



June 9, 2023

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

Via electronic submission

RE: CMS-1785-P; RIN 0938-AV08: Medicare Program; Proposed Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Policy Changes and Fiscal Year 2024 Rates; Quality Programs and Medicare Promoting Interoperability Program Requirements for Eligible Hospitals and Critical Access Hospitals; Rural Emergency Hospital and Physician-Owned Hospital Requirements; and Disclosures of Ownership Comment Solicitation

Administrator Brooks-LaSure:

The Arkansas Hospital Association (AHA) is a membership organization that proudly represents more than one hundred health care facilities – and their more than 45,000 employees – as they strive to provide care for all Arkansans. On behalf of its member hospitals, I appreciate this opportunity to provide comments to the Centers for Medicare & Medicaid Services (CMS) regarding the proposed rule to update the Medicare fee-for-service (FFS) hospital Inpatient Prospective Payment System (IPPS) for fiscal year (FY) 2024. This proposed rule holds the potential to bring about significant changes to the Medicare IPPS, specifically addressing the operating and capital-related costs of acute care hospitals, as well as introducing improvements to Medicare graduate medical education (GME) and other crucial policy adjustments. We are especially pleased with the provisions that support rural hospitals that convert to Rural Emergency Hospitals (REH) to be designated as a non-provider site for GME and we support several quality-related proposals to modernize the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey. Nevertheless, it is with deep concern that we address certain other aspects of the proposed rule, as we anticipate their potential

adverse impact. We firmly believe that addressing these concerns is vital to ensuring optimal health care outcomes and maintaining the well-being of our community.

Payment Updates

CMS proposes an FY2024 market basket update of 3.0% less a productivity adjustment of 0.2 percentage points, resulting in a net update of 2.8%. The AHA is deeply concerned about the inadequacy of the proposed increase of just 2.8% for FY 2024 given the historical inflationary increases hospitals are facing – and have faced for two years now – in labor, equipment, supplies, and drug costs. On top of the proposed 3% market basket update, less a productivity adjustment of 0.2 percentage points and budget neutrality adjustments, the net rate update is 2.3% for hospitals in compliance with the inpatient quality reporting program (QRP) and electronic health record meaningful use requirements.

For Arkansas, specifically, the proposed rule is estimated to provide an overall increase to Arkansas hospitals of \$31,992,400, or 2.9%, when proposed changes are considered. That increase does not come close to covering the 4% increase in health care inflation for 2022 based on the United States (U.S.) Inflation Calculator. When other policy proposals are considered, such as the decrease in uncompensated care payments (UCP), quality-based payment adjustments, and new technology add-on payments (NTAPs), the proposed rule is estimated to result in an even lower increase for Arkansas hospitals. Without a more significant increase in the payment update in the final rule, Arkansas hospitals will struggle to continue to provide essential services to their communities.

The FY 2024 proposal deficiency is exacerbated by underfunding both FY 2023 and FY 2022. Because hospitals are facing sustained financial pressures and continued workforce shortages, it is imperative that this payment rate is increased.

We urge CMS to evaluate the negative inflationary impacts on health care and appropriately support hospitals in the final rule. We also ask CMS to implement, for FY 2024, a retrospective adjustment using its “special exceptions and adjustments” authority to account for the deficiencies in the FY 2022 market basket. Further, we urge the agency to ensure that market basket adjustments for FY 2023 are adequate.

The AHA also asks that CMS eliminate the 0.2% productivity cut for FY 2024. The measure of productivity used by CMS is intended to ensure payments more accurately reflect the true cost of providing patient care and effectively assumes the hospital field can mirror productivity gains across the private nonfarm business sector. However, in an environment of high turnover, staffing shortages, and supply chain disruptions – not

to mention the financial pressures hospitals face during the unwinding of the COVID-19 public health emergency (PHE) – this is not a reasonable assumption. We have strong concerns about the proposed productivity cut given the extreme and uncertain circumstances in which our hospitals are currently operating.

CMS provided an additional payment for New COVID-19 Treatments Add-on Payment (NCTAP) during the federal PHE, with these payments set to end Sept. 30, 2023. The NCTAPs for drugs and biological products used for the treatment of COVID-19 helped mitigate financial challenges for hospitals for COVID-19 treatment during the PHE. **The AHA recommends that CMS continue the NCTAP payments through Dec. 31, 2023, to provide financial assistance for COVID-19 treatments as hospitals navigate the PHE unwinding.**

Disproportionate Share Hospital (DSH) and Uncompensated Care (UCC) Payments

We are deeply concerned about the Centers for Medicare and Medicaid Services' (CMS) proposal to decrease Disproportionate Share Hospital (DSH) payments by approximately \$115 million for the fiscal year 2024. These payments play a critical role in supporting our hospitals, especially considering the rising costs of uncompensated care in Arkansas since 2018. The significance of these payments is amplified in 2024 due to the current situation where vulnerable patients are experiencing a loss of healthcare coverage during the Medicaid redetermination process following the conclusion of the Public Health Emergency.

As of May 31, 2023, the redetermination process has resulted in the disenrollment of 41,654 Medicaid enrollees in our state. DSH and Uncompensated Care (UCC) Medicare payments play a pivotal role in assisting hospitals that serve a disproportionate number of vulnerable individuals with low incomes. **Given this context, the AHA strongly urges the CMS to support these hospitals by maintaining DSH and UCC Medicare payments. Doing so will ensure that hospitals can retain access to crucial funds, enabling them to continue delivering essential healthcare services to Arkansas's most vulnerable patients.**

Additionally, we question the agency's estimate that the uninsured rate will decrease from 9.3% to 9.2% from FY 2023 to FY 2024 when determining DSH payments. In our communities, it is clear that a large increase in the number of uninsured, not a decrease, is upon us as the public health emergency coverage provisions continue to unwind. **We ask that CMS use more recent data and update its estimates of the Medicare DSH amount to more accurately reflect both discharge volume and the**

uninsured rate. This would yield figures that more accurately reflect changes in discharge volume and health insurance coverage and losses.

Area Wage Index Modifications

As you are aware, Arkansas has long been at a disadvantage in recruiting healthcare workers because of our depressed Area Wage Index (AWI) – ranking 44th in the nation for FY2024 - but this was never as starkly apparent as during the pandemic.

Consistently, the AHA strongly supports policies that would create more equitable payment across regions and states, such as what would be accomplished through the establishment of a national rural AWI or a national AWI floor. We further request that CMS consider approaches toward mitigating wage index disparities that do not depend upon budget neutrality. While there are several AWI provisions in the proposed rule that are of particular importance to our state, two of utmost importance are ensuring that the permanent cap on the wage index and bottom quartile payment adjustments are continued in a non-budget-neutral manner.

Permanent Cap on Wage Index: In the FY 2020, FY 2021, and the previous year's rule, CMS adopted a policy intended to reduce large swings in year-to-year wage index changes and increase the predictability of IPPS payments by placing a 5% cap on any decrease in a hospital's wage index. Unfortunately, the cap is applied regardless of the reason for the decrease and is implemented in a budget-neutral manner. While the AHA appreciates CMS' recognition that significant year-to-year changes in the wage index can occur due to external factors beyond a hospital's control, the **AHA objects to the CMS implementing this policy in a budget-neutral manner through a reduction to the standardized operating rate, which reduces operating payments to all hospitals. We urge CMS to fully fund this policy initiative using separate and additional funds in a non-budget-neutral way.**

Low Wage Areas – Bottom Quartile: Beginning in FY 2020, CMS 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 indicated that it would adopt this policy for at least four years to allow the low-wage hospitals to use the increased wage index to appropriately increase their wages to ultimately receive a higher wage index. In this rule, CMS stated that it has only one year of data to evaluate this policy (FY2020 cost report data), and it is unclear how many years of data CMS will be required to evaluate whether the policy has, in fact, increased wages for low-wage hospitals. Because Arkansas hospitals are chronically underfunded by Medicare, **it is imperative that wage index increases for low-wage hospitals be implemented quickly and in a non-budget-neutral manner.**

Graduate Medical Education in Rural Emergency Hospitals

The Consolidated Appropriations Act of 2021 established rural emergency hospitals (REHs) as a new Medicare provider type, effective Jan. 1, 2023. During Arkansas's 94th General Assembly, the state created licensure for REHs through Act 59 of 2023. CMS allows hospitals to count residents training in “non-provider” sites for direct GME and indirect medical education (IME) payment as long as the facility meets the non-provider setting requirements. CMS acknowledges that the term “non-provider” is not explicitly defined in statute; therefore, since October 1, 2019, the agency has allowed a Critical Access Hospital (CAH) as a “non-provider” and, in this proposed rule, will extend that logic to also define an REH as a “non-provider,” which would allow hospitals to count training time in REHs in their direct GME and IME FTE counts. **The AHA supports CMS counting REH residents for GME and IME payment purposes and further requests that CMS pay for the resident training at 101% of the reasonable cost under section 1861(v) of the Social Security Act, which would align with CAH payments based on reasonable cost principals.**

Hospital Quality Programs

CMS is proposing several significant changes to hospital quality programs. The AHA applauds CMS's goal of incentivizing hospitals to reduce preventable mortality and improve patient care. Throughout every proposal, the AHA urges CMS to rely on evidence-based approaches and to ensure that hospitals have adequate resources to comply with new or modified mandates.

COVID-19 Vaccination Coverage among Healthcare Personnel: CMS has proposed a modification to the COVID-19 Vaccination Coverage among Healthcare Personnel measure to replace the term complete vaccination course with up to date in the measure definition. The AHA supports vaccination as a means of keeping both staff and patients safe and applauds the CMS' efforts to ensure all health care providers are up to date on vaccinations but have concerns regarding this measure. This measure – while well-intentioned – will likely have unintended consequences.

The CDC maintains different definitions for “up to date” and “fully vaccinated,” and the differences in these definitions could be misreported and give the public a misleading picture of a facility's vaccination rate. The CDC maintains guidance that receiving a dose of COVID-19 vaccine may or should be delayed if a person has or has recently had COVID-19 infection. This could impact the timing of an employee's vaccine dosage, resulting in an inaccurate reporting of employees up to date on vaccination. We agree that the ever-changing definition of “up to date” is challenging and voluntary reporting of health care providers who are up to date has proven logistically challenging. Currently,

most hospitals only require the initial vaccination series. Given the current workforce shortage, implementing additional requirements of the health care workforce will exacerbate this already challenging situation. Although this measure is not a mandate, it will impact how health care systems and providers approach vaccination requirements. It will especially discourage entry-level employees from working at hospitals when they can work in other industries without those requirements. For example, this requirement would likely have a negative impact on attracting environmental services and food service employees. **The AHA opposes the proposed modification to the COVID-19 vaccination among healthcare personnel measure and urges the CMS to not finalize the modified measure.**

High-Cost Outlier LTCH PPS Standard Federal Payment Rate

In addition to the market basket, quality reporting, and vaccination measure concerns expressed for hospitals, the AHA has significant concerns with High-Cost Outlier (HCO) cases that have high costs compared to typical discharges in our Long-Term Acute Hospitals. 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, which is a 150% increase. Such a threshold would result in severe restrictions in access for the most critically ill Medicare beneficiaries; it would be devastating to LTCHs' ability to care for the sickest of the sick, which is a patient population they take on at what is sometimes already a considerable financial loss. The AHA urges CMS to consider the alternatives for calculating the outlier threshold provided by the American Hospital Association in its June 9, 2023 letter.

Thank you, again, for the opportunity to comment on the Medicare FFY 2024 IPPS Proposed Rule. Please let me know how I can provide further information to you to help you as you move forward.

Sincerely,



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