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Advancing Health in America

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June 17, 2022

The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
Submitted electronically

Re: 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 2023 Rates; Quality Programs and Medicare Promoting Interoperability Program Requirements for Eligible Hospitals and Critical Access Hospitals; Costs Incurred for Qualified and Non Qualified Deferred Compensation Plans; and Changes to Hospital and Critical Access Hospital Conditions of Participation

Dear Administrator Brooks-LaSure:

On behalf of our nearly 5,000 member hospitals, health systems and other health care organizations, including approximately 300 long-term care hospitals (LTCH), and our clinician partners — more than 270,000 affiliated physicians, 2 million nurses and other caregivers — and the 43,000 health care leaders who belong to our professional membership groups, the American Hospital Association (AHA) appreciates the opportunity to comment on the fiscal year (FY) 2023 LTCH prospective payment system (PPS) proposed rule. We are submitting separate comments on the rule's inpatient PPS proposals.

We are concerned that CMS is proposing policies and payment adjustment that do not take into account the current the COVID-19 public health emergency (PHE) and its atypical market forces and pandemic-driven aberrations affecting the utilization and cost of providing LTCH services. Specifically, we are concerned by proposals for an inadequate market basket update and an untenable spike in the high-cost outlier threshold.

Proposed FY 2023 Payment Update Falls Short

For FY 2023, for cases paid a standard LTCH PPS rate, which comprise 72% of all cases and generally have higher acuity levels, CMS proposes a market basket update of 3.1%. This would be reduced by a productivity adjustment of 0.4 percentage points,

resulting in an update of 2.7%. This update, as well as the FY 2022 payment update of 2.6%, are woefully inadequate and do not capture the unprecedented inflationary environment LTCHs are experiencing. This is because the market basket is a time-lagged estimate that uses historical data to forecast into the future. **When historical data are no longer a good predictor of future changes, the market basket methodology becomes ineffective.** Indeed, using more recent data[1], the market basket for FY 2022 is trending toward 3.9%, well above the 2.6% LTCH PPS update that actually was implemented last year. Additionally, the latest data also indicate *decreases* in productivity, not gains.[2]

Therefore, because the statute provides CMS with LTCH PPS oversight authority broader than the level granted for other Medicare payment systems, we urge CMS to use this authority to 1) implement an adjustment for FY 2023 to account for the difference between the market basket update that was implemented for FY 2022 and what the market basket is currently projected to be for FY 2022; and 2) eliminate the productivity cut for FY 2023.

CMS has unique and extensive oversight authority of the LTCH PPS. In multiple rules over the years, the agency has cited its "broad authority under section 123 of the BBRA as amended by section 307(b)(1) of the BIPA to determine appropriate adjustments under the LTCH PPS, including whether (and how) to provide for adjustments to reflect variations in the necessary costs of treatment among LTCHs."[3] Indeed, Congress specifically granted CMS the statutory authority to make adjustments to the LTCH PPS. Section 123 of the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999 (BBRA), as amended by section 307(b)(1) of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000, states that "[t]he Secretary shall examine and may provide for appropriate adjustments to the long-term hospital payment system, including adjustments to DRG weights, area wage adjustments, geographic reclassification, outliers, updates, and a disproportionate share adjustment…"[4]

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[1] IHS Global, Inc.'s (IGI's) forecast of the IPPS market basket increase, which uses historical data through third quarter 2021 and fourth quarter 2021 forecast.
[2] "Productivity and Costs, First Quarter 2022, Preliminary - 2022 Q01 Results." U.S. Bureau of Labor Statistics. U.S. Bureau of Labor Statistics, May 5, 2022. https://www.bls.gov/news.release/pdf/prod2.pdf.
[3] RY 2008 LTCH PPS Final Rule, 72 Fed. Reg. 26870, 26900 (May 11, 2007); *also* RY 2006 LTCH PPS Final Rule, 70 Fed. Reg. 24168, 24199 (May 6, 2005) ("[W]e have broad authority under section 123 of Pub. L. 106-113, including whether (and how) to provide for adjustments to reflect variations in the necessary costs of treatment amount LTCHs").
[4] Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000, Pub. L. No. 106-554, § 307(b)(1), 114 Stat. 276 (2000) (emphasis added).

CMS has frequently used this authority to establish payment adjustment policies in the LTCH PPS, including to adjust for high-cost outliers,[5] short stay outliers,[6] and area wage levels.[7] In fact, this FY 2023 proposed rule cites the agency's "broad authority" for LTCH PPS payment adjustments to propose a 10% cap on MS-LTC-DRG relative weight decreases. **We urge CMS to use this same authority to support stability for the LTCH field as it continues to respond to the unusual and extreme circumstances wrought by the PHE; this is both appropriate and warranted.**

Context of the Inflationary Economy. The current inflationary economy combined with the COVID-19 crisis has put unprecedented pressure on America's hospitals and health systems. Health care providers remain on the front lines fighting this powerful virus, while at the same time struggling with persistently higher costs and additional downstream challenges that have emerged as a result of the lasting and durable impacts of high inflation and the pandemic. **We urge CMS to consider the changing health care system dynamics, including those described below, and their effects on hospitals. Taken together, these shifts in the health care environment are putting enormous strain on hospitals and health systems, which will continue in FY 2023 and beyond.**

Historic inflation has continued and heightened the severe economic instability that the pandemic wrought on hospitals and health systems. Specifically, high inflation began to take hold in the second half of CY 2021, with the consumer price index (CPI), a measure of general inflation, ultimately hitting its 12-month high in March 2022 at 8.5%.[8] Fannie Mae forecasts that inflation will remain elevated through at least the end of 2022, averaging 5.5% in the fourth quarter.[9] Because this high rate of inflation is not projected to abate in the near term, it is critical to account for it when considering hospital and health system financial stability in FY 2023 and beyond. As described in a report by FTI Consulting, which is attached to this letter, more recent inflationary pressures also are likely to work their way into wage expectations, particularly in industry sectors where labor is in short supply, thus driving up labor costs even further.

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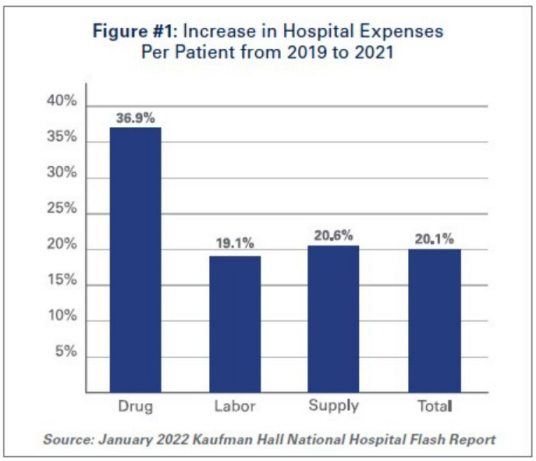
[5] FY 2015 IPPS/LTCH PPS, 79 Fed. Reg. 49854, 50398 (Aug. 22, 2014) ("Under the broad authority conferred upon the Secretary by section 123 of the BBRA as amended by section 307(b) of the BIPA, in the regulations at § 412.525(a), we established an adjustment for additional payments for outlier cases that have extraordinarily high costs relative to the costs of most discharges.").
[6] 70 Fed. Reg. at 24197.
[7] 79 Fed. Reg. at 50392 ("Under the authority of section 123 of the BBRA, as amended by section 307(b) of the BIPA, we established an adjustment to the LTCH PPS standard Federal rate to account for differences in LTCH area wage levels . . . .").
[8] U.S. Bureau of Labor Statistics. "Consumer Price Index Summary - 2022 M04 Results." May 11, 2022. https://www.bls.gov/news.release/cpi.nr0.htm; Statista. May 13, 2022. Monthly 12-month inflation rate in the United States from April 2021 to April 2022. https://www.statista.com/statistics/273418/unadjusted-monthly-inflation-rate-in-the-us/
[9] "Inflation Rate Signals Tighter Monetary Policy and Threatens 'Soft Landing'." Fannie Mae, April 19, 2022. https://www.fanniemae.com/research-and-insights/forecast/inflation-rate-signals-tighter-monetary-policy-and-threatens-soft-landing

Indeed, the financial pressures providers are experiencing are massive. Expenses continue to rise across the board; hospitals face increasing costs for labor, drugs, purchased services, personal protective equipment (PPE), and other medical and safety supplies needed to care for patients. Specifically, an April 2022 report by the AHA highlights the significant cost growth in hospital expenses across labor, drugs and supplies (as shown in the reproduced chart below), as well as the impact that rising inflation is having on hospital prices. By the end of calendar year 2021, total hospital expenses per adjusted discharge were up 20.1% compared to pre-pandemic levels in 2019.



One of our members reported that from the first quarter of calendar year 2019 to the first quarter of calendar year 2022, salaries across their LTCHs rose by 35 percent for registered nurses, 46 percent for nurse aides and 39 percent for respiratory therapists. Overall, their labor costs during this time period rose by 27 percent.

Another of our members reported similar numbers. Specifically, during the same time period, salaries rose by 56 percent for registered nurses, 39 percent for licensed practical nurses and certified nursing assistants, and 31 percent for respiratory therapist.

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 services more accurately reflect the cost of providing care.

Market Basket. CMS proposes a market basket update of 3.1%, reduced by a productivity adjustment of 0.4 percentage points, resulting in an update of 2.7% for FY 2023. These estimates were produced using historical data through the third quarter of calendar year (CY) 2021, forecast into the future. In a steady-state economy with small and stable changes in inflation and costs, it is possible to predict with some accuracy the anticipated rate of increase in the cost of goods and services to determine provider reimbursements. That is, the rationale for using historical data as the basis for a

forecast is reasonable in a typical economic environment. However, we are not in a typical economic environment. **The end of CY 2021 into CY 2022 should not, in any sense, be considered a steady-state economic environment that is a continuance of past trends. Relying on this timeframe results in a woefully inadequate market basket update that will exacerbate Medicare underpayment if not corrected.**

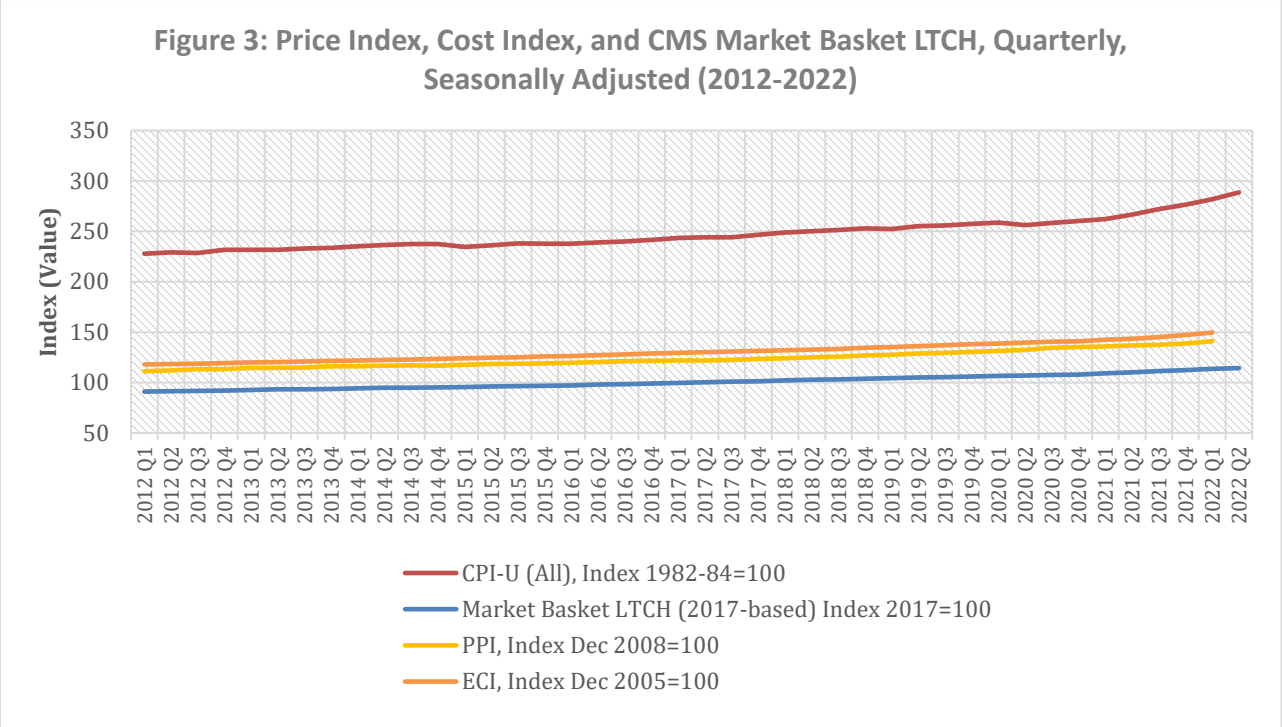
Specifically, the market basket is a time-lagged estimate that cannot fully account for unexpected changes that occur, such as historic inflation and increased labor and supply costs faced by the health care industry beginning in late CY 2021. For its FY 2022 final market basket update of 2.6%, CMS utilized estimates from historical data through the first quarter of CY 2021, forecast into the future. Because this market basket was a forecast of what was *expected* to occur, it missed the *unexpected* trends that actually did occur. For example, the inflation rate in March 2021 was 2.6%, but by December 2021 it skyrocketed to 7%.[10] Clearly, the FY 2022 market basket was unable to capture the extraordinarily high inflationary spikes that occurred towards the latter half of CY 2021.

The FY 2022 market basket also was unable to capture large increases in labor and wage costs, which also occurred towards the latter half of CY 2021. When we examine preliminary labor costs reported on the Medicare cost report, we find that contract labor costs increased by 55% and total labor expenses increased by nearly 8% for those cost reports ending between April 2021 – December 2021 compared to the year prior (those cost reports ending between April 2020 – March 2021).[11] Indeed, the FY 2022 market basket in the final rule missed these unexpected turns reflected in the data. Specifically, as more recent data becomes available beyond that used to forecast the FY 2022 market basket[12], the FY 2022 market basket is trending toward 3.9%, well above the 2.6% CMS actually implemented.

In addition to the fact that the market basket, by nature, largely misses unexpected trends, its construction dulls the impact of any unexpected spikes that occur. For instance, the market basket uses three price proxies to measure price changes over time – the Employment Cost Index (ECI), which measures changes in compensation costs; the Consumer Price Index (CPI), which measures changes in prices paid by consumers; and the Producer Price Index (PPI), which measures changes in price experienced by producers. The graph below, reproduced from the FTI report attached at the end of this letter, shows the three components that make up the market basket. In particular, CPI has a significantly steeper upward trend than is reflected in the market basket for LTCH services. This suggests that when the market basket captures shocks, it is much more muted than what hospitals and health systems actually experience in those shocks because it is a time-lagged rolling average estimate. Again, in a steady-

[10] https://www.statista.com/statistics/273418/unadjusted-monthly-inflation-rate-in-the-us/
[11] AHA analysis of hospital Medicare cost reports reported to the Healthcare Cost Report Information System (HCRIS).
[12] IHS Global, Inc.'s (IGI's) forecast of the IPPS market basket increase, which uses historical data through third quarter 2021 and fourth quarter 2021 forecast.

state economy with small and stable changes in inflation and costs, this may be a reasonable approach. However, in an atypical environment, such as the one we are currently in, payment updates must adequately account for these dynamic changes.



Given these extreme and uncontrollable circumstances, we strongly urge CMS to use its statutory authority over the LTCH PPS to implement an adjustment to account for the difference between the market basket adjustment that was implemented for FY 2022 and what the market basket is currently projected to be for FY 2022, and add that adjustment to the FY 2023 update. While this difference is currently 1.3% (3.9% minus 2.6%, as mentioned above), we ask that CMS use the most recent data available to re-calculate this adjustment and implement a corresponding adjustment to FY 2023 update in the final rule.

Productivity. Under the Affordable Care Act, the LTCH 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).[13] This measure was intended to ensure payments more accurately reflect the true cost of providing patient care. For FY 2023, CMS proposes a productivity cut of 0.4 percentage points.

[13] Centers for Medicare and 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

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. **Thus, this measure effectively assumes that LTCHs can mirror productivity gains across the private nonfarm business sector. However, in an economy marked by great uncertainty due to inflation as well as demand and supply shocks, this assumption generates significant departures from economic reality.**

In fact, CMS itself has acknowledged that hospitals are unable to achieve the productivity gains assumed by the general economy over the long run. Specifically, research indicates that hospitals can only achieve a productivity gain that is one-third of the gains seen in the private nonfarm business sector.[14] Thus, using the private nonfarm business sector TFP to adjust the market basket exacerbates Medicare underpayments to hospitals – particularly in a period of record inflation.

The use of an adjustment that is a 10-year moving average also negates year-to-year fluctuations that might occur. For example, over the last decade, there have been four quarters of productivity decreases. Two of these quarters occurred during the past 12 months – a 0.4 percent decline in the third quarter of calendar year 2021 and a 0.6 percent decline in the first quarter of calendar year 2022 . Two productivity declines in the last 12-month period is a material disruptor of the relatively steady-state increases in private, nonfarm productivity gains. Although the productivity adjustment uses a 10-year moving average, two quarter declines in 12 months in this metric is also noteworthy enough that it should be considered when deciding upon the appropriate productivity adjustment to implement for FY 2023.

In addition, whereas the private nonfarm business economy experienced a rapid increase in output and productivity gains when communities began emerging from COVID-19 lockdowns in late 2021, the same has not been true for hospital services. Generally, hospital services have not recovered to pre-pandemic levels,[15] and it is highly unlikely that hospitals have achieved the significant productivity gains incorporated into the proposed FY 2023 payment update. Specifically, Bureau of Labor Statistics data show that hospital employment levels have decreased by approximately 100,000 from pre-pandemic levels.[16]

Further, the combination of employee burnout and fewer available staff have forced hospitals to rely heavily on contract staff, especially contract nurses. The loss of

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[14] Centers for Medicare and 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

[15] Kaufman Hall (May 2022). National Hospital Flash Report. https://www.kaufmanhall.com/sites/default/files/2022-05/KH-NHFR-05-2022-May.pdf

[16] American Hospitals Association. (April 2022). Massive Growth in Expenses and Rising Inflation Fuel Continued Financial Challenges for America's Hospitals and Health Systems. https://www.aha.org/costsofcaring

established employees and the reliance on contract staffing firms to help address staffing shortages all echo our members' experiences related to declines in productivity during the pandemic, not gains. Indeed, an October 2021 survey conducted by Kaufman Hall found that many hospitals and health system leaders feel the COVID-19 pandemic made it significantly more difficult for them to improve their performance.[17]

The AHA has deep concerns about the proposed productivity cut, given the extreme and uncontrollable circumstances hospitals and health systems are currently operating in. As such, we ask CMS to use its existing statutory authority over the LTCH PPS to eliminate the proposed productivity cut for FY 2023. It is clear that significant uncertainty will continue to persist regarding the direction and magnitude of U.S. economic performance as inflationary pressures caused by multiple factors (such as fiscal and monetary policy, supply chain disruptions and the war in Ukraine) continue to affect productivity. This uncertainty, as well as the continued divergence in hospital productivity from overall private nonfarm business sector productivity, must be accounted for in the FY 2023 payment update.

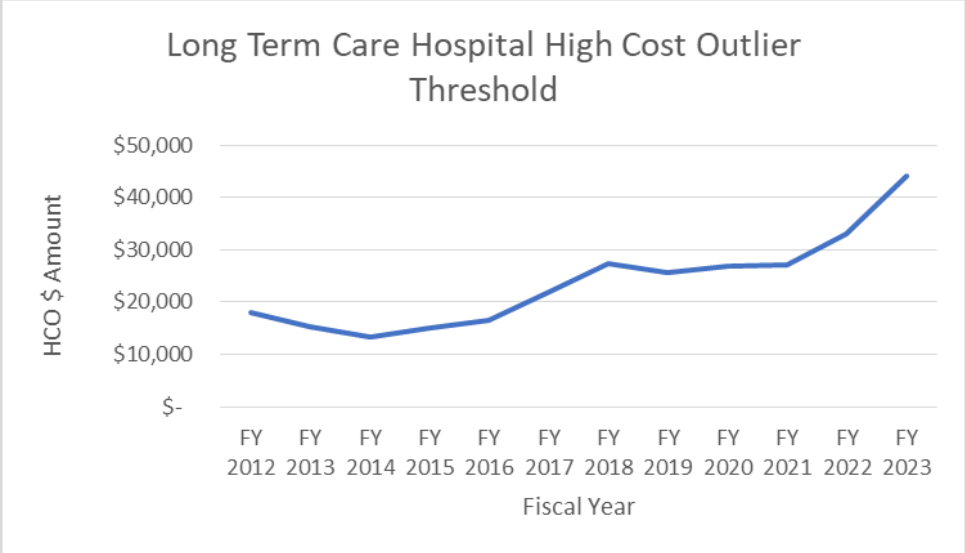
Proposed Update for High-cost Outliers (HCO)

The AHA is concerned about the dramatic scale of the proposed increase in the high-cost outlier threshold from $33,015 to $44,182 – a 34% increase. This increase would significantly decrease the number of cases that qualify for an outlier payment. The LTCH PPS outlier pool is set to equal 7.975% of total LTCH payments. CMS indicates that it is projecting FY 2022 outlier payments to total 9.7%, exceeding the threshold by approximately 1.7 percentage points. Thus, CMS suggests it needs to raise its projection for FY 2023 in order to bring HCO payments back down to 7.975%.

The outlier pool of 7.975% is larger than that of other Medicare fee-for-service payment systems in recognition of the higher acuity and higher resource needs of the LTCH patient population. It reflects the dual goals of allocating additional resources to high-need, higher-cost patients, without under-funding the remainder of LTCH cases. We understand and support this objective in general, and are concerned that finalizing the proposed threshold in FY 2023 would not be aligned with this goal. In fact, it would greatly exacerbate the financial pressures already felt by the LTCH field.

The chart below shows the outlier threshold over the past decade, with dramatic increases in the past two years.

[17] https://www.kaufmanhall.com/insights/research-report/2021-state-healthcare-performance-improvement-report-covid-creates



Source: FY 2013 – 2022 outlier thresholds as published in their respective final rules; FY 2023 outlier threshold as proposed.

Even more problematic is that in FY 2022, CMS implemented two technical changes to its HCO payment policy methodology to account for atypical PHE trends; these changes contributed to a 20% increase in the HCO threshold compared to the FY 2021 level. As such, the proposed 34% increase in the threshold for FY 2023 would build upon this 20% increase, yielding a staggering increase of more than 60% in two years. The scale of this change is of great concern. Increases of this magnitude would be very difficult to bear during typical times, and would be particularly onerous during the PHE. **To avoid underpayment for the sickest patients that would occur from this spike in the HCO threshold, we strongly urge CMS to explore ways to reduce the proposed fixed-loss threshold in FY 2023, even if such changes are only temporary.**

We appreciate that CMS has taken steps to avoid an even higher HCO threshold in FY 2023 by accounting for some of the pandemic-related factors that may have driven the increase, which are unlikely to fully apply in FY 2023. However, we ask CMS to examine its methodology more closely and consider making additional, temporary changes to help mitigate the substantial increases that are still occurring in the outlier threshold. For example, rather than using a 50/50 blend of COVID and non-COVID cases to determine the outlier threshold, a blend of 2019 and 2021 data may more accurately reflect the impact of the pandemic in FY 2023 on the outlier threshold.

Proposed Permanent Cap on Wage Index Decreases

In order to mitigate instability and increase predictability in LTCH PPS payments due to any significant wage index decreases, CMS proposes a permanent 5.0% cap on any decrease to a provider's wage index, relative to the prior year, regardless of the

circumstances causing the decline. CMS proposes that this permanent cap would be implemented in a budget-neutral manner. CMS would therefore account for this policy when calculating the area wage level budget neutrality factor. We agree that such a cap would help maintain stability for this payment system, and the others for which CMS also is proposing this cap. **Therefore, we support this proposed policy; however, we urge the agency to use its existing authority to implement the change in a non-budget-neutral manner. Only then would the proposed cap truly help stabilize hospital finances.**

MS-DRG Relative Weight Setting

CMS proposes to use FY 2021 claims and FY 2020 cost report data for FY 2023 rate-setting purposes. However, anticipating LTCH admissions for COVID-19 will continue in FY 2023, the agency is proposing several modifications to the usual rate-setting methodology to account for the continued effects of the pandemic. Specifically, CMS is proposing modifications to determine the MS-DRG weights for FY 2023 by averaging the relative weights as calculated with and without COVID-19 cases. For example, 50% of the relative weight calculation would come from all applicable cases and 50% would come from cases without COVID-19. CMS believes this approach would reduce, but not entirely remove, the effect of COVID-19 cases. Additionally, CMS also is proposing a permanent 10% cap on the reduction in a MS-DRG relative weight for a given fiscal year, which would be applied in a budget-neutral manner. **While we agree in general that such a cap would help maintain stability for this payment system, we ask that CMS share in the final rule an impact analysis of this proposed change as it pertains to high-volume versus low-volume MS-LTC-DRGs.** We are concerned that the proposed threshold is unlikely to be triggered by high-volume MS-LTC-DRGs. **As such, our support of this proposed threshold is contingent upon the agency using its existing authority to implement the change in a non-budget-neutral manner. If the agency were to essentially use payments for high-volume MS-LTC-DRGs to offset low-volume MS-LTC-DRGs that would trigger the proposed threshold, the proposed cap would not actually help stabilize hospital finances.**

Thank you for the opportunity to comment on this proposed rule. If you have questions please contact me or feel free to have a member of your team contact Rochelle Archuleta, AHA's director of policy, at rarchuleta@aha.org.

Sincerely,

/s/

Stacey Hughes
Executive Vice President for Government Relations and Public Policy

Enclosure: FTI Consulting Report, Assessing the Adequacy of Proposed Updates to the Hospital Inpatient Prospective Payment System

REPORT

Assessing the Adequacy of Proposed Updates to the Hospital Inpatient Prospective Payment System

Overview

On April 18, 2022, the Centers for Medicare & Medicaid Services (CMS) released its annual proposed rule for the fiscal year (FY) 2023 Inpatient Prospective Payment System (IPPS), projecting a market basket update of 3.1 percent, to be reduced by a 0.4 percent productivity adjustment.[1] This year marks the third consecutive rate setting period mired in pandemic-related uncertainty. While federal relief funding sustained hospitals and health systems through the initial waves of COVID-19, providers continue to grapple with myriad financial pressures, from supply chain disruptions to labor shortages to rising inflation. FTI Consulting's analysis finds that reliance on lagging indicators of hospital costs to determine prospective market basket and productivity adjustments in this highly dynamic and uncertain health care environment would likely result in significant underpayments to acute care hospitals in FY 2023.

[1] FY 2023 Hospital Inpatient Prospective Payment System (IPPS) and Long Term Care Hospitals (LTCH PPS) Proposed Rule - CMS-1771-P." CMS, April 18, 2022. https://www.cms.gov/newsroom/fact-sheets/fy-2023-hospital-inpatient-prospective-payment-system-ipps-and-long-term-care-hospitals-ltch-pps.

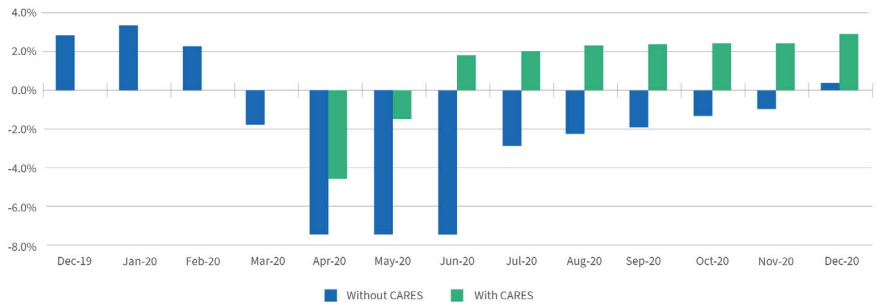
Background: Financial Condition of U.S. Hospitals

Impacts of COVID-19 Continue to Reverberate

The U.S. health care system has undergone a period of severe disruption in recent years driven by the COVID-19 pandemic and record-high inflation. In the early stages of the pandemic, hospitals curtailed elective procedures to free up capacity to care for COVID-19 patients while demand for emergency services dropped as a result of lockdowns.[2,3] Coupled with a rise in the number of uninsured patients, this dramatic decline in patient volume cut off many hospitals' most essential revenue streams,[4] just as the cost of providing care began to rise. Although Congress and the Biden Administration implemented numerous policies to lessen the adverse impact of the pandemic, including the creation of the Provider Relief Fund (PRF), which allocated over $170 billion to heath care providers,[5] financial challenges persist for many hospitals.

Though many hospitals have long struggled to stay afloat on narrow margins, the COVID-19 pandemic put additional, unforeseen strains on hospitals and health systems, particularly in rural and underserved areas. Skyrocketing expenses – driven by the rising cost of supplies, supply chain issues, and labor shortages – led to a 14.4 percent increase in labor expenses per adjusted discharge in 2020 compared to pre-pandemic levels.[6] As a result of this and other pandemic-related challenges, hospitals' median operating margins fell 55.6 percent in 2020 and have yet to fully recover (Figure 1).[7] More recently, during the peak of the Omicron surge in early 2022, government assistance to hospitals was insufficient to fully offset inflationary pressures, alongside continuing supply chain challenges, and widespread labor shortages that caused wage escalation, leaving many hospitals in the red.[8] In April 2022, total expenses and total labor expenses were 25.2 and 26.2 percent higher than 2020 levels, respectively.[9] As federal COVID-19 funds are depleted and inflationary pressures continue to escalate, hospitals are likely to remain embroiled in a precarious financial position throughout the remainder of 2022 and into FY 2023.

Figure 1: Kaufman Hall Operating Margin Index YTD by Month



Source: "National Hospital Flash Report: January 2021." Kaufman Hall, January 25, 2021.

[2] Mattingly, Aviva S., Liam Rose, Hyrum S. Eddington, Amber W. Trickey, Mark R. Cullen, Arden M. Morris, and Shery M. Wren. "Trends in US Surgical Procedures and Health Care System Response to Policies Curtailing Elective Surgical Operations During the COVID-19 Pandemic." JAMA Network Open. JAMA Network, December 8, 2021. https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2786935.

[3] Hartnett, Kathleen P., Aaron Kite-Powell, Jourdan DeVies, Michael A. Coletta, Tegan K. Boehmer, Jennifer Adjemian, and Adi V. Gundlapalli. "Impact of the COVID-19 Pandemic on Emergency Department Visits - United States, January 1, 2019–May 30, 2020." Centers for Disease Control and Prevention. Centers for Disease Control and Prevention, June 11, 2020. https://www.cdc.gov/mmwr/volumes/69/wr/mm6923e1.htm.

[4] Boserup, Brad, Mark McKenney, and Adel Elkbuli. "The Financial Strain Placed on America's Hospitals in the Wake of the COVID-19 Pandemic." The American Journal of Emergency Medicine. Elsevier Inc., July 2021. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7347328/#:~:text=The%20financial%20strain%20created%20by,the%20current%20surge%20in%20unemployment.

[5] Biniek, Jeannie Fuglesten, Nancy Ochieng, MaryBeth Musumeci, and Tricia Neuman. "Funding for Health Care Providers during the Pandemic: An Update." KFF, January 27, 2022. https://www.kff.org/coronavirus-covid-19/issue-brief/funding-for-health-care-providers-during-the-pandemic-an-update/.

[6] "National Hospital Flash Report: January 2021." Kaufman Hall, January 25, 2021. https://www.kaufmanhall.com/insights/research-report/national-hospital-flash-report-january-2021.

[7] "High Hospitalization Rates, Consumer Fears Hit Hospitals, Physician Groups Hard." Kaufman Hall, January 25, 2021. https://www.kaufmanhall.com/news/high-hospitalization-rates-consumer-fears-hit-hospitals-physician-groups-hard.

[8] Swanson, Erik. "National Hospital Flash Report: May 2022." Kaufman Hall, May 31, 2022. https://www.kaufmanhall.com/insights/research-report/national-hospital-flash-report-may-2022.

[9] Ibid.

Even setting aside pandemic-related pressures, Medicare has historically under-reimbursed hospitals for their services, putting them in a deficit position. Hospitals' aggregate Medicare margins have ranged from -5.4 percent to as low as -9.9 percent over the last decade according to the Medicare Payment Advisory Commission (MedPAC).[10,11] In its most recent report to Congress, MedPAC predicted that IPPS hospitals' Medicare margins will be around -9 percent in 2022 even after COVID-19 relief funds are factored in, and nearly -10 percent without COVID-19 relief.[12] These persistent negative margins in uncertain economic times demonstrate the importance of ensuring that adjustments to IPPS payment rates reflect the current financial reality faced by hospitals and health systems.

Macroeconomic-Level Factors

IPPS, which determines payments for acute care hospital inpatient stays under Medicare Part A, relies on lagging indicators of hospital costs to set reimbursements prospectively.[13] For example, the FY 2023 proposed payment adjustments incorporate FY 2021 Medicare Provider Analysis and Review (MedPAR) data, as well as FY 2020 Medicare Cost Reports, while relying upon a 2018-based market basket to determine cost and expenditure weights and the third quarter 2021 Employment Cost Index (ECI) to predict changes in the price proxies.[14] This results in a projected market basket update of 3.1 percent, which is then reduced by 0.4 percentage points to account for a productivity adjustment.[15] To the extent that historical data are good predictors of future changes in market basket components, it is reasonable from an economic perspective to use such historical data to calculate prospective Medicare rate changes. However, it is highly unlikely that the COVID-19 pandemic and the ensuing recovery period would in any sense be considered indicative of a steady-state economic environment. To that end, these lagging indicators and outdated data do not adequately capture and thereby cannot predict the significant disruptions created by the COVID-19 pandemic for hospitals, health systems, and other providers.

"To the extent that historical data are good predictors of future changes in market basket components, it is reasonable from an economic perspective to use such historical data to calculate prospective Medicare rate changes. However, it is highly unlikely that the COVID-19 pandemic and the ensuing recovery period would in any sense be considered indicative of a steady-state economic environment."

The demand and supply shocks experienced during the early years of the pandemic and continuing well into this year strongly indicate that great caution and consideration must be factored into calculating the market basket and productivity adjustments in setting prospective payment rates. In the FY 2023 IPPS proposed rule, price proxies in the market basket reflect IHS Global Inc.'s (IGI's) fourth quarter 2021 forecast, which is based on a four-quarter percentage change in the moving average. Although these adjustments are based on forecasts using the most recent data available at the time of the proposed rate setting, the results are released on a lagged basis, usually three to four months after preparation of the forecast. As such, they do not adequately account for recent economic trends that have significantly increased costs to hospitals, including labor and inflation.

Hospital Labor Costs and Workforce Shortages

Hospitals and health systems have been especially hard hit by the workforce shortages associated with the pandemic. The pandemic exacerbated existing shortages of physicians, nurses, and other hospital personnel by increasing competition for workers, as well as driving up the burnout rate among clinicians.[16] With hospital workers stretched to the limit due to the demand for hospital services and the burden of caring for severely ill patients in record numbers, widespread burnout placed enormous pressure on health

[10] "March 2021 Report to the Congress: Medicare Payment Policy." MedPAC, March 15, 2021. https://www.medpac.gov/document/march-2021-report-to-the-congress-medicare-payment-policy/.

[11] "March 2022 Report to the Congress: Medicare Payment Policy." MedPAC, March 15, 2022. https://www.medpac.gov/document/march-2022-report-to-the-congress-medicare-payment-policy/.

[12] Ibid.

[13] "FY 2023 Hospital Inpatient Prospective Payment System (IPPS) and Long Term Care Hospitals (LTCH PPS) Proposed Rule - CMS-1771-P." CMS, April 18, 2022. https://www.cms.gov/newsroom/fact-sheets/fy-2023-hospital-inpatient-prospective-payment-system-ipps-and-long-term-care-hospitals-ltch-pps.

[14] Ibid.

[15] Ibid.

[16] "Impact of the COVID-19 Pandemic on the Hospital and Outpatient Clinician Workforce." The Office of the Assistant Secretary for Planning and Evaluation (ASPE). Department of Health and Human Services, May 3, 2022. https://aspe.hhs.gov/sites/default/files/documents/9cc72124abd9ea25d58a22c7692dccb6/aspe-covid-workforce-report.pdf.

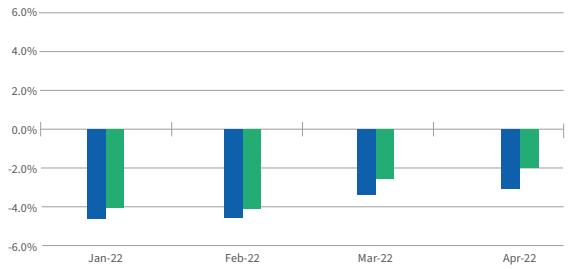
systems to pay more to attract and retain workers. That trend has yet to abate: a March 2022 report from Elsevier Health found that 47 percent of U.S. clinicians plan to leave their jobs in the next two to three years.[17]

Moreover, hospitals 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.[18] 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.[19] Median wages for contract nurses reached triple the median wages of employed nurses in March 2022.[20] Due to rising labor expenses coupled with only small increases in volume and revenue, hospitals saw large declines in operating margins in January through March 2022.[21]

Although the inflated wages and benefits offered by traveling and temporary staffing nursing agencies have somewhat moderated in recent months,[22] it is unlikely that the upward pressures on labor costs for hospitals will be mitigated anytime soon. An October 2021 survey by Kaufman Hall indicated that 92 percent of hospitals have experienced challenges in attracting and retaining support staff.[23]

Significant increases in hospitals' labor costs, coupled with workforce shortages, continue to place immense strain on the health care system. All told, as of March 2022, hospital labor expenses had increased by more than one-third relative to pre-pandemic levels.[24] Hospital financials for the first quarter of 2022 returned to worrisome levels due to the Omicron surge in early 2022 (Figure 2).[25] Inflationary pressures within the economy and fierce competition for health care workers will continue to put upward pressure on wages and benefits through 2022 and likely into 2023. Using data that typically lags two to four years to project labor costs in this uncertain economic environment will fail to account for the ongoing staffing challenges faced by acute care hospitals. CMS should recognize in its market basket adjustments how the understated market basket forecasts for 2021 and 2022 due to COVID-19 and inflation are embedded in payments, as well as how upward pressure on wages and benefits, and costs of supplies and pharmaceuticals, will likely be a mid- to long-term factor adversely affecting hospital operating costs and margins.

Figure 2: Kaufman Hall Operating Margin Index YTD by Month



Source: Swanson, Erik. "National Hospital Flash Report: May 2022." Kaufman Hall, May 31, 2022.

[17] "Clinician of the Future Report 2022." Elsevier, March 15, 2022. https://www.elsevier.com/__data/assets/pdf_file/0004/1242490/Clinician-of-the-future-report-online.pdf.

[18] Yang, Y. Tony, and Diana J. Mason. "Covid-19's Impact on Nursing Shortages, The Rise of Travel Nurses, And Price Gouging." Health Affairs, January 28, 2022. https://www.healthaffairs.org/do/10.1377/forefront.20220125.695159/.

[19] "The Financial Effects of Hospital Workforce Dislocation: A Special Workforce Edition of the National Hospital Flash Report." Kaufman Hall, May 11, 2022. https://www.kaufmanhall.com/insights/research-report/special-workforce-edition-national-hospital-flash-report.

[20] Ibid.

[21] Ibid.

[22] Norman, Hannah. "Travel Nurses Raced to Help during Covid. Now They're Facing Abrupt Cuts." NBCNews.com. NBCUniversal News Group, May 8, 2022. https://www.nbcnews.com/health/health-news/travel-nurses-raced-help-covid-now-facing-abrupt-cuts-rcna27716.

[23] "2021 State of Healthcare Performance Improvement Report: COVID Creates a Challenging Environment." Kaufman Hall, October 18, 2021. https://www.kaufmanhall.com/insights/research-report/2021-state-healthcare-performance-improvement-report-covid creates#:~:text=2021%20State%20of%20Healthcare%20Performance%20Improvement%20Report%3A%20COVID%20Creates%20a%20Challenging%20Environment,-October%2018%2C%202021&text=The%20COVID%2D19%20pandemic%20continues,health%20systems%20across%20the%20country.

[24] "The Financial Effects of Hospital Workforce Dislocation: A Special Workforce Edition of the National Hospital Flash Report." Kaufman Hall, May 11, 2022. https://www.kaufmanhall.com/insights/research-report/special-workforce-edition-national-hospital-flash-report.

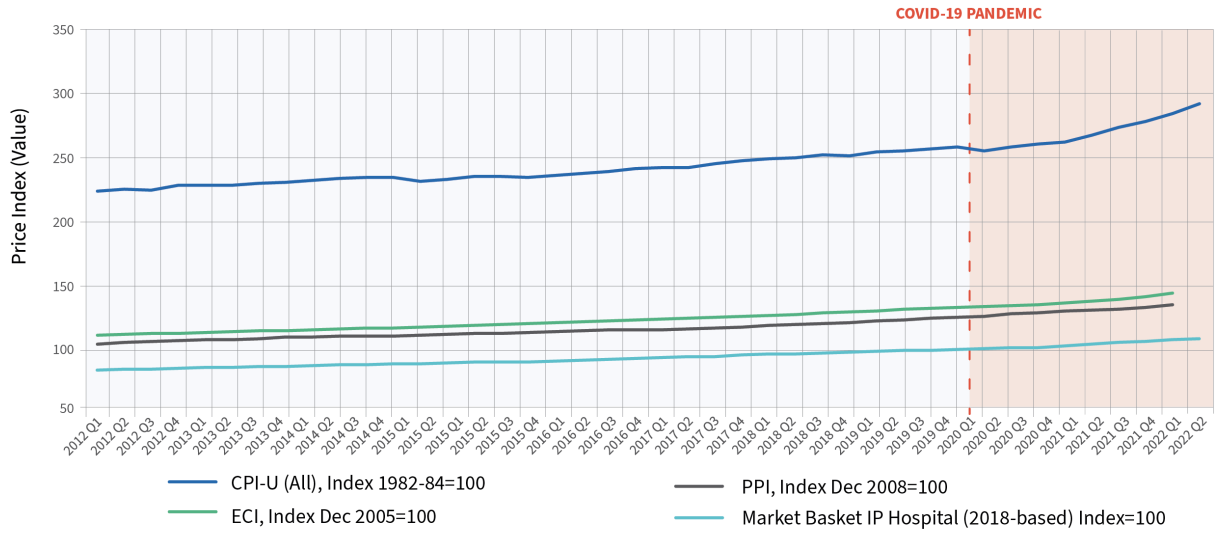
[25] Swanson, Erik. "National Hospital Flash Report: May 2022." Kaufman Hall, May 31, 2022. https://www.kaufmanhall.com/insights/research-report/national-hospital-flash-report-may-2022.

Current and Projected Inflation

In an era of historic inflation across the broader economy, the Altarum Institute notes that health care inflation hovers close to its historic average of two percent as a result of prospective rate-setting.[26] This contrasts sharply with the Consumer Price Index (CPI), a measure of general inflation, which hit 8.6 percent over the 12-month period ending in May 2022.[27] The differential exists because health care costs paid by consumers typically reflect rates negotiated in the year prior, rather than the actual cost of inputs borne by hospitals and health systems at the time of care delivery.[28]

In a steady state economy with small and stable changes in inflation and costs, it is possible to predict with some accuracy the anticipated rate of increase in the cost of goods and services to determine provider reimbursements. That is the rationale for using historical data and adjusting IPPS price proxies using the ECI, a measure of compensation costs, despite its reliance on lagging indicators. However, significant changes in the CPI, which measures changes in prices paid by consumers, and the Producer Price Index (PPI), which tracks changes in price experienced by producers, can have a major impact on wage and salary expectations that can feed into future changes to the ECI. Higher inflation can create upward pressure on wage expectations as workers seek an increase in wages to better meet the increasing cost of living. This can be exacerbated when labor is in short supply, as is currently the case in the hospital sector. Figure 3, below shows the major price indices relevant to understanding these inflationary pressures for hospital workers. These data reveal that – despite shocks in price indices over time – the market basket captures these in a muted way that is in stark contrast to what hospitals and health systems actually experience.

Figure 3: Price Index, Cost Index, and CMS Market Basket IP Hospital, Quarterly, Seasonally Adjusted (2012-2022)

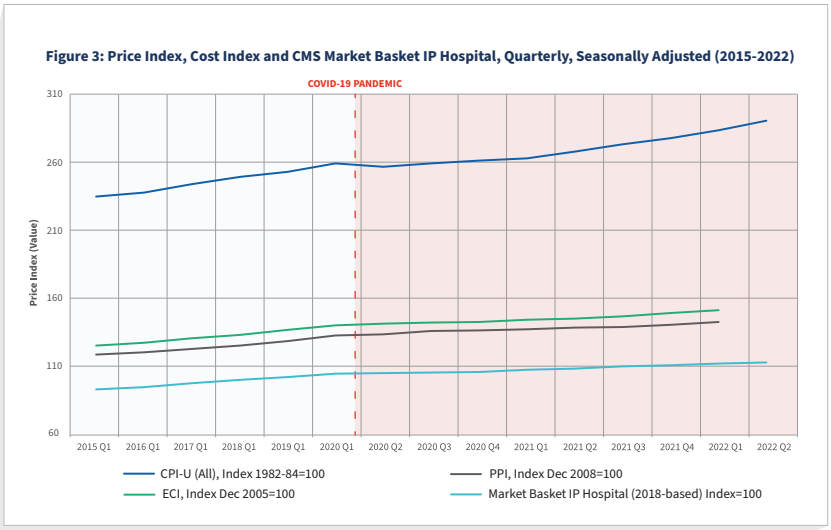


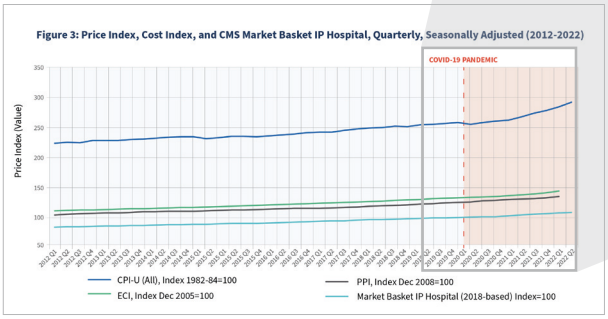
Source: Consumer Price Index (CPI) Databases, U.S. Bureau of Labor Statistics; Employment Cost Index (ECI), FRED, Federal Reserve Bank of St. Louis; Producer Price Index (PPI), FRED, Federal Reserve Bank of St. Louis; CMS Market Basket Index Levels, IHS Global Inc. (IGI) 2021q4 Forecast by CMS, OACT, National Health Statistics Group

[26] "Inflation Is Booming. Why Hasn't It Hit Health Care?" Advisory Board. Advisory Board, April 15, 2022. https://www.advisory.com/daily-briefing/2022/04/15/inflation-us.

[27] "Consumer Price Index Summary - 2022 M05 Results." U.S. Bureau of Labor Statistics. U.S. Bureau of Labor Statistics, June 10, 2022. https://www.bls.gov/news.release/cpi.nr0.htm.

[28] "Inflation Is Booming. Why Hasn't It Hit Health Care?" Advisory Board. Advisory Board, April 15, 2022. https://www.advisory.com/daily-briefing/2022/04/15/inflation-us.





Source: Consumer Price Index (CPI) Databases, U.S. Bureau of Labor Statistics; Employment Cost Index (ECI), FRED, Federal Reserve Bank of St. Louis; Producer Price Index (PPI), FRED, Federal Reserve Bank of St. Louis; CMS Market Basket Index Levels, IHS Global Inc. (IGI) 2021q4 Forecast by CMS, OACT, National Health Statistics Group

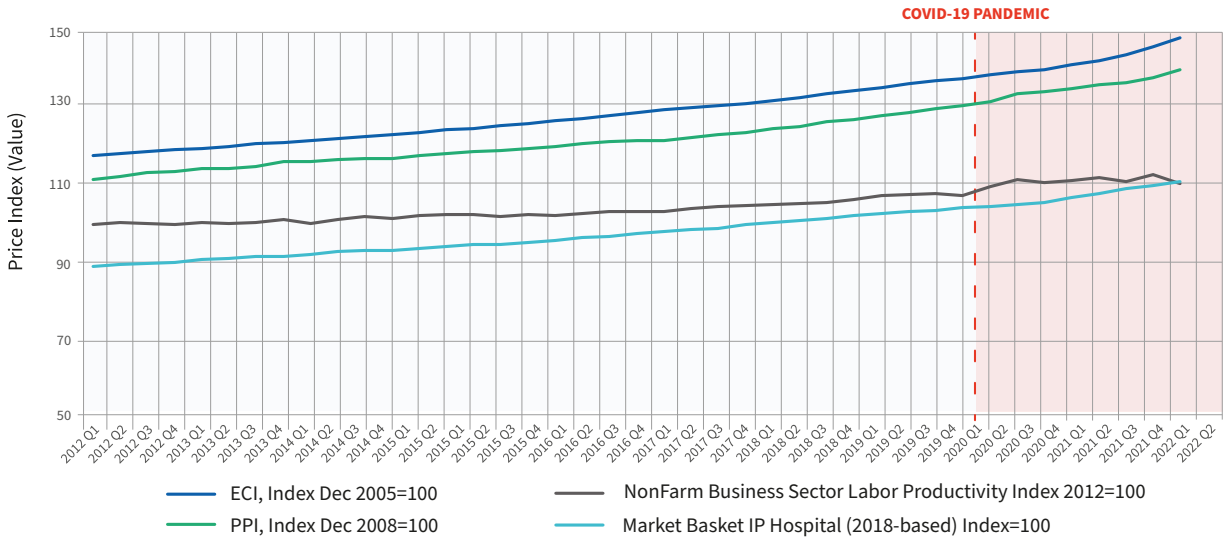
The CPI for All Urban Consumers (CPI-U) for all services shows a significantly steeper upward trend than is reflected in the market basket for inpatient hospital services. Since the start of the pandemic, this growth has exceeded growth in the Market Basket for Inpatient Hospital Services (Figure 3).[29] These more recent inflationary pressures are likely to work their way into wage expectations, particularly in industry sectors where labor is in short supply, thus driving up labor costs even further.

Using the third quarter 2021 data for market basket forecasting, as the FY 2023 IPPS Proposed Rule would do, risks capturing only the very beginning of this upward pressure on prices and wages in the economy (Figure 4).[30] Although the ECI has historically been fairly stable with annual growth rates ranging from a low of about 1.6 percent to a high of 2.8 percent just prior to the beginning of the pandemic, compensation costs have increased rapidly over the past year. From 2.6 percent in April 2021 to the most current estimate of 5.0 percent in January 2022, workers are commanding significantly higher wages. Historical data from the fourth quarter of 2021 misses this continuing upward trend in early 2022.

[29] Consumer Price Index (CPI) Databases, U.S. Bureau of Labor Statistics; Employment Cost Index (ECI), FRED, Federal Reserve Bank of St. Louis; Producer Price Index (PPI), FRED, Federal Reserve Bank of St. Louis; CMS Market Basket Index Levels, IHS Global Inc. (IGI) 2021q4 Forecast by CMS, OACT, National Health Statistics Group

[30] Employment Cost Index (ECI), FRED, Federal Reserve Bank of St. Louis; Producer Price Index (PPI), FRED, Federal Reserve Bank of St. Louis; NonFarm Business Sector Labor Productivity, FRED, Federal Reserve Bank of St. Louis; CMS Market Basket Index Levels, IHS Global Inc. (IGI) 2021q4 Forecast by CMS, OACT, National Health Statistics Group

Figure 4: Cost Index and CMS Market Basket IP Hospital, Quarterly, Seasonally Adjusted (2012-2022)



Source: Employment Cost Index (ECI), FRED, Federal Reserve Bank of St. Louis; Producer Price Index (PPI), FRED, Federal Reserve Bank of St. Louis; NonFarm Business Sector Labor Productivity, FRED, Federal Reserve Bank of St. Louis; CMS Market Basket Index Levels, IHS Global Inc. (IGI) 2021q4 Forecast by CMS, OACT, National Health Statistics Group

Although it may reach its peak in 2022, the high rate of inflation the U.S. economy is experiencing is not projected to abate in the near term, furthering the critical need to consider the likelihood that these inflationary pressures will factor into costs and wage expectations. Fannie Mae projects that inflation, as measured by the CPI, peaked in March 2022 at an annual rate of 8.5 percent, although month-to-month changes may continue.[31] Nonetheless, Fannie Mae forecasts inflation to remain elevated, averaging 5.5 percent in the fourth quarter of 2022.[32] With respect to ECI, the Congressional Budget Office (CBO) projects a 5.4 percent increase for 2022 and a 4.1 percent increase for 2023.[33] The CBO estimates the ECI increased 5.0 percent in 2021. The CBO's projections typically fall in the middle range of the likely outcomes under current law, suggesting the possibility that the actual increase in compensation costs could be even higher.[34]

Accounting for recent and future trends in inflationary pressures and cost increases in the Hospital Market Basket will be essential to ensuring that Medicare payments for acute care services in FY 2023 more accurately reflect the cost of providing hospital care.

[31] "Inflation Rate Signals Tighter Monetary Policy and Threatens 'Soft Landing'." Fannie Mae, April 19, 2022. https://www.fanniemae.com/research-and-insights/forecast/inflation-rate-signals-tighter-monetary-policy-and-threatens-soft-landing#:~:text=Inflation%2C%20as%20measured%20by%20the,and%20declines%20in%20auto%20and.

[32] Ibid.

[33] "The Budget and Economic Outlook: 2022 to 2032." Congressional Budget Office, May 25, 2022. https://www.cbo.gov/publication/58147.

[34] Ibid.

Productivity

Under the Affordable Care Act (ACA), CMS is required to annually adjust hospital payments under the IPPS to reflect anticipated gains in productivity over time.[35] The productivity adjustment is equal to the 10-year moving average of changes in the annual economy-wide, private nonfarm business total factor productivity (TFP).[36] The measure is intended to contain health care spending by ensuring payments more accurately reflect the true cost of providing hospital care. In the FY 2023 IPPS Proposed Rule, CMS proposes using IHS Global, Inc.'s (IGI's) fourth-quarter 2021 forecast of the IPPS market basket rate of increase, which uses data through third-quarter 2021.[37] This produces a projected productivity adjustment of 0.4 percentage points to the proposed FY 2023 market basket adjustment of 3.1 percent, reducing the update to 2.7 percent.[38,39]

The use of nonfarm business TFP by CMS in its productivity adjustment formula is meant to capture gains from new technologies, economies of scale, business acumen, managerial skills, and changes in production.[40] Using private nonfarm business TFP effectively assumes the hospital sector should be able to mirror productivity gains across the broad private nonfarm business sector. However, in an economy marked by great uncertainty in performance due to the demand and supply shocks of dealing with a public health crisis such as COVID-19, this assumption may generate significant departures from economic reality.

Basing the adjustment on a 10-year moving average of the change in TFP also mitigates large year-to-year fluctuations that might occur. Over the last decade, there have been only four periods of productivity decreases. Notably, two of the periods of decreased productivity occurred during the COVID-19 pandemic – a 0.4 percent decline in July 2021 and a 0.6 percent decline in January 2022.[41] Two productivity declines in the last 12-month period is a material disruptor of the relatively steady-state increases in private, nonfarm productivity gains. Although the productivity adjustment uses a 10-year moving average for private nonfarm business productivity gains, two declines in this productivity metric should be noteworthy when considering the appropriate payment updates in the FY 2023 IPPS.

CMS has acknowledged the disconnect between Medicare productivity and the 10-year moving average private nonfarm business TFP. A 2016 analysis by the CMS Office of the Actuary (OACT) found that the average growth rate of hospital multi-factor productivity (now referred to as TFP) ranged from 0.1 percent to 0.6 percent compared with the average growth of private nonfarm business multifactor productivity (MFP) of 1.0 percent.[42] More recent research cited in the CMS OACT analysis indicates that hospitals could achieve productivity gains of 0.4 percent per year over the long run compared with an assumed growth in private nonfarm business MFP of 1.1 percent, representing just over one-third (36.3 percent) of the gains in the private nonfarm business sector.[43] Particularly in a period of record inflation and unprecedented public health challenges, using the 10-year moving average nonfarm business sector TFP to adjust the market basket percentage increase could exacerbate Medicare underpayments to hospitals.

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[35] "Methodology for Projecting Total Factor Productivity for the Private Nonfarm Business Sector." CMS, March 2022. https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MedicareProgramRatesStats/Downloads/TFP_Methodology.pdf.

[36] "Compilation Of The Social Security Laws." Social Security Administration. Accessed June 1, 2022. https://www.ssa.gov/OP_Home/ssact/title18/1886.htm.

[37] "Methodology for Projecting Total Factor Productivity for the Private Nonfarm Business Sector." CMS, March 2022. https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MedicareProgramRatesStats/Downloads/TFP_Methodology.pdf.

[38] Total factor productivity is calculated as follows: *TFP growth = Output growth - [(labor input growth * labor share) + (capital input growth * capital share)].* This is a measure of changes in efficiency that cannot be accounted for by the change in total combined inputs (i.e., hours worked, capital and intermediate purchases).

[39] "FY 2023 Hospital Inpatient Prospective Payment System (IPPS) and Long Term Care Hospitals (LTCH PPS) Proposed Rule - CMS-1771-P." CMS, April 18, 2022. https://www.cms.gov/newsroom/fact-sheets/fy-2023-hospital-inpatient-prospective-payment-system-ipps-and-long-term-care-hospitals-ltch-pps.

[40] Methodology for Projecting Total Factor Productivity for the Private Nonfarm Business Sector." CMS, March 2022. https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MedicareProgramRatesStats/Downloads/TFP_Methodology.pdf.

[41] "Methodology for Projecting Total Factor Productivity for the Private Nonfarm Business Sector." CMS, March 2022. https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MedicareProgramRatesStats/Downloads/TFP_Methodology.pdf.

[42] Spitalnic, Paul, Stephen Heffler, Bridget Dickensheets, and Mollie Knight. "Hospital Multifactor Productivity: An Updated Presentation of Two Methodologies." CMS, February 22, 2016. https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/ReportsTrustFunds/Downloads/ProductivityMemo2016.pdf.

[43] Ibid.

The COVID-19 pandemic continues to negatively affect hospital services, unlike other areas of private nonfarm business economy. Whereas the private nonfarm business economy experienced a rapid increase in output and productivity gains when communities began emerging from COVID-19 lockdowns in late 2021, the same has not been true for hospital services.[44] Generally, hospital services have been slower to return to pre-pandemic levels,[45] and it is highly unlikely that hospitals have achieved the significant productivity gains incorporated into the FY 2023 IPPS prospective rate adjustments. An October 2021 survey conducted by Kaufman Hall found that many hospitals and health system leaders feel the COVID-19 pandemic made it significantly more difficult for them to improve their performance.[46]

CMS currently relies on the most recent TFP forecast available even when economic trends, such as employment and labor productivity, are uncertain or highly variable. Recently, the COVID-19 pandemic, along with the trillions of dollars in relief funds appropriated in response, injected significant volatility into the U.S. economy. This in turn exacerbated the disconnect between projections used in the proposed rules and the most recent data available prior to finalizing the IPPS productivity adjustment. For example, in FY 2021, CMS initially proposed a negative productivity adjustment of .4 percent to the IPPS market basket,[47] which was ultimately set to zero in the final rule.[48]

According to the Bureau of Labor and Statics' (BLS) most recent release on TFP, nonfarm business sector labor productivity decreased 7.3 percent in the first quarter of 2022 as output decreased 2.3 percent and hours worked increased 5.4 percent.[49] This represents the largest decline in quarterly productivity since the third quarter of 1947.[50] This decrease in TFP is more akin to FY 2021 productivity adjustments where a decrease in productivity of 0.1 percent points resulted in a zero productivity adjustment.[51] Here, if the decrease in productivity continues into the second quarter, we should expect to see a significant reduction in the productivity adjustment, possibly even a zero productivity adjustment. It is important to note that the FY 2021 zero adjustment is based on a forecast of a 0.1 percentage point decline in TFP that pales in comparison to the most recent productivity declines.

Significant uncertainty will persist into the first half of 2023, and likely beyond, regarding the direction and magnitude of U.S. economic performance as inflationary pressures caused by multiple factors (such as fiscal and monetary policy, supply chain disruptions, and the war in Ukraine) have affected productivity. This uncertainty, as well as the likely greater divergence of hospital services productivity from overall private nonfarm business sector productivity, should be considered in settling on a productivity adjustment for FY 2023.

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[44] "Employment Recovery Continues In 2021, With Some Industries Reaching or Exceeding Their Prepandemic Employment Levels." U.S. Bureau of Labor Statistics, May 2022. https://www.bls.gov/opub/mlr/2022/article/employment-recovery-continues-in-2021.htm.

[45] Swanson, Erik. "National Hospital Flash Report: May 2022." Kaufman Hall, May 31, 2022. https://www.kaufmanhall.com/insights/research-report/national-hospital-flash-report-may-2022.

[46] "2021 State of Healthcare Performance Improvement Report: COVID Creates a Challenging Environment." Kaufman Hall, October 18, 2021. https://www.kaufmanhall.com/insights/research-report/2021-state-healthcare-performance-improvement-report-covid-creates#:~:text=2021%20State%20of%20Healthcare%20Performance%20Improvement%20Report%3A%20COVID%20Creates%20a%20Challenging%20Environment,-October%2018%2C%202021&text=The%20COVID%2D19%20pandemic%20continues,health%20systems%20across%20the%20country.

[47] "Fiscal Year (FY) 2021 Medicare Hospital Inpatient Prospective Payment System (IPPS) and Long Term Acute Care Hospital (LTCH) Proposed Rule (CMS-1735-P), CMS, May 11, 2020. https://www.cms.gov/newsroom/fact-sheets/fiscal-year-fy-2021-medicare-hospital-inpatient-prospective-payment-system-ipps-and-long-term-acute.

[48] "Fiscal Year (FY) 2021 Medicare Hospital Inpatient Prospective Payment System (IPPS) and Long Term Acute Care Hospital (LTCH) Final Rule (CMS-1735-F)." CMS, September 2, 2020. https://www.cms.gov/newsroom/fact-sheets/fiscal-year-fy-2021-medicare-hospital-inpatient-prospective-payment-system-ipps-and-long-term-acute-0.

[49] "Productivity and Costs, First Quarter 2022, Revised." U.S. Bureau of Labor Statistics. U.S. Bureau of Labor Statistics, May 5, 2022. https://www.bls.gov/news.release/pdf/prod2.pdf.

[50] Ibid.

[51] FY 2022 IPPS productivity adjustment was proposed at 0.2 percentage points based on IGI's fourth quarter 2021 forecast of TFP but IGI's second quarter 2021 forecast reflected a significant change in the estimate to 0.4 percentage points for FY 2022. The FY 2021 productivity adjustment proposed was 0.4 percentage points using IGI's fourth quarter 2019 forecast. More recent data based on IGI's June 2020 forecast indicated a -0.1 percentage point growth for FY 2021. As section 1886(b)(3)(B)(xi)(I) of the Act requires a reduction not an increase for the productivity adjustment, the adjustment was set to zero.

Conclusion: Current Economic Realities Are Not Reflected in Proposed IPPS Update, Put Hospitals' Financial Viability at Risk

As CMS prepares to finalize the FY 2023 IPPS and LTCH PPS Rule – as well as Fiscal Year 2023 Inpatient Rehabilitation Facility (IRF), Inpatient Psychiatric Facility (IPF), and Medicare Hospital Outpatient Prospective Payment System (PPS) Final Rules – considering the ongoing impacts of COVID-19 and recent inflationary pressures will be essential to ensuring the stability and resiliency of the health care system as it emerges from a global pandemic. Hospital operating margins in 2022 reveal the adverse impact of higher costs and a change in the mix of resources needed to respond to new surges and new COVID-19 variants. The proposed FY 2023 IPPS rate adjustment effectively attempts to return to the steady-state lagged adjustment methodology used prior to the pandemic without fully accounting for dynamics like the continuing effects of wage and inflationary pressures. Given the long history of Medicare underpayments, the failure to account for these pressures in the latest IPPS rule will likely exacerbate the deficit in Medicare funding that hospitals already experience and create further challenges for our hospitals and health system, at a time when they remain vulnerable to financial distress.

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