. In addition, even using a market basket-based CIF, the FAH recommends including site-neutral patients and excluding dialysis patients, as described above.

**Alternative #3: Use pre-pandemic data as the health care system transitions out of the PHE.** Finally, the FAH believes that the rationale that supported using pre-PHE data for FY 2023 likewise supports using pre-PHE data for FY 2024. In looking at the impact of the PHE on care patterns relevant to LTCH cases and expectations for the first post-PHE fiscal year, it is reasonable to assume that LTCH patient care in FY 2024 will more closely resemble the pre-PHE time period. Therefore, if CMS does not wish to adopt the alternatives outlined above, the FAH supports using FY 2019 data in calculating the outlier threshold, keeping all other portions of the methodology as proposed.

\* \* \*

The FAH appreciates the opportunity to offer comments on the FY 2024 IPPS Proposed Rule. If you have any questions or would like to discuss further, please do not hesitate to contact me or a member of my staff at (202) 624-1534.

Sincerely,



***American Hospital Association and Federation of American  
Hospitals Report:  
CMS Misses the Mark in Payment Updates Due to Changes in Labor  
Composition and Cost Growth***

June 2023



# ***American Hospital Association and Federation of American Hospitals Report: CMS Misses the Mark in Payment Updates Due to Changes in Labor Composition and Cost Growth***

## **1. Overview**

The Centers for Medicare & Medicaid Services (“CMS”) determines its annual updates to Inpatient Prospective Payment System (“IPPS”) rates using the IPPS hospital market basket.<sup>1</sup> The IPPS hospital market basket is designed to measure the change in prices of goods and services hospitals purchase to provide inpatient care.<sup>2</sup>

Because Medicare pays for a large share of the patients who visit hospitals annually and since other payers often set their hospital payments based on Medicare reimbursement, updates to the IPPS rates can have a substantial impact on hospital margins – and mismeasurement of changes in hospital costs has the potential to push hospitals into significant financial distress. For example, in 2019, Medicare patients accounted for 49% of a typical hospital’s volume.<sup>3</sup> At the same time, cumulative hospital expense grew by more than double the cumulative increase in Medicare IPPS reimbursement from 2019 to 2022, contributing to over half of hospitals in 2022 operating at a financial loss.<sup>4</sup> During this period, CMS’s IPPS Final Rule rate updates fell below the realized increase in the IPPS hospital market basket. However, even if the IPPS Final Rule had matched the IPPS hospital market basket, it would have failed to keep up with actual changes in hospital costs.

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<sup>1</sup> Department of Health and Human Services, “Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Proposed Policy Changes and Fiscal Year 2022 Rates; Quality Programs and Medicare Promoting Interoperability Program Requirements for Eligible Hospitals and Critical Access Hospitals; Proposed Changes to Medicaid Provider Enrollment; and Proposed Changes to the Medicare Shared Savings Program,” Federal Register 86(88), pp. 25070–25790 (“Federal Register 86(88)”) at p. 25070.

<sup>2</sup> Centers for Medicare & Medicaid Services, Office of the Actuary, National Health Statistics Group, “FAQ – Market Basket Definitions and General Information,” May 2022, available at <https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MedicareProgramRatesStats/downloads/info.pdf> (“CMS (2022)”) (“Although “market basket” technically describes the mix of goods and services used in providing health care, this term is also commonly used to denote the input price index (that is, cost category weights and price proxies combined) derived from that market basket.... [I]t measures the change in price, over time, of the same mix of goods and services purchased in the base period.”).

<sup>3</sup> American Hospital Association (2021). Fact Sheet: Hospital Costs Explained. <https://www.aha.org/system/files/media/file/2020/09/fact-sheet-billing-explained-o820.pdf>

<sup>4</sup> American Hospital Association (2023). Cost of Caring. <https://www.aha.org/costsofcaring>

While there may be a number of reasons for CMS’s Final Rule rate increases to have fallen below rates of hospital cost increases, one prominent reason appears to be the way the IPPS hospital market basket measures the cost of hospital labor inputs that are needed to provide inpatient care (which include nursing and other highly-skilled professional labor hours). The single largest input that is included in the construction of the 2018-based IPPS hospital market basket (the last time the IPPS market basket was rebased and revised), with a weight of 53 percent, is compensation for hospital workers.<sup>5</sup>

Given the high share of labor inputs in the IPPS hospital market basket, it is important for CMS to use a proxy for labor costs that closely matches hospitals’ actual labor costs. Since 2020, this does not appear to have been the case. CMS relies on the Employment Cost Index (“ECI”) for the hospital industry, prepared by the Bureau of Labor Statistics (“BLS”), as the price proxy for this category of input costs. While the ECI has some advantages,<sup>6</sup> it has not incorporated several significant shifts in hospitals’ labor force – particularly the greater use of contract labor – because it lacks timeliness: it only periodically updates the frequency with which a particular job is expected to occur. For example, while the hospital field has increasingly used high-cost contract labor in recent years, the ECI has not updated with this growth in contract labor. As a result, we find that the ECI has likely underestimated the hospital labor cost growth since the COVID-19 pandemic, leading to insufficient updates to Medicare rates.

Further, we expect that the labor component of the IPPS hospital market basket is unlikely to catch up with the overall level of hospital labor cost increases. Since contract labor use and general workforce composition will not likely revert to its earlier levels, the estimated cumulative growth of labor costs, based on the ECI, will continue to lag behind the cumulative growth in hospital labor costs. Any current underestimates of labor cost growth will take years to make up, and that timeline

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<sup>5</sup> The Federal Register includes the current set of weights in the IPPS hospital market basket. See Table IV-05 in Department of Health and Human Services, “Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Proposed Policy Changes and Fiscal Year 2022 Rates; Quality Programs and Medicare Promoting Interoperability Program Requirements for Eligible Hospitals and Critical Access Hospitals; Proposed Changes to Medicaid Provider Enrollment; and Proposed Changes to the Medicare Shared Savings Program,” Federal Register 86(88), pp. 25070–25790, (“Federal Register 86(88)”) at p. 25425, Table IV-05. available at <https://www.govinfo.gov/content/pkg/FR-2021-05-10/pdf/2021-08888.pdf>. The ECI is limited to civilian workers.

<sup>6</sup> “We use the ECI because it reflects the price increase associated with total compensation (salaries plus fringes) rather than just the increase in salaries. In addition, the ECI includes managers as well as other hospital workers.” *Federal Register* 86(88) at p. 25401.

would be extended indefinitely if more-expensive contract labor continues to make up a larger share of hospital labor, and continues to experience more rapid cost growth than in-house labor.

Key takeaways:

- In the wake of the COVID-19 pandemic, the ECI has recorded substantially less growth in hospital labor costs than a closely-related measure—the Employer Costs of Employee Compensation (“ECEC”). Between 2019 Q4 and 2022 Q4, the ECI for hospital industry wages grew by 13 percent, seven percentage points below the 20 percent increase over the same period in the ECEC for hospital industry wages. The growth in total compensation shows a similar pattern to the growth in wages, with the ECI<sup>7</sup> and the ECEC recording growth of 12 percent and 17 percent, respectively, a four percentage point gap.<sup>8</sup>
- The gap between the ECI and the ECEC may in part be explained by the shift to increased reliance on contract labor over this time period—a labor segment with high and quickly-growing pay rates. The ECEC incorporates both increases in compensation and changes in the mix of labor inputs on a timelier basis than the ECI. When the ECEC grows faster than the ECI, this suggests that the mix of labor inputs is moving towards greater utilization of high-cost-level or fast-cost-growth categories of labor. This is exactly what occurred in the hospital field between 2019 and 2022, and is expected to continue.
- The ECI will not quickly, or potentially ever, catch up with the overall level of actual hospital labor cost increases. Since underestimates in one direction compound over time, it could take several years of overshooting the true growth rate for the ECI to catch up with costs. Thus, without compensatory changes CMS updates to hospital prices are likely to remain substantially below the trend of hospital costs.

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<sup>7</sup> BLS only publishes a wages and salaries ECI and a total compensation ECI for the hospital industry. As noted in section 3, CMS uses the hospital industry total compensation ECI as its price proxy for employee benefits.

<sup>8</sup> Percent growth and percentage point gap values do not sum due to rounding.

## 2. The hospital industry has experienced a rapid shift towards contract labor in recent years

The hospital industry has been buffeted by extreme disruptions in staffing for medical professionals, particularly since the onset of the COVID-19 pandemic. Hospitals experienced greater turnover in their nursing staff, leading to increases in training costs, along with a substantial decline in the number of nurses.<sup>9</sup> At the same time, hospitals experiencing a surge of patients needed to rapidly increase their staffing, leading them to make greater use of short-term contract labor, such as traveling nurses.<sup>10</sup>

The shift towards contract labor has not subsided even as the strain of the pandemic has eased.<sup>11</sup> One factor in this shift, nursing shortages, may have been exacerbated by the pandemic but has continued past it,<sup>12</sup> forcing hospitals to continue to rely more on contract labor.<sup>13</sup> Hospital staff in salaried positions have also been incentivized to move into contract positions, given the greater flexibility and increasingly higher wages that contract positions offer.

Over the 2019 to 2022 period, the usage of and pay rates for contract labor saw dramatic increases. A recent edition of *Hospital Vitals: Financial and Operational Trends* documents these substantial increases.<sup>14</sup> Full-time equivalent staffing hours for contract labor increased 138.5% over this period. As a share of total worked hours, contract labor increased by 133.1%. At the same time, wages for contract labor

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<sup>9</sup> Auerbach et. al. (2022), “A Worrisome Drop In The Number Of Young Nurses”, *Health Affairs*, April 13, 2022, available at <https://www.healthaffairs.org/content/forefront/worrisome-drop-number-young-nurses>

<sup>10</sup> See, e.g., Karen Roush (2022), “Staffing Crisis Fueled by COVID-19 Creates Boom for Travel Nurse Industry,” *AJN, American Journal of Nursing* 122(5), May 2022, p. 12, available at [https://journals.lww.com/ajnonline/fulltext/2022/05000/staffing\\_crisis\\_fueled\\_by\\_covid\\_19\\_creates\\_boom.5.aspx](https://journals.lww.com/ajnonline/fulltext/2022/05000/staffing_crisis_fueled_by_covid_19_creates_boom.5.aspx).

<sup>11</sup> KaufmanHall (2022), “The Financial Effects of Hospital Workforce Dislocation: A Special Workforce Edition of the National Hospital Flash Report,” May 2022, pp. 1–14 at pp. 7–10, available at <https://www.kaufmanhall.com/sites/default/files/2022-05/KH-NHFR-Special-Report-2.pdf> (“KaufmanHall (2022), ‘National Hospital Flash Report’”).

<sup>12</sup> Brendan Martin, Nicole Kaminski-Ozturk, Charlie O’Hara, Richard Smiley (2023), “Examining the Impact of the COVID-19 Pandemic on Burnout and Stress Among U.S. Nurses,” *J Nurs Regul* 14(1), April 2023, pp. 4–12, available at <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC10074070/pdf/main.pdf> (“Martin, Kaminski-Ozturk, O’Hara, and Smiley (2023)”).

<sup>13</sup> KaufmanHall (2022), “National Hospital Flash Report.”

<sup>14</sup> Syntellis and the American Hospital Association (2023), “Hospital Vitals: Financial and Operational Trends: Workforce Pressures Take Their Toll in 2022,” February 2023, pp. 1–9 at pp. 2–5, available at [https://www.syntellis.com/sites/default/files/2023-03/AHA%20Q2\\_Feb%202023.pdf](https://www.syntellis.com/sites/default/files/2023-03/AHA%20Q2_Feb%202023.pdf) (“Syntellis and AHA (2023).”).

increased from already high levels. For example, Kaufman Hall reports that hourly wages for contract nurses more than doubled, increasing from \$64 in 2019 to \$132 in 2022 Q1, a 106% increase. By contrast, in-house nursing staff wages rose only 12% over the same period, from \$35 to \$39.<sup>15</sup>

### **3. The labor cost index used by the CMS is likely to have underestimated labor cost growth for hospitals since 2019**

As discussed above, compensation for hospital workers accounts for a large share of CMS's 2018-based hospital market basket – about 53 percent. As such, underestimating changes in hospital labor costs can have a substantial impact on the overall hospital market basket. The recent shift towards contract labor in the hospital industry is likely to cause such an underestimation.

In order to assess the ECI's ability to account for the recent changes in hospital staffing practices and associated labor cost growth, it is helpful to briefly review the construction of the ECI for the hospital industry. The hospital market basket features two components of compensation, both of which use a version of the ECI for the hospital industry as the corresponding price proxy:

- The wages and salaries component, with a weight of 41 percent in the 2018-based hospital market basket, uses the ECI for wages and salaries;
- The employee benefits component, with a weight of 12 percent in the 2018-based hospital market basket, uses the ECI for total compensation.<sup>16</sup>

The ECI is constructed through a multi-step process that is intended to smooth out short-term fluctuations in the composition of the labor pool.<sup>17</sup> Construction begins with a set of hospital “jobs,” which are groups of positions that have similar characteristics. Such characteristics include whether a position is full-time vs. part-

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<sup>15</sup> KaufmanHall (2022), “National Hospital Flash Report” at p. 11.

<sup>16</sup> *Federal Register* 86(88) at p.25425, Table IV-o5.

<sup>17</sup> See Bureau of Labor Statistics, “National Compensation Measures: Calculation”, *Handbook of Methods*, December 15, 2017, available at <https://www.bls.gov/opub/hom/ncs/calculation.htm> (“The ECI is a measure of the change in the cost of labor, independent of the influence of employment shifts among occupations and industry categories.”) (“BLS (2017), ‘Calculation’”).

time, has union vs. non-union status, has time-base vs. incentive-based pay structure, and has similar work levels.<sup>18</sup> The BLS collects pay rates for each of these jobs from a set of hospitals that have been selected to be part of its employer survey.<sup>19</sup>

A hospital and job will remain in the sample for 3 years once they enter the sample.<sup>20</sup> Each year, new hospitals and jobs are added, while others reach the end of their 3-year window and are dropped, so that the sample updates slowly over time.

The BLS assigns each job in the sample to a specific occupation, which corresponds to one of 9 broad occupation categories.<sup>21</sup> The BLS then calculates the cost growth for each occupation as a weighted average across jobs assigned to the occupation, where the weight for each job corresponds to its size when it first entered the sample. Finally, the BLS calculates the growth rate for the hospital industry using a weighted average across occupations. The weights for this final step are updated infrequently – about once every ten years.<sup>22</sup>

Each of these steps are likely to have caused the ECI to underestimate labor cost changes in the light of recent changes in hospital labor practices.

- First, the ECI can miss rapid changes in the hospital industry because it only includes a job in the calculation of the within-occupation average cost growth if it has been in the sample for at least two consecutive quarters.<sup>23</sup> This means that jobs are six months old by the

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<sup>18</sup> BLS (2017), “Calculation.” The BLS selects hospitals to be a part of the National Compensation Survey (NCS). See Bureau of Labor Statistics, “National Compensation Measures: Collections and Data Sources,” *Handbook of Methods*, December 15, 2017, available at <https://www.bls.gov/opub/hom/ncs/data.htm> (“BLS (2017), ‘Collections and Data Sources’”) (“The National Compensation Survey (NCS) uses Bureau of Labor Statistics (BLS) field economists to collect compensation data from survey respondents.”).

<sup>19</sup> BLS (2017), “Collections and Data Sources.”

<sup>20</sup> Gwyn R. Ferguson, Joan L. Coleman, and Chester H. Ponikowski (2011), “Update on the Evaluation of Sample Design Issues in the National Compensation Survey,” Bureau of Labor Statistics, August 2011, available at <https://www.bls.gov/osmr/research-papers/2012/pdf/st120280.pdf> (“Ferguson, Coleman, and Ponikowski (2011)”).

<sup>21</sup> BLS (2017), “Calculation.” The BLS performs this calculation for 59 industries, and refers to the combination of an industry and occupation as a “cell.” Because we consider only the hospital industry, the occupations we refer to are also cells.

<sup>22</sup> See U.S. Bureau of Labor Statistics (2023), “Employment Cost Index: Reweighting and Recoding in the ECI,” January 25, 2023, available at <https://www.bls.gov/eci/factsheets/eci-reweighting-and-recoding.htm> (“BLS (2023), ‘Reweighting and Recoding.’”).

<sup>23</sup> BLS (2017), “Calculation” (“All wage and benefit indexes are computed from the following data:

time they enter the calculation. Thus, new contract jobs in the hospital industry will already have been present, and causing higher labor costs, well before they are included.

- Second, when averaging the growth rates of jobs within an occupation, the ECI fixes the sampling weight of a job at its weight when it first entered the sample.<sup>24</sup> Thus, a job first sampled in 2020 retains the 2020 weight even when it is used to calculate cost growth between 2022 Q2 and 2022 Q3. This job would retain the same weight until it exits the sample after 3 years. The fixed sampling weight for a job means that changes in the mix of jobs within an occupation (e.g., due to a shift towards greater use of contract labor) can be delayed several years as the sample of jobs and their associated weights turns over.
- Third, because the ECI calculation holds the mix of occupations fixed between rebasings,<sup>25</sup> rapid changes in the importance of different occupations may take some time to be incorporated.

An alternate measure of labor cost growth, the Employer Cost of Employee Compensation (“ECEC”), presents a useful comparison to the ECI.<sup>26</sup> The ECEC is constructed based on the same data as the ECI, but the sampling weights in the ECEC are based on the current quarter, rather than the quarter the job entered the

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Matched quotes are average hourly wages (or benefit costs) for detailed occupations (six-digit SOC) or groups of occupations, in sample establishments for which data are available for both the current and previous quarters.”).

<sup>24</sup> Michael K. Lettau, Mark A. Loewenstein, and Aaron T. Cushner (1997), “Explaining the Differential Growth Rates of the ECI and the ECEC,” *Compensation and Working Conditions* Summer 1997, pp. 15–23 at pp. 16, 23, available at <https://www.bls.gov/opub/mlr/cwc/explaining-the-differential-growth-rates-of-the-eci-and-ecec.pdf> (“Lettau, Loewenstein, and Cushner (1997)”).

<sup>25</sup> Updates to the weights for aggregating over industry-occupation cells happens about once every 10 years. See BLS U.S. Bureau of Labor Statistics (2023), “Employment Cost Index: Reweighting and Recoding,” in the ECI,” July 25, 2023, available at <https://www.bls.gov/eci/factsheets/eci-reweighting-and-recoding.htm> (“U.S. BLS (2023)”).

<sup>26</sup> In addition, the ECEC satisfies the CMS criteria of reliability (BLS reports modest standard errors for ECEC). See Bureau of Labor Statistics, “Employer Costs for Employee Compensation Relative Standard Errors,” March 17, 2023, available at <https://www.bls.gov/web/ec/ec/ecec-rse.htm> (“BLS (2023), ‘ECEC Standard Errors’”) (for discussion and data on ECEC Relative Standard Errors). ECEC also satisfies the CMS criteria of availability (the relevant ECEC measure is published publicly), and timeliness (ECEC is available quarterly). ECEC publication is slightly delayed relative to the schedule for ECI releases. See U.S. Bureau of Labor Statistics, “Schedule of Releases for the Employer Costs for Employee Compensation,” available at [https://www.bls.gov/schedule/news\\_release/ecec.htm](https://www.bls.gov/schedule/news_release/ecec.htm) (U.S. BLS, “ECEC Release Schedule”) and U.S. Bureau of Labor Statistics, “Schedule of Releases for the Employment Cost Index,” (“BLS (2023), ‘(U.S. BLS, “ECI Release Schedule.”)’”) available at [https://www.bls.gov/schedule/news\\_release/eci.htm](https://www.bls.gov/schedule/news_release/eci.htm).

sample<sup>27</sup>, and occupation weights are also based on the current quarter, rather than a base year. Further, the ECEC includes new jobs immediately, without the requirement that they are in the sample for two consecutive quarters. Thus, the ECEC is affected by both increases in compensation and by changes in the mix of labor inputs on a timelier basis. This means that the ECEC will more rapidly account for changes in the workforce mix and compensation. As explained in more detail in Appendix A, when the ECEC grows faster than the ECI this suggests that the mix of labor inputs is moving towards greater utilization of high-cost-level or fast-cost-growth categories of labor. This is exactly what occurred in the hospital field between 2019 and 2022, and is expected to continue.

A comparison of the ECI and the ECEC between 2019 Q4 and 2022 Q4 suggests that the ECI has not been capturing changes in the workforce on a timely basis. Exhibit 1 compares the ECI and the ECEC between 2019 Q4 and 2022 Q4. For the wages and salaries component, the ECI and the ECEC show a growth rate of 13.3 percent and 20.0 percent respectively, a 6.7 percentage point gap. The growth in the total compensation component, which CMS uses to track benefits, is slightly lower with the ECI and the ECEC recording growth of 12.4 percent and 16.6 percent, respectively, a 4.2 percentage point gap.

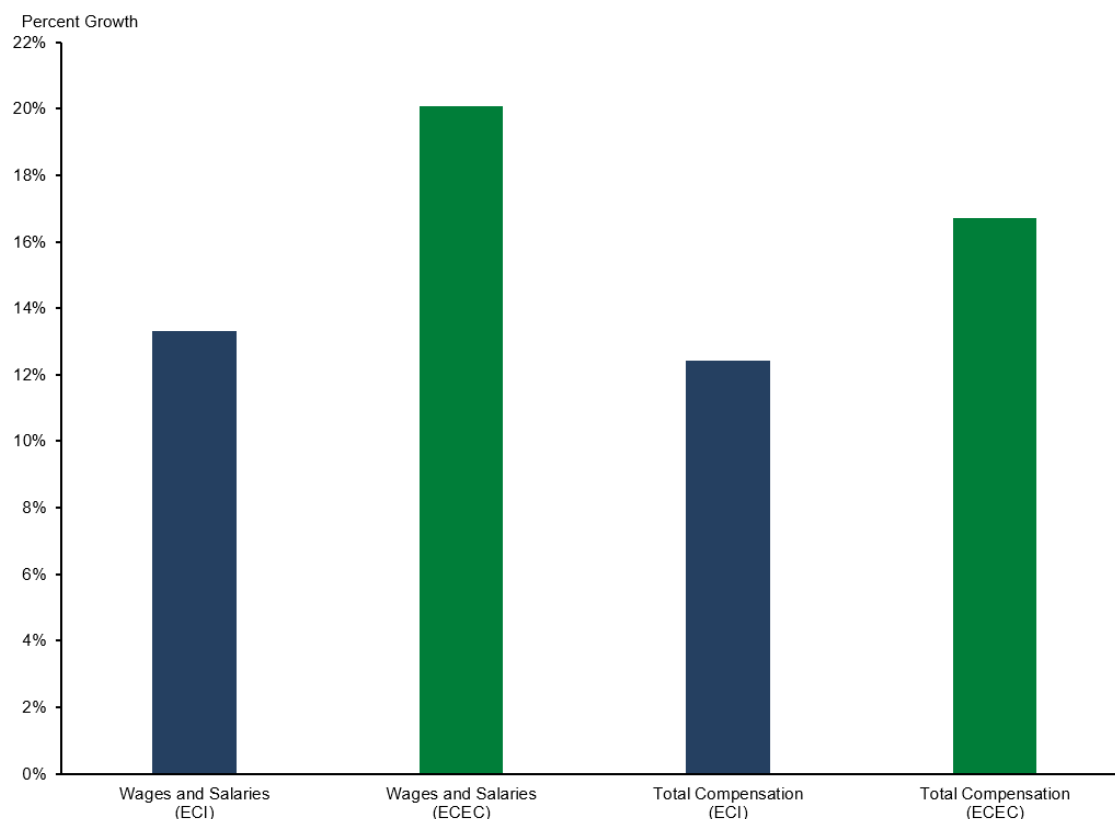
### **Exhibit 1: Hospital Labor Cost Growth: ECI vs. ECEC (2019 Q4 – 2022 Q4)<sup>28</sup>**

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<sup>27</sup> BLS (2017), “Calculation” (“The ECEC uses current employment weights (as opposed to fixed employment weights used in the ECI) to reflect the changing composition of today’s labor force to calculate cost levels.”).

<sup>28</sup> BLS Indices CIU1026220000000I, CMU1026220000000D, CIU1016220000000I, CMU1016220000000D, available at <https://data.bls.gov/cgi-bin/srgate>.





Combining the wages and salaries component, and the total compensation component (under current hospital market basket weights), the ECI measures lead to an estimated 13 percent increase in hospital labor costs.<sup>29</sup> In contrast, using the ECEC for the wage and salaries, and total compensation growth over this period would result in a hospital labor cost growth rate of 19 percent, six percentage points higher than generated by the ECI.<sup>30</sup> This difference in measured growth could have had a substantial impact on the IPPS hospital market basket used by CMS.

Notably, the ECI's failure to fully capture underlying hospital cost growth understates the gaps between CMS's recent rate setting adjustments and the published hospital market basket cost increases. As shown in Table 1 below, the cumulative gap between cost growth estimates incorporated in rate setting for an ECI-based market basket in final rules versus actual ECI-based market basket estimates is three percentage points between 2019 and the proposed 2024 rate (19.5% and 22.5%, respectively). If we switched to calculating the market basket using the ECEC rather than the ECI as a price proxy, the cumulative gap between the

<sup>29</sup>  $(41/(41+12)) * 13\% + (12/(41+12)) * 12\% = 13\%$

<sup>30</sup>  $(41/(41+12)) * 20\% + (12/(41+12)) * 17\% = 19\%$

ECI-based market basket final rule and ECEC-based market basket (i.e., realized cost growth) expands to almost eight percentage points (19.5% and 27.4%, respectively).

**Table 1: Hospital Labor Cost Growth – ECEC-based Market Basket versus ECI-based Market Basket (Actual and Final Rule)**

	FY 2019	FY 2020	FY 2021	FY 2022	FY 2023	FY 2024
<b>Cumulative Growth<sup>[1]</sup></b>						
ECEC-based Market Basket <sup>[2]</sup>	3.6%	4.8%	8.9%	15.2%	23.7%	27.4%
ECI-based Market Basket (Actual) <sup>[3]</sup>	2.4%	4.4%	7.6%	13.7%	18.9%	22.5%
ECI-based Market Basket (Final Rule) <sup>[4]</sup>	2.9%	6.0%	8.5%	11.5%	16.0%	19.5%

Source: Bureau of Labor Statistics; CMS Market Basket Data; CMS Regulation No. CMS-1785-P

Notes:

[1] Cumulative growth is the compounded growth over all prior fiscal year four-quarter growth rates.

[2] ECEC-based Market Basket adjusts the market basket prepared by CMS – ECI-based Market Basket (Actual) in the table – by substituting the percent change in hospital ECI with the corresponding ECEC series. For growth between FY 2022 and FY 2023, the four-quarter growth adjusts the CMS FY 2023 forecast by the gap between the four-quarter percent change in the ECI and ECEC in 2022 Q4. No adjustment is made to the CMS forecast for growth between FY 2023 and FY 2024.

[3] ECI-based Market Basket (Actual) accumulates the Current Estimates of four-quarter growth rates in Q3 of the corresponding calendar year, as reported by CMS on 4/20/23. The underlying growth rates for FY 2023 and FY 2024 are forecasts.

[4] ECI-based Market Basket (Final Rule) reports the cumulation of the forecasted fiscal year hospital basket increases cited by CMS in setting the fiscal year PPS adjustment. The growth from FY 2023 to FY 2024 reflects the hospital market basket update cited in the proposed rulemaking. It does not take into account other payment policies, such as those related to disproportionate share hospital or outlier payments.

As discussed further in the next section, this gap between the ECI and ECEC measures of hospital labor costs is indicative of a change in the composition of the hospital labor force towards more expensive contract labor.

### *3.1. Changes in contract labor utilization are consistent with the ECEC – ECI gap*

An exact analysis of the divergence between the ECI and the ECEC is not possible with publicly available information. It would require access to underlying data used in the construction of these indices (e.g., detailed survey data and sampling weights) which the BLS does not make publicly available.<sup>31</sup> However, since the ECI adjusts the sampling weights of different jobs slowly, compared to the ECEC, it is likely that the

<sup>31</sup> For an example of such an exact decomposition, including discussion of effects within industry-occupation cells, see Lettau, Loewenstein, and Cushner (1997).

ECI would be slow to incorporate the shift towards greater use of contract labor that has occurred in the hospital industry since the COVID-19 pandemic.<sup>32</sup>

Recent hospital industry reports demonstrate that the increases in pay and utilization of contract labor are reasonably likely to explain the observed gap between the published ECI and ECEC for the hospital industry.<sup>33</sup> These reports include data on the levels and growth of contract labor in hospitals, as well as wages for contract and in-house labor, allowing us to demonstrate, in a simplified form, how a shift towards contract labor can cause the ECI and ECEC to diverge.

Exhibit 2 presents two hypothetical labor cost indices calculated based on data on wages and utilization for in-house staff and contract labor available in recent industry reports.<sup>34</sup> These can be compared to the published BLS ECI and ECEC series as a way to demonstrate how the shift toward contract labor could help explain the difference between the ECI and ECEC.<sup>35</sup> First, we take an approach analogous to the ECI and aggregate growth in wages for in-house and contract labor with the share of labor hours and labor expense fixed at the 2019 level. This index finds overall price growth of 13 percent over the period from 2019 to 2022. Second, we take an approach analogous to the ECEC and account for the shift towards a higher share of labor hours coming from contract labor and a lower share coming from in-house staff.<sup>36</sup> This index finds overall price growth of 17 percent over the period from 2019 to 2022. This comparison of two hypothetical indices (shown as Contract / In-House Mix bars) shows that the shift towards contract labor could have accounted for an extra 4 percentage points of hospital labor cost growth not accounted for in the ECI, over half of the observed 7 percentage point gap between the BLS's ECI and ECEC.

## **Exhibit 2: Hypothetical Wage Growth Aggregating Across Contract and In-House Labor Using Industry Sources, vs. BLS Series<sup>37</sup>**

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<sup>32</sup> ECI is known for holding fixed the mix of employment, but this is only true across industry-occupation categories and between rebasing periods. Within an industry-occupation, ECI allows for composition effects but instead delays incorporating these types of shifts. See Appendix B for more details.

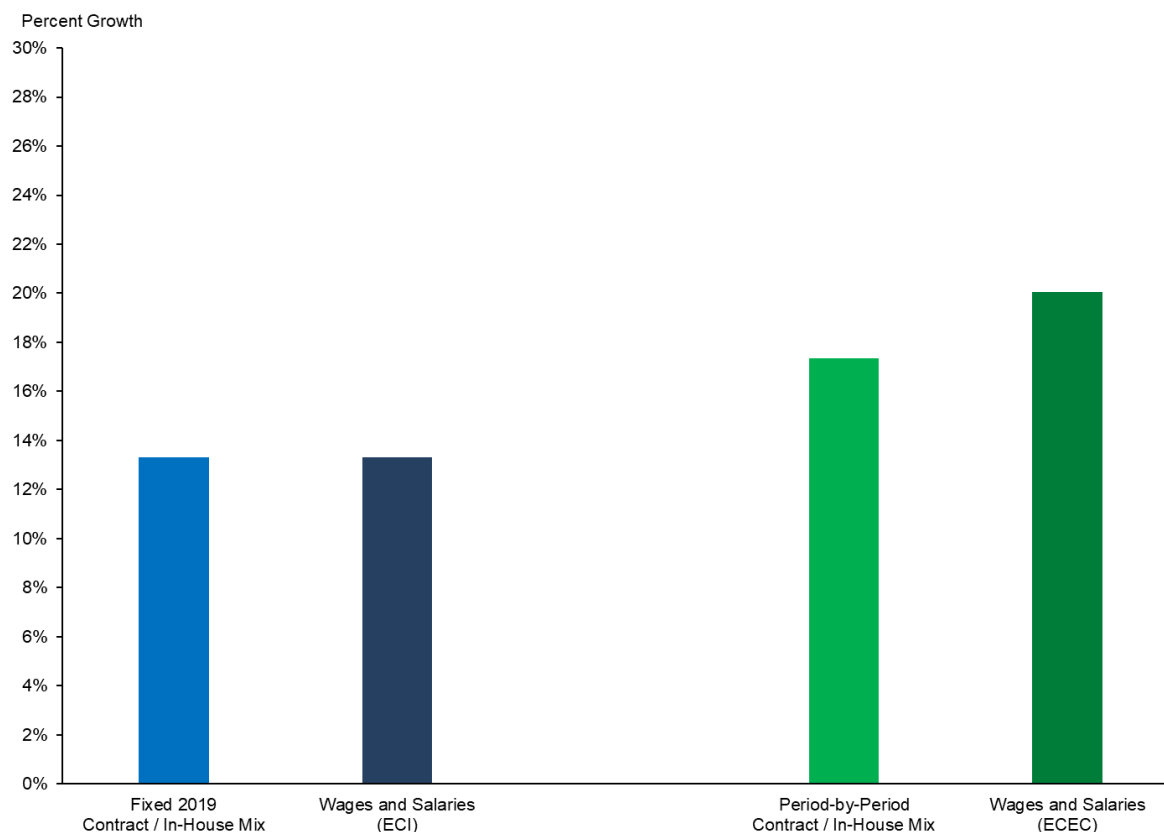
<sup>33</sup> See Syntellis and AHA (2023); KaufmanHall (2022), “National Hospital Flash Report.”

<sup>34</sup> See Syntellis and AHA (2023); KaufmanHall (2022), “National Hospital Flash Report.”

<sup>35</sup> Details of these estimates are discussed in Appendix B.

<sup>36</sup> For this discussion labor utilization is the share of total hours. Thus growth in one segment's share must be associated with a lower share for the other segment.

<sup>37</sup> BLS Indices CIU1026220000000I and CMU1026220000000D; KaufmanHall (2022), “National Hospital Flash Report” at pp. 7, 9, 11; Syntellis and AHA (2023) at p. 3.



#### **4. The ECI is unlikely to catch up with overall level of hospital labor cost increases**

The extent to which the ECI is likely to continue to underestimate hospital labor cost growth going forward depends on two aspects of the hospital labor market. First, will the mix of labor revert to its earlier mix or permanently move towards this new regime? Second, how will growth in wages/salaries and benefits vary across the new labor input mix? If the ratio of in-house salaried to contract labor does not revert to its earlier levels, growth in the ECI will continue to lag behind growth in hospital labor costs. Even if the ratio does revert to something closer to pre-pandemic levels, however, current and prior undermeasurement means ECI will take time to – or potentially never – catch up to the level that hospital labor costs would have reached absent these earlier underestimates.

#### *4.1. The hospital ECI's undermeasurement of labor cost growth has been persistent and compounded over the period from 2019 to 2022*

It is expected, given sampling and design differences, that in any given period estimates of labor cost growth may differ among different price proxies. Such discrepancies may not lead to substantial cumulative effects if differences are offsetting over time. However, as errors in one direction persist, the effect on cumulative growth over time can be substantial.

As discussed above, the ECI growth has been lower than the ECEC during the period from 2019 to 2022. Starting from this already depressed base, the ECI would have to grow substantially faster going forward to eliminate the effects of the years of under-measurement in the growth rate of labor costs. Given the prospect of compounded under-measurement of the ECI, simply relying on the hospital ECI could leave IPPS reimbursements too low relative to hospitals costs for a period of several years—further compressing hospital margins—even if hospital labor cost growth rates eventually return to prior trends.

To see mechanically how these quarter-by-quarter growth rates feed into cumulative growth, it is helpful to compare the ECI and ECEC to another measure of hospital labor costs prepared by the BLS – average weekly earnings as reported in the Current Employment Statistics (“CES”).<sup>38</sup> Exhibits 3 and 4 show growth rates and index levels (cumulative growth) for these three statistics, respectively. The CES average weekly earnings is calculated similarly to the ECEC, but uses data from a different survey, and thus offers additional evidence for the patterns we observe in the ECEC.

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<sup>38</sup> Specifically, we look at average weekly earnings of all employees in the hospital industry (CEU6562200011). CES data are published monthly and have the same industry scope as ECI or ECEC, but however the types of labor costs considered may differ between the two cost measures. See U.S. Bureau of Labor Statistics, “Current Employment Statistics – National: Calculation,” May 4, 2022, available at <https://www.bls.gov/opub/hom/ces/calculation.htm> and BLS (2022). See also, e.g., U.S. Bureau of Labor Statistics, “Current Employment Statistics - CES (National),” May 5, 2023, available at <https://www.bls.gov/web/empsit/ceseeb1a.htm>; cf. U.S. Bureau of Labor Statistics, “BLS Data Viewer: Wages and salaries for All Civilian workers in Hospitals, Index,” May 25, 2023, available at <https://beta.bls.gov/dataViewer/view/timeseries/CIU1026220000000I>. (Both indices reference NAICS Code 622, for Civilian Workers in Hospitals.). The analysis here uses the third quarter of each month (March, June, September, December) to compare against ECI and ECEC values. See U.S. Bureau of Labor Statistics, “Current Employment Statistics,” available at <https://www.bls.gov/ces/>.

The sequence of short-run growth rates<sup>39</sup> for each series is shown in Exhibit 3. Comparing the ECEC to the CES, the ECEC grew somewhat slower in 2021 and 2022 until there was a large increase in the ECEC in 2022 Q4. In turn, comparing the ECEC to the ECI, growth rate differences are roughly offsetting over 2019 and 2020, but since 2021 the ECEC has grown either faster or at the same rate as the ECI.

### Exhibit 3: Period-by-Period Hospital Labor Cost Growth (2019 Q1 – 2022 Q4)<sup>40</sup>



Exhibit 4 looks at the index level for these three labor cost measures, showing the cumulative growth since 2019Q1. Here, we can see that from mid-2020 the CES grew faster than the ECEC, and it is only the rapid growth of the ECEC in 2022Q4 that has closed that gap and brought those two measures back into alignment in terms of

<sup>39</sup> The short-run growth rate presented is a four-quarter growth rate: the annualized version of the geometric mean of growth rates for the four previous quarters. We use four-quarter growth rates here to smooth over high-frequency adjustments in the data, such as seasonal variation.

<sup>40</sup> BLS Indices CIU1026220000000I and CMU1026220000000D; CES Index CEU6562200011, available at <https://data.bls.gov/cgi-bin/srgate>.

cumulative growth. Cumulative growth in ECI did not have the same type of rapid growth, so ECI will need some period of much higher growth (as the ECEC had at the end of 2022) to catch up to the cumulative growth in the CES and ECEC.

#### Exhibit 4: Cumulative Hospital Cost Growth (2019 Q1 – 2022 Q4)<sup>41</sup>



#### 4.2. Shift to contract labor can reasonably be expected to persist

Kaufman Hall reports that healthcare facilities are “planning for at least a three-to-four year transition” to a new stable labor market.<sup>42</sup> The wave of workers leaving health care or retiring, together with a limited pipeline of newly trained staff, makes it likely that even if hospitals can successfully move away from current utilization levels for high-cost contract labor, they will not return to the levels seen prior to the

<sup>41</sup> BLS Indices CIU1026220000000I and CMU1026220000000D; CES Index CEU6562200011.

<sup>42</sup> KaufmanHall (2022), “2022 State of Healthcare Performance Improvement: Mounting Pressures Pose New Challenges,” October 2022, available at <https://www.kaufmanhall.com/sites/default/files/2022-10/2022-State-Healthcare-Performance-Improvement.pdf>. (“KaufmanHall (2022B)”).

pandemic.<sup>43</sup> Already, hospitals are moving to build more infrastructure around contract labor including establishing staffing agencies within health systems.<sup>44</sup>

#### *4.3. The ECI will not quickly, or potentially ever, catch up with the overall level of actual hospital labor cost increases*

If the ratio of contract labor relative to in-house labor declines toward pre-pandemic levels, then the ECI will indicate labor cost increases that are higher than the true cost increases, until hospital labor costs stabilize at a new level. However, since errors in one direction compound over time, it could take several years of overshooting the true growth rate for the ECI to catch up with costs.

This catch-up problem can be illustrated with a simple simulation of wage measures from 2019 to 2028. This simulation is not intended to be a prediction of hospital labor composition or costs; instead, it is an illustration of how a downward trend in the use of contract labor will not bring estimates of labor costs, in levels, back to their original trend line.

For the purpose of the simulation, we take estimates of labor costs and hours from 2022 and assume that contract labor's share of hours declines from about 2.6% down to 1.5% over several quarters, lower than today but still up from 2019 pre-pandemic level of 1%. In addition, the simulation assumes that contract labor prices stay elevated relative to in-house wages but that the growth rates for both contract and in-house labor costs are the same going forward. Specifically, we assume growth of 4% for 2023 and 2024, falling back to 2% annually through 2028 for both contract and in-house labor. Actual hospital labor composition and wage growth could more rapidly and completely fall back to pre-pandemic norms, in which case the gap between ECI estimates of growth and hospitals experienced labor cost growth would close more quickly, but still lead to underestimates of hospital labor cost growth for

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<sup>43</sup> Martin, Kaminski-Ozturk, O'Hara, and Smiley (2023). Brendan Martin, Nicole Kaminski-Ozturk, Charlie O'Hara, Richard Smiley, "Examining the Impact of the COVID-19 Pandemic on Burnout and Stress Among U.S. Nurses," *J Nurs Regul* 14(1), April 2023, pp. 4–12, available at <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC10074070/pdf/main.pdf>.

<sup>44</sup> Alan Condon, "Health systems see internal staffing agencies as path to solving labor challenges," *Becker's Hospital CFO Report*, February 20, 2023, available at <https://www.beckershospitalreview.com/finance/health-systems-see-internal-staffing-agencies-as-path-to-solving-labor-challenges.html>.



several years. Or it could happen more slowly, which would leave a significant gap for even longer.

### Exhibit 5: Cumulative Hospital Cost Growth (2019 Q1 – 2022 Q4)<sup>45</sup>

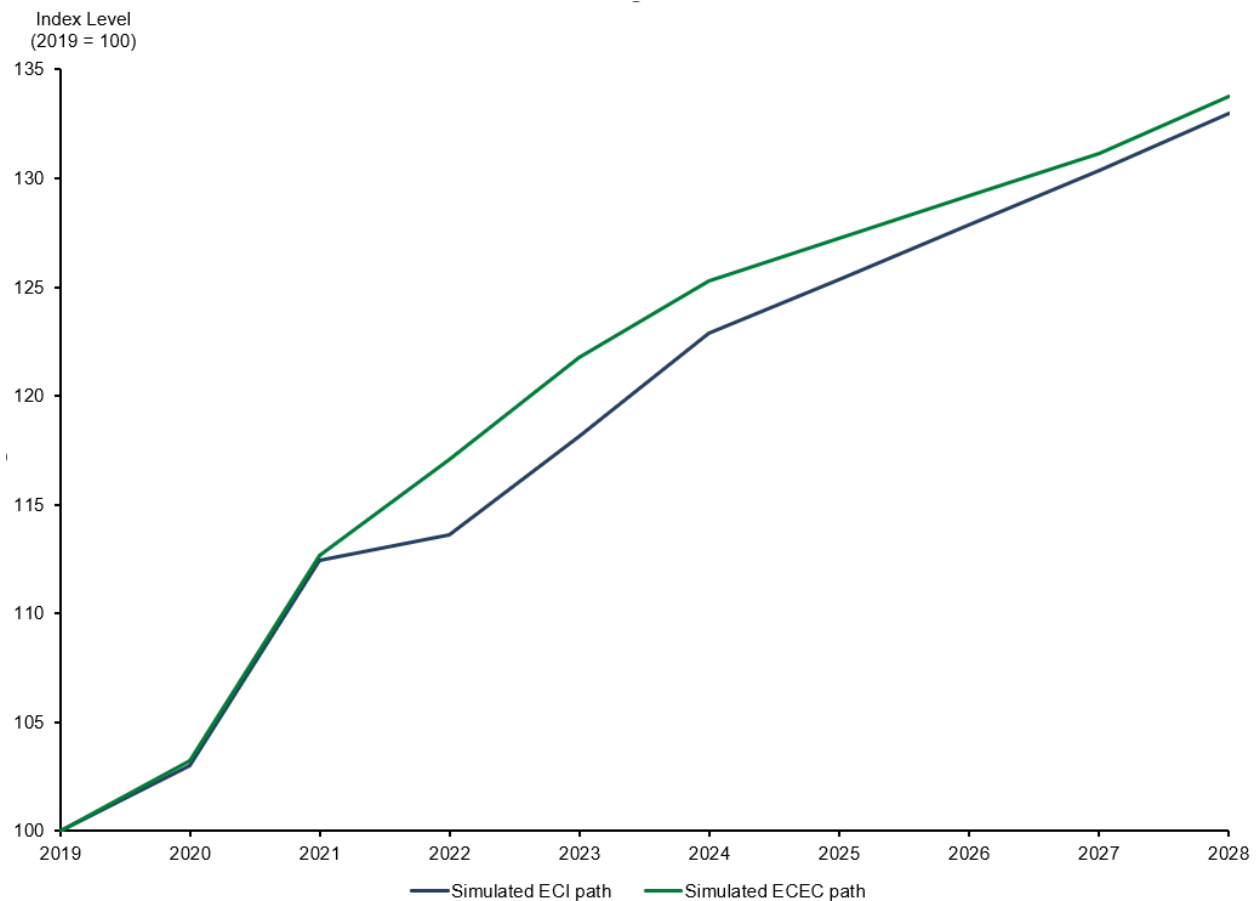


Exhibit 5 reports the path for this simulation exercise, starting in 2019.<sup>46</sup> After 2022, the ECI path catches up somewhat with the ECEC path as the mix reallocates away from expensive contract labor. During this period, the ECI annual growth is higher than the ECEC. However, the depressed base for ECI from its earlier underweighting of the run up in cost of contract labor together with the permanent (albeit smaller) shift towards contract labor means that the ECI never fully catches up in terms of cumulative level of cost increases. In this simulation, the cumulative gap falls from 3 percentage points in 2022 down to 1 percentage point in 2028. Thus, the

<sup>45</sup> KaufmanHall (2022), “National Hospital Flash Report” at p. 7, 11; Syntellis and AHA (2023) at p. 3.

<sup>46</sup> As in the exercise in Exhibit 2, the gap in the simulation between ECEC and ECI is smaller than in the observed data by 2022 because we only account for the effect of the contract labor adjustment.

gap does not fully close, and there are several years in which the CMS update to hospital prices could remain substantially below the trend in costs.

While this section has focused on the issue of increased reliance on contract labor, there are a number of other ongoing shifts in hospital staffing that have raised costs. Staff turnover – which remains elevated – generates costs for hospitals for recruitment. This increases competition for staff, and leads to greater reliance on contract staff and overtime hours while attempts are made to replace lost team members. Signing and retention bonuses have grown in size and popularity.<sup>47</sup> Overall, one industry report finds the average cost of a turnover for a Registered Nurse is \$52,350 in 2022.<sup>48</sup> In light of current and likely future shortages of skilled hospital staff<sup>49</sup> this full suite of pressures on hospital labor costs is unlikely to relent in the foreseeable future. Thus, going forward for a hospital cost measure such as the ECI to be relevant depends significantly on its ability to capture shifts in hospital costs across categories of staff and types of expenses accurately and in a timely manner.

## 5. Appendix A: Fixed-based Indices versus Average Cost Growth

This section considers idealized versions of the ECI and ECEC – a pure Laspeyres index and a pure average cost growth series. A Laspeyres index is a method to aggregate price increases for a variety of inputs into a single overall measure of cost growth.<sup>50</sup> Consider a set of labor inputs, each indexed by  $i$ , and an interval of time over which growth is to be measured. The cumulative growth factor in a Laspeyres index from a base period (indexed as time 0) to a future reference period (indexed as time 1) is given by:

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<sup>47</sup> All Zone (2022) “Hospitals Increased Recruitment and Retention Strategies”, available at <https://www.allzonems.com/hospitals-increased-recruitment-and-retention-strategies/>

<sup>48</sup> NSI Nursing Solutions Inc. (2023) “2023 NSI National Health Care Retention & RN Staffing Report”, available at [https://www.nsinursingsolutions.com/Documents/Library/NSI\\_National\\_Health\\_Care\\_Retention\\_Report.pdf](https://www.nsinursingsolutions.com/Documents/Library/NSI_National_Health_Care_Retention_Report.pdf)

<sup>49</sup> Haines, Julia (2022) “The State of the Nation’s Nursing Shortage” in *U.S. News and World Report* November 1, 2022, available at <https://www.usnews.com/news/health-news/articles/2022-11-01/the-state-of-the-nations-nursing-shortage>

<sup>50</sup> For further discussion of Laspeyres Indices, see IMF (2020), “Consumer Price Index Manual, Concepts and Methods,” pp. 1–509 at Appendix 6, pp. 453–454, available at <https://www.imf.org/-/media/Files/Data/CPI/cpi-manual-concepts-and-methods.ashx> (“IMF (2020)”).

$$P_{1,0}^{Laspeyres} = \sum_i \left( \frac{p_{i1}}{p_{i0}} \right) s_{i0} = \frac{\sum_i p_{i1} \pi_{i0}}{\sum_i p_{i0} \pi_{i0}}$$

where  $p_{it}$  is the price of input  $i$  in periods 1 and 0, respectively,  $s_{it}$  is the share of item  $i$  in total expenditures, and  $\pi_{it}$  is fraction of item  $i$  labor inputs among total labor inputs (measured as hours).<sup>51</sup>

The first expression for the Laspeyres index shows that the index can be thought of as measuring overall growth in prices as a weighted average of price growth for individual inputs, with each input weighted by its share of labor expenses in the base period. The second (and equivalent) expression for the Laspeyres index shows that the index can be thought of as the growth in the cost of hiring the same basket of inputs that was used in the base period. Since both the weights and the labor input basket do not change as the reference period is adjusted, the Laspeyres index is known as a fixed weight index.

An alternative approach to measuring cost growth is to calculate the proportional increase in average cost between two periods. The average cost is written as:

$$Average\ Cost_t = \sum_i p_{it} \pi_{it}$$

In turn the growth factor of average prices may be written as:

$$P_{1,0}^{average\ cost} = \frac{\sum_i p_{i1} \pi_{i1}}{\sum_i p_{i0} \pi_{i0}}$$

To understand the sources of differences between average cost growth and a Laspeyres index, it is useful to rewrite the average cost growth into two components – a Laspeyres index and an additional adjustment term:

$$\frac{\sum_i p_{i1} \pi_{i1}}{\sum_i p_{i0} \pi_{i0}} = \frac{\sum_i p_{i1} \pi_{i0}}{\sum_i p_{i0} \pi_{i0}} + \frac{\sum_i p_{i1} \Delta \pi_i}{\sum_i p_{i0} \pi_{i0}} = \frac{\sum_i p_{i1} \pi_{i0}}{\sum_i p_{i0} \pi_{i0}} + \frac{\sum_i \Delta p_i \Delta \pi_i}{\sum_i p_{i0} \pi_{i0}} + \frac{\sum_i p_{i0} \Delta \pi_i}{\sum_i p_{i0} \pi_{i0}}$$

where a  $\Delta$  refers to the change in the level of a value (prices or share of hours) between period 1 and period 0 (e.g.  $\Delta \pi_i = \pi_{i1} - \pi_{i0}$ ).

<sup>51</sup> See IMF (2020) at p. 453, Appendix 6, Expressions A6.1 and A6.7.

The second component, which generates the gap between average cost growth and the Laspeyres index, is only present when there is a change in the composition of the labor force between the base period and the future period (i.e.  $\Delta\pi_i \neq 0$ ). In this report, we refer to this term as a composition effect.

The first version of the composition effect expresses this force in terms of how the labor mix shifts across categories with different prices in the reference period. If the labor mix moves away from low-cost categories and into high-cost categories, then the composition effect will lead average costs to rise faster than is reflected in a Laspeyres index.

Another, equivalent, way to consider the composition effect is as the sum of two terms—an interaction of labor share changes and price changes, together with shifts across categories with different prices in the base period. When changes in the labor mix are driven by price changes, economic theory would predict that the interaction between changes in price and changes in the labor mix should be negative, i.e., tend to lower average cost growth relative to what a Laspeyres index would measure. This force is known as a substitution effect and reflects the idea that buyers would, all else equal, adjust the input mix in a way that helps avoid the impact of a price increase.

This negative substitution effect can fail to appear for two reasons. The standard negative substitution effect can coexist with a positive composition effect if price changes push employers into more heavily using inputs that were initially more expensive. Alternatively, if the shifts in the mix of labor inputs reflects non-price factors such as a broader change in labor market conditions or staffing practices then economic theory does not predict a specific relationship between price changes and shifts in the labor input mix.

## 6. Appendix B – Estimating labor cost growth with constant contract labor share

Yet another way to write the composition effect is useful for making use of the available public data on the shift towards contract labor. Specifically, we can write the growth in average labor costs as:

$$\frac{\sum_i p_{i1} \pi_{i1}}{\sum_i p_{i0} \pi_{i0}} = \sum_i \left( \frac{p_{i1}}{p_{i0}} \right) s_{i0} + \sum_i \left( \frac{p_{i1}}{p_{i0}} \right) \left( \frac{\pi_{i1}}{\pi_{i0}} - 1 \right) s_{i0}$$

This formulation requires estimates of five objects, which are drawn from Kaufman Hall (2022) or Syntellis and AHA (2023):

- Growth in wage rates for contract labor:  $(132/64)-1$
- Growth in wage rates for in-house labor  $(39/35)-1$
- Growth in contract labor share of total hours (133.1%)
- Initial share of contract labor in total labor expenses (2%)
- Initial contract labor share of labor hours (1%)

With this information, we can also back out two other inputs by using the fact that shares add up to 1 within each period:

- Initial in-house employee share of total labor expenses (98%)
- Growth of in-house labor share of total hours (-1.3%)

The table below shows how to take these values and construct the Laspeyres index over in-house and contract labor, as well as making an adjustment for composition effects.

**Table 2: Average Cost Growth Calculation<sup>52</sup>**

<b>Expense Shares, 2019</b>		
[A]	Contract Labor	2.0%
[B] = 1 - [A]	In-House Labor	98.0%
<b>Percentage Change in Wage, 2022–2019</b>		
[C]	Contract Labor	+106.3%
[D]	In-House Labor	+11.4%
[E] = ( [A] * [C] + [B] * [D] )	<b>Laspeyres Index Percent Change</b>	+13.3%
<b>Labor Hour Share, 2019</b>		
[F]	Contract Labor	1.0%
[G] = 1 - [F]	In-House Labor	99.0%
<b>Percent Change in Hour Share, 2022–2019</b>		
[H]	Contract Labor	+133.1%
[I] = (1-[H]*[F])/[G]-1	In-House Labor	-1.3%
[A] * ( [C] + 1 ) * [F] + [B] * ( [D] + 1 ) * [G]	<b>Composition Effect</b>	+4.0%
[E] + [H]	<b>Average Cost Growth</b>	+17.3%

<sup>52</sup> KaufmanHall (2022), “National Hospital Flash Report” at pp. 7, 9, 11; Syntellis and AHA (2023) at p. 3.

**Summary of research modeling**  
**FY 2024 Proposed Inpatient Prospective Payment System**

**Outlier Payments**

Date: June 8, 2023

*Introduction*

Watson Policy Analysis (WPA) was asked to analyze issues and replicate outlier payments from the Centers for Medicare & Medicaid Services (CMS) Fiscal Year (FY) 2024 Inpatient Prospective Payment System (IPPS) proposed rule. In short, this outlier policy sets forth a set of rules whereby CMS provides payment to inpatient hospitals for a portion of their high cost inpatient cases once particular thresholds are met. CMS describes its methodology and logic starting on page 27216 of the Federal Register.<sup>1</sup> We attempted to replicate the CMS logic and then compared our results and made a variety of adjustments to assess the impact of using different parameters. This report summarizes our findings.

With the end of the COVID-19 Public Health Emergency, CMS is planning not to do anything unusual for COVID, instead reverting to the historical method of computing weights and outliers. For all analyses, CMS is proposing to use FY2022 MedPAR data, December release. In the final rule, they will use the more recent March release of the MedPAR data, as well as other updated information. However, the factors CMS uses should not change materially.

*Summary*

A summary of findings is as follows:

- WPA was able to come close to the CMS calculation of the Fixed Loss Threshold (FLT).
  - CMS published \$40,732
  - WPA calculated \$40,835
- WPA replicated other factors that went into the payment calculation.
- WPA was able to replicate the CMS calculation of the necessary adjustment for the target percentage based on the outlier reconciliations reported in the cost reports.
- WPA was able to come close to the estimate of charge inflation.
- Using some alternative assumptions, WPA was able to generate alternative Fixed Loss Thresholds that may be more appropriate.

*Background on outlier payments*

In the IPPS program, CMS has established the concept of “outliers” to be high cost cases which are paid an additional amount so that providers’ potential losses are limited. When the

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<sup>1</sup> "Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long Term Care Hospital Prospective Payment System and Proposed Policy Changes and Fiscal Year 2024 Rates; Quality Programs and Medicare Promoting Interoperability Program Requirements for Eligible Hospitals and Critical Access Hospitals; Rural Emergency Hospital and Physician-Owned Hospital Requirements; and Provider and Supplier Disclosure of Ownership". Published in Federal Register, Vol 88, No. 83., Monday, May 1, 2023

estimated costs of a case exceed the payment for the case, plus a threshold, CMS will generally pay 80% of the costs that exceed the payment plus the threshold. CMS pays 90% for discharges assigned to one of the “burn” diagnosis related groups (DRGs).

This threshold is known as the “fixed loss threshold” (FLT) and is set prospectively with each rule based on a target that operating outlier payments will be 5.1% of total operating payments, including outliers. This target is determined by simulations of expected payments.

Background from CMS on outlier payments can be found at:

<http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/outlier.html>

Additional detail is provided by CMS each year in the IPPS rule.

### **Analysis 1: Replication of the CMS estimated FY 2024 outlier payment from the FY 2024 IPPS proposed rule**

WPA estimated payments, including outlier payments from the FY 2022 Proposed Medicare Provider Analysis and Review (MedPAR) Proposed File, following the methodology set forth in various IPPS rules. In modeling payments, WPA used information from the following data sources:

- MedPAR FY 2024 proposed file: contains inpatient hospital claims from FY 2022 that were used by CMS to model proposed FY 2024 payments,
- Table 5 – Weight file: contains the proposed weights for FY 2024,
- Impact file: contains hospital specific characteristics and payment factors,
- DSH Supplemental File: contains uncompensated care per claim payment amounts for providers,
- The FY2024 Proposed IPPS rule, in particular information on cost and charge inflation factors, and
- Inpatient Provider of Services File: contains provider specific information.
- Hospital Cost Reporting Information System (HCRIS) data containing cost reports from providers. This information was used to calculate the adjustment to the outlier target based on the historical outlier reconciliation.

In addition, other factors such as charge inflation, CCR adjustment factors, and standardized payment amounts from the proposed rule were used.

Complete payments were calculated including operating, capital, disproportionate share hospital (DSH), indirect medical education (IME), uncompensated care, etc. for each case, following the CMS methodology. The CMS methodology excludes sole community hospitals, hospitals that have become Critical Access Hospitals (CAHs), and Maryland hospitals.

Using the proposed blended weights, WPA calculated a fixed loss threshold of: \$40,835 versus the published number of \$40,732, a difference of \$103 or about 0.25%.

Please note that the FLT will adjust with the release of the final rule and associated files, in addition to the recalculated weights.



## **Analysis 2: Comparison of Cost-to-Charge ratios from the FY 2024 proposed rule Impact file and the Inpatient Provider Specific File**

As part of the analysis, we compared the CCRs included in the impact file (used in modeling the FLT) with the CCRs from the Provider Specific File (PSF). CMS used the same CCRs both in the proposed blended methodology and in the alternative methodology.

For the modeling using the FY 2022 data, used the December 2022 release of the PSF file. Comparing the 3,199 providers listed in the impact file and the December 2022 PSF file, we had a match rate of 96.34% (3,082 providers).

Using this data, the average difference in operating CCRs between the impact file and the PSF file (weighted by discharges) was 0.001% when all providers were used, and 0.018% when just providers with differences were used.

For the modeling using the FY 2022 data, used the March 2023 release of the PSF file. Comparing the 3,199 providers listed in the impact file and the March 2023 PSF file, we had a match rate of 73.40% (2,488 providers).

Using this data, the average difference in operating CCRs between the impact file and the PSF file (weighted by discharges) was -0.002% when all providers were used, and -0.007% when just providers with differences were used.

The table of matching statistics reported nearly nine years ago in a report from The Moran Company – “Modeling Fiscal Year 2015 Inpatient Prospective Payment System Outlier Payments” dated June 23, 2014, and then updated with WPA calculated data is as follows:

<b>IPPS Rule for FY</b>	<b>Matching Rate Between Impact file and Most recent PSF CCRs</b>	<b>Average Percent Difference Between the Impact File and Most Recent PSF Operating CCR of the Same Hospital (weighted By Discharges)</b>
Final 2010*	93.2%	0.4%
Final 2011*	96.4%	0.1%
Final 2012 - Dec 2010 Update	96.9%	0.2%
Final 2012 - March 2011 Update	65.3%	1.6%
Final 2013	92.1%	0.0%
Final 2014	97.2%	-0.1%
Proposed 2015 - Dec 2015 Update	98.8%	-2.7%
Proposed 2015 - March 2015 Update	64.8%	1.0%
Proposed 2016 - Dec 2015 Update	89.6%	-0.02%
Proposed 2016 - March 2015 Update	61.6%	0.19%
Proposed 2017 - Dec 2016 Update	94.16%	-0.014%
Proposed 2017 - March 2017 Update	65.70%	0.236%
Proposed 2018 – December 2017 update	94.33%	-0.017%
Proposed 2018 – March 2018 update	67.33%	-0.342%
Proposed 2019 – December 2018 update	97.33%	-0.002%
Proposed 2019 – March 2018 update	67.69%	0.240%
Proposed 2020 – December 2018 update	97.49%	-0.027%
Proposed 2020 – March 2019 update	70.12%	0.209%
Proposed 2021 – December 2020 update	97.49%	-0.027%
Proposed 2021 – March 2020 update	70.12%	0.209%
Proposed 2022 – December 2019 update	96.35%	-0.648%
Proposed 2022 – March 2020 update	68.49%	-0.208%

Proposed 2023 – December 2021 update	75.23%	0.119%
Proposed 2023 – March 2021 update	78.59%	0.001%

\* Vaida Health Data Consulting, Modeling FY 2013 IPPS Outlier Payment. June 11, 2012

Note that WPA developed new programs to analyze the data, so there may be differences with the previous analyses by The Moran Company and Vaida Health Consulting. However, the matching percentage calculated by WPA is within a similar matching percentage as that calculated by the Moran Company. In addition, the average difference in operating CCR is much smaller.

### Analysis 3: Fixed Loss Threshold over time

From examining the fixed loss threshold in proposed rules and final rules, there is a pattern of the fixed loss threshold declining. The following table shows the fixed loss thresholds for recent years.

FY	Final	Proposed	Variance	% of Variance
2009	\$ 20,045	\$ 21,025	\$ (980)	-4.66%
2010	\$ 23,140	\$ 24,240	\$ (1,100)	-4.54%
2011	\$ 23,075	\$ 24,165	\$ (1,090)	-4.51%
2012	\$ 22,385	\$ 23,375	\$ (990)	-4.24%
2013	\$ 21,821	\$ 23,630	\$ (1,809)	-7.66%
2014	\$ 21,748	\$ 24,140	\$ (2,392)	-9.90%
2015	\$ 24,626	\$ 25,799	\$ (1,173)	-4.55%
2016	\$ 22,544	\$ 24,485	\$ (1,941)	-7.93%
2017	\$ 23,573	\$ 23,681	\$ (108)	-0.46%
2018	\$ 26,537	\$ 26,713	\$ (176)	-0.66%
2019	\$ 25,769	\$ 27,545	\$ (1,776)	-6.45%
2020	\$ 26,552	\$ 26,994	\$ (521)	-1.93%
2021	\$ 29,064	\$ 30,006	\$ (942)	-3.31%
2022	\$ 30,988	\$ 30,967	\$ 21	0.07%
2023	\$ 38,788	\$ 43,214	\$ (4,355)	-11.21%
2024		\$ 40,732		

Note: FY 2023 is based on the proposed blended weight for weighting. Final rule FLT is also blended. Methodology for FY2023 final rule FLT is different than the proposed rule due to the blending, so change from proposed to final should be viewed with caution and not a standard change.

Note: FY 2024 reverted back to not using blended weight or FLT.

#### Analysis 4: Outlier Reconciliation

In the FY2020 IPPS rule, CMS finalized a new methodology to adjust the outlier target percentage to account for outlier reconciliation. WPA was successful in replicating the CMS calculations exactly given the logic described. WPA matched their calculation of -0.01% when using the December 2022 data. However, using the March 2023 data, WPA found a slightly different reconciliation factor of: -0.02%. The change from -0.01% to -0.02% for the Final Rule may be immaterial, given CMS currently rounds to the nearest 3rd decimal place. The outlier target will stay at .949 (5.1%) regardless if the reconciliation factor is -0.01% or -0.02% (.9491 or .9492, respectively). The reason for the increase in the factor was an increase in the number of providers reporting reconciliation, going from five in the December data (matching CMS) to 11 in the March data. The March data will be used in the final rule.

#### Analysis 5: Explorations on high charge cases

As evidenced in Analysis 3, the Fixed Loss Threshold has been adjusting over time, generally increasing. In response to this, WPA conducted various examinations and probing of the data and other issues that may relate to the Fixed Loss Threshold.

No single, definitive, cause for the increase was identified. However, one intriguing finding of this research was:

- a) The impact of “extreme” cases on the Fixed Loss Threshold; and
- b) The increase in the rate of “extreme” cases.

In the IPPS rate-setting process, statistical outliers – extreme cases – generally are removed from the calculations during the normal methodology. However, these cases are left in during the calculation of the Fixed Loss Threshold.

To examine this issue, WPA tested trimming out cases with covered charges greater than particular thresholds. This removed the case if the covered charges were greater than a threshold.

The following table shows the results at different trim points when using the proposed blended weights data.

Scenario	Cases remaining	Removed cases	FLT	Percentage of cases removed
Base	6,801,215	-	\$40,835	0.00%
Trim at: 3,000,000	6,800,464	751	\$38,247	0.01%
Trim at: 2,750,000	6,800,207	1,008	\$37,856	0.01%
Trim at: 2,500,000	6,799,857	1,358	\$37,355	0.02%
Trim at: 2,250,000	6,799,382	1,833	\$36,777	0.03%
Trim at: 2,000,000	6,798,705	2,512	\$36,093	0.04%
Trim at: 1,750,000	6,797,569	3,646	\$35,210	0.05%
Trim at: 1,500,000	6,795,849	5,366	\$34,123	0.08%
Trim at: 1,250,000	6,792,704	8,511	\$32,640	0.13%
Trim at: 1,000,000	6,786,035	15,180	\$30,477	0.22%
Trim at: 750,000	6,770,411	30,804	\$27,335	0.45%
Trim at: 500,000	6,720,300	80,915	\$22,290	1.19%
Trim at: 250,000	6,449,456	351,759	\$13,298	5.17%

Removing a relatively small number of cases can have the impact of shifting the Fixed Loss Threshold potentially thousands of dollars.

As was noted in previous years, the number and proportion of very high charge cases (defined here as having covered charges greater than \$1.5 million) have been increasing over time. In the FY2022 data, this trend continued. (Note: 2021 data has also been updated to the final rule.)

Year	Number of cases over \$1.5 million	Percentage of total cases	Number of unique providers
2011	926	0.0088%	272
2012	994	0.0098%	272
2013	1,092	0.0111%	283
2014	1,329	0.0141%	306
2015	1,539	0.0161%	320
2016	1,733	0.0185%	334
2017	2,291	0.0250%	403
2018	2,650	0.0286%	398
2019	3,128	0.0348%	441
2020	3,666	0.0474%	474
2021	4,719	0.0650%	530
2022	5,366	0.0789%	581

### Analysis 6: Alternative assumptions

The modeling of the Fixed Loss Threshold is based on different assumptions, most notably that the input factors are correct and the general assumption that the future will be like the past. However, that may not always be the case.

WPA was asked to model some different alternatives and see the impact on the FLT.

#### *Alternative 1: Updated payment rate*

Assuming that the market basket index used to adjust the payment rate from year to year is not actually capturing hospitals' inflation accurately, WPA was asked to model the impact on the FLT of an increase in the payment rate by 5.8% versus the 2.8% used in the rule. When that was done, WPA calculated a Fixed Loss Threshold of approximately \$38,689.

#### *Alternative 2: Different assumptions on COVID cases*

There are still COVID cases in the 2022 data, but based on different reporting, the volumes have been going down and the severity has been decreasing. As a result, it may not be appropriate to assume that same volume and severity level for the future.

WPA was asked to model the FLT while adjusting the COVID cases in the following way:

- 1) Remove all COVID cases from the first half of FY 2022, and
- 2) Counting each COVID case from the second half of FY 2022 as two cases. This is to reflect a belief that the future COVID severity and volume may be best reflected by the COVID cases in the second half of FY 2022.

When that was done, WPA calculated an FLT of \$40,013

*Alternative 3: Combine alternatives 1 and 2*

This alternative implemented the changes from both alternatives 1 and 2 simultaneously.

With both changes occurring simultaneously, WPA calculated an FLT of \$37,889.