The Hospital + Healthsystem Association of Pennsylvania

Leading for Better Health

June 10, 2024

The Honorable Chiquita Brooks-LaSure
Centers for Medicare & Medicaid Services
Hubert H. Humphrey Building
200 Independence Avenue, SW, Room 445-G
Washington, DC 20201

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

Dear Administrator Brooks-LaSure:

On behalf of The Hospital and Healthsystem Association of Pennsylvania (HAP), representing more than 230 hospitals and health systems statewide, we appreciate the opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS) hospital inpatient prospective payment system proposed rule for fiscal year (FY) 2025.

For FY 2025, CMS proposes a market basket increase of a net update of 2.6 percent. This is simply not enough. HAP has grave concerns about this inadequate update, especially when taken together with the underwhelming market basket increases from FY 2022, 2023, and 2024. It does not capture either the unprecedented inflationary environment or the other persistent financial headwinds hospitals and health systems are experiencing. It also fails to account for the fact that labor composition and costs have remained extraordinarily high and that, as a result, the hospital field continues to face sustained financial pressures and workforce shortages.

Given all the above, HAP strongly urges CMS to find ways to account for these increased costs to ensure that beneficiaries continue to have access to quality inpatient care.

In addition, we incorporate, by reference, all of the comments provided in the AHA's response to the proposed rule.

Thank you for your consideration of HAP's comments about this proposed rule regarding inpatient payment and other provisions related to hospitals and the patients they serve in Pennsylvania.

If you have any questions, contact **Brooke Bowers**, HAP's director, financial reimbursement and analysis.

Sincerely,

Jolene H. Calla, Esq.
Vice President, Finance and Legal Affairs
Attachment

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HAP Comments—Inpatient Prospective Payment System
Proposed Rule for Fiscal Year 2025

PAYMENT UPDATE

Inpatient Prospective Payment System Outlier Threshold—HAP is concerned about the proposed increase in the high-cost outlier threshold—a 15 percent increase from the FY 2024 threshold—that would significantly decrease the number of cases that qualify for an outlier payment. The agency states that this increase, from $42,750 in FY 2024 to $49,237 in FY 2025, is necessary to align total FY 2025 outlier payments with its target of 5.1 percent of total inpatient prospective payment system (PPS) payments. Not only is this increase substantial, but it is also coming after a decade of increases which amount to a staggering 126 percent increase from FY 2013 through FY 2025 (as proposed).

We believe much of the increase in FY 2025 is being driven by the fact that CMS has estimated and proposed to use a one-year national operating cost-to-charge ratios (CCR) adjustment factor of 1.03331. This CCR adjustment factor is much higher than it has been in the past.

However, this large increase in FY 2025's adjustment factor is largely driven by CCRs that are reflecting the high-cost inflation—namely labor costs—that the field experienced during 2022 and 2023. ***As such, we urge CMS to examine its methodology more closely and consider making additional, temporary changes to help mitigate the substantial increases that are occurring in the outlier threshold.*** For example, CMS could instead apply the FY 2024 CCR adjustment factor in calculating the FY 2025 outlier threshold, which would mitigate the anomalous increase. Additionally, HAP has significant concerns over Transmittal 12594, published on April 26, 2024, which concerns outlier reconciliation and cost-to-charge ratio updates for the inpatient and long-term care hospitals (LTCH) PPS. In this transmittal, CMS changed the threshold and criteria for a facility to qualify for outlier reconciliation. As CMS knows, this will subject many additional facilities to the reconciliation process—a process that is already backlogged and takes several years to complete. This is a substantive change to CMS's payment policy, which is subject to notice and comment rulemaking under the Medicare statute. ***Therefore, we urge CMS to withdraw the transmittal. To the extent CMS wishes to implement this policy, it must be issued through notice and comment rulemaking.***

Detailed comments on specific proposed changes for LTCH's have been submitted in a separate letter.

AREA WAGE INDEX

Permanent Cap on Wage Index Decreases—In last year's rule, CMS finalized a policy to apply a 5 percent cap on all wage index decreases, regardless of the reason, in a budget neutral manner; it proposes to continue this policy for FY 2025. ***HAP appreciates CMS's recognition that significant year-to-year changes in the wage index can occur due to***

external factors beyond a hospital's control. While we support this policy that would increase the predictability of inpatient PPS payments, we continue to urge CMS to apply this policy in a non-budget neutral manner.

Core-based Statistical Areas for the Hospital Wage Index—CMS proposes to apply the most recent labor market areas in the FY 2025 inpatient PPS wage index. The most recent delineations were issued by the Office of Management and Budget (OMB) in July 2023's Bulletin No. 23-01 and include an updated list of Core-based Statistical Areas (CBSA) that reflect the OMB's new 2020 standards and 2020 Census data. This update will result in a number of significant changes to the existing labor markets. Because CMS will apply the 5 percent cap on any decrease that hospitals may experience from the prior FY, it is not proposing any transition period and believes that the cap policy would sufficiently mitigate significant financial impacts affected by the proposed OMB updates. ***HAP believes it is vitally important to mitigate the negative effects of the application of the new OMB labor market delineations on hospitals and thanks CMS for applying the 5 percent cap on wage index decreases***.

Low-wage Hospital Policy—Beginning in FY 2020, CMS finalized a policy to increase wage index values for low-wage hospitals. Specifically, for hospitals with a wage index value below the 25th percentile, the agency increased the hospital's wage index by half the difference between the otherwise applicable wage index value for that hospital and the 25th percentile wage index value for all hospitals. CMS had indicated that it would adopt this policy for at least four years for low-wage hospitals to use the increased wage index to increase their wages and therefore receive a higher wage index. While this policy had been originally scheduled to expire after FY 2023, CMS has indicated in this rule that it has been unable to disentangle the effects of the COVID-19 pandemic and the low-wage index policy to determine whether the policy has successfully resulted in hospital raising wages to get a higher wage index. Therefore, it is proposing that the low wage index hospital policy and the related budget neutrality adjustment would be effective for at least three more years, beginning in FY 2025.

As we have stated previously, hospitals have repeatedly expressed concern that the wage index is greatly flawed in many respects, including its accuracy, volatility, circularity and substantial reclassifications and exceptions. Members of Congress and Medicare officials also have voiced concerns with the present system. To date, a consensus solution to the wage index's shortcomings has yet to be developed. ***HAP appreciates CMS's recognition of the wage index's shortcomings, but we maintain that budget neutrality is not a requirement of the statute. In addition to statutory permissibility, HAP continues to believe there is strong policy rationale for making the low-wage hospital policy non-budget neutral. As we have previously stated, Medicare consistently reimburses inpatient PPS hospitals less than the cost of care.*** For example, MedPAC estimates that hospitals' aggregate Medicare margins will be negative 13 percent in 2024. Aggregate Medicare margins in 2022 were a negative 12.7 percent excluding federal relief funds. Unfortunately, these figures

are a continuance of a longstanding trend of substantially negative Medicare margins. Taken together, these observations strongly suggest that there is a need to add funds into the system, such as by implementing this policy in a non-budget-neutral manner.

Wage index increases for low-wage hospitals provide these facilities with sorely needed funds that will begin to address chronic Medicare underfunding. However, CMS is not bound by statute to make such increases budget neutral; indeed, reducing the standardized amount for all PPS hospitals intensifies historical Medicare underpayment. ***As such, HAP urges CMS to implement the low-wage hospital policy in a non-budget neutral manner.***

Imputed Rural Floor Calculation—As required by law, CMS proposes to continue the minimum area wage index for hospitals in all-urban states, known as an "imputed rural floor," for FY 2025. This policy applies to states that have no rural hospitals or no rural areas to set a rural floor wage index for those states. Also as required by law, CMS proposes to apply this policy in a non-budget-neutral manner. ***We support this proposal.***

RURAL HOSPITAL PROVISIONS

Low-volume Adjustment and Medicare-dependent Hospital Program—The CCA of 2024 extended both the low-volume adjustment (LVA) and Medicare-dependent Hospital (MDH) programs through December 31, 2024. Beginning January 1, 2025, the LVA would revert to statutory requirements that were in effect prior to FY 2011. Similarly, beginning January 1, 2025, the MDH program would expire.

HAP supports congressional action that would extend the enhanced LVA permanently so that hospitals can continue to qualify for and be paid under the current enhanced method. We also support congressional action to permanently extend the MDH program, with an additional base year that hospitals may choose for calculating MDH payments to provide more flexibility for these hospitals to provide care for their patients.

In this rule, CMS is proposing to revert to statutory requirements that would define LVA as one that is located more than 25 road miles from another subsection (d) hospital and has fewer than 800 total discharges. In addition, it proposes the same payment adjustment that was effective from FY 2005 through 2011. Specifically, the agency would apply a 25 percent LVA to all qualifying hospitals with less than 200 discharges, but hospitals with between 200 and 799 discharges would not receive any adjustment. This proposal would significantly impact hospitals that are currently receiving LVA. Less than 4 percent of hospitals eligible for LVH would continue to be eligible under this proposal, significantly impacting the financial position of rural hospitals that are chronically underfunded.

We urge CMS to ensure that all hospitals currently eligible for LVH continue to receive this much needed funding to ensure continued access to high quality health care in rural communities.

TRANSFORMING EPISODE ACCOUNTABILITY MODEL (TEAM)

In the proposed rule, CMS introduced a new mandatory alternative payment model, essentially expanding on current bundled payment models, like the Comprehensive Care for Joint Replacement (CJR), for certain surgical procedures.

The proposal requires all inpatient PPS hospitals within selected CBSAs (25 percent of the 803 eligible CBSAs) to participate in all five surgical episode categories proposed for TEAM including: coronary artery bypass graft, lower extremity joint replacement, major bowel procedure, surgical hip/femur fracture treatment, and spinal fusion. Selected geographies will be identified at a later date.

TEAM is expected to launch January 1, 2026, and continue for five years through the end of 2030. Episodes would begin with the hospital stay or anchor procedure and continue 30 days post-discharge and would include the surgical procedure, any inpatient stay, as well as all related care covered under Medicare Parts A and B.

Pennsylvania hospitals and health systems have been leaders in promoting accountable, coordinated care. Significant efforts continue to be made to increase the value and better serve patients across the commonwealth.

There are several areas of concern within the TEAM proposal. Mandatory participation will likely be financially damaging to smaller hospitals with low volumes across these bundles or the inability to financially support the investments necessary to be successful in this type of model.

Additionally, the rule proposes a 3 percent discount factor right off the top, regardless of bundle performance. This will be significantly challenging in most of these bundles where the majority of episode spending is accounted for by the anchor hospitalization or anchor procedure, leaving very little opportunity to achieve savings in the post-acute setting.

Finally, we have identified three areas of problematic design elements including:

- Insufficient Risk Adjustment Factors to adequately account for patient differences in patient complexity and resource use across hospitals
- Inadequate Glidepath to Two-sided Risk
- Inadequate Low-volume Threshold

Specifically, we strongly recommend that CMS make TEAM voluntary, lower the 3 percent discount factor to no more than 1 percent, and address certain problematic design elements.

RFI: OBSTETRICAL SERVICES STANDARDS FOR HOSPITALS, CRITICAL ACCESS HOSPITALS (CAH), AND RURAL EMERGENCY HOSPITALS (REH)

The proposed rule includes a request for information seeking to gather information on what should be the overarching requirement, scope, and structure for OB services CoPs including what types of facilities and care settings to which CoP should apply. CMS is also interested in comments on required training, protocols, or equipment for hospital non-OB unit, emergency department, CAH and REH staff that treat pregnant and postpartum patients as a stop-gap measure to ensure individuals living without access to maternal health care can safely and effectively receive necessary services.

In Pennsylvania, efforts at the state level have intensified to address maternal health outcomes, particularly around disparities experienced by Black birthing patients. The Pennsylvania Black Maternal Health Caucus in March released a legislative package called the PA MOMNIBUS that aims to address these disparities and improve access to care. Those proposals include:

- Extending Medicaid coverage for doula services and the establishment of a doula advisory board.
- Expanding private insurance coverage for doula services.
- Requiring Medicaid and private insurance coverage for blood pressure cuffs at discharge for new parents.
- Establishing a designation for maternal health deserts and at-risk counties.
- Enhancing access to care for mental health services for pregnant and postpartum individuals.
- Requiring health-related boards within the Department of State to complete implicit bias training as part of continuing education requirements.
- Distributing maternal and newborn supply kits ("Welcome Baby Kits") to provide essential resources and support to new mothers.

Stakeholders are also calling for an increase in state funding to Medicaid supplemental payments to hospitals, specifically to an $7 million General Fund increase to support obstetric and neonatal units. This will allow Pennsylvania to draw down federal dollars for maternal and infant care.