The Hospital + Healthsystem
Association of Pennsylvania

Leading for Better Health

June 9, 2023

The Honorable Chiquita Brooks-LaSure
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
Attention: CMS 1785-P
P.O. Box 8013
Baltimore, MD 21244-1850

RE: CMS 1785-P, Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Policy Changes and Fiscal Year 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: Proposed Rule (Vol. 88, No. 83), May 1, 2023.

Dear Administrator Brooks-LaSure:

On behalf of The Hospital and Healthsystem Association of Pennsylvania (HAP), which represents approximately 235 member institutions, we appreciate the opportunity to comment about the Centers for Medicare & Medicaid Services' (CMS) hospital inpatient prospective payment system (IPPS) proposed rule for federal fiscal year 2024.

HAP has strong concerns about the proposed payment updates. In particular, we are deeply concerned about the inadequacy of the proposed market basket update given the changing health care system dynamics and its workforce challenges. As such, we strongly urge CMS to utilize its authority to provide a market basket adjustment to account for what the agency missed in the fiscal year (FY) 2022 market basket forecast. We also are concerned about the agency's proposed cuts to disproportionate share hospital (DSH) payments and the lack of transparency in the underlying calculations. A summary of our key recommendations follows.

IPPS Payment Update

CMS proposes a market basket update of 3.0 percent less a productivity adjustment of 0.2 percentage points, resulting in a net update of 2.8 percent. This update, especially when taken together with the FY 2022 payment update of 2.7 percent, continues to be woefully inadequate. These updates fail to account for the fact that labor composition and costs have not reverted to "normal" levels and that, as a result, the hospital field has continued to face sustained financial pressures. Workforce shortages continue to create outsized pressures on hospitals and health systems, and workforce financial pressures are particularly challenging because labor on average accounts for about half of a hospital's budget. **Therefore, HAP urges CMS to use its "special exceptions and adjustments" authority to make a**

retrospective adjustment to account for the difference between the market basket update that was implemented for FY 2022 and what the market basket is for FY 2022. We also urge the agency to use the same authority to eliminate the productivity cut for FY 2024 and to fully restore the shortfall resulting from the American Taxpayer Relief Act of 2012 documentation and coding adjustments.

DSH Payments

HAP continues to be concerned about the agency's lack of transparency with regard to how it is calculating DSH payments. **Specifically, we disagree with the agency's estimates of the number of uninsured for FY 2024.** For instance, CMS maintains that the rate of the insured stayed the same as FY 2023. However, it is expected that health coverage for millions of people will end as the Medicaid continuous coverage requirements are now unwinding. As such, we expect to see a large **increase** in the number of the uninsured in FY 2024. **We urge CMS to consider additional data by researchers and policy stakeholders to reach a more reasonable estimate of the percent of uninsured.**

Thank you for your consideration of HAP's following comments regarding this proposed rule. If you have any questions, contact **Kate Slatt**, vice president, innovative payment and care delivery, at (717) 561-5317.

Sincerely,

Jeffrey W. Bechtel
Senior Vice President, Health Economics and Policy

Attachment

HAP Comments—Inpatient Prospective Payment System Proposed Rule for Fiscal Year 2024

INPATIENT PROSPECTIVE PAYMENT SYSTEM PAYMENT UPDATE

For fiscal year (FY) 2024, the Centers for Medicare & Medicaid Services' (CMS) proposes a market basket update of 3.0 percent less a productivity adjustment of 0.2 percentage points, resulting in a net update of 2.8 percent. This update, especially when taken together with the FY 2022 payment update of 2.7 percent, continues to be woefully inadequate. These payment updates ignore the fact that hospitals and health systems have continued to face unprecedented increases in labor costs and other supply costs. They fail to account for the fact that labor composition and costs have not reverted to "normal" levels and that, as a result, the hospital field has continued to face sustained financial pressures. **HAP urges CMS to use its "special exceptions and adjustments" authority to implement a retrospective adjustment for FY 2024 to account for the difference between the market basket update that was implemented for FY 2022 and what the currently projected market basket is for FY 2022. Specifically, the current projected market basket for FY 2022 is 5.7 percent—a full 3.0 percentage points higher than what hospitals actually received in 2022. Additionally, we also urge CMS to eliminate the productivity cut for FY 2024, as we detail below.**

Financial Context

After battling near historic inflation and the COVID-19 crisis, hospitals and health systems are facing a new existential challenge—sustained and significant increases in the costs required to care for patients and the communities they serve. **We urge CMS to consider the changing health care system dynamics, the unlikelihood of these dynamics returning to "normal" trends and their effects on hospitals. As we detail below, these shifts in the health care environment are putting enormous strain on hospitals and health systems, which will continue in FY 2024 and beyond.**

Throughout 2022, hospitals battled historic inflation and rising labor and supply costs. These financial pressures have continued into 2023 and will not abate soon. For example, overall hospital expenses increased by 17.5 percent from 2019 through 2022, yet Medicare Inpatient Prospective Payment System (IPPS) reimbursement grew at less than half that rate.[1] In fact, over half of hospitals ended 2022 operating at a financial loss.[2] So far, that trend has continued into 2023 with negative median operating margins in January and February. According to a recent analysis, the first quarter of 2023 saw the highest number of bond defaults among

[1] American Hospital Association (April 2023). The Financial Stability of America's Hospitals and Health Systems is at Risk as the Costs of Caring Continue to Rise. https://www.aha.org/costsofcaring
[2] Kaufman Hall (January 2023). National Hospital Flash Report. https://www.kaufmanhall.com/sites/default/files/2023-01/KH_NHFR_2023-01.pdf

hospitals in over a decade.[3]

Workforce shortages continue to create outsized pressures on hospitals and health systems.[4] As the demand for hospital care increased, hospitals were increasingly forced to turn to health care staffing agencies to fill necessary gaps, especially for bedside nursing and other critical allied health professionals such as respiratory and imaging technicians. **As a result, contract labor full-time equivalents (FTE) jumped 139 percent from 2019 through 2022.[5] Accordingly, hospitals' contract labor expenses increased a staggering 257.9 percent in 2022 relative to 2019 levels.[6] This, in part, drove up overall hospital labor expenses during the same time period by 20.8 percent. These increases are particularly challenging because labor on average accounts for about half of a hospital's budget.** Our members indicate that, while contract labor use has eased somewhat in 2023, they do not see the hospital field reverting to pre-pandemic labor composition or cost structure—changing workforce dynamics will continue to play out in the future.

At the same time, non-labor expenses have also continued to increase due to a historic rise in inflation. Since 2019, non-labor expenses, such as those for drugs, medical supplies and equipment, and purchased services, have increased 16.6 percent on a per patient basis.[7] For example, hospital supply expenses per patient increased 18.5 percent from 2019 through 2022, outpacing increases in inflation. Hospitals also rely on a global supply chain for access to these supplies and equipment, and ongoing supply chain disruptions have led to higher manufacturing, packaging, and shipping costs, which translate into higher prices for hospitals. In fact, the National Academies recently released a report highlighting the ongoing challenges that supply chain disruptions place on providers needing to access medical supplies.[8]

Appropriately accounting for recent and future trends in inflationary pressures and cost increases in the hospital payment update is essential to ensure that Medicare payments for acute care services more accurately reflect the cost of providing hospital care. Indeed, Medicare only pays 84 percent of hospital costs on average according

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[3] Becker's Hospital Review (April 2023). Hospitals See Most 1st-Quarter Defaults Since 2011. https://www.beckershospitalreview.com/finance/hospitals-see-most-1st-quarter-defaults-since-2011.html.
[4] McKinsey & Company (September 2022). The Gathering Storm: The Transformative Impact of Inflation on the Healthcare Sector. https://www.mckinsey.com/industries/healthcare/our-insights/the-gathering-storm-the-transformative-impact-of-inflation-on-the-healthcare-sector
[5] Syntellis (February 2023). Hospital Vitals: Financial and Operational Trends. https://www.syntellis.com/sites/default/files/2023-03/AHA%20Q2_Feb%202023.pdf
[6] Syntellis (February 2023). Hospital Vitals: Financial and Operational Trends. https://www.syntellis.com/sites/default/files/2023-03/AHA%20Q2_Feb%202023.pdf
[7] American Hospital Association (April 2023). The Financial Stability of America's Hospitals and Health Systems is at Risk as the Costs of Caring Continue to Rise. https://www.aha.org/costsofcaring
[8] National Academies Sciences Engineering Medicine (2022). Building Resilience into the Nation's Medical Product Supply Chains. https://nap.nationalacademies.org/catalog/26420/building-resilience-into-the-nations-medical-product-supply-chains

to our latest analysis.[9] In 2021, Medicare margins fell to **negative** 8.2 percent without COVID-19 relief funds,[10] after hitting an all-time low of **negative** 12.3 percent in 2020. Inadequate payment updates that have not accounted for inflation have caused this underpayment to become even worse since 2021. Specifically, the Medicare Payment Advisory Commission (MedPAC) projects 2023 Medicare margins will fall below **negative** 10 percent, the **twentith straight year** of Medicare paying below costs.

Market Basket

For FY 2022, CMS finalized a market basket of 2.7 percent, based on estimates from historical data through March 2021. As detailed in the AHA comment letter on the FY 2023 IPPS proposed rule, because the market basket was a forecast of what was **expected** to occur, it missed the **unexpected** trends that actually did occur in the latter half of 2021 into 2022 with hospitals combatting high inflation and workforce shortages. **Indeed, including data through September 2022 yields a CMS estimate of 5.7 percent for the actual FY 2022 market basket—a staggering 3.0 percentage points higher than the IPPS payment update that was given to hospitals.**

The rationale for using historical data as the basis for a forecast is reasonable in a typical economic environment. However, when hospitals and health systems continue to operate in atypical environments, the market basket updates become inadequate. This is, in large part, because the market basket is a time-lagged estimate that cannot fully account for unexpected changes that occur, such as historic inflation and increased labor and supply costs. This is exactly what had occurred at the end of the calendar year (CY) 2021 into CY 2022, which resulted in a large forecast error in the FY 2022 market basket update.

In addition to the fact that the market basket, by nature, largely misses unexpected trends, its construction does not fully capture the labor dynamics occurring in the health care field. Specifically, CMS uses the Employment Cost Index (ECI) to measure changes in labor compensation in the market basket.[11] However, the ECI may no longer accurately capture the changing composition and cost structure of the hospital labor market given the large increases in short-term contract labor use and its growing costs. By design, the ECI cannot capture changes in costs driven by shifts between different categories of labor. Yet, as mentioned above, this comes at the exact time that hospitals have had to dramatically turn

[9] American Hospital Association (February 2022). Underpayment by Medicare and Medicaid Fact Sheet. https://www.aha.org/system/files/media/file/2022/02/medicare-medicaid-underpayment-fact-sheet-current.pdf

[10] MedPAC. (2023). March 2023 Report to the Congress: Medicare Payment Policy. Chapter 3 – Hospital inpatient and outpatient services. https://www.medpac.gov/wp-content/uploads/2022/03/Mar22_MedPAC_ReportToCongress_SEC.pdf

[11] 86 Fed. Reg. 25401 (May 10, 2021). "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. This methodology to compute the monthly update factors uses actual quarterly ECI data and assures that the update factors match the actual quarterly and annual percent changes."

to contract labor in order to meet patient demand. Contract hours as a percentage of worked hours rose 133 percent in 2022 compared to 2019[12] and contract FTEs grew in all clinical departments, ranging from surgical, imaging, emergency to nursing. The largest growth was in nursing where contract FTEs grew 180 percent from 2019 to 2022.

CMS itself recognizes that the ECI does not capture these shifts in occupation.[13] This is because the ECI holds the composition of labor fixed between salaried and short-term contract based on a point in time using weights.[14] In fact, from December 2013 through September 2022, the ECI was based on the composition of labor in 2012. This means that, in the FY 2022 and FY 2023 market basket payment updates, which used ECI data through March 2022,[15] the price changes in labor compensation were based on the composition of salaried and contract labor from 2012, more than a decade ago. Said another way, *the FY 2022 and 2023 market basket updates used ECI changes that measured the percent increase in the cost of hiring a 2012 labor force*. Clearly, this would not have been an accurate reflection of labor cost growth in FY 2022 or FY 2023 when contract labor use and expense has shifted dramatically.[16]

Indeed, when an alternative labor cost index, the Employer Costs for Employee Compensation (ECEC), is examined, it shows just how much bias is created by ECI's lag in updating the labor composition. 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.[17] Since the fourth quarter of 2019, ECEC-based wage and salary costs rose 6.7 percentage points more than ECI-based costs (20% vs. 13.3%) with a large proportion of the gap attributable to 2022 Q4 alone. This all suggests that because the ECI does not account for the change in labor composition, it fails to accurately capture the changing dynamic of the current healthcare workforce. Specifically, the ECI fails to capture that labor costs have increased more rapidly due to 1) hospitals using a more expensive mix of labor and 2) that the cost of contract labor is increasing more rapidly than the cost of salaried workers. **These additional shortcomings are yet another reason that HAP urges CMS to use its "special exceptions and adjustments" authority to correct for the market basket forecast error that occurred**

[12] Syntellis (February 2023). Hospital Vitals: Financial and Operational Trends.
https://www.syntellis.com/sites/default/files/2023-03/AHA%20Q2_Feb%202023.pdf

[13] 86 Fed. Reg. 25421 (May 10, 2021). CMS stated that ECI measures "the change in wage rates and employee benefits per hour… [and are superior] because they are not affected by shifts in occupation or industry mix."

[14] U.S. Bureau of Labor Statistics. National Compensation Measures.
https://www.bls.gov/opub/hom/ncs/calculation.htm#computing-the-employment-cost-index-eci

[15] 87 Fed. Reg. 49052 (August 10, 2022). CMS uses IGI's second quarter 2022 forecast with historical data through first quarter 2022 to finalize the FY 2023 IPPS market basket.

[16] While we recognize that CMS updates the composition of labor relative to other hospital inputs through its rebasing process, this was last done in FY 2022 using FY 2018 hospital cost reports. CMS rebases the cost categories between wages and salary, employee benefits and contract labor costs and assigns cost weights every four years. However, adjusting the composition, otherwise known as cost weights, in the overall market basket does not address the problem in measuring labor cost growth, known as price proxies, that are due to a stagnant labor composition in the ECI.

[17] U.S. Bureau of Labor Statistics. National Compensation Measures.
https://www.bls.gov/opub/hom/ncs/calculation.htm#employer-costs-for-employee-compensation-ecec

in FY 2022—the 3.0 percentage point difference in what was finalized in FY 2022 at 2.7 percent and what the market basket actually is at 5.7 percent. Additionally, we ask that CMS expeditiously examine its rebasing and revising methods for the hospital market basket so that it can more accurately reflect the changing labor dynamics. For example, while the ECI has been updated to reflect the composition of labor in 2021,[18] this still means that price changes in the labor compensation category of the market basket going forward measures the **percent difference in the cost of hiring a 2021 labor force**. Again, we do not believe this would be an accurate reflection of labor cost growth going forward.

Productivity

Under the Affordable Care Act, the IPPS payment update is reduced annually by a productivity factor, which is equal to the 10-year moving average of changes in the annual economy-wide, private nonfarm business total factor productivity (TFP).[19] This measure was intended to ensure payments more accurately reflect the true cost of providing patient care. For FY 2024, CMS proposes a productivity cut of 0.2 percentage points.

HAP continues to have deep concerns about the proposed productivity cut, particularly given the extreme pressures in which hospitals and health systems continue to operate. As such, we ask CMS to use its "special exceptions and adjustments" authority to eliminate the productivity cut for FY 2024. As detailed in the AHA's comments last year, the use of the private nonfarm business TFP is meant to capture gains from new technologies, economies of scale, business acumen, managerial skills and changes in production. However, in an economy marked by great uncertainty due to workforce shortages and supply and demand shocks, this assumption generates significant departures from economic reality. Indeed, the nonfarm business sector labor productivity decreased 2.7 percent in the first quarter of 2023 compared to the previous quarter.[20] Compared to the same quarter a year ago, it has decreased 0.9 percent, the first time since 1948 that the four-quarter change series has remained negative for five consecutive quarters, as shown in the graph below. Although the productivity adjustment uses a 10-year moving average, the consistent declines in this metric is also noteworthy enough that they should be given particular consideration when deciding upon the appropriate productivity adjustment for FY 2024.

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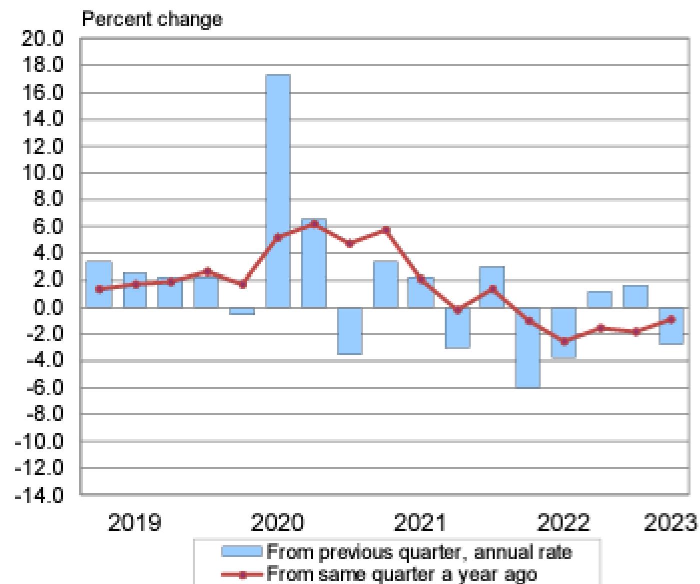
[18] In December 2022, the ECI was updated to weights using the composition of labor in 2021. https://www.bls.gov/eci/notices/2022/eci-2021-fixed-weights-and-2018-soc-update.htm

[19] Centers for Medicare & Medicaid Services. (February 2016). Hospital Multifactor Productivity: An Updated Presentation of Two Methodologies. https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/ReportsTrustFunds/Downloads/ProductivityMemo2016.pdf

[20] U.S. Bureau of Labor Statistics. (May 4, 2023). Productivity and Costs, First Quarter 2023, Preliminary. https://www.bls.gov/news.release/pdf/prod2.pdf, https://www.bls.gov/opub/ted/2023/labor-productivity-rose-at-1-1-percent-annual-rate-from-fourth-quarter-2019-to-first-quarter-2023.htm



Source: U.S. Department of Labor Bureau of Labor Statistics
Productivity and Costs News Release, First Quarter 2023, Preliminary

MEDICARE DISPROPORTIONATE SHARE HOSPITAL PAYMENT

Under the disproportionate share hospital (DSH) program, hospitals receive 25 percent of the Medicare DSH funds they would have received under the former statutory formula (described as "empirically justified" DSH payments). The remaining 75 percent flows into a separate funding pool for DSH hospitals. This pool is reduced as the percentage of uninsured declines and is distributed based on the proportion of total uncompensated care each Medicare DSH hospital provides.

Transparency Related to DSH Calculations

HAP continues to be very concerned about the agency's marked lack of transparency with regard to how it and the Office of the Actuary (OACT) are calculating DSH payments. Without additional information, stakeholders cannot validate and evaluate the complex calculations CMS has made in estimating the percent of uninsured and other factors used to determine DSH payments. **We urge the agency to provide information that we outline below to the hospital field in advance of publication of the final rule and in the IPPS proposed rule each year going forward.** As we have communicated before, the agency's lack of transparency is particularly troubling because Congress has generally foreclosed subsequent review, making the adequacy and completeness of notice-and-comment rulemaking that much more important from a constitutional due-process perspective. In

addition, in a year with turbulent coverage losses, HAP urges CMS to carefully consider its reliance on current data sources and methodologies to estimate the rate of the uninsured. Data and projections that have previously worked when coverage levels were more stable may no longer be adequate during these times of turmoil.

Factor 1

Factor 1 is the estimate of what total DSH payments would have been under the former statutory formula. In estimating Factor 1, CMS used a variety of data inputs, including discharge numbers, case-mix and other components that impact Medicare DSH. It includes in the rule a table explaining the factors it applied for FYs 2021 through 2024 to estimate Factor 1.[21] In this table, the agency includes an "Other" column that it says "shows the increase in other factors that contribute to the Medicare DSH estimates," including the difference between the total inpatient hospital discharges and the IPPS discharges, and various adjustments to the payment rates that have been included over the years but are not reflected in the other columns (such as the 20% add-on for COVID-19 discharges). It also includes a factor for the estimated changes in Medicaid enrollment.

In this year's rule, CMS has revised its estimate of FY 2023 discharges substantially downward yet increased its estimate of "Other," which yielded the proposed decrease in estimated DSH payments. **We thank CMS for increasing the "Other" column from what was finalized in last year's rule for FY 2023, from 0.9793 to what is now being proposed at 1.0484. However, the agency fails to detail how the various inputs into the "Other" column are actually calculated, which limits the HAP's ability to comment sufficiently on this issue.** For example, stakeholders are unable to determine which of the following inputs, or combination thereof, is driving the change in the "Other" column: Medicaid enrollment, 20 percent add-on, differences between total inpatient hospital discharges and IPPS discharges, or some other adjustment that contributes to Medicare DSH estimates. Without CMS' methodology detailing how each of the inputs is considered in the "Other" column, it is simply a guess why Medicare DSH estimates are changing year to year. **As such, we urge transparency on CMS' calculations. Specifically, the agency should, for this year and going forward, publish a detailed methodology of its "Other" calculation, including how all the components contribute and their estimates from year to year.**

In addition, CMS has adjusted its estimates for the number of fee-for-service (FFS) inpatient hospital discharges, decreasing its estimates substantially for FY 2022 and FY 2023. For example, in last year's rule, CMS estimated that the discharge factor for FY 2023 would be 1.05. In this proposed rule, CMS updated its estimate to be 0.975, stating that it is preliminary, and that, for FY 2024, its estimate of 0.976 is based on assumption of "recent trends recovering back to the long-term trend and assumption related to how many beneficiaries will be enrolled

[21] 88 Fed. Reg. 26991 (May 1, 2023).

in Medicare Advantage plans."[22] With half of all eligible Medicare beneficiaries enrolled in Medical Assistance (MA) nationally,[23] we expect that this discharge factor will continue to decrease and are concerned about the effect this will have on hospitals serving a disproportionate share of lower-income beneficiaries. **HAP would like to see detailed calculations of the discharge estimates in the IPPS proposed rule each year going forward so that we have sufficient information to evaluate the impact on FFS inpatient hospital payments and provide feedback to the agency on how growth in MA is affecting the development of FFS rates over time.** Additionally, HAP encourages CMS to work with the AHA to examine the impacts of MA enrollment on FFS inpatient hospital payments.

Factor 2

CMS establishes Factor 2 in the calculation of uncompensated care DSH payments as one minus the percent change in the percent of individuals who are uninsured, determined by comparing the percent of the individuals who were uninsured in 2013 and the percent of individuals who were uninsured in the most recent period for which data is available. In the FY 2023 final rule, CMS determined that the uninsured rate was 9.2 percent. In this rule, CMS proposes to maintain this uninsured rate at 9.2 percent for FY 2024. **HAP strongly disagrees with this estimate. Indeed, it is expected that health coverage for millions of people will end as the Medicaid continuous coverage requirements are now unwinding. As such, we expect to see a large *increase* in the number of the uninsured in FY 2024.**

To determine FY 2024 uninsured rates, OACT uses projections from the latest National Health Expenditure Accounts (NHEA) historical data, which accounts for expected changes in enrollment across several categories of insurance coverage, including Medicaid. OACT projects enrollment and spending trends for the coming 10-year period; the most recent projections are for 2021 through 2030 and used NHEA historical data through 2020. NHEA projected that in 2023, Medicaid enrollment would drop significantly (by 2.6 million, or 3.2%) as states are expected to proactively trim their enrollments as part of the Medicaid redetermination process. However, the NHEA projects that in 2024 there would be modest growth in Medicaid enrollment (0.8%) as a result of further assumed state program expansions.[24] **HAP and many other researchers and policymakers, disagree with these Medicaid enrollment estimates and subsequently the rate of the uninsured.**

For example, the Kaiser Family Foundation finds that 18 million people could lose Medicaid

[22] 88 Fed. Reg. 26991 (May 1, 2023).
[23] Kaiser Family Foundation (May 2023). Half of All Eligible Medicare Beneficiaries Are Now Enrolled in Private Medicare Advantage. https://www.kff.org/policy-watch/half-of-all-eligible-medicare-beneficiaries-are-now-enrolled-in-private-medicare-advantage-plans/
[24] Centers for Medicare & Medicaid Services. National Health Expenditure Projections 2021-2030. https://www.cms.gov/files/document/nhe-projections-forecast-summary.pdf

coverage in the 14 months following the end of the COVID-19 public health emergency.[25] While we recognize that some people who lose Medicaid coverage may be eligible for other subsidized health insurance coverage, many people losing coverage become uninsured. For example, of the 18 million estimated to lose Medicaid coverage, Kaiser Family Foundation estimates that 3.8 million will become uninsured. The Congressional Budget Office (CBO) estimates that 6.2 million of the people leaving Medicaid as a result of the pandemic unwinding will become uninsured, and that the uninsured rate will increase to 10.1 percent by 2033.[26] Additionally, the extent to which the uninsured rate may rise in the near term is difficult to predict; people who disenroll from Medicaid may not know they are eligible or transition to other coverage. A study found that in the year following disenrollment from Medicaid, roughly two-thirds of people had a period of uninsurance.[27] Similarly, the Department of Health and Human Services (HHS) itself estimates that 15 million individuals will leave the program once Medicaid's continuous enrollment provision comes to an end.[28] Of these, only one-third of the adults would be eligible for Marketplace subsidies. In fact, CMS, in the proposed rule itself, states that Medicaid enrollment is estimated to decrease by 11.1 percent in FY 2024.[29]

For the NHEA to project that there would be modest growth in Medicaid enrollment for 2024 begs belief, and is in contrast to HHS' and CMS' own projections. Indeed, it is difficult to reconcile the agency's own analysis with its proposal that the FY 2024 uninsured rate will maintain at the same level as FY 2023 rates. As evidenced above, Medicaid coverage losses will be substantial as states work through the redetermination process during the next year. **While the failure of CMS to publish its methodology severely limits the hospital community's ability to comment sufficiently on this issue, HAP urges the agency to consider additional data, including its own, to reach a more reasonable estimate of the percent of uninsured. We also, again, urge CMS to publish a detailed methodology on the calculation of Factor 2 and how it uses and incorporates NHEA projections. Lastly, the agency has also stated that it may consider the use of more recent data to estimate the uninsured rate. HAP urges the agency to do so.**

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[25] Kaiser Family Foundation. (December 5, 2022). The Impact of the COVID-19 Public Health Emergency Expiration on All Types of Health Coverage https://www.urban.org/research/publication/impact-covid-19-public-health-emergency-expiration-all-types-health-coverage

[26] Congressional Budget Office (May 2023). CBO Publishes New Health Insurance Coverage Projections for 2023 to 2033. https://www.cbo.gov/publication/59132

[27] Kaiser Family Foundation. (January 25, 2023). What Happens After People Lose Medicaid Coverage? https://www.kff.org/medicaid/issue-brief/what-happens-after-people-lose-medicaid-coverage/

[28] Assistant Secretary for Planning and Evaluation, HHS. (August 2022). Unwinding the Medicaid Continuous Enrollment Provision: Projected Enrollment Effects and Policy Approaches. https://aspe.hhs.gov/sites/default/files/documents/404a7572048090ec1259d216f3fd617e/aspe-end-mcaid-continuous-coverage_IB.pdf

[29] 88 Fed. Reg. 26991 (May 1, 2023).

Use of Worksheet S-10 Data

CMS proposes to use three years of audited data to determine uncompensated care payments beginning in FY 2024. Specifically, the agency proposes to use the three-year average of the uncompensated care data from the three most recent fiscal years for which audited data are available. Therefore, for FY 2024, CMS would average FYs 2018, 2019, and 2020 data to determine the distribution of uncompensated care payments in FY 2024.

HAP supports the use of audited S-10 data in order to promote accuracy and consistency. We continue to believe that audited data and, by extension, ongoing refinements to the audit process, result in data that are most appropriate for use in Medicare DSH payments. We, therefore, support the use of FYs 2018, 2019, and 2020 S-10 data to determine each Medicare DSH hospital's share of uncompensated care in FY 2024.

Additionally, HAP appreciates and supports CMS' proposal to use a three-year average to determine uncompensated care payments, which would address concerns from stakeholders regarding substantial year-to-year fluctuations in uncompensated care payments. As we have commented previously, utilizing a single year of S-10 data may increase the potential for anomalies and instability in uncompensated care payments—especially when hospitals experience unforeseen circumstances such as a pandemic.

AREA WAGE INDEX (AWI)

Permanent Cap on Wage Index Decreases

In the FY 2020 final rule, CMS adopted a transitional policy that placed a 5 percent cap on any decrease in a hospital's wage index due to the combined effects of policy changes. In FY 2021, CMS again adopted a 5 percent cap on any decrease in a hospital's final wage index due to its adoption of updates from Office of Management and Budget bulletin 18-04. In last year's rule, CMS permanently adopted the 5 percent cap for all wage index decreases, regardless of the reason, in a budget neutral manner; as such, it proposes to continue this policy for FY 2024. **HAP appreciates CMS' 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 IPPS payments, HAP continues to urge CMS to apply this policy in a non-budget neutral way.**

Low-wage Hospital Policy

CMS previously finalized a policy to increase wage index values for low-wage hospitals, beginning in FY 2020. Specifically, for hospitals with a wage index value below the twenty-fifth 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 twenty-fifth percentile wage

index value for all hospitals. CMS had indicated that it would adopt this policy for at least four years in order for low-wage hospitals to use the increased wage index to increase their wages and therefore receive a higher wage index. However, in this rule, the agency stated that it only has one year of data to evaluate this policy (FY 2020 cost report data); therefore, it is proposing to continue the policy for FY 2024.

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' 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 IPPS hospitals less than the cost of care. For example, a 2023 MedPAC Report estimates that hospitals' aggregate Medicare margins will be **negative** 10 percent in 2023. Aggregate Medicare margins in 2021 were a **negative** 8.2 percent excluding federal relief funds (-6.2% including 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 IPPS hospitals intensifies historical Medicare underpayment. As such, HAP urges CMS to implement the low-wage hospital policy in a non-budget-neutral manner.